United States Department of Labor
Employees' Compensation Appeals Board

M.G., Appellant	)	
and	)	**Docket No. 16-1791**
	)	**Issued: February 22, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Bellmawr, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On September 7, 2016 appellant, through counsel, filed a timely appeal from a May 18, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merit decision in this case.

ISSUE

The issue is whether appellant has met her burden of proof to establish an occupational disease causally related to factors of her federal employment.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On January 4, 2015 appellant then a 53-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that she developed carpal tunnel syndrome as a result of performing repetitive duties required in her job. She first became aware of her condition on November 3, 2014 and realized that it was causally related to her employment on December 17, 2014. Appellant stopped work on January 9, 2015.

In a statement dated January 9, 2015, appellant indicated that on December 15, 2014 she experienced severe pain and numbness in her left wrist while working on a flat sorter machine. She indicated that her hand pain continued daily until January 2, 2015 when it became unbearable and she sought treatment.

Appellant was treated in an emergency room on January 2, 2015 by Dr. Russell Harris, Board-certified in emergency medicine, who diagnosed carpal tunnel syndrome and prescribed medication. She submitted a January 2, 2015 work excuse form, signed by an unidentified health care provider, who noted that appellant could return to work in two to three days.

Appellant came under the treatment of Dr. John M. Bednar, a Board-certified orthopedist, for bilateral carpal tunnel syndrome. In duty status reports dated January 9 to 23, 2015, Dr. Bednar diagnosed bilateral carpal tunnel syndrome and noted that appellant could work with restrictions. In a January 23, 2015 attending physician's report, he diagnosed median neuropathy, bilateral carpal tunnel syndrome, bilateral ulnar neuropathy, bilateral cubital tunnel syndrome, and degenerative arthritis of the carpometacarpal joint and left elbow. Dr. Bednar noted appellant's symptoms were due to work activities. He checked a box marked "yes" that appellant's condition was caused or aggravated by work activity indicating that her symptoms were secondary to hand use. Dr. Bednar returned her to work with restrictions.

On February 9, 2015 OWCP advised appellant of the type of evidence needed to establish her claim, particularly a physician's reasoned opinion addressing the relationship between her claimed condition and specific work factors.

In a statement dated February 18, 2015, appellant asserted that her repetitive job duties as a mail handler caused her bilateral hand conditions. She indicated that she does not have any hobbies outside of work. Appellant noted her symptoms of wrist, hand, and thumb pain and numbness were worse at night. She reported having worked as a mail handler for 15 years lifting and pushing all-purpose containers, hampers and tubs with sacks of mail weighing up to 100 pounds, for eight hours a day for five days a week.

Appellant provided a January 9, 2015 report from Dr. Bednar who treated appellant for bilateral hand pain, numbness and tingling in the thumb, index, and long finger, and left elbow stiffness and pain. She had a history of diabetes. Appellant had full range of motion of the elbow, tenderness of the left medial epicondyle, and positive Tinel's sign at the cubital and carpal tunnel. X-rays of both wrists revealed degenerative arthritis at the carpometacarpal joint of the thumb. An x-ray of the left elbow revealed mild degenerative change on the medial aspect of the elbow. Dr. Bednar diagnosed median neuropathy, bilateral carpal tunnel syndrome,

bilateral ulnar neuropathy, bilateral cubital tunnel syndrome, and degenerative arthritis of the carpometacarpal joint, thumb, and left elbow. He returned appellant to light duty.

In a January 16, 2015 duty status report, Dr. Bednar diagnosed bilateral carpal tunnel syndrome and returned appellant to work full time with restrictions. Appellant submitted a February 3, 2015 work status report from Dr. Bednar which reflected a diagnosis of left carpal tunnel syndrome and triggering of the left index. Dr. Bednar continued appellant's work restrictions. In February 6 and 20, 2015 attending physician's reports, he noted appellant's symptoms were secondary to work activities. Dr. Bednar again noted, by checking a box marked "yes" that appellant's condition was caused or aggravated by work activity indicating that her symptoms were due to hand use. Dr. Bednar returned her to work with restrictions. In a work capacity evaluation dated February 6, 2015, he returned appellant to full-time light-duty work.

In an April 6, 2015 decision, OWCP denied appellant's claim, finding that she failed to establish that her claimed medical condition was related to the established work-related events.

On April 14, 2015 appellant requested an oral hearing which was held on July 9, 2015. She also submitted records of previous medical treatment. This included an August 30, 2010, work status note from Dr. Victor Diaz, a Board-certified family practitioner advising that appellant could return to full duty. In notes dated May 25 and August 12, 2013, Dr. Diaz noted that appellant could return to work full duty in six months.[3]

In an April 22, 2015 report, Dr. Bednar treated appellant for bilateral hand pain, numbness and tingling in her thumb, index and long finger, and stiffness in her left elbow. Appellant reported her symptoms had been progressive since December 2014. Dr. Bednar noted that a January 16, 2015 electromyogram (EMG) revealed left median motor latency and mild slowing across the ulnar nerve at the elbow. Steroid injections into her left side carpal tunnel and left thumb and finger did not improve her condition. Dr. Bednar noted treating appellant on April 3, 2015 for bilateral wrist pain, swelling, and weakness. He diagnosed median neuropathy, bilateral carpal tunnel syndrome, bilateral ulnar neuropathy, bilateral cubital tunnel syndrome, degenerative arthritis of the carpometacarpal joint, thumb, and left elbow, and flexor tenosynovitis of the left thumb and left index finger. Dr. Bednar opined that the causality of the median and ulnar neuropathy and flexor tenosynovitis diagnoses was multifactorial. He noted that appellant's diabetes did have some causal relation with regards to these diagnoses, but opined that appellant's work history and work activities as a postal handler were responsible for material worsening of these diagnoses and the resultant impairment. Dr. Bednar noted that appellant was not receptive to surgery. He advised that surgery would not return appellant to normal status and the prognosis for return to pain free function was poor. Dr. Bednar advised his opinion was set forth within a reasonable degree of medical certainty.

In a decision dated September 3, 2015, an OWCP hearing representative affirmed the April 6, 2015 decision.

[3] Dr. Diaz did not specify any condition for which appellant was treated. Appellant also submitted medical records from Dr. Annie M. Peter, a Board-certified internist, and Dr. Alan Askenase, a Board-certified cardiologist, from 2012 and 2013 who treated appellant for cardiac and other nonorthopedic conditions. On September 9, 2013 Dr. Askenase returned appellant to full duty.

On October 2, 2015 appellant requested reconsideration. She submitted a January 16, 2015 EMG which revealed severe left subacute carpal tunnel syndrome and moderate right chronic carpal tunnel syndrome, and left chronic cubital tunnel syndrome. A May 22, 2015 EMG revealed moderate left chronic carpal tunnel syndrome and early/mild right chronic carpal tunnel syndrome.

Appellant was treated by Dr. Bruce Monoghan, a Board-certified orthopedist, on July 20, 2015, for pain in both hands and arms which was present since November 2014. Appellant attributed her symptoms to pushing and pulling heavy equipment and repetitive lifting of mail and mail tubs. Findings included tenderness in the trapezius, deltoid, biceps muscle, and positive Tinel's sign. X-rays of both elbows were unremarkable and x-rays of the wrists and thumb revealed basilar joint arthritis. Dr. Monoghan diagnosed bilateral carpal tunnel syndrome and ulnar neuropathy, left index finger and left thumb stenosing tenosynovitis, bilateral thumb carpometacarpal degenerative joint disease and possible fibromyalgia. He recommended carpal tunnel braces, diagnostic injections and continued limited duty.

In reports dated August 3 and 31, 2015, Dr. Monoghan noted positive Tinel's sign in both hands and tenderness over the A1 pulley of her left thumb and index finger. He performed a steroid injection of both thumb and index fingers. Dr. Monoghan noted significant improvement in symptoms and range of motion after the injections. On September 23, 2015 he noted the injections afforded appellant some relief, but she still remained symptomatic in her index and middle fingers. Dr. Bednar noted limited range of motion over the A1 pulley and thumb with positive Tinel's sign. Dr. Monoghan recommended endoscopic carpal tunnel release and A1 pulley release of the thumb on the left hand and left A1 pulley release of the index finger with traction tenolysis of the deep and superficial flexor tendons. On October 29, 2015 appellant underwent left index finger A1 pulley release traction tenolysis, left thumb A1 pulley release and left endoscopic carpal tunnel release.[4] On November 9, 2015 Dr. Monoghan treated appellant in follow-up and reported experiencing significant discomfort and she was uncertain whether the numbness and tingling resolved. He recommended physical therapy.

In a decision dated May 18, 2016, OWCP denied modification of the September 3, 2015 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim. When an employee claims that he or she sustained an injury in the performance of duty, the employee must submit sufficient evidence to establish that he experienced a specific event, incident or exposure occurring at the time, place, and in the manner alleged. Appellant must also establish that such event, incident or exposure caused an injury.[5]

[4] The full October 29, 2011 operative report is not in the record.

[5] *See Walter D. Morehead,* 31 ECAB 188, 194 (1979) (occupational disease or illness); *Max Haber,* 19 ECAB 243, 247 (1967) (traumatic injury). *See generally John J. Carlone,* 41 ECAB 354 (1989); *Elaine Pendleton,* 40 ECAB 1143 (1989).

Whether an employee actually sustained an injury in the performance of duty begins with an analysis of whether fact of injury has been established.[6] To establish fact of injury in an occupational disease claim, an employee must submit: (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.[7]

The medical evidence required to establish causal relationship is generally rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized 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.[8]

ANALYSIS

It is undisputed that appellant's duties as a mail handler included lifting and pushing all-purpose containers, hampers and tubs with sacks of mail weighing up to 100 pounds. It is also undisputed that appellant was diagnosed with bilateral carpal tunnel syndrome and ulnar neuropathy, left index finger and left thumb stenosing tenosynovitis, and bilateral thumb carpometacarpal degenerative joint disease. However, appellant failed to submit sufficient medical evidence to establish that her diagnosed medical conditions are causally related to specific factors of her federal employment.

In his April 22, 2015 report, Dr. Bednar noted appellant's progressive symptoms since December 2014. He diagnosed median neuropathy, bilateral carpal tunnel syndrome, bilateral ulnar neuropathy, bilateral cubital tunnel syndrome, degenerative arthritis of the carpometacarpal joint, thumb, and left elbow, and flexor tenosynovitis of the left thumb and left index finger. Dr. Bednar opined that the diagnosed median and ulnar neuropathy and flexor tenosynovitis had multifactorial causality. Dr. Bednar opined within a reasonable degree of medical certainty that appellant's diabetes had some effect on these diagnoses, but he opined that appellant's work history and work activities as a postal handler were responsible for material worsening of these diagnoses and the resultant impairment. The Board finds that, although Dr. Bednar supported causal relationship, he did not provide medical rationale explaining the basis of his conclusory opinion regarding the causal relationship.[9] Dr. Bednar did not explain the process by which

[6] *S.P.*, 59 ECAB 184, 188 (2007).

[7] *R.R.*, Docket No. 08-2010 (issued April 3, 2009); *Roy L. Humphrey*, 57 ECAB 238, 241 (2005).

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

[9] *See T.M.*, Docket No. 08-975 (issued February 6, 2009) (a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

repetitively lifting and pushing all-purpose containers, hampers, and tubs with sacks of mail would cause or aggravate the diagnosed conditions. This report is thus insufficient to establish appellant's claim.

Attending physician reports from Dr. Bednar dated January 23 to February 20, 2015 noted diagnoses and indicated that appellant's symptoms were secondary to work activities. Dr. Bednar noted by checking a box marked "yes" that appellant's condition was caused or aggravated by an employment duty and indicating that her symptoms were secondary to hand use. The Board has held that when a physician's opinion on causal relationship consists only of checking "yes" to a form question, without explanation or rationale, that opinion is of diminished probative value and is insufficient to establish a claim.[10] Other reports from Dr. Bednar are of limited probative value as they did not further address causal relationship.

Reports from Dr. Monoghan dated July 20 to September 23, 2015 noted appellant's treatment for pain in both hands and arms. Appellant attributed her symptoms to pushing and pulling heavy equipment and repetitive lifting of mail and mail tubs. He noted findings and diagnosed bilateral carpal tunnel syndrome and ulnar neuropathy, left index finger and left thumb stenosing tenosynovitis, bilateral thumb carpometacarpal degenerative joint disease and possible fibromyalgia. On October 29, 2015 Dr. Monoghan performed a left index finger A1 pulley release traction tenolysis, left thumb A1 pulley release and left endoscopic carpal tunnel release. Regarding causal relationship, he repeats the history of injury as reported by appellant without providing his own opinion regarding whether appellant's condition was work related. To the extent that Dr. Monoghan is providing his own opinion, he failed to provide a rationalized opinion regarding the causal relationship between appellant's diagnosed conditions and the factors of employment believed to have caused or contributed to such condition.[11] Therefore, these reports are insufficient to meet appellant's burden of proof.

Other medical evidence of record is of limited probative value as it either predates the onset of appellant's claimed condition or does not specifically address how the accepted work factors caused or aggravated the claimed condition.[12] Consequently, the medical evidence of record is insufficient to establish appellant's claim.

An award of compensation may not be based on surmise, conjecture, or speculation. Neither the fact that appellant's condition became apparent during a period of employment nor the belief that his condition was caused, precipitated, or aggravated by his employment is sufficient to establish causal relationship. Causal relationship must be established by rationalized medical opinion evidence.[13] Appellant failed to submit such evidence and OWCP therefore properly denied appellant's claim for compensation.

[10] *D.D.*, 57 ECAB 734 (2006); *Sedi L. Graham*, 57 ECAB 494 (2006).

[11] *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value); *Jimmie H. Duckett*, 52 ECAB 332 (2001).

[12] *A.D.*, 58 ECAB 149 (2006) (medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

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

On appeal appellant, through counsel, disagrees with OWCP's decision denying her claim for compensation and noted that she submitted sufficient evidence to establish her claim. As noted above, the medical evidence does not establish that appellant's diagnosed conditions are causally related to her employment. Reports from appellant's physician's failed to provide sufficient medical rationale explaining how appellant's injuries are causally related to particular employment factors.

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 her burden of proof to establish an occupational disease causally related to factors of her federal employment.

ORDER

IT IS HEREBY ORDERED THAT the May 18, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 22, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board