United States Department of Labor
Employees' Compensation Appeals Board

J.S., Appellant	)	
and	)	**Docket No. 19-0892**
	)	**Issued: November 4, 2020**
U.S. POSTAL SERVICE, MAIN POST OFFICE, Dallas, TX, Employer	)	

Appearances:
M. Jermaine Watson, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 21, 2019 appellant, through counsel, filed a timely appeal from an October 24, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP).[2] Pursuant to the

[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] Appellant timely requested oral argument before the Board. By order dated July 20, 2020, the Board exercised its discretion and denied the request as the matter could be adequately addressed based on a review of the case record. *Order Denying Request for Oral Argument*, Docket No. 19-0892 (issued July 20, 2020).

Federal Employees' Compensation Act[3] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[4]

ISSUE

The issue is whether appellant has met his burden of proof to establish total disability from work for the period July 26, 2014 to August 7, 2017 causally related to his accepted February 29, 2012 employment injury.

FACTUAL HISTORY

On March 1, 2012 appellant, then a 58-year-old tractor-trailer operator, filed a traumatic injury claim (Form CA-1) alleging that on February 29, 2012 he injured his left shoulder and neck when he was backing in a dock and a bobtail tried to pass him while in the performance of duty. He stopped work on March 1, 2012. OWCP assigned OWCP File No. xxxxxx752. It accepted appellant's claim for neck sprain and brachial neuritis or radiculitis and subsequently expanded acceptance of his claim to include left rotator cuff shoulder sprain. OWCP paid him wage-loss compensation on the supplemental rolls beginning April 5, 2012.

By decision dated December 17, 2012, OWCP terminated appellant's wage-loss compensation and medical benefits, effective that day, because he no longer had residuals or disability causally related to the accepted February 29, 2012 employment injury.

Appellant continued to receive medical treatment, including cervical steroid injections, and submitted additional medical reports.

In a disability certificate note dated August 1, 2014, Dr. Gary Bonacquisti, a Board-certified family physician, indicated that appellant was totally incapacitated from July 28 to 30, 2014 due to a medical condition.

OWCP received reports dated August 25 to October 21, 2015 by Dr. Robert Ippolito, a Board-certified plastic surgeon. In the initial August 25, 2015 report, Dr. Ippolito noted appellant's complaints for chronic pain to both right and left hands. Upon examination of appellant's upper extremities, he observed marked tenderness along the cubital tunnels of both wrists and positive Phalen's, Tinel's, and compression tests. Dr. Ippolito diagnosed bilateral carpal tunnel, bilateral cubital tunnel, bilateral lateral epicondylitis, and bilateral radial styloid tendinitis tenosynovitis.

In a July 10, 2015 report by Dr. Byron E. Strain, Board-certified in physical medicine and rehabilitation, recounted that appellant continued to complain of left shoulder pain radiating to his

[3] 5 U.S.C. § 8101 *et seq.*

[4] The Board notes that, following the October 24, 2018 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*

left hand with numbness and tingling. He reviewed appellant's history and conducted an examination. Dr. Strain related that electrodiagnostic studies conducted that day was significant for mild left ulnar neuropathy at the wrist.

On January 6, 2016 appellant filed an occupational disease claim (Form CA-2) alleging that he developed thoracic spinal epidural lipomatosis as a result of medical treatment that he received in order to treat his work-related injuries. OWCP assigned that case OWCP File No. xxxxxx134. In an attached statement, appellant described his cervical and shoulder injuries under OWCP File No. xxxxxx752 and his bilateral upper extremity injuries under OWCP File No. xxxxxx993.[5] He related that from 2012 through 2014 he received several thoracic and cervical spinal steroid injections to treat his multiple work-related injuries. Appellant alleged that his thoracic spinal epidural lipomatosis was a consequential injury from the steroid injections he received to treat his work-related injuries.

In a January 21, 2016 letter, OWCP informed appellant that it was converting his new occupational disease claim into a recurrence claim (Form CA-2a). It explained that, since he was alleging a consequential injury resulting from medical treatment for the accepted conditions under two separate cases, *i.e.*, OWCP File Nos. xxxxxx752 and xxxxxx993, it would combine these two case files and develop the current recurrence claim under the master OWCP File. No. xxxxxx752.[6]

In an August 8, 2015 letter, Dr. Priscilla Hollander, a Board-certified internist who specializes in endocrinology, diabetes, and metabolism, indicated that in 2014 appellant began to experience varied neurological symptoms, including loss of lower extremity strength, and mobility. She noted that he had a history of at least two years of major steroid injections for his back and neck issues and opined that his steroid treatment for his disc and joint disease played a major role in triggering his spinal epidural lipomatosis.

In a September 14, 2015 physical performance examination report, Dr. Sean Jones-Quaidoo, a Board-certified orthopedic surgeon, noted that appellant had been off work since September 2014. He reported that appellant was status post laminectomy and fusion of his thoracic spine and had developed thoracic epidural lipomatosis with several complications, including severe weakness and inability to work.

In reports dated January 6 and March 2, 2016, Dr. Karen M. Perl, Board-certified in physical medicine and rehabilitation, noted physical examination findings of decreased flexion and lateral rotation of the cervical spine and positive Spurling's test. She diagnosed musculoskeletal injuries related to a workers' compensation claim on February 11, 2013, C6-7 two-mm disc bulge with radicular symptoms into the upper extremities, cervical facet syndrome status post facet injections, and bilateral radial and ulnar neuropathy.

[5] Under OWCP File No. xxxxxx993, appellant filed a Form CA-2 alleging that he developed severe pain in his neck radiating down to both arms and wrists as a result of his repetitive employment duties. OWCP accepted his claim for bilateral rotator cuff syndrome, bilateral lateral epicondylitis, de Quatrain's tenosynovitis, bilateral carpal tunnel syndrome, and bilateral cubital tunnel syndrome, and paid medical benefits.

[6] The case record reveals that, despite OWCP's letter, OWCP File No. xxxxxx993 was not combined with the current claim.

In an August 2, 2016 examination note, Dr. Jones-Quaidoo noted appellant's complaints of muscle aches, weakness, and back pain and provided examination findings. He assessed that appellant had thoracic epidural lipomatosis and was working to apply for disability. Dr. Jones-Quaidoo reported further diagnoses of extensor carpi radials tenosynovitis, rotator cuff shoulder syndrome and allied disorders, carpal tunnel syndrome, epicondylitis, cervical spondylosis with radiculopathy, lumbosacral radiculopathy, rotator cuff syndrome, epidural lipomatosis, thoracic spondylosis with myelopathy, complex regional pain syndrome, and lesion of the ulnar nerve.

In a May 18, 2016 letter, Dr. Hollander indicated that she first treated appellant in 2015 for varied neurological symptoms, the most aggressive problem being loss of lower extremity strength and mobility. She explained that it took a while to diagnose the rare condition of spinal epidural lipomatosis and noted that the disease was mainly associated with patients who had been on long term steroid treatment. Dr. Hollander related that appellant had a history of at least two years of major steroid injections for back and neck issues. She noted that his last steroid treatment was in the spring of 2014, and indicated that such therapy can set up what is called Cushing's syndrome. When such syndrome is present, it can suppress production of cortisol by the adrenal system. Dr. Hollander further opined that current testing showed that appellant's adrenal system was in fact suppressed. She opined that the steroid injections treatment played a major role in triggering the spinal epidural lipomatosis.

In a May 20, 2016 report, Dr. Perl noted that appellant had sustained occupational injuries to his cervical and lumbar spine and underwent multiple steroid injections from different physicians. She indicated that, due to his excessive amount of steroid injections, he developed a complication called spinal epiduramotosis. Dr. Perl noted that appellant had difficulty being able to walk and had to undergo surgery. She provided physical examination findings and assessed that he had thoracic epiduramotosis related to steroid complication. Dr. Perl further reported that appellant "developed acute onset of weakness and inability to walk directly related to steroid complication from his [f]ederal [w]orkers' [c]ompensation claim."

On June 17, 2016 appellant filed another Form CA-2 alleging that he developed thoracic spinal epidural lipomatosis as a result of excessive steroid treatment to treat his previously accepted injuries. OWCP assigned that case OWCP File No. xxxxxx338. In an August 18, 2016 letter, it informed appellant that it was converting his occupational disease claim to a recurrence of disability claim under Master OWCP File No. xxxxxx752.

In a November 2, 2016 progress note, Dr. Perl noted that appellant's examination findings were mostly unchanged from his previous visit. She assessed musculoskeletal injuries related to workers' compensation claim, cervical facet syndrome status post facet injections, C6-7 two-mm disc bulge with radicular symptoms into the upper extremities, and bilateral radial and ulnar neuropathy.

In a February 27, 2017 decision, OWCP denied appellant's recurrence claim finding that the medical evidence of record was insufficient to establish that he was totally disabled from work due to a consequential condition stemming from his original injury because it had not "authorized the multiple injections." It noted that his case was closed on December 17, 2012 and that it had only authorized treatment of steroid injections on August 31, 2012 for treatment administered from September 2 to October 2, 2012.

On April 25, 2017 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review. By decision dated July 28, 2017, an OWCP hearing representative set aside the February 27, 2017 decision, and remanded the case for further development to determine whether appellant developed thoracic epidural lipomatosis as a consequence of the medical treatment that he received to treat his accepted conditions under OWCP File No. xxxxxx752 and OWCP File No. xxxxxx993. She also instructed OWCP to combine OWCP File No. xxxxxx993 with the current claim under OWCP File No. xxxxxx752.[7]

After referral to Dr. Adam Carter, Board-certified in physical and rehabilitation medicine a second-opinion physician, OWCP expanded acceptance of appellant's claim, in a May 24, 2018 decision, to include lipomatosis. However, it found that the condition resolved based on Dr. Carter's February 22, 2018 report effective February 15, 2018.[8]

On June 24, 2018 appellant filed a claim for wage-loss compensation (Form CA-7) for the period August 8, 2015 to August 7, 2017.

In a development letter dated July 10, 2018, OWCP advised appellant of the type of evidence needed to establish his wage-loss compensation claim for the period August 8, 2015 to August 7, 2017.

In a July 27, 2018 letter, Dr. Jones-Quaidoo recounted that appellant had two on-the-job injuries, one on February 29, 2012 and the other on February 11, 2013 which led him to undergo epidural steroid injections and physical therapy. He reported that over time the "repeated injections and the patient's predisposition may have led to further epidural fat deposits and progressed [appellant's] spinal stenosis." Dr. Jones-Quaidoo noted that on July 26, 2014 appellant's legs gave out on him. He indicated that appellant continued to decline physically. Dr. Jones-Quaidoo opined that the accepted diagnosis still applied to appellant and that the source of his pain and resultant disability was due to degeneration. He further noted that the treatments over time also possibly furthered the disease process of epidural lipomatosis, which resulted in further disability.

On August 5, 2018 appellant filed another Form CA-7 claiming wage-loss compensation for the period July 26, 2014 to August 6, 2017.

OWCP received several "Explanation of Benefits" forms from appellant's private insurance for service dates of July 28, 2014 to May 31, 2018.

By decision dated October 24, 2018, OWCP denied appellant's claim for wage-loss compensation due to total disability for the period July 26, 2014 through August 7, 2017. It found

[7] The case record reveals that, despite the decision of OWCP's hearing representative, OWCP File No. xxxxxx993 was not combined with the current claim.

[8] OWCP noted that Dr. Carter had opined in his February 15, 2018 report that appellant had developed thoracic epidural lipomatosis as a direct result of his multiple cervical and lumbar epidural injections received for case OWCP File Nos. xxxxxx752 and xxxxxx993.

that the medical evidence of record was insufficient to establish that he was disabled from work due to a material change or worsening of his accepted injuries.

LEGAL PRECEDENT

An employee seeking benefits under FECA[9] 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.[10] The term disability is defined as the incapacity, because of an employment injury, to earn the wages the employee was receiving at the time of the injury.[11] For each period of disability claimed, the employee has the burden of proof to establish that he or she was disabled from work as a result of the accepted employment injury.[12]

Whether a particular injury causes an employee to become disabled from work, and the duration of that disability, are medical issues that must be proven by a preponderance of the reliable, probative, and substantial medical evidence.[13] The medical evidence required to establish causal relationship between a claimed period of disability and an employment injury is rationalized medical opinion evidence. 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 claimed disability and the specific employment factors identified by the claimant.[14]

The Board will not require OWCP to pay compensation for disability in the absence of medical evidence directly addressing the specific dates of disability for which compensation is claimed. To do so would essentially allow an employee to self-certify his or her disability and entitlement to compensation.[15]

ANALYSIS

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

Appellant submitted reports from Dr. Hollander which strongly suggest that appellant was unable to work due to his accepted lipomatosis injury. In an August 8, 2015 letter, she indicated that in 2014 he began to experience varied neurological symptoms, including loss of lower

[9] *Supra* note 3.

[10] *See B.K.*, Docket No. 18-0386 (issued September 14, 2018); *see also Amelia S. Jefferson*, 57 ECAB 183 (2005); *Nathaniel Milton*, 37 ECAB 712 (1986).

[11] 20 C.F.R. § 10.5(f); *S.T.*, Docket No. 18-0412 (issued October 22, 2018); *Cheryl L. Decavitch*, 50 ECAB 397 (1999).

[12] *See D.G.*, Docket No. 18-0597 (issued October 3, 2018); *Amelia S. Jefferson*, *supra* note 10.

[13] *Amelia S. Jefferson*, *id.*; *William A. Archer*, 55 ECAB 674 (2004).

[14] *V.A.*, Docket No. 19-1123 (issued October 29, 2019).

[15] *See S.G.*, Docket No. 18-1076 (issued April 11, 2019); *William A. Archer*, 55 ECAB 674 (2004); *Fereidoon Kharabi*, 52 ECAB 291 (2001).

extremity strength and mobility. In a May 18, 2016 letter, Dr. Hollander related that appellant had a history of at least two years of major steroid injections for back and neck issues and opined that the steroid injections treatment played a major role in triggering the spinal epidural lipomatosis. She noted that his last steroid treatment was in the spring of 2014, and indicated that such therapy can set up what is called Cushing's syndrome. When such syndrome is present, it can suppress production of cortisol by the adrenal system. Dr. Hollander further opined that current testing showed that appellant's adrenal system was in fact suppressed.

The Board finds that, while the reports from Dr. Hollander are not completely rationalized, they are consistent in indicating that appellant was unable to work beginning in 2014 due to the development of his lipomatosis condition and are not contradicted by any substantial medical or factual evidence of record.[16] While these reports do not provide medical rationale to establish his inability to work during the claimed period due to his consequential injury, they strongly suggest and support a relationship between his accepted lipomatosis condition and resultant disability from work. Although the reports of Dr. Hollander are insufficient to meet appellant's burden of proof to establish the claim, they raise an uncontroverted inference between appellant's accepted lipomatosis condition and disability from work from July 26, 2014 to August 7, 2017, and thus, they are sufficient to require OWCP to further develop the medical evidence.[17]

It is well established that proceedings under FECA are not adversarial in nature, and while appellant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[18] It has an obligation to see that justice is done.[19] Thus, the Board will remand the case to OWCP for further development of the medical evidence in order to determine whether appellant's inability to work from July 26, 2014 to August 7, 2017 was causally related to his consequential lipomatosis injury.

Furthermore, on remand the Board finds that OWCP should administratively combine OWCP File No. xxxxxx993 with master OWCP File No. xxxxxx752.[20] OWCP's procedures provide that cases should be administratively combined when correct adjudication of the issues depends on frequent cross-referencing between files.[21] In the instant case, appellant has alleged that his lipomatosis condition was a consequential injury of his accepted claims under OWCP File Nos. xxxxxx993 and xxxxxx752. The record reflects that OWCP had administratively combined

[16] *See D.G.*, Docket No. 18-0043 (issued May 7, 2019).

[17] *See E.J.*, Docket No. 09-1481 (issued February 19, 2010); *Richard E. Simpson*, 55 ECAB 490, 500 (2004); *John J. Carlone*, 41 ECAB 354, 360 (1989).

[18] *See e.g.*, *M.G.*, Docket No. 18-1310 (issued April 16, 2019); *Walter A. Fundinger, Jr.*, 37 ECAB 200, 204 (1985); *Michael Gallo*, 29 ECAB 159, 161 (1978); *William N. Saathoff*, 8 ECAB 769-71; *Dorothy L. Sidwell*, 36 ECAB 699, 707 (1985).

[19] *See A.J.*, Docket No. 18-0905 (issued December 10, 2018); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983); *Gertrude E. Evans*, 26 ECAB 195 (1974).

[20] *See W.W.*, Docket No. 19-0884 (issued June 16, 2020).

[21] Federal (FECA) Procedure Manual, Part 2 -- Claims, *File Maintenance and Management*, Chapter 2.400.8(c) (February 2000).

his prior claims for thoracic epidural lipomatosis with the current claim. However, OWCP has not administratively combined the present claim with appellant's prior claim under OWCP File No. xxxxxx993 despite its frequent references to combine all the case files together. Thus, the Board finds that, for a full and fair adjudication, OWCP must administratively combine OWCP File No. xxxxxx993 with Master OWCP File No. xxxxxx752 in order to review all medical records pertaining to appellant's accepted lipomatosis condition and any resultant disability.

On remand, OWCP shall combine these case files, prepare a statement of accepted facts concerning appellant's accepted injuries and refer the matter to a medical specialist in the appropriate field of medicine, consistent with OWCP's procedures, to determine whether his inability to work from July 26, 2014 through August 7, 2017 was causally related to his accepted conditions.[22] The chosen physician shall provide a rationalized opinion as to whether the diagnosed conditions are causally related to the accepted factors of appellant's federal employment. If the physician opines that the diagnosed conditions are not causally related, he or she must explain with rationale how or why the opinion differs from that of Dr. Hollander. Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[22] *See id.* Chapter 2.8109.b(1) (June 2015).

ORDER

IT IS HEREBY ORDERED THAT the October 24, 2018 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: November 4, 2020
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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