



## **FACTUAL HISTORY**

On February 11, 2010 appellant, then a 50-year-old claims representative, filed an occupational disease claim alleging shoulder and neck pain, bursitis, carpal tunnel syndrome and tennis elbow due to constant computer work, filing, writing applications, typing, faxing documents, lifting folders, faxing and stapling documents. He first became aware of his conditions on March 1, 2009 and realized that it resulted from his work duties on March 23, 2009.

In a February 9, 2009 report, Dr. Glenn J. Jonas, a Board-certified orthopedic surgeon, reviewed appellant's background and noted his complaints of bilateral epicondylitis, shoulder impingement and bilateral mild carpal tunnel syndrome. Appellant described his left elbow as painful and achy when lifting and carrying and his arm was painful with overhead use. Dr. Jonas noted full range of motion of both shoulders in all planes and negative results for Yergason sign and O'Brien test. Upon examination, he observed bilateral shoulder impingement with internal rotation and forward elevation at 100 degrees. On examination, appellant's hands revealed mild Phalen's maneuver at approximately one minute, normal radial and ulnar pulses and good vascularity. Magnetic resonance imaging (MRI) scans did not reveal glenohumeral arthritis or acromioclavicular (AC) joint spurring in his left shoulder nor periostitis and ulnohumeral arthritis in his left elbow. It also demonstrated well-maintained midcarpal and radiocarpal joints in his left hand. Dr. Jonas recommended a rehabilitation protocol for appellant's bilateral shoulder complaints and bilateral wrist splints for mild carpal tunnel syndrome.

In a March 23, 2009 report, Dr. Jonas stated that appellant was doing some laundry over the weekend, when he started to experience pain in his right shoulder, which became aggravated with overhead use. The examination revealed mild impingement sign but no evidence of deltoid atrophy, internal or external rotation, decreased range of motion, weakness or AC joint pain. Appellant's adduction test was also negative.

In a May 29, 2009 report, Dr. Luis Naranjo, a chiropractor, noted appellant's complaints of back and neck pain with radiation to the right upper extremity and the right lower extremity, with shoulder spasm, left/right wrist pain and left elbow pain. The examination revealed tenderness to palpation and muscle spasm of his paracervical, paradorsal, and paralumbar muscles, upper and lower extremity right side, left elbow and both wrists. Dr. Naranjo diagnosed radiculopathy and/or neuropathy of the cervical and lumbosacral spine, carpal tunnel syndrome, right shoulder and left elbow tendinitis, sacroiliac segmental dysfunction, lumbar segmental dysfunction, radiculitis lumbosacral, sciatic radiculitis, myofibrositis, myofascitis and cervicocranial syndrome.

In treatment notes dated June 4 to 23, 2009, Dr. Naranjo reported appellant's complaints of neck and back pain with radiation to the upper extremity right side and lower extremity left side. He observed decreased range of motion in appellant's flexion extension left rotation, right rotation, left lateral flexion and right lateral flexion of the cervical lumbodorsal spine with pain.

In an April 9, 2010 letter, OWCP advised appellant that the evidence submitted was insufficient to establish his claim and requested additional information. It requested a comprehensive medical report from his treating physician, including a description of his

symptoms, results of his examination and tests, diagnosis, treatment provided and a physician's opinion, with medical reasons, explaining how his claimed conditions were caused by factors of his employment.

In an April 23, 2010 report, Dr. Thomas M. McQuail, a Board-certified orthopedic surgeon, examined appellant for right shoulder and left elbow pain and reviewed his medical and social history. Appellant first experienced shoulder problems the prior year and described his pain through the shoulder, with minimal radiation and along the lateral aspect of the elbow. Appellant noted that he also had carpal tunnel syndrome, but Dr. McQuail stated that no nerve conduction study was obtained to verify that diagnosis. The examination revealed that appellant's cervical spine range of motion was intact and his back was also tender to supraspinatus and biceps tendon. Appellant's Hawkins and impingement signs were positive but Tinel's and compression tests over the median nerve of the right wrist were negative. Dr. McQuail reported that appellant's right elbow had full range of motion, was tender to the lateral epicondyle, and resulted in no pain with resisted wrist and finger extension. X-rays also revealed slight type II acromion of his shoulder and normal elbow and lateral cervical spine. Dr. McQuail diagnosed right shoulder impingement and frozen shoulder. In an addendum that same day, he reported that appellant's repetitive work at a desk could contribute to any carpal tunnel syndrome or the elbow problems. Dr. McQuail did not believe that appellant's shoulder condition resulted from his job.

By decision dated May 24, 2010, OWCP denied appellant's occupational disease claim. It accepted that his job as a claims representative involved constant typing, filing papers, faxing and stapling documents, and lifting folders, but the medical evidence did not establish that his claimed medical conditions resulted from the accepted work factors.

On June 28, 2010 appellant submitted a request for reconsideration. He also submitted various physical therapy notes dated February 18, 2009 to May 27, 2010 by Kari Jacobs, a physical therapist, who diagnosed right shoulder impingement, right lateral epicondylitis and cervical radiculopathy. Appellant also resubmitted Dr. McQuail's April 23, 2010 medical report.

In a June 14, 2010 medical report, Dr. McQuail reevaluated appellant's right shoulder and noted that it was possible that his right shoulder pain was due to his cervical spine. Appellant also complained of right-sided foot pain and stated that he sustained a fracture three years prior at the base of the 5<sup>th</sup> metatarsal. An examination of his shoulder revealed an intact cervical spine range of motion and an examination of the foot revealed full ankle and subtalar range of motion. Dr. McQuail opined that appellant's right shoulder pain was probably due to his cervical spine.

In a decision dated August 16, 2010, OWCP denied modification of the May 24, 2010 decision.

## LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his claim by the weight of the reliable, probative and substantial evidence<sup>2</sup> including that he sustained an injury in the performance of duty and that any specific condition or disability for work for which he claims compensation is causally related to that employment injury.<sup>3</sup> In an occupational disease claim, appellant's burden requires submission of the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.<sup>4</sup>

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.<sup>5</sup> Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is a causal relationship between the employee's diagnosed condition and the specified employment factors or incident.<sup>6</sup> The opinion of the physician must be based on a complete factual and medical background of the employee, 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 employee.<sup>7</sup> The mere fact that work activities may produce symptoms revelatory of an underlying condition does not raise an inference of an employment relation. Such a relationship must be shown by rationalized medical evidence of a causal relation based upon a specific and accurate history of employment conditions which are alleged to have caused or exacerbated a disabling condition.<sup>8</sup>

Section 8101(2) of FECA<sup>9</sup> provides that the term physician, as used therein, includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist and subject to regulations by the Secretary. Without diagnosing a subluxation from

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<sup>2</sup> *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

<sup>3</sup> *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989); *M.M.*, Docket No. 08-1510 (issued November 25, 2010).

<sup>4</sup> *R.H.*, 59 ECAB 382 (2008); *Ernest St. Pierre*, 51 ECAB 623 (2000); *D.U.*, Docket No. 10-144 (issued July 27, 2010).

<sup>5</sup> *D.I.*, 59 ECAB 158 (2007); *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *W.D.*, Docket No. 09-658 (issued October 22, 2009).

<sup>6</sup> *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

<sup>7</sup> *B.B.*, 59 ECAB 234 (2007); *D.S.*, Docket No. 09-860 (issued November 2, 2009).

<sup>8</sup> *Patricia J. Bolleter*, 40 ECAB 373 (1988).

<sup>9</sup> 5 U.S.C. § 8101(2).

x-ray, a chiropractor is not a physician under FECA and his opinion on causal relationship does not constitute competent medical evidence.<sup>10</sup>

### ANALYSIS

The Board finds that appellant failed to meet his burden of proof to establish that he sustained an injury in the performance of duty. OWCP accepted that his employment involved working with a computer, filing and processing applications. The Board finds that appellant failed to submit sufficient medical evidence to establish that he sustained his claimed medical conditions from performing the accepted work duties.

Regarding appellant's alleged bilateral carpal tunnel syndrome, he first related his complaints regarding this condition to Dr. Jonas. The Board notes that Dr. Jonas generally described appellant's complaints while lifting, carrying, during overhead use of his arms and during computer use, but did not relate a history which acknowledged with any specificity the employment duties accepted by OWCP. In a February 9, 2009 report, Dr. Jonas noted a mild finding during the Phalen's maneuver, (without specifying whether this finding was bilateral) but normal radial and ulnar pulses and good vascularity. He also related that the 2009 MRI scan of appellant's left hand revealed a well-maintained midcarpal and radiocarpal joints. While Dr. Jonas ultimately recommended bilateral wrist splints for mild carpal tunnel, he never explained the medical basis of his diagnosis, given the findings upon examination. Furthermore, he offered no opinion regarding the cause of the mild carpal tunnel syndrome. Dr. Jonas' reports lacked an adequate history regarding appellant's accepted employment duties, an explanation with a firm medical diagnosis and no opinion regarding causal relationship. They are of limited probative value in establishing appellant's bilateral carpal tunnel claim.

Similarly, Dr. McQuail did not relate a history of appellant's accepted employment duties in his reports of April 23 or June 14, 2010. Regarding the diagnosis, he noted that a nerve conduction study was never obtained to verify the claimed carpal tunnel syndrome and that his Tinel's and compression tests over the median nerve were negative. In an addendum dated April 23, 2010, Dr. McQuail stated that "appellant's repetitive work at a desk can contribute to any carpal tunnel syndrome." The Board finds this opinion of limited probative value because the Dr. McQuail failed to identify any specific repetitive work activities and he never diagnosed carpal tunnel syndrome.

Although Dr. Naranjo diagnosed carpal tunnel syndrome and left elbow tendinitis, his opinion is of limited probative value because the term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.<sup>11</sup> Dr. Naranjo's diagnoses regarding carpal tunnel syndrome and left elbow tendinitis were not for spinal subluxation, therefore for these diagnoses he is not a physician under FECA and his opinion cannot be considered medical evidence.

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<sup>10</sup> See generally *Theresa K. McKenna*, 30 ECAB 702 (1979).

<sup>11</sup> 5 U.S.C. § 8101(2); *Paul Foster*, 56 ECAB 208 (2004).

The medical evidence of record evaluating appellant's left tennis elbow, consists of Dr. Jonas who noted that appellant had complaints regarding the left elbow. He concluded that the 2009 MRI scan did not show any periostitis or ulnohumeral arthritis of the left elbow. Dr. Jonas did not diagnose or discuss any cause of this condition. Dr. McQuail noted appellant's complaints of left elbow pain, but then only made findings of tenderness of the lateral condyle of the right elbow and noted that x-rays revealed a "normal elbow." The Board has generally held that pain in the absence of objective findings is not a firm medical diagnosis and is not compensable.<sup>12</sup> While Dr. McQuail concluded that appellant's "repetitive work at a desk" could contribute to his "elbow problems," he did not specify the repetitive duties involved in this process or offer any medical rationale supporting causal relationship.

As to any bilateral shoulder condition, the Board finds that the medical reports and findings support a diagnosis of bilateral shoulder impingement. Dr. Jonas observed bilateral shoulder impingement signs with internal rotation and forward elevation at 100 degrees. Similarly, Dr. McQuail reported that appellant's Hawkins and impingement signs were positive and x-rays revealed slight type II acromion of the shoulder. The medical evidence is insufficient to establish that appellant's bilateral shoulder condition is causally related to the accepted work factors. Dr. Jonas diagnosed bilateral shoulder impingement, but he did not provide any opinion regarding the cause of the condition or explain whether the condition resulted from the accepted employment duties. The Board has held that medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.<sup>13</sup> Dr. McQuail's medical reports also fail to establish causal relationship. In his April 23, 2010 medical report, he stated that he did not think that appellant's shoulder condition resulted from his job. In a June 14, 2010 medical report, Dr. McQuail further noted that it was possible that appellant's right shoulder pain was probably due to cervical spine and makes no reference to his employment. Thus, the medical evidence of record fails to establish that appellant's shoulder condition was causally related to factors of his employment.

On appeal, appellant contends that he experiences pain continuously without any improvement. The question of causal relationship, however, is a medical one and must be resolved by probative medical evidence.<sup>14</sup> Appellant failed to submit such probative medical evidence which explained, with medical rationale, how his accepted employment factors caused his right shoulder condition. Thus, he did not meet his burden of proof to establish his claim.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

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<sup>12</sup> See *Ruth Seuell*, 48 ECAB 188 (1996); see also *P.H.*, Docket No. 10-212 (October 4, 2010).

<sup>13</sup> *K.W.*, 59 ECAB 271 (2007); *A.D.*, 58 ECAB 149 (2006); *Linda I. Sprague*, 48 ECAB 386 (1997).

<sup>14</sup> *D.I.*, 59 ECAB 158 (2007); *Margaret Carvello*, 54 ECAB 498 (2003).

**CONCLUSION**

The Board finds that appellant did not meet his burden of proof to establish that he sustained carpal tunnel syndrome, elbow tendinitis and bilateral shoulder impingement in the performance of duty.

**ORDER**

**IT IS HEREBY ORDERED THAT** the August 16 and May 24, 2010 merit decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: July 25, 2011  
Washington, DC

Colleen Duffy Kiko, Judge  
Employees' Compensation Appeals Board

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

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