United States Department of Labor
Employees' Compensation Appeals Board

D.L., Appellant	)	
and	)	**Docket No. 07-2238**
	)	**Issued: April 16, 2008**
U.S. POSTAL SERVICE, POST OFFICE, Santa Maria, CA, Employer	)	

Appearances:
Martin Kaplan, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 4, 2007 appellant filed a timely appeal from decisions of the Office of Workers' Compensation Programs dated September 11, 2006 and August 9, 2007, which denied her claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the appeal.

ISSUE

The issue is whether appellant met her burden of proof to establish that she has a shoulder or neck condition causally related to factors of her federal employment.

FACTUAL HISTORY

On January 19, 2005 appellant, then a 43-year-old letter carrier who had stopped work on November 17, 2003, filed a Form CA-2, occupational disease claim, alleging that factors of her

federal employment caused bilateral shoulder and neck conditions.[1] In support of her claim, she submitted reports from Dr. Michael J. Behrman, Board-certified in orthopedic surgery, dated August 21, 2003 to January 17, 2005.[2] On August 21, 2003 Dr. Behrman noted appellant's complaints of numbness and tingling in both hands and pain radiating from both hands to the shoulders. He provided physical findings and diagnosed bilateral flexor tenosynovitis with bilateral carpal tunnel syndrome and probable bilateral ulnar neuropathies at the elbows. Dr. Behrman opined that appellant had suffered significant cumulative trauma from her federal employment. He performed right carpal tunnel release on November 10, 2003 and left carpal tunnel release on March 8, 2004.

On June 9, 2004 Dr. Francis P. Lagattuta, a Board-certified physiatrist, advised that appellant had a normal cervical and right upper extremity electromyogram (EMG) and nerve conduction study (NCS). By report dated June 24, 2004, Dr. Behrman noted that appellant reported continued pain in her right elbow radiating into her right shoulder and diagnosed right shoulder pain with impingement and right medial epicondylitis. In reports dated August 23 and October 28, 2004, he noted appellant's complaint of worsening right shoulder pain. Physical examination demonstrated right shoulder tenderness with a positive impingement sign.

Magnetic resonance imaging (MRI) scan of the right shoulder on November 23, 2004 demonstrated minimal tendinopathy/bursal surface partial tear of the infraspinatus tendon near the critical area with mildly unfavorable acromioclavicular (AC) joint and acromial morphology, no evidence of a full-thickness tear or retraction and a normal appearing glenohumeral joint and labrum. On November 29, 2004 under file number 132082617, the Office referred appellant to Dr. Margaret Elfering, Board-certified in orthopedic surgery, for a second opinion evaluation.

On December 10, 2004 Dr. Behrman reiterated that appellant had pain and numbness in both hands extending to the shoulders due to repetitive movement in her hands and shoulders while at work. On December 13, 2004 he advised that her right shoulder pain had not improved and noted examination findings of tenderness in the anterior aspect of the right shoulder and a positive impingement sign on the right. Dr. Behrman diagnosed right shoulder impingement with partial thickness rotator cuff tear and advised that appellant was disabled due to rotator cuff tendinopathy and ulnar nerve compression.

By report dated December 13, 2004, Dr. Elfering noted her review of the medical record and appellant's complaints of right shoulder and cervical spine pain. Physical examination demonstrated normal cervical spine and shoulder range of motion and 5/5 shoulder strength. Dr. Elfering diagnosed bilateral carpal tunnel syndrome, post release, right medial epicondylitis and right rotator cuff tear, per history. In a work capacity evaluation dated December 28, 2004, she advised that appellant could not perform her usual job duties due to her shoulder and

[1] Under Office file number 132082617 appellant was receiving wage-loss compensation for accepted bilateral carpal tunnel and right medial epicondylitis conditions. The instant case was adjudicated under file number 132124084. The record before the Board contains both case files.

[2] Under the instant claim, file number 132124084, appellant also submitted a statement and medical evidence regarding her previous claim, file number 132082617. Under that claim, on March 30, 2006 she received a schedule award for an 11 percent impairment of the right upper extremity and an 11 percent impairment of the left upper extremity.

provided permanent restrictions that appellant could perform no heavy lifting or work above shoulder height.

In a statement dated February 14, 2005, appellant reported that, between the time she filed her carpal tunnel claim in May 2003 and her first visit with Dr. Behrman in August 2003, the tingling, numbness and pain increased dramatically and moved upward from her right and left hands to her elbows, shoulders and neck. From May to November 2003 she continued to work regular letter carrier duties, which she described, for six days, 56 hours a week.

By letter dated March 4, 2005, the Office informed appellant of the evidence needed to develop the claim. It asked Dr. Behrman to provide information regarding appellant's claimed right shoulder and neck conditions. In a March 12, 2005 response, appellant stated that her upper extremity pain that began in 2003 had worsened. She and attributed her shoulder and neck condition to her letter carrier duties.

In a report dated March 14, 2005, Dr. Behrman described his August 2003 findings regarding appellant's carpal tunnel and elbow conditions. With regard to the right shoulder, he stated that this was a compensatory condition that occurred because she held her arm in an internally rotated position due to pain in the elbows and hands. In turn this led to irritation and inflammation of the rotator cuff. He stated that this was known as shoulder/hand syndrome and was not an unusual occurrence. Dr. Barry J. Ross, a Board-certified physiatrist, performed physical examination and a right upper extremity EMG on April 7, 2005. This demonstrated electrodiagnostic evidence consistent with mild ulnar neuropathy at the wrist consistent with compression at the Guyon canal. By report dated April 21, 2005, Dr. Behrman noted appellant's medical history, reiterating that she developed a right shoulder impingement syndrome due to alterations in the use of the right upper extremity. He noted appellant's current complaints of bilateral hand and elbow pain and right shoulder pain and provided physical findings, noting that bilateral shoulder range of motion was normal and diagnosed status post bilateral carpal tunnel releases, clinical evidence of bilateral ulnar nerve compression at the elbows, electrodiagnostic evidence of right ulnar nerve compression at the wrist and right shoulder impingement, all of which were employment related. Dr. Behrman provided an impairment rating and advised that appellant could not return to her usual occupation and might need subacromial decompression on the right in the future. He continued to advise that appellant was totally disabled due to impingement and medial epicondylitis.

On June 15, 2005 under file number 132124048, the Office referred appellant to Dr. Alice M. Martinson, a Board-certified orthopedic surgeon, for a second opinion evaluation.[3] On June 20, 2005 Dr. Behrman approved a job offer as a full-time modified lobby director. Appellant returned to work on July 6, 2005 at this position. An August 18, 2005 EMG and NCS was interpreted by Dr. Ross as normal with no evidence of carpal tunnel syndrome, ulnar or median neuropathy, brachial plexus injury, cervical radiculopathy or myopathy.

[3] The statement of accepted facts provided to Dr. Martinson indicated that the claim was for right shoulder and right elbow conditions. The questions provided to the physician, however, asked for an opinion regarding right elbow, right shoulder and cervical conditions.

In a report dated September 7, 2005, Dr. Martinson noted the history of injury, her review of the medical record and appellant's past medical history, including that she had sustained burns over 40 percent of her body surface including the arms and chest in a boat fire. Examination of the right shoulder demonstrated 160 degrees of flexion and abduction in comparison to 170 degrees on the left with mild discomfort but no weakness found with resisted abduction and external rotation of the right shoulder. The right AC joint was somewhat prominent with tenderness to direct pressure over the distal clavicle. Dr. Martinson noted her review of the November 14, 2004 MRI scan of the right shoulder, advising that this demonstrated no significant abnormalities but some hypertrophic arthropathy of the AC joint. Her diagnoses included mild right AC arthritis. Dr. Martinson opined: "while her mild AC arthritis could certainly have become somewhat symptomatic in the context of her personal employment, there is nothing about the characteristics of her job or any specific history of injury, which was the direct cause of that condition." In an attached work capacity evaluation, she advised that appellant could not work as a letter carrier but could perform the duties of lobby director with permanent restrictions of no reaching above the shoulder, repetitive movements of the wrists and elbows, no pushing or pulling and 10-pound lifting restriction.

By decision dated October 20, 2005, the Office found that appellant's cervical and shoulder conditions were not related to her federal employment.

On February 15, 2006 appellant, through her attorney, requested reconsideration. By report dated December 20, 2005, Dr. Ross diagnosed chronic upper limb pain syndrome.

In a March 15, 2006 decision, the Office denied modification of the October 20, 2005 decision.

On June 5, 2006 appellant, through her attorney, requested reconsideration. In a May 9, 2006 report, Dr. Christopher S. Proctor, a Board-certified orthopedic surgeon, who advised that he had reviewed Dr. Martinson's report and the November 23, 2004 right shoulder MRI scan. He noted that appellant had right shoulder surgery on April 11, 2006 which found impingement with AC joint arthrosis and labral degeneration and tearing. Dr. Proctor noted Dr. Martinson's conclusion that appellant's AC joint arthritis was not caused or aggravated by work. However, he stated that Dr. Martinson did not discuss appellant's impingement syndrome/rotator cuff tendinosis or partial thickness rotator cuff tear which he opined had a significant contribution from appellant's work duties, specifically the repetitive reaching and motion activities required of her normal job.

By decision dated September 11, 2006, the Office denied modification of the March 15, 2006 decision. The Office noted that, because appellant was claiming a combination of factors, both consequential and employment related, in file number 132124084 claim, the medical evidence in claim file number 132082617 was reviewed and that medical evidence under the latter claim was provided to Dr. Martinson.

On May 18, 2007 appellant's attorney requested reconsideration. In a May 7, 2007 report, Dr. Proctor opined that there was a conflict in medical opinion between himself and Dr. Martinson. He stated that he had examined appellant multiple times with findings of a positive impingement sign, AC joint tenderness and a positive adduction test which, consistent

with and supported by MRI scan findings. Dr. Proctor opined that appellant's shoulder condition was due to the repetitive activities of her job duties which, along with AC joint arthrosis, caused an impingement syndrome, and confirmed by the surgery he performed.

In a merit decision dated August 9, 2007, the Office denied modification of the September 11, 2006 decisions.

LEGAL PRECEDENT

An employee seeking benefits under the Federal Employees' Compensation Act[4] has the burden of establishing the essential elements of his or her claim including the fact that the individual is an employee of the United States within the meaning of the Act, that the claim was timely filed within the applicable time limitation period of the Act, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury. Regardless of whether the asserted claim involves traumatic injury or occupational disease, an employee must satisfy this burden of proof.[5]

Office regulations define the term "occupational disease or illness" as a condition produced by the work environment over a period longer than a single workday or shift."[6] To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant. The medical opinion must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[7]

In discussing the range of compensable consequences, once the primary injury is causally connected with the employment, Larson notes that, when the question is whether compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury, the rules that come into play are essentially based upon the concepts of direct and natural results and of claimant's own conduct as an independent intervening cause. The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.[8]

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[4] 5 U.S.C. §§ 8101-8193.

[5] *Gary J. Watling*, 52 ECAB 278 (2001).

[6] 20 C.F.R. § 10.5(ee).

[7] *Solomon Polen*, 51 ECAB 341 (2000).

[8] Larson, *The Law of Workers' Compensation* § 1300; *see Charles W. Downey*, 54 ECAB 421 (2003).

Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[9] Rationalized medical evidence is medical evidence which includes a physician's rationalized medical opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[10] Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[11]

ANALYSIS

The Office accepted that appellant sustained employment-related bilateral carpal tunnel syndrome and right medical epicondylitis under file number 132082617. She filed the instant claim for a shoulder and neck conditions in January 2005. Appellant did not work from November 2003, when she had her initial carpal tunnel surgical procedure, until her return to a lobby director position on July 6, 2005.

The Board finds that appellant has not established that she sustained a cervical or left shoulder condition causally related to factors of her federal employment. The only medical reports that discuss a cervical condition include the June 9, 2004 report of Dr. Lagattuta who advised that appellant had a normal cervical EMG and NCS. In a December 13, 2004 report, Dr. Elfering noted appellant's complaint of cervical pain and found normal cervical range of motion. She did not diagnose any cervical condition. An August 18, 2005 EMG demonstrated no cervical pathology. The Board finds there is insufficient medical evidence of record to establish a cervical condition due to appellant's federal employment while appellant complained of bilateral shoulder pain, the record is silent regarding a diagnosed left shoulder condition. Appellant has not established a cervical or left shoulder condition. She did not meet her burden of proof to establish that these conditions were caused by factors of her federal employment.[12]

The Board, however, finds that the case is not in posture for decision regarding her right shoulder condition. The medical evidence is generally supportive of the contention that her right shoulder condition was employment related. In August 2003, Dr. Behrman noted appellant's complaint of hand pain radiating to her shoulders and opined that she had suffered significant cumulative trauma in her federal employment. He performed carpal tunnel releases in November 2003 and March 2004 and noted her complaints of right shoulder pain and tenderness on examination. While physical examination demonstrated normal shoulder range of motion, in October 2004 Dr. Behrman advised that examination demonstrated a positive impingement sign.

[9] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[10] *Id.*

[11] *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

[12] *Solomon Polen*, *supra* note 7.

A November 23, 2004 MRI scan of the right shoulder demonstrated a minimal tendinopathy/bursal surface partial tear of the infraspinatus tendon near the critical area with mildly unfavorable AC joint and acromial morphology with no evidence of a full-thickness tear or retraction and a normal appearing glenohumeral joint and labrum. In reports dated March 14 and April 21, 2005, Dr. Behrman opined that appellant's right shoulder impingement syndrome was due to alterations in the use of her right upper extremity that occurred because she held her arm in an internally rotated position due to pain in the elbows and hands which led to irritation and inflammation of the rotator cuff. He stated that this was known as shoulder/hand syndrome and was not an unusual occurrence related to her work activities. In his May 2006 and May 2007 reports, Dr. Proctor noted that he had examined appellant multiple times and performed shoulder surgery on appellant in April 2006. At surgery, he found impingement with AC joint arthrosis and labral degeneration and tearing. Dr. Proctor opined that, in all medical probability, her work duties had significantly contributed to her right shoulder condition, specifically the repetitive reaching and motion activities required of her normal job.

Dr. Martinson provided a second opinion evaluation. She advised that appellant had minimally decreased right shoulder flexion and tenderness on examination of the AC joint but no weakness. A November 2004 MRI scan demonstrated no significant abnormalities but some hypertrophic arthropathy of the AC joint. Dr. Martinson and diagnosed mild right AC arthritis. He stated: "while her mild AC arthritis could certainly have become somewhat symptomatic in the context of her personal employment, there is nothing about the characteristics of her job or any specific history of injury, which was the direct cause of that condition."

When the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless the worsening is due to an independent intervening cause. The basic rule is that a subsequent injury whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.[13] Dr. Behrman and Dr. Proctor were consistent in their opinions that appellant's right shoulder condition was aggravated by her work as a letter carrier and to the alteration in posture and use of her right upper extremity. Furthermore, Dr. Martinson did not rule out the possibility that appellant's right shoulder condition was aggravated by employment factors. She rated that appellant's AC arthritis could have become symptomatic in the context of her employment but she expressed no specific knowledge regarding the physical activities performed by a letter carrier.

The Board has stated that, when the Office selects a physician for an opinion on causal relationship, it has an obligation to secure, if necessary, clarification of the physician's report and to have a proper evaluation made. Where, as here, the Office referred a claimant for a second opinion physician and the report did not adequately address the relevant issues, the Office should secure a report on the relevant issues.[14] As the Office undertook development of the medical evidence regarding appellant's right shoulder by referring her to a second opinion physician, it should secure a report adequately addressing the relevant issue of whether this condition was

[13] Larson, *The Law of Workers' Compensation* § 10.01 (December 2000); *see Charles W. Downey*, 54 ECAB 421 (2003).

[14] *Peter C. Belkind*, 56 ECAB 580 (2005).

caused or aggravated by employment factors. The Office should secure clarification from Dr. Martinson on whether appellant's right shoulder condition was a consequence of her accepted bilateral carpal tunnel syndrome and right epicondylitis conditions or aggravated by her federal employment duties. The case will be remanded to the Office.

The Office's procedures provide that cases should be doubled if a new injury is reported for an employee with a claim for the same part of the body.[15] In this case, appellant filed a claim for a right shoulder injury in January 2005, adjudicated by the Office under file number 132124084 and has an accepted claim for bilateral carpal tunnel syndrome and right medial epicondylitis, adjudicated under file number 132082617. Examination of the record, shows that the medical evidence for both claims is intermixed with some evidence pertaining to appellant's right shoulder found only in the 132082617 file. On remand, the cases should be doubled. After such further development as the Office deems necessary, the Office shall issue an appropriate decision.

CONCLUSION

The Board finds that appellant failed to meet her burden of proof to establish that she sustained an employment-related cervical or left shoulder condition. The case is not in posture for decision regarding whether she sustained an employment-related right shoulder condition. The case is remanded for further development of the medical evidence.

[15] Office (FECA) Procedure Manual, Part 2 -- Claims, *Doubling Case Files*, Chapter 2.400.8(c)(1) (February 2000).

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated August 9, 2007 and September 11, 2006 be affirmed, in part, and set aside in part. The case is remanded to the Office for proceedings consistent with this opinion of the Board.

Issued: April 16, 2008
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board