United States Department of Labor
Employees' Compensation Appeals Board

E.H., Appellant	)	
and	)	**Docket No. 17-1402**
	)	**Issued: November 8, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Elizabeth, CO, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 12, 2017 appellant, filed a timely appeal of a May 15, 2017 merit decision 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.

ISSUE

The issue is whether OWCP properly terminated compensation for wage loss effective May 14, 2017.

FACTUAL HISTORY

On December 29, 2015 appellant, then a 69-year-old postmaster, filed an occupational disease claim (Form CA-2), asserting that she developed a strain as a result of repetitive motions

[1] 5 U.S.C. § 8101 *et seq.*

of grasping and casing mail over the years. She first became aware of her illness and realized it was causally related to factors of her federal employment on July 1, 2010.

Appellant was treated by Dr. Daniel R. Henley, a Board-certified family practitioner, on December 2, 2015, for chronic left thumb pain over several years. Dr. Henley diagnosed pain in the thumb and osteoarthritis of the knee and recommended a thumb brace.

Appellant came under the treatment of Dr. Karl M. Larsen, a Board-certified orthopedist, on December 14, 2015, for chronic left thumb-base pain. She related her condition to working for the employing establishment for 34 years. Appellant managed her condition with thumb spica braces. Dr. Larsen noted findings on examination of an obvious shoulder sign to the left thumb, normal capillary refill in the digits, normal gross sensation to light touch in the pads of the digits, she could achieve full fist, full digital extension, abnormal tenderness over the thumb carpometacarpal (CMC) joint, positive CMC joint grind test, unstable metacarpophalangeal (MCP) joint, and negative Tinel's sign over the superficial radial nerve distribution. Dr. Larsen noted x-rays of the thumb, lateral wrist, and hyperpronated thumb revealed severe thumb CMC arthritis with subluxation and erosion of the radial margin and the trapezium. He diagnosed thumb CMC osteoarthritis and likely associated carpal tunnel syndrome. Dr. Larsen provided a corticosteroid injection.

On February 22, 2016 OWCP denied the claim finding that appellant had submitted insufficient medical evidence to establish causal relationship.

Appellant requested reconsideration on March 13, 2016 and continued to submit medical evidence. In a March 2, 2016 report, Dr. Larsen indicated that the diagnosed thumb-base arthritis with associated MCP joint instability and carpal tunnel syndrome on the left side was causally related to her employment. He opined that appellant's repeated gripping, grasping, and pinching activities at work, holding packets of mail, and boxing mail, aggravated her arthritic condition to the point where she required treatment earlier than would otherwise be required absent these work activities. Dr. Larsen advised that she failed reasonable nonsurgical treatment including corticosteroid injections and bracing, and he recommended surgical intervention. In a March 2, 2016 return to work slip, he noted that appellant was undergoing left hand surgery on March 15, 2016 and would be incapacitated for 12 to 16 weeks. Appellant stopped work on March 2, 2016 to undergo surgery

In an operative report dated March 15, 2016, Dr. Larsen performed a left thumb CMC arthroplasty, left thumb MCP joint arthrodesis, and left carpal tunnel release. He diagnosed left thumb carpometacarpal osteoarthritis with MCP joint instability and left carpal tunnel syndrome. On April 25, 2016 Dr. Larsen treated appellant in follow-up postsurgery and noted findings of solid and nontender arthrodesis, stable thumb base, and normal sensation to light touch in the pads of the digits. He indicated that x-rays of the thumb revealed solidifying arthrodesis with no hardware issues. Dr. Larsen opined that appellant was doing well and he recommended physical therapy. On June 6, 2016 he treated appellant in follow-up and appellant reported burning discomfort over her dorsal thumb MCP joint. Dr. Larsen noted findings of stable MCP arthrodesis, stable CMC arthroplasty, tenderness over her fixation hardware with mild cutaneous hypersensitivity. He noted x-rays of the left hand revealed the arthrodesis was solidifying nicely with no changes in her hardware. Dr. Larsen advised that appellant developed some

hypersensitivity over the digit and appears to be having irritation from her hardware. He noted that it was too early to consider hardware removal and recommended observation.

On May 5, 2016 OWCP accepted temporary aggravation of osteoarthritis of the first CMC joint of the left hand. It advised appellant as to how she could claim wage-loss compensation.[2] OWCP noted that carpal tunnel syndrome was not accepted.

In a letter dated June 22, 2016, OWCP requested appellant provide a periodic medical report from her treating physician addressing whether the work-related condition was resolved.

On July 14, 2016 appellant indicated that she was using her own sick leave and personal insurance to cover her work injury and she received no compensation for her claim.[3]

In a report dated August 3, 2016, Dr. Larsen treated appellant in follow-up for left thumb CMC arthroplasty and MCP arthrodesis. He noted that appellant was doing very well and her thumb sensitivity improved. Dr. Larsen indicated that appellant's motion improved and she was starting to use her hand more normally. He noted findings of nontender arthrodesis, some sensitivity in the dorsal skin flap, localized over the proximal fixation hardware, and stable thumb base which was painless to stress. Dr. Larsen noted x-rays of the left thumb revealed a solid arthrodesis, no hardware issue and a well-preserved trapezial resection space. He noted that appellant's sensitivity over the hardware improved and he released appellant from his care. In a return to work slip dated August 3, 2016, Dr. Larsen returned appellant to work without restrictions.[4]

In a statement dated August 18, 2016 and an e-mail dated August 22, 2016, appellant indicated that she submitted new medical treatment documentation and a request for leave under the Family Medical Leave Act (FMLA).

In an OWCP telephone log, the employing establishment indicated that appellant had taken sick leave since full-duty release on August 3, 2016. It indicated that appellant would be retiring effective September 30, 2016.

Appellant underwent physical therapy for her left thumb from April 26 to May 27, 2016.

Appellant submitted an earlier report from Dr. Larsen dated March 2, 2016 who treated her for left thumb CMC arthritis with MCP instability and carpal tunnel syndrome. Dr. Larsen noted that the corticosteroid injection provided only temporary relief. He noted findings of hyperextension and abduction instability of the thumb MCP joint, abnormal tenderness of the thumb CMC joint, with positive grind test. Dr. Larsen noted that appellant had persistent

[2] OWCP subsequently authorized the March 15, 2016 surgery.

[3] The record does not indicate that appellant has claimed wage-loss compensation for any period that may have been necessitated by the accepted condition or the authorized surgery.

[4] Appellant also submitted July 12 and August 16, 2016 reports from Dr. Kyle Schauf, a Board-certified family practitioner, who treated her for back pain, hypertension, hyperlipidemia, and left-sided thoracic pain and spasm. On August 4, 2016 Dr. Henley treated appellant for thoracic back pain and radiculopathy.

symptoms due to thumb-base arthritis, associated MCP instability, numbness, and tingling consistent with carpal tunnel syndrome. He recommended a CMC arthroplasty with MCP arthrodesis and carpal tunnel release. Dr. Larsen opined that appellant's arthritis, while potentially preexisting or associated with normal aging process, had been aggravated during her work activities to the point where she was required treatment earlier than she might have otherwise required. On March 28, 2016 he treated appellant status post left thumb surgery and noted findings on examination of improved numbness and tingling, intact sensation, the incisions were clean and dry without evidence of infection, and a stable thumb base. Dr. Larsen diagnosed two weeks' status post left thumb CMC arthroplasty, MCP arthrodesis, and carpal tunnel release. In a note dated April 25, 2016, he diagnosed left thumb CMC arthroplasty, MCP arthrodesis and referred appellant for physical therapy twice a week for six weeks and for hand and forearm splints. In a report dated May 20, 2016, Dr. Larsen opined that appellant had permanent aggravation of her thumb-base arthritis associated with her work activities. He noted that this was not a discrete event but spanned more than 30 years of gripping and pinching activities performed in the course of her work activities. Dr. Larsen further noted that the arthritis progressed and she had developed secondary instability of the MCP joint that required arthrodesis and associated carpal tunnel syndrome. He advised that the requirement for treatment in the form of surgery with CMC arthroplasty, MCP joint arthrodesis and carpal tunnel release was a direct result of the unrelenting pinching and gripping activities spent across a long career.

On March 2, 2017 OWCP proposed to terminate all benefits finding that the August 3, 2016 report of appellant's treating physician Dr. Larsen established no continuing residuals of her work-related conditions.

In a statement dated March 14, 2017, appellant indicated that her date of retirement from the employing establishment was September 30, 2016. She indicated that she never received any compensation from OWCP for her claim. Appellant submitted a report from Dr. Larsen dated August 3, 2016 and a return to work slip from Dr. Larsen dated August 3, 2016, both previously of record.

In a decision dated May 15, 2017, OWCP terminated appellant's eligibility for wage-loss compensation benefits effective May 14, 2017. It based its decision on the August 3, 2016 report of Dr. Larsen, appellant's treating physician, who opined that appellant's accepted work-related conditions had resolved without residuals, and that she could return to work without restrictions. OWCP did not terminate medical benefits.

LEGAL PRECEDENT

Once OWCP accepts a claim it has the burden of justifying modification or termination of an employee's benefits. After it has determined that an employee has disability causally related to his or her federal employment, it may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[5]

[5] *Kenneth R. Burrow*, 55 ECAB 157 (2003).

ANALYSIS

OWCP accepted appellant's claim for temporary aggravation of osteoarthritis of the first CMC joint of the left hand and authorized left thumb CMC arthroplasty, left thumb MCP joint arthrodesis, and left carpal tunnel release which was performed on March 15, 2016. Appellant stopped work on March 2, 2016 to undergo surgery and was released to work without restrictions on August 3, 2016. She retired on September 30, 2016.

Appellant submitted reports from Dr. Larsen in March 2016 supporting that she had an employment-related condition. On March 15, 2016 Dr. Larsen performed a left thumb CMC arthroplasty, left thumb MCP joint arthrodesis, and left carpal tunnel release. He diagnosed left thumb CMC osteoarthritis with MCP joint instability and left carpal tunnel syndrome. Appellant underwent physical therapy from April 26 to May 27, 2016. In his report of August 3, 2016, Dr. Larsen continued to treat appellant and noted that she was doing very well and her thumb sensitivity improved. He indicated that appellant had improved motion and was starting to use her hand more normally. Dr. Larsen noted findings of nontender arthrodesis, some sensitivity in the dorsal skin flap, localized over the proximal fixation hardware, and stable thumb base which was painless to stress. He noted x-rays of the left thumb revealed a solid arthrodesis, no hardware issue, and a well-preserved trapezial resection space. Dr. Larsen noted that appellant's sensitivity over the hardware improved and he released appellant from his care. In a return to work slip dated August 3, 2016, he returned appellant to work without restrictions.

The Board finds that the opinion of Dr. Larsen, the treating physician, represents the weight of the evidence and establishes that any work-related disability had resolved by May 14, 2017. He indicated that appellant did not have residuals from the condition of temporary aggravation of osteoarthritis of the first CMC joint of the left hand and that she could return to her regular duties. There is no contemporaneous or subsequent medical evidence supporting appellant's claim for continuing disability or residuals of the accepted condition.[6]

For these reasons, OWCP met its burden of proof to terminate appellant's eligibility for wage-loss benefits for her accepted conditions.

On appeal appellant asserts that she never received any monetary compensation from OWCP for her accepted employment injury. The record before the Board does indicate that she never claimed wage-loss compensation for any disability attributable to her accepted condition prior to the termination of wage-loss benefits. As explained, however, the Board finds that the August 3, 2016 report from Dr. Larsen supports OWCP's finding that appellant was not entitlement to wage-loss compensation causally related to her accepted condition after May 14, 2017. There is no other evidence to support continuing disability.

[6] As indicated, *supra* note 4, appellant also submitted July 12 and August 16, 2016 reports from Drs. Schauf and Henley, who treated her for back conditions, radiculopathy, and hypertension. However, OWCP has not accepted these other conditions. For conditions not accepted by OWCP as being employment related, it is the employee's burden of proof to provide rationalized medical evidence sufficient to establish causal relation; *see Alice J. Tysinger*, 51 ECAB 638 (2000).

CONCLUSION

The Board finds that OWCP has met its burden of proof to terminate wage-loss benefits effective May 14, 2017.

ORDER

IT IS HEREBY ORDERED THAT the May 15, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 8, 2017
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board