United States Department of Labor
Employees' Compensation Appeals Board

R.M., Appellant	)	
and	)	**Docket No. 14-198**
	)	**Issued: April 8, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Little Rock, AR, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On November 4, 2013 appellant filed a timely appeal from August 29 and October 17, 2013 merit decisions of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[2]

ISSUE

The issue is whether appellant met his burden of proof to establish that his bilateral shoulder conditions are causally related to factors of his employment.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that appellant submitted additional evidence following the October 17, 2013 decision. Since the Board's jurisdiction is limited to evidence that was before OWCP at the time it issued its final decision, the Board may not consider this evidence for the first time on appeal. *See* 20 C.F.R. § 501.2(c); *Sandra D. Pruitt,* 57 ECAB 126 (2005). Appellant may submit that evidence to OWCP with a request for reconsideration.

FACTUAL HISTORY

This case was previously before the Board. The relevant facts are set forth below.

On September 18, 2007 appellant, then a 50-year-old letter carrier, filed a traumatic injury claim alleging that on September 17, 2007 he sustained abrasions to his left arm, elbow and chin when he fell at work. He stopped work and returned on September 24, 2007. OWCP denied appellant's traumatic injury claim and he filed an appeal to the Board. In a September 24, 2009 decision, the Board remanded the case for further development of the medical evidence.[3] On November 16, 2009 OWCP accepted that on September 17, 2007 appellant sustained traumatic bursitis of the left elbow as a result of the fall at work. It also accepted a permanent aggravation of osteoarthritis to the right elbow. This claim was adjudicated by OWCP under File No. xxxxxx847.

On October 27, 2008 OWCP accepted that appellant sustained right carpal tunnel syndrome as a result of factors of his employment. Appellant stopped work on September 29, 2008 and returned to light duty on March 16, 2009. OWCP subsequently accepted bilateral carpal tunnel syndrome and lateral epicondylitis. This claim was adjudicated by OWCP under File No. xxxxxx920.

On March 24, 2011 OWCP combined both claims under master File No. xxxxxx920.

On May 29, 2009 appellant filed a schedule award claim. By decision dated June 19, 2012, the Board affirmed OWCP's determination that appellant had no more than 13 percent right upper extremity impairment and 4 percent on the left.[4] The facts of the previous Board decisions are incorporated herein by reference.

Following the Board's decision, appellant submitted an August 18, 2012 report by Dr. Robert E. Holder, a Board-certified family practitioner, who noted appellant's present conditions of bilateral/lateral epicondylitis, bilateral carpal tunnel syndrome, right cubital tunnel syndrome and right elbow degenerative joint disease. Dr. Holder related that appellant's right upper arm and shoulder started to hurt after work even with restrictions. Upon examination of the right elbow and forearm, he observed a full range of motion without pain and intact circulation with normal pulse and no edema. Resistive tennis elbow and passive tennis elbow tests were positive. Examination of the left elbow and forearm revealed full range of motion without pain and intact circulation. Golfer's elbow test was positive. Dr. Holder diagnosed bilateral elbow pain and right and left elbow epicondylitis. He stated that appellant continued to have bilateral elbow pain and recently developed right shoulder pain. Dr. Holder opined that appellant's pain was likely due to adjustments he was making due to the right elbow pain.

In a December 5, 2012 report, Dr. Holder addressed appellant's complaints of right shoulder pain. Upon examination, he observed intact motors and circulation with normal pulses and no edema. Cross shoulder adduction and Hawkins' test were positive. Dr. Holder noted

[3] Docket No. 9-259 (issued September 24, 2009).

[4] Docket No. 12-255 (issued June 19, 2012).

diagnoses of cubital tunnel syndrome, carpal tunnel syndrome, right elbow lateral epicondylitis, left elbow medial epicondylitis, shoulder pain and rotator cuff syndrome. He noted that appellant was given a steroid injection and would be reexamined in six weeks.

In a January 23, 2103 report, Dr. Holder related that appellant's right shoulder was better following a steroid injection. Examination revealed full range of motion and negative impingement signs. Dr. Holder stated that the symptoms prompting the injection at the last visit had fully resolved in his right shoulder. He diagnosed shoulder pain, rotator cuff syndrome (unspecified disorders of bursae and tendons in shoulder region) and improved right shoulder impingement syndrome.

In a letter dated April 16, 2013, appellant requested that OWCP accept his claim for a bilateral shoulder condition. He stated that he used his shoulders more at work to try and take effort away from his elbows and hands and his work at the employing establishment exacerbated his conditions. Appellant did not perform other activities and was not involved in any sports or athletic activities.

In an April 24, 2013 report, Dr. Holder related appellant's complaints of pain on the superior aspect of his right shoulder when he raised his arms and raised it to shoulder height. Upon examination, there was moderate tenderness in the greater tuberosity and mild-to-moderate tenderness in the long head of the biceps. Circulation was intact with normal pulses and no edema was found. Dr. Holder noted a full range of motion without pain and normal sensation. Acromioclavicular (AC) joint compression and distraction tests were both negative. Hawkins' test was positive flexion to 90 degrees. Impingement sign and Neer's tests were also positive. Dr. Holder diagnosed shoulder pain, rotator cuff syndrome, unspecified disorders of bursae and tendons in the shoulder and impingement syndrome. He noted that appellant had AC joint osteoarthritis but opined that there was no rotator cuff tear. Dr. Holder recommended a magnetic resonance imaging (MRI) scan for better evaluation.

By letter dated May 10, 2013, OWCP requested that appellant submit additional evidence to establish that he sustained bilateral shoulder conditions as a result of factors of his employment. It noted that Dr. Holder provided a diagnosis for his right shoulder but not the left shoulder.

In a May 14, 2013 MRI scan of the right shoulder, Dr. Chintan Desai, a Board-certified diagnostic radiologist, noted mild T2 hyperintense signals within the substance of supraspinatus tendon, consistent with tendinosis and no evidence of tendon tear. He also observed moderate fibro-osseous capsular hypertrophy with marrow edema at the AC joint. Dr. Desai diagnosed supraspinatus tendinosis, AC joint arthrosis and SLAP Type 1 superior labral tear.

OWCP requested a district medical adviser address whether appellant's claim should be accepted for a bilateral shoulder condition. On July 22, 2013 Dr. Daniel D. Zimmerman, a Board-certified internist, reviewed the medical records and noted that from March 3, 2010 to August 8, 2012 there was no evidence that appellant complained of shoulder pain. The August 8, 2012 report indicated that appellant's right shoulder was beginning to hurt but it did not address whether the condition was work related. Dr. Zimmerman noted that there was no medical rationale by any examining physician addressing how appellant's right or left shoulder

diagnoses were consequential to the accepted injury. He recommended that OWCP not accept the bilateral shoulder conditions.

In a July 31, 2013 report, Dr. Holder stated that appellant's right shoulder pain had returned. Upon examination, he observed intact motors and circulation with normal pulses and no edema. Sensation was also normal. Dr. Holder reported that impingement was positive bilaterally and noted that the right was less positive than the previous examination. He diagnosed cubital tunnel syndrome, ulnar nerve compression at elbow, carpal tunnel syndrome, right elbow lateral epicondylitis, left elbow medial epicondylitis, shoulder pain, rotator cuff syndrome and impingement syndrome. Dr. Holder concluded that no significant changes justified surgical intervention and recommended that appellant continue work with modifications.

In a decision dated August 29, 2013, OWCP denied appellant's claim for bilateral shoulder conditions finding the medical evidence insufficient to establish causal relationship to the August 1, 2003 work-related injury.

In a letter dated September 27, 2013, appellant requested reconsideration of the August 29, 2013 decision. He submitted the September 20, 2013 report by Dr. Wesley Cox, a Board-certified orthopedic surgeon, who treated him for previously accepted conditions. Dr. Cox stated that he treated appellant for several years for bilateral elbow tendinitis and bilateral shoulder impingement and tendinitis. He reported that with appropriate exercise, anti-inflammatory medications and occasional injections, appellant was able to continue to work. Dr. Cox opined that due to the repetitive nature of appellant's work and the significant elbow tendinitis for which he was treated, there was evidence of overuse which led to his bilateral shoulder tendinitis.

By decision dated October 17, 2013, OWCP denied modification of the August 29, 2013 denial decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[5] has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative and substantial evidence[6] including that he or she sustained an injury in the performance of duty and that any specific condition or disability for work for which he or she claims compensation is causally related to that employment injury.[7]

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

[5] 5 U.S.C. §§ 8101-8193.

[6] *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

[7] *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[8]

The Board has held that if a member weakened by an employment injury contributes to a later injury, the subsequent injury will be compensable as a consequential injury, if the further medical complication flows from the compensable injury, so long as it is clear that the real operative factor is the progression of the compensable injury.[9]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[10] 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.[11]

ANALYSIS

OWCP accepted that appellant sustained work-related bilateral carpal tunnel syndrome, bilateral/lateral epicondylitis and permanent aggravation of osteoarthritis of the left elbow as a result of his employment. In a letter dated April 16, 2013, appellant requested that it accept bilateral shoulder conditions. He stated that he used his shoulders more at work to relieve the pain in his elbow and hands. By decisions dated August 29 and October 17, 2013, OWCP denied appellant's claim. The Board finds that appellant did not meet his burden of proof to establish that he sustained bilateral shoulder conditions causally related to his federal employment.

Appellant submitted reports dated August 18, 2012 to July 31, 2013 from Dr. Holder, who addressed appellant's accepted conditions and noted pain to the right upper arm and shoulder. Dr. Holder noted that appellant's recent right shoulder pain was likely due to adjustments he made to accommodate his right elbow pain. On December 5, 2012 he noted appellant's findings on examination. Dr. Holder diagnosed shoulder pain and rotator cuff syndrome. On January 23, 2013 he stated that appellant's shoulder was much better following a steroid injection. Examination revealed full range of motion and negative impingement signs. On July 31, 2013 Dr. Holder reported that appellant's right shoulder pain had returned. There were positive impingement signs bilaterally. Sensation and circulation were normal. Dr. Holder diagnosed shoulder pain, rotator cuff syndrome and impingement syndrome.

Although Dr. Holder provided findings on examination and diagnosed rotator cuff and impingement syndrome, he did not provide sufficient medical rational explaining how appellant's shoulder conditions were caused or contributed to by his work or the accepted upper

[8] *R.H.*, 59 ECAB 382 (2008); *Ernest St. Pierre*, 51 ECAB 623 (2000).

[9] *S.M.*, 58 ECAB 166 (2006); *Raymond A. Nester*, 50 ECAB 173, 175 (1998).

[10] *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *D.I.*, 59 ECAB 158 (2007).

[11] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 465 (2005).

extremity conditions to the elbows or hands. He noted an increase in pain, a symptom, but he did not provide any opinion as to the cause of appellant's bilateral shoulder conditions. Dr. Holder did not provide any medical rationale to explain how appellant's accepted elbow and wrist conditions or modified-duty work caused the rotator cuff syndrome or impingement syndrome.

Dr. Desai's May 14, 2013 report also provided examination findings and medical diagnoses but offered no opinion or explanation as to the cause of appellant's bilateral shoulder conditions. He offered an explanation as to how appellant's bilateral shoulder conditions were causally related to his accepted conditions. The medical reports, therefore, are insufficient to establish appellant's claim that his bilateral shoulder conditions were consequential to his accepted injury.

Appellant also submitted a September 20, 2013 report by Dr. Cox who noted that he treated appellant for bilateral elbow tendinitis and bilateral shoulder impingement and tendinitis. Dr. Cox opined that due to the repetitive nature of appellant's work and the significant elbow conditions there was clear evidence of overuse and adjusted use which had led to his bilateral shoulder conditions. The Board notes that, although he related appellant's bilateral shoulder conditions to the repetitive nature of appellant's work, he failed to an appropriate history of injury with a description of his duties as a letter carrier. The Board has found that rationalized medical opinion evidence must relate specific employment factors identified by the claimant to the diagnosed condition.[12] Dr. Cox did not provide any explanation, based on his examination, as to how appellant's duties as a letter carrier caused or contributed to his bilateral shoulder conditions.[13] His opinion, therefore, is also insufficient to establish appellant's claim.

The Board notes that Dr. Zimmerman reviewed appellant's medical records and found no medical rationale by a physician to support that appellant's shoulder conditions were due to the accepted injuries or duties at work. Dr. Zimmerman recommended that OWCP not accept the bilateral shoulder condition because there was no explanation of how appellant's shoulder conditions were related to the accepted August 1, 2003 employment injury.

On appeal, appellant alleged that Dr. Cox's report was sufficient to establish causal relationship. The Board finds that Dr. Cox's opinion is of limited probative value. Dr. Cox failed to address how appellant's bilateral shoulder conditions resulted from factors of his employment. The issue of causal relationship is a medical question that must be established by probative medical opinion from a physician.[14] Because appellant failed to provide such probative medical opinion, the Board finds that OWCP properly denied his request to expand his claim.

[12] *L.F.*, Docket No. 10-2287 (issued July 6, 2011); *Solomon Polen*, 51 ECAB 341 (2000).

[13] *J.F.*, Docket No. 09-1061 (issued November 17, 2009); *A.D.*, 58 ECAB 149 (2006) (medical evidence that states a conclusion but does not offer any rationalized medical explanation regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

[14] *W.W.*, Docket No. 09-1619 (issued June 2, 2010); *David Apgar*, 57 ECAB 137 (2005).

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.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that his bilateral shoulder conditions were causally related to factors of his employment.

ORDER

IT IS HEREBY ORDERED THAT the October 17 and August 29, 2013 merit decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: April 8, 2014
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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