United States Department of Labor
Employees' Compensation Appeals Board

R.G., Appellant	)	
and	)	**Docket No. 17-1179**
	)	**Issued: February 8, 2018**
U.S. POSTAL SERVICE, CITIGATE PROCESSING & DISTRIBUTION CENTER, Columbus, OH, Employer	)	

Appearances:
Stanley R. Stein, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 8, 2017 appellant, through counsel, filed a timely appeal from a February 22, 2017 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 merits of this case.

[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.*

ISSUE

The issue is whether appellant established a recurrence of total disability on May 16, 2015 and partial disability beginning June 25, 2015.

On appeal counsel asserts that the medical evidence of record establishes that appellant was unable to perform the duties of the modified position he began on January 26, 2015 due to the many accepted bilateral hand conditions.

FACTUAL HISTORY

On August 29, 2009 appellant, then a 46-year-old maintenance mechanic, filed an occupational disease claim (Form CA-2) alleging that his job duties caused right wrist pain. He stopped work that day. On September 11, 2009 OWCP accepted bilateral aggravation of carpal tunnel syndrome, bilateral aggravation of carpometacarpal (CMC) joint arthropathy of thumbs, and bilateral aggravation of trigger finger of long and ring fingers. Appellant stopped work on January 30, 2010. He received wage-loss compensation and was placed on the periodic compensation rolls in April 2010. Appellant briefly returned to work in June 2010 and was returned to the periodic rolls in August 2010.

Appellant began treatment with Dr. Eric A. Schaub, Board-certified in internal and occupational medicine, on August 18, 2009.

Dr. Lawrence M. Lubbers, Board-certified in orthopedic and hand surgery, performed trigger finger releases on February 8 and April 6, 2010, a right carpal tunnel release on July 26, 2010, resection arthroplasty of left thumb CMC joint on September 27, 2010, and the right thumb on November 22, 2010. He performed an additional right thumb procedure on January 24, 2011, and additional left thumb procedures on February 14, May 9, and August 2, 2011.

OWCP expanded the accepted conditions to include localized primary osteoarthritis of the right hand, bilateral closed dislocation of wrist, bilateral closed dislocation of finger, and bilateral ulnar nerve lesion.

On September 11, 2013 Dr. Lubbers performed right cubital tunnel release and cubital tunnel release on the left on April 9, 2014.

A July 17, 2014 functional capacity evaluation (FCE) noted that appellant could occasionally lift 15 pounds below waist and to shoulder height, could carry 15 pounds, and could push and pull 23 pounds. He was able to constantly perform fingering, simple hand grasping, firm hand grasping, and fine/gross manipulation. Bilateral upper and lower extremity active range of motion was within functional limits.

Appellant was referred for vocational rehabilitation services with Gordon McNamee, a rehabilitation counselor, in September 2014.

In a November 5, 2014 report, Dr. Schaub noted 5+ grip strength bilaterally, a negative Tinel's sign bilaterally, and pronounced decreased sensation in the fifth digits bilaterally with

modest decreased sensation in the fourth digits bilaterally. He diagnosed bilateral ulnar neuropathy, status post release with persistent pain and paresthesias, bilateral carpal tunnel syndrome, and status post release. On a duty status report (Form CA-17) also dated November 5, 2014, Dr. Schaub noted that appellant could sit, stand, and walk four to six hours daily, could push and pull 23 pounds of force, and could perform simple grasping and fine manipulation. He referenced the July 17, 2014 FCE. On December 3, 2014 Bethany Stranges, a physician assistant to Dr. Schaub, repeated the restrictions provided by Dr. Schaub.

On December 29, 2014 Mr. McNamee reported that appellant had a 70 percent Veterans Administration disability based on a back injury, post-traumatic stress disorder, and diabetes with osteoarthritis. He opined that these conditions, along with appellant's severe bilateral work-related arm conditions, rendered him unemployable in the general labor market.

On January 14, 2015 the employing establishment offered appellant a modified maintenance mechanic position. Appellant was to perform standard duties of a maintenance mechanic for eight hours daily with intermittent sitting, standing, walking, and grasping limited to four to six hours daily and a 15-pound weight restriction. Bending and stooping were limited to 1 to 3 hours intermittently and he was to have 15-minute breaks twice daily. Appellant returned to this position on January 26, 2015.[3]

On January 28, 2015 Dr. Schaub reiterated appellant's physical restrictions. In a February 13, 2015 treatment note, he reported appellant's complaint that he had difficulty with pinch grip at work, noting that tightening machine bolts required awkward hand postures that caused swelling and pain. Dr. Schaub found questionable swelling on examination, and advised that he was adjusting appellant's restrictions. On a February 13, 2015 duty status report (Form CA-17), he advised that appellant's pinch, grasp, and fine manipulation should be limited to occasional as tolerated. On June 3, 2015 Dr. Schaub noted that appellant was off work. He noted appellant's grip strength as 4+ to 5-/5+ and advised that he would reduce appellant's work hours to four hours a day, five days a week, due to increased hand pain and weakness. On a duty status report of the same date, Dr. Schaub reiterated that appellant's pinch, grasp, and fine manipulation should be limited to occasional as tolerated.

On June 25, 2015 the employing establishment offered appellant a modified position for four hours daily. Appellant was to scan placards on the dock, coming off and going onto trailers. Intermittent standing, sitting, and walking, and simple grasping were limited to four hours with a 15-pound lifting restriction. He accepted the position on June 26, 2015.

On July 22, 2015 Dr. Schaub noted that appellant was working reduced hours and that, while his hand pain and paresthesias increased by the end of his shift, he could tolerate them. He recommended an electromyograph/nerve conduction velocity study (EMG/NCV) to evaluate his paresthesias. Dr. Schaub continued to limit appellant to four hours of limited duty daily with pinch, grip, and fine manipulation limited to occasional as tolerated.

[3] Appellant's effective pay rate was greater than that when injured. On April 7, 2015 OWCP noted that he had been working consistently for over 60 days with no wage loss.

An October 14, 2015 EMG/NCV revealed likely significant residual damage from prior carpal tunnel on the right and bilateral ulnar neuropathies. On October 30, 2015 Dr. Schaub opined that the EMG/NCV findings appeared to be related to appellant's prior nerve injuries and surgeries. He recommended pain management and reiterated appellant's restrictions. On December 23, 2015 Dr. Schaub noted that appellant had seen Dr. Kedar K. Deshpande, a Board-certified physiatrist, for pain management. On January 6, 2016 he noted appellant's many hand surgeries, advising that appellant's improvement after the surgeries was limited with continued hand pain and weakness.

In a January 5, 2016 report, Dr. Deshpande noted appellant's complaint of bilateral right upper extremity pain radiating from the elbows into the hands. He diagnosed carpal tunnel syndrome, lesion of ulnar nerve, and primary localized osteoarthrosis of the hand, and described appellant's pain management.

On January 11, 2016 appellant filed a claim for compensation (Form CA-7) for the period May 16, 2015 to January 8, 2016. Time analysis forms (Form CA-7a), certified by the employing establishment, indicated that he did not work from May 16 through June 22, 2015 when he took annual and sick leave and claimed leave without pay (LWOP). Appellant returned to four hours of daily work on June 25, 2015 and claimed approximately four hours of LWOP thereafter through January 8, 2016.

In a January 20, 2016 report, Dr. Schaub noted examination findings of decreased sensation in all digits with bilateral paresthesias in the fourth and fifth digits. He recommended that appellant apply ice and/or heat throughout the day for additional pain relief and reiterated his restrictions. Dr. Schaub continued to submit reports noting decreased sensation in both hands. He reiterated his restrictions.[4] Dr. Deshpande continued to provide pain management.

By decision dated April 19, 2016, OWCP denied appellant's claim for a recurrence of total disability beginning May 16, 2015 and partial disability beginning June 25, 2015. It found the medical evidence insufficient to establish the disability claimed, noting that pain, without more rationale, did not constitute a basis for the payment of compensation.

Appellant, through counsel, timely requested a hearing with OWCP's Branch of Hearings and Review. Additional medical evidence submitted included pain management treatment notes from Dr. Deshpande dated December 16, 2015 to October 4, 2016. On March 2, 2016 Dr. Deshpande noted examination findings of paresthesias in the ulnar distribution of bilateral upper extremities.

Dr. Robin S. Berner, an associate of Dr. Schaub who is Board-certified in occupational medicine, saw appellant on April 20, 2016. She described appellant's history, noting that he returned to a mechanic position in January 2015, but could not tolerate that work beyond four hours. Examination revealed bilateral well-healed surgical scars at the elbow, wrist, and overlying the thumb CMC joint. Appellant was tender to palpation of both wrists with diminished sensation in median and ulnar distribution. Carpal tunnel compression test and

[4] A March 9, 2016 magnetic resonance imaging scan of the cervical spine demonstrated multilevel degenerative changes.

Tinel's sign at both wrists and elbows were positive. Digit and thumb range of motion were diminished. Dr. Berner diagnosed bilateral cubital tunnel syndrome and bilateral primary osteoarthritis of both first CMC joints. She advised that appellant had persistent pain and functional limitations associated with his multiple upper extremity diagnoses that prevented his return to full-time work and substantially impacted his recreational pursuits. Dr. Berner noted that an EMG/NCV showed chronic and active denervation of the median nerve bilaterally which was a possible source of the on-going symptoms. She recommended follow-up with Dr. Lubbers and reiterated Dr. Schaub's restrictions of limiting pinch and fine manipulation to occasionally as tolerated and working up to four hours daily. Dr. Berner restated her conclusions on May 23, 2016.

In a June 27, 2016 report, Dr. Lubbers noted appellant's complaint of paresthesias and dysesthesias. He reviewed the October 14, 2015 EMG/NCV and found a positive Tinel's sign at both wrists on examination with pseudomotor changes present on the left and thenar atrophy of 40 percent bilaterally. Dr. Lubbers noted that appellant's bilateral CMC joint surgery limited examination of his thenar atrophy, and recommended a diagnostic ultrasound.[5]

On June 29, 2016 Dr. Berner noted that appellant had seen Dr. Lubbers. She told appellant that she needed specific activity/restriction guidelines from Dr. Lubbers. Dr. Berner reiterated her conclusions about appellant's condition and extended his previous restrictions. On July 29, 2016 she indicated that he could work eight hours daily, but should continue to limit pinch, fine manipulation, and forceful grip to four hours daily. Dr. Berner reiterated these findings and conclusions on September 9, 2016.

On December 12, 2016 Dr. Jeffrey A. Strakowski, Board-certified in physiatry and pain medicine, described appellant's complaints of chronic arm pain, numbness, and tingling. Appellant had right thumb and small finger triggering and pain on the right with Spurling's maneuver. A high frequency ultrasound study showed findings consistent with persistent right median nerve entrapment at the carpal tunnel level with overlying scar. Appellant had borderline enlargement of the left median nerve at the carpal tunnel, and an anatomic variant of early bifurcation of the median nerve above the left carpal tunnel space as well as evidence of stenosing tenosynovitis of the right thumb and small finger. Dr. Strakowski opined that these were clear signs of persistent median nerve compression on the right and borderline evidence on the left. He suggested correlating with EMG studies.

In a January 4, 2017 report, Dr. Schaub noted the accepted conditions. He advised that on June 3, 2015 appellant was having increasing hand pain, weakness, and numbness. Dr. Schaub felt that this was related to overuse of his hands at work, opining that he felt the overuse was aggravating appellant's arthropathy and possibly was causing increased symptoms from his surgically released median and ulnar nerves. He noted that appellant continued to attempt to work in spite of pain, weakness, and numbness, but his symptoms increased to the point that he stopped work on May 16, 2015. Dr. Schaub indicated that appellant's examination on June 3, 2015 demonstrated impaired grip strength and this objective physical finding in addition to reported pain and weakness was enough to recommend a reduction in appellant's

[5] Dr. Lubbers also noted that appellant had associated findings per dictation by his nurse practitioner. The record before the Board does not contain this dictation.

work hours. He maintained that appellant's objective hand weakness was sufficient to try a reduction in work activity.

At the hearing, held on January 18, 2017, counsel asserted that appellant's return to work in January 2015 caused his employment-related arm conditions to flare, and Dr. Schaub placed additional restrictions. Appellant testified that when he returned to work in January 2015 he was doing standard mechanic duties such as vacuuming and cleaning machines and replacing parts with nuts and bolts, and this caused his hands to swell with limited range of motion, numbness, and cramping. He noted that in June 2015 the employing establishment offered him a part-time position that he could tolerate, and in October 2016 began working that job full time.

By decision dated February 22, 2017, an OWCP hearing representative affirmed the denial of the claim for recurrence finding that appellant did not establish total disability beginning May 16, 2015 and partial disability beginning June 25, 2015. He found Dr. Schaub's January 4, 2017 report insufficient to establish that appellant sustained a recurrence of disability, noting that Dr. Schaub attributed the worsening of appellant's conditions to overuse of his hands at work and not to a recurrence of disability.

LEGAL PRECEDENT

A recurrence of disability means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition which had resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness.[6] This term also means an inability to work when a light-duty assignment made specifically to accommodate an employee's physical limitations due to the work-related injury or illness is withdrawn (except when such withdrawal occurs for reasons of misconduct, nonperformance of job duties or a reduction-in-force), or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations.[7]

When an employee, who is disabled from the job he or she held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence establishes that light duty can be performed, the employee has the burden of proof to establish by the weight of reliable, probative, and substantial evidence a recurrence of total disability. As part of this burden of proof, the employee must show either a change in the nature and extent of the injury-related condition, or a change in the nature and extent of the light-duty requirements.[8]

An individual who claims a recurrence of disability resulting from an accepted employment injury has the burden of proof to establish that the disability is related to the accepted injury. This burden requires furnishing medical evidence from a physician who, on the basis of a complete and accurate factual and medical history, concludes that the disabling

[6] 20 C.F.R. § 10.5(x); *see Theresa L. Andrews*, 55 ECAB 719 (2004).

[7] *Id.*

[8] *Shelly A. Paolinetti*, 52 ECAB 391 (2001); *Robert Kirby*, 51 ECAB 474 (2000); *Terry R. Hedman*, 38 ECAB 222 (1986).

condition is causally related to the employment injury and supports that conclusion with sound medical reasoning.[9]

ANALYSIS

The Board finds that this case is not in posture for decision.

Appellant began treatment with Dr. Schaub in August 2009. On January 14, 2015 the employing establishment offered him a modified maintenance mechanic position based on restrictions provided by Dr. Schaub in November 2014 of sitting, standing, and walking limits to four to six hours daily, pushing and pulling limited to 23 pounds of force. Dr. Schaub also advised that appellant could perform simple grasping and fine manipulation. On January 26, 2015 appellant returned to the modified position that included standard duties of a maintenance mechanic for eight hours daily with intermittent sitting, standing, walking, and grasping limited to four to six hours daily, with a 15-pound weight restriction. Bending and stooping were limited to one to three hours intermittently, and appellant was to have 15-minute breaks twice daily.

Appellant did not work from May 16 through June 22, 2015. On June 25, 2015 he returned to a modified position for four hours daily with duties of scanning placards on the dock, coming off and going onto trailers. Intermittent standing, sitting, and walking, and simple grasping were limited to four hours with a 15-pound lifting restriction. Appellant claimed total disability for the period May 16 through June 22, 2015, and partial disability beginning June 25, 2015.

The medical evidence supporting an increase in disability includes reports from Dr. Schaub, who began treating appellant in 2009. On February 13, 2015 less than 30 days after appellant began his modified position, he reported to Dr. Schaub that the awkward hand postures required for repairing machines caused hand swelling and pain. Dr. Schaub found possible swelling on examination and advised that pinch, grip, and fine manipulation should be limited to occasional as tolerated. On June 3, 2015 he noted that appellant's grip strength, which had been 5+ bilaterally, was reduced to 4+ to 5-/5+. Dr. Schaub advised that appellant should only work four hours daily and reiterated his restrictions on pinch, grip and fine manipulation. On July 22, 2015 he recommended an EMG/NCV to evaluation appellant's paresthesias. This was done on October 14, 2015 and demonstrated significant residual damage on the right and bilateral ulnar neuropathies.

In a January 20, 2016 report, Dr. Schaub noted decreased sensation in all digits with bilateral paresthesias in the fourth and fifth digits. On January 4, 2017 he described appellant's medical and surgical history. Dr. Schaub noted that he felt appellant's complaints of hand pain, weakness, and numbness were related to overuse at work which aggravated his arthropathy and that, on June 3, 2015, appellant's findings included impaired grip strength which, together with his reported pain and weakness, was enough to recommend a reduction in work hours.

Dr. Berner, who began treating appellant in April 2016, also described objective findings including wrist tenderness and diminished sensation in the median and ulnar distribution with

[9] *S.S.*, 59 ECAB 315 (2008).

positive carpal tunnel compression tests and Tinel's signs. She opined that his pain and functional limitations associated with his multiple upper extremity diagnoses prevented his return to full-time work and substantially impacted his recreational pursuits. Dr. Berner noted the EMG/NCV findings of chronic and active denervation of the median nerve bilaterally and opined that this was a possible source of the on-going symptomatology. She recommended that appellant see Dr. Lubbers.

On June 27, 2016 Dr. Lubbers noted examination findings of positive Tinel's signs at both wrists with pseudomotor changes present on the left and thenar atrophy of 40 percent bilaterally. He recommended a diagnostic ultrasound. Dr. Strakowski performed an ultrasound of both hands and wrists on December 12, 2016. It showed persistent right median nerve entrapment at the carpal tunnel level with overlying scar, evidence of borderline enlargement of the left median nerve at the carpal tunnel, and an anatomic variant of the early bifurcation of the median nerve above the carpal tunnel space on the left, and evidence of right thumb and small finger stenosing tenosynovitis. Dr. Strakowski opined that these were clear signs of persistent median nerve compression on the right and borderline evidence on the left.

The Board finds that while these reports, which showed evidence of objective upper extremity findings beginning in February 2015, lack detailed medical rationale sufficient to discharge appellant's burden of proof that he was totally disabled for the period May 16 to June 22, 2015 and partially disabled beginning June 25, 2015 until he returned to full-time modified duty in October 2016, this does not mean that they may be completely disregarded by OWCP. It merely means that their probative value is diminished.[10] As delineated above, each physician described physical findings which could preclude appellant from performing either modified machine mechanic position on a part or full-time basis.

It is well established that proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[11]

The case shall therefore be remanded to OWCP. On remand, OWCP shall refer appellant, an updated statement of accepted facts, and the medical evidence of record to an appropriate Board-certified specialist for an examination, diagnosis and a rationalized opinion as to whether he was totally disabled from May 16 to June 22, 2015 and partially disabled at any time beginning June 25, 2015 due to the accepted conditions. After this and such further development deemed necessary, it shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision regarding whether appellant established total disability for the period May 16 to June 22, 2015 and partial disability beginning June 25, 2015.

[10] *O.P.*, Docket No. 15-0435 (issued September 22, 2016); *John J. Carlone*, 41 ECAB 354 (1989).

[11] *William J. Cantrell*, 34 ECAB 1223 (1983).

ORDER

IT IS HEREBY ORDERED THAT the February 22, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: February 8, 2018
Washington, DC

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

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

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