United States Department of Labor
Employees' Compensation Appeals Board

L.B., Appellant	)	
and	)	**Docket No. 20-0462**
	)	**Issued: August 18, 2020**
U.S. POSTAL SERVICE, POST OFFICE, Los Angeles, CA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On December 21, 2019 appellant filed a timely appeal from a June 27, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of this case.

ISSUE

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

[1] The timeliness of the appeal was determined by the date on appellant's appeal request form and not the date that the Clerk of the Board received it, December 26, 2019, as the latter date would have rendered the appeal untimely and the record does not contain a copy of the postmark. *See* 20 C.F.R. § 501.3(f)(1).

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On August 22, 2017 appellant, then a 62-year-old telephone agent and international research agent, filed an occupational disease claim (Form CA-2) alleging that she experienced daily pain in her neck, right arm, right clavicle, right thigh, and back due to factors of her federal employment, including sitting at her desk where she worked on a computer 10 hours per day, reaching for and typing reports as she looked at the computer screen, and speaking with customers on the telephone. She noted that she first became aware of her conditions and their relationship to her federal employment on April 21, 2017. On the reverse side of the claim form, the employing establishment controverted the claim, noting that appellant had a one-hour lunch break and three 15-minute breaks and, thus, she only worked 9 hours and 15 minutes per day. Appellant also had an option to sit or stand while working.

In support of her claim, appellant submitted an August 25, 2017 attending physician's report (Form CA-20) by Dr. Neha N. Sahni, an occupational medicine specialist. Dr. Sahni noted a date of injury as April 21, 2017. She related a history of injury that appellant developed pain in her neck, left arm, right hand, right clavicle, and back that went down to her right leg with a burning sensation in her right thigh and hip, and numbness in her left shoulder and left hand/wrist. Dr. Sahni conducted an examination and diagnosed neck and lumbar muscle strains, initial encounter, and right shoulder tendinitis. She advised that her findings and diagnoses were consistent with appellant's account of or injury or onset of illness. Dr. Sahni concluded that she could perform full-duty work.

In a development letter dated September 12, 2017, OWCP informed appellant that the evidence submitted was insufficient to establish her claim. It advised her of the type of factual and medical evidence needed and provided a questionnaire for her completion. In a separate development letter, OWCP requested that the employing establishment provide additional information, including comments from a knowledgeable supervisor and an explanation of appellant's work activities. It afforded both parties 30 days to respond.

In an August 30, 2017 memorandum, the employing establishment responded to OWCP's development letter. It described appellant's work duties, restated that she was allowed three 15-minute breaks and a 1-hour lunch break, and contended that her claimed injuries were not caused by her employment. The employing establishment also contended that she had not submitted any medical evidence to establish a work-related injury. It submitted an official position description for a customer care agent.

On September 29, 2017 appellant responded to OWCP's development letter and provided more details regarding the factors of her federal employment. She also described activities outside her federal employment.

OWCP, by decision dated November 17, 2017, denied appellant's occupational disease claim finding that the evidence of record was insufficient to establish a diagnosed medical condition in connection with the accepted factors of her federal employment. It concluded therefore that the requirements had not been met to establish an injury as defined by FECA.

Thereafter, OWCP continued to receive medical evidence. In duty status reports dated February 21, March 1 and 30, and April 19, 2018, Dr. Christopher P. DeCarlo, an attending physiatrist, listed a date of injury as March 17, 2017 and noted that the affected body parts included the cervical and lumbar spines and right shoulder. He advised that appellant could return to limited-duty work with restrictions from February 21 through May 24, 2018. In a March 1, 2018 federal physician's progress report, Dr. DeCarlo provided examination findings and diagnosed lumbar spine degenerative disc disease with L3-4 spinal canal stenosis, cervical spine multilevel degenerative disc disease with spinal canal neural foraminal stenosis, and right shoulder partial thickness rotator cuff tear with biceps tenosynovitis. He released appellant to return to modified work with the restrictions set forth in his form reports on the date of his examination.

On May 3, 2018 appellant requested reconsideration of the November 17, 2017 decision and submitted additional evidence. In an April 19, 2018 narrative report, Dr. DeCarlo noted appellant's employment history beginning in 1979 and her work duties. He also noted the development of her claimed injuries beginning in 2014 and that she previously experienced neck and low back pain from 2009 to 2010. Dr. DeCarlo reported findings on physical examination and reviewed diagnostic test results. He reiterated his prior diagnoses of lumbar spine degenerative disc disease with L3-4 spinal canal stenosis, cervical spine multilevel degenerative disc disease with spinal canal neural foraminal stenosis, and right shoulder partial thickness rotator cuff tear with biceps tenosynovitis. Dr. DeCarlo opined that the diagnosed conditions were caused by appellant's repetitive work duties. He noted that she had worked in a call center since 2013, which required constant sitting, use of a mouse, keyboard, and telephone system, and reaching across a desk to write customer information on a whiteboard and then again to wipe the information out. Dr. DeCarlo further noted that appellant had significant stressors placed on her right shoulder and cervical axial system. During eight hours of work appellant constantly used her right upper extremity, entered data, moved her head from side-to-side, forward, and backward, went from her monitor to a chalkboard, and used a mouse. Dr. DeCarlo maintained that the repetitive stretching and twisting involved in these activities produced inflammation in the tissues of the cervical spine and the tissues became fatigued as they moved beyond the acceptable range of motion and resulted in inflammatory changes and disc bulges as noted on magnetic resonance imaging (MRI) scan studies. He further maintained that the repetitive movement of the right upper extremity at the shoulder caused the acromion to press down on the rotator cuff with the forces from the acromion repeatedly injuring the supraspinatus and infraspinatus tendons as they ran under the acromion bone. Dr. DeCarlo advised that this led to inflammatory changes and then eventually to the partial thickness tear noted on the MRI scan study. He determined that constant activities involving the use of the right upper extremity and neck at appellant's work station produced her present pathology and symptomatology. Regarding her lumbar spine pain with a burning sensation going down the right lower extremity, Dr. DeCarlo indicated that prolonged sitting had transferred increased biomechanical forces into the lumbar axial skeletal system, which eventually caused a weakening of the intervertebral disc at a layer or annulus fibrosus. He related that, with weakening of the annulus fibrosus, the disc now started to extend beyond its normal physiologic position pushing into areas in the surrounding environment, *i.e.*, the spinal canals. Dr. DeCarlo also related that nerves ran through these canals, which had been demonstrated on appellant's lumbar spine MRI scan and electromyogram/nerve conduction velocity (EMG/NCV) study. He advised that these discs began to press directly on the exiting nerve roots. Dr. DeCarlo reminded that it was not necessary to prove a significant contribution of factors of employment to a condition for the purpose of establishing causal relationship. If the medical evidence revealed that an employment

factor contributed in any way to the employee's condition, such a condition would be considered employment related for the purposes of compensation under FECA as outlined in OWCP's procedures. Dr. DeCarlo listed appellant's work restrictions.

Appellant also submitted diagnostic test reports from Dr. Ashkon Senaati, a diagnostic radiologist. In a February 26, 2018 lumbar spine MRI scan report, Dr. Senaati provided impressions of moderate L3-4 spinal canal stenosis and degenerative changes as detailed in his report. Also, on February 26, 2018 he noted that a cervical spine MRI scan revealed no acute abnormality and showed degenerative changes as detailed in his report. Additionally, on February 26, 2018 Dr. Senaati reported that a right shoulder MRI scan showed a partial thickness tear of the bursal surface of the distal supraspinatus tendon, tendinopathy of the insertional aspect of the infraspinatus tendon, and long head biceps tendon tenosynovitis.

Dr. Maliheh Massih, a physiatrist, related that appellant's March 21, 2018 EMG/NCV study of the lower extremities was somewhat abnormal. He noted that the findings were suggestive of highly probable proximal root pathology of the L5 and S1 nerve roots. Dr. Massih related that a needle EMG examination did not show any active denervation. He concluded therefore that, based on the electrodiagnostic study, there was no evidence of radiculopathy with the exception of the delayed reflexes. Dr. Massih recommended that his study be correlated with MRI scan studies for the possibility of bilateral L5-S1 proximal root pathology.

OWCP subsequently received an additional form report dated May 24, 2018 by Dr. DeCarlo who continued to note that the affected body parts were cervical and lumbar spines and right shoulder. Dr. DeCarlo released appellant to return to limited-duty work with restrictions through November 19, 2018.

OWCP also received an April 5, 2018 report from Johannes Schothorst, LAc, Ph.D., a licensed acupuncturist and physician of philosophy, who treated appellant's cervical and lumbar spines and right shoulder pain.

By decision dated July 23, 2018, OWCP affirmed the November 17, 2017 decision, as modified, finding that the evidence of record was sufficient to establish a diagnosed medical condition. It denied the claim, however, finding that the medical evidence of record failed to address whether appellant's underlying stenosis and degenerative disc disease was aggravated by the accepted factors of her federal employment.

On December 20, 2018 appellant requested reconsideration.

OWCP, by decision dated January 17, 2019, denied appellant's request for reconsideration of the merits of her claim pursuant to 5 U.S.C. § 8128(a).

Thereafter, OWCP continued to receive medical evidence from Dr. DeCarlo. In a partial letter dated December 27, 2018, Dr. DeCarlo noted that he was writing in response to OWCP's July 23, 2018 decision and contended that appellant's claim should be accepted. He reiterated his prior opinion that her diagnoses of lumbar spine degenerative disc disease with canal stenosis, cervical spine multilevel degenerative disc disease with stenosis, and right shoulder partial thickness rotator cuff tear, and biceps tenosynovitis were caused by her repetitive work duties. Additionally, Dr. DeCarlo reiterated his explanation that significant stresses placed upon

appellant's right shoulder, cervical, and axial skeletal system during the eight hours she constantly worked using her right upper extremity, entering data, and moving her head from side-to-side, forward and backward, and going from her monitor to a chalkboard, and using a mouse. He also restated that these constant repetitive motions produced inflammatory changes in the tissues of the cervical spine by the repetitive stretching and twisting that occurred during these activities with the tissues becoming fatigued as they moved beyond the acceptable range of motion and resulted in inflammatory changes and disc bulges in the cervical spine as clearly noted on February 26, 2018 MRI scan studies. Dr. DeCarlo reported that these studies showed a one-millimeter (mm) disc osteophyte complex resulting in mild spinal canal stenosis at C2-3; a two-mm disc osteophyte complex resulting in moderate ventral cerebrospinal fluid (CSF) space narrowing with mild cord deformity and mild spinal canal and mild bilateral neural foraminal stenosis at C3-4; a two-mm disc osteophyte complex resulting in a moderate cord deformity and severe narrowing of the ventral CSF space, ligamentum flavum hypertrophy posteriorly resulting in moderate dorsal a CSF space narrowing, and mild-to-moderate spinal canal stenosis and mild-to-moderate bilateral neural foraminal stenosis at C4-5; a two-mm disc osteophyte complex resulting in moderate narrowing of the ventral CSF space and mild spinal canal stenosis and mild bilateral neural foraminal stenosis at C5-6; and a left paracentral/subarticular annular tear measuring three mm in the anterior posterior dimension and mild cord deformity and mild spinal canal stenosis at C6-7. He also reported that a February 26, 2018 lumbar spine MRI scan demonstrated a one-mm broad-based disc bulge with mild bilateral facet arthrosis at Ll-2; a two-mm broad-based disc bulge and ligamentum flavum hypertrophy resulting in mild bilateral neural foraminal stenosis with mild-to-moderate spinal canal stenosis at L2-3; a three-mm broad-based disc bulge with moderate-to-severe bilateral facet arthrosis and ligamentum flavum hypertrophy resulting in mild bilateral neural foraminal stenosis and moderate spinal canal stenosis at L3-4; a three-mm broad-based disc bulge-resulting in mild spinal canal stenosis, broad-based disc bulge and ligamentum flavum hypertrophy resulting in mild-to-moderate bilateral neural foraminal stenosis with moderate bilateral facet arthrosis at L4-5; and moderate right facet arthrosis at L5-S1. Dr. DeCarlo noted that a February 26, 2018 right shoulder MRI scan a partial thickness tear of the bursal surface of the distal supraspinatus tendon, tendinopathy of the insertional aspect of the infraspinatus tendon, and long head of the biceps tendon tenosynovitis. He maintained that clearly, these pathological changes were caused by appellant's above-mentioned work duties over many years of working for the employing establishment. Dr. DeCarlo restated that the repetitive movement of the right upper extremity at the shoulder caused the acromion to press down on the rotator cuff with the forces from the acromion repeatedly injuring the supraspinatus and infraspinatus tendons as they ran under the acromion bone. He also restated that this led to inflammatory changes and then eventually to the partial thickness tear as noted on the above-mentioned MRI scan study. Dr. DeCarlo again determined that the constant activities involving the use of the right upper extremity and neck at appellant's workstation produced her present pathology and symptomatology that was clearly shown on the MRI scan studies.

Dr. DeCarlo noted that his findings on physical examination consistently showed tenderness to palpation along the biceps tendon groove and surrounding the posterior capsule, point tenderness over the supraspinatus-deltoid junction, and positive impingement signs on both Hawkins and Neer testing. Regarding the cervical spine, he noted that there was significant tenderness over the right greater than left paraspinal musculature with slight spasming. Appellant also had an anterior head carriage, which indicated loss of normal cervical spine lordosis. Regarding her lumbar spine pain with a burning sensation going down the right lower extremity,

Dr. DeCarlo indicated that prolonged sitting had transferred increased biomechanical forces into the lumbar axial skeletal system, which eventually caused a weakening of the intervertebral disc at a layer or annulus fibrosus. He related that, with weakening of the annulus fibrosus, the disc now started to extend beyond its normal physiologic position pushing into areas in the surrounding environment, *i.e.*, the spinal canals. Dr. DeCarlo also related that nerves ran through these canals, which had been demonstrated on appellant's lumbar spine MRI scan. Additionally, he related that there were some positive findings on an EMG/NCS study which suggested a proximal root pathology at L5-S1, but did not show a true radiculopathy based on the study. Dr. DeCarlo indicated that, still during physical examination of the lumbar spine, there was significant tenderness across the lower paraspinal musculature. Appellant was able to forward flex to almost 90 degrees and extend to only about 15 degrees, but with reported increased low back pain. She had difficulty exhibiting heel-toe walking due to increased pain and there was a positive straight leg raise to 50 degrees on the right side.

Dr. DeCarlo opined it appeared that, if appellant had not engaged in all of the repetitive duties as described in his report, she would not have had the above-mentioned pathological findings on the above-mentioned MRI scan studies or exhibited her present complaints of neck, low back, and right shoulder pain. As such, he concluded that it was clear that many years of performing the described repetitive activities caused her diagnoses of lumbar spine degenerative disc disease with canal stenosis, cervical spine multilevel degenerative disc disease with stenosis, and right shoulder partial thickness rotator cuff tear and biceps tenosynovitis.

In a January 7, 2019 duty status report, Dr. DeCarlo again noted that the affected body parts were cervical and lumbar spines and right shoulder. He released appellant to return to limited-duty work through February 7, 2019.

On April 1, 2019 appellant again requested reconsideration of the July 23, 2018 decision and submitted a complete copy of Dr. DeCarlo's December 27, 2018 response letter in which he related her employment history beginning in 1991 and her work duties. Dr. DeCarlo noted that since March 2017 she had opted to work at a sit-stand work station and she was able to shift between seated and standing work, as needed. He restated appellant's computer and telephone work activities.

By decision dated June 27, 2019, OWCP denied modification of its July 23, 2018 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] has the burden of proof to establish the essential elements of his or her claim, including that the individual is an employee of the United States within the meaning of FECA, that the claim was filed within the applicable time limitation period of FECA,[4] that an injury was sustained while in the performance of duty as alleged, and that any disability or specific condition for which compensation is claimed is causally related to

[3] *Id*.

[4] *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

the employment injury.[5] These are the essential elements of each and every compensation claim, regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[6]

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.[7]

Causal relationship is a medical issue, and the medical evidence required to establish causal relationship is rationalized medical opinion evidence.[8] 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.[9]

In any case where a preexisting condition involving the same part of the body is present and the issue of causal relationship, therefore involves aggravation, acceleration, or precipitation, the physician must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.[10]

ANALYSIS

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

In support of her claim, appellant submitted an April 19, 2018 report and a December 27, 2018 letter by Dr. DeCarlo which indicated that she complained of pain in her neck, right shoulder, right arm, right hip, and back. Dr. DeCarlo noted her medical history of neck and back conditions, conducted a physical examination, reviewed her MRI scans of her cervical and lumbar spines and right shoulder and EMG/NCV study of her bilateral lower extremities, and diagnosed lumbar spine degenerative disc disease with L3-4 spinal canal stenosis, cervical spine multilevel degenerative disc disease with spinal canal neural foraminal stenosis, and right shoulder partial thickness rotator cuff tear with biceps tenosynovitis. He opined that appellant's diagnosed conditions were caused by factors of her employment, including sitting, computer use, and reaching while working as a

[5] *J.M.*, Docket No. 17-0284 (issued February 7, 2018); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[6] *K.M.*, Docket No. 15-1660 (issued September 16, 2016); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

[7] *S.C.*, Docket No. 18-1242 (issued March 13, 2019); *R.H.*, 59 ECAB 382 (2008).

[8] *A.M.*, Docket No. 18-1748 (issued April 24, 2019); *T.H.*, 59 ECAB 388 (2008).

[9] *M.V.*, Docket No. 18-0884 (issued December 28, 2018); *I.J.*, 59 ECAB 408 (2008).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013); *C.C.*, Docket No. 19-1631 (issued February 12, 2020).

customer care agent in a call center. Dr. DeCarlo advised that constant activities involving her use of her right upper extremity and neck produced her current pathology and symptomatology based on his physical examination findings, and the results of the February 26, 2018 MRI scans of the lumbar and cervical spines and right and the March 21, 2018 EMG/NCV study.

The Board finds that, although Dr. DeCarlo's April 19, 2018 report and December 27, 2018 letter are not fully rationalized, they are relevant evidence in support of appellant's claim, as they explain the physiological process by which her accepted factors of federal employment caused or aggravated her diagnosed lumbar, cervical, and right shoulder conditions. Dr. DeCarlo's April 19, 2018 report and December 27, 2018 letter therefore raise an uncontroverted inference of causal relation between her claimed lumbar, cervical, and right shoulder conditions and the accepted factors of her federal employment. Further development of appellant's claim is therefore required.[11]

On remand OWCP shall prepare a statement of accepted facts setting forth the employment factors which have been established and refer appellant to an appropriate second opinion physician for an examination and a rationalized medical opinion as to whether her accepted employment factors either caused or aggravated her lumbar, cervical, and right shoulder conditions.[12] If the second opinion physician disagrees with the pathophysiological explanation provided by Dr. DeCarlo, he or she must provide a fully-rationalized explanation explaining why Dr. DeCarlo's opinion is unsupported. After this and other such further development deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[11] *See A.T.*, Docket No. 19-1972 (issued June 25, 2020); *K.T.*, Docket No 19-1436 (issued February 21, 2020); *John J. Carlone*, 41 ECAB 354, 356-57 (1989).

[12] *See supra* note 10.

ORDER

IT IS HEREBY ORDERED THAT the June 27, 2019 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: August 18, 2020
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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