United States Department of Labor
Employees' Compensation Appeals Board

M.G., Appellant	)	
and	)	**Docket No. 20-0748**
	)	**Issued: October 27, 2020**
U.S. POSTAL SERVICE, DALLAS NETWORKDISTRIBUTION CENTER, Coppell, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On February 19, 2020 appellant filed a timely appeal from a February 12, 2020 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.[2]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that appellant submitted additional evidence on appeal. 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.*

ISSUE

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

FACTUAL HISTORY

On November 26, 2018 appellant, then a 41-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that she developed constant pain in her shoulders, hands, knees, cervical spine, and lumbar spine due to factors of her federal employment, including constant grasping, lifting, twisting, bending, reaching, pulling, and standing. She further indicated that she experienced numbness and tingling in her wrists. Appellant noted that she first became aware of her condition on September 1, 2017 and first realized its relation to her federal employment on April 19, 2018. She did not stop work.

In support of her claim, appellant submitted magnetic resonance imaging (MRI) scans, dated July 26 and 27, 2018. An MRI scan of appellant's right shoulder revealed partial tearing of the supraspinatus and infraspinatus tendons, glenohumeral joint effusion, moderate acromioclavicular joint arthrosis, and mild lateral acromion downsloping. An MRI scan of her cervical spine revealed mild left neural foraminal narrowing at C3-4, disc bulge with mild left neural foraminal narrowing at C4-5 and C5-6, and disc bulge at C6-7 and C7-T1. An MRI scan of her lumbar spine revealed a right renal cyst, disc bulge at L2-3, disc protrusion/herniation at L4-5, and broad disc protrusion-herniation with moderate bilateral neural foraminal narrowing at L5-S1, with potential bilateral L5 nerve root impingement. An MRI scan of her right ankle revealed mild tendinosis of the Achilles tendon and corticated plantar calcaneal spur. An MRI scan of her right knee revealed patellofemoral osteoarthritis with multifocal full-thickness cartilage loss. An MRI scan of her left knee revealed a vertical tear of the posterior horn of the medial meniscus. An MRI scan of her right wrist revealed no abnormalities. An MRI scan of her left wrist revealed mild arthritis and remote appearing ulnar styloid fracture.

Electromyography and nerve conduction (EMG/NCV) studies, dated August 18, 2018, revealed bilateral L5 lumbar radiculopathy, extremity paresthesias, and extremity pain.

In a development letter dated December 10, 2018, OWCP advised appellant of the deficiencies of her claim. It requested that she submit additional factual and medical evidence and provided a questionnaire for her completion. In a separate development letter of even date, OWCP also requested additional information from the employing establishment. It afforded both parties 30 days to respond.

OWCP subsequently received x-rays of appellant's left wrist and left elbow, dated January 29, 2018, which revealed no acute abnormalities.

An electrophysiological evaluation, dated February 5, 2018, revealed mild-to-moderate carpal tunnel syndrome involving the right upper extremity, mild carpal tunnel syndrome involving the left upper extremity, and subtle evidence of multilevel cervical radiculopathy involving the right C5, left C6, and bilateral C7 nerve roots.

In a December 21, 2018 report, Dr. Russell Skinner, a specialist in chiropractic and family medicine, noted that appellant worked as a mail handler and listed her work activities. He reviewed x-rays and MRI scans and examined her. Dr. Skinner conducted physical and neurological studies and evaluations. He diagnosed lumbosacral radiculopathy, cervical disc disorder with radiculopathy, lumbar sprain, left knee sprain, right knee sprain, bilateral carpal tunnel syndrome, neck sprain, right shoulder rotator cuff strain, and left shoulder rotator cuff strain. Dr. Skinner indicated that appellant's repetitive bending forward at the waist caused anterior pressure on the lumbar discs, which in turn, placed pressure on the nerve roots in the lumbar region causing radiculopathy. He opined that appellant's work activities caused repetitive forward flexion which led to disc displacement. Dr. Skinner further noted that appellant's flexing and rotating of her head placed prolonged stress on the anterior portion of her cervical discs, which stressed the disc beyond its normal physiological limits, causing the disc to bulge and place pressure on the cervical nerve roots. He opined that this prolonged pressure caused cervical radiculopathy. Dr. Skinner also indicated that appellant's repetitive walking, bending, stooping, squatting, and standing for long periods of time stressed the ligaments of her knees beyond their normal physiological limits, leading to bilateral knee sprains. He opined that appellant's repetitive lifting, grasping, and squeezing caused wrist tendon inflammation. Dr. Skinner noted that over time, the swelling of appellant's wrist flexor tendons placed pressure on the median nerve passing through the carpal tunnel, which caused bilateral carpal tunnel syndrome. He opined that appellant's work activities also stressed her left and right rotator cuff ligaments beyond their normal physiological limits leading to bilateral sprains of the rotator cuffs.

In a narrative statement dated December 21, 2018, appellant responded to OWCP's development questionnaire. She noted that she worked on a machine constantly lifting, bending, stretching, and grasping mail. Appellant indicated that she lifted mail weighing up to 70 pounds. She stated that she worked 8 to 12 hours per day, 5 to 6 days per week, for 20 years. Appellant noted that she did not engage in activities outside of her work and that she had no previous injuries to her hands, arms, or wrists.

By decision dated January 16, 2019, OWCP denied appellant's occupational disease claim, finding that the medical evidence of record was insufficient to establish causal relationship between her diagnosed conditions and the accepted factors of her federal employment. Specifically, it noted that the medical evidence did not address her preexisting conditions.

On September 23, 2019 appellant requested reconsideration. In an accompanying narrative statement, dated July 30, 2017, she again listed her work activities and alleged that they caused her medical conditions.

OWCP subsequently received additional medical evidence, including a duty status report (Form CA-17) dated August 4, 2017, with an illegible signature, which diagnosed a lower back injury and indicated that appellant could return to full-time work.

In an April 19, 2018 report, Dr. Skinner noted that appellant worked as a mail handler and had progressively worsening pain. He indicated that her work activities caused her to develop pain in her hands, shoulders, knees, neck, and low back. Dr. Skinner examined appellant and diagnosed lumbar sprain, bilateral knee sprains, bilateral carpal tunnel syndrome, neck sprain, right rotator cuff strain, and unspecified injury of the left shoulder rotator cuff.

In a report dated May 2, 2018, Dr. Skinner noted that appellant had chronic and ongoing pain. He examined her and diagnosed lumbar sprain, bilateral knee sprains, bilateral carpal tunnel syndrome, neck sprain, right rotator cuff strain, and unspecified injury of the left shoulder rotator cuff.

In an August 10, 2018 report, Dr. Skinner noted that appellant's pain had progressively worsened and that she had sharp, ongoing back pain. He reviewed MRI scans and examined her. Dr. Skinner diagnosed lumbosacral radiculopathy, cervical disc disorder with radiculopathy, lumbar sprain, bilateral knee sprains, bilateral carpal tunnel syndrome, neck sprain, right rotator cuff strain, and unspecified injury of the left shoulder rotator cuff.

On September 21, 2018 Dr. Skinner noted that appellant's weight loss had helped with her low back pain. He examined her and diagnosed lumbar sprain, bilateral knee sprains, neck sprain, right shoulder rotator cuff strain, and unspecified injury of the left shoulder rotator cuff.

In a report dated October 19, 2018, Dr. Skinner noted that appellant had continued bilateral shoulder pain and bilateral knee pain. He examined her and diagnosed partial left and right rotator cuff tears, herniation of the lumbar intervertebral disc with radiculopathy, lumbar radiculopathy, displacement of the cervical intervertebral disc without myelopathy, lumbosacral radiculopathy, cervical disc disorder with radiculopathy, lumbar sprain, bilateral knee sprains, bilateral carpal tunnel syndrome, neck sprain, and right rotator cuff strain.

In a November 16, 2018 report, Dr. Skinner noted that stretching and walking had helped appellant decrease her symptoms. He examined appellant and diagnosed partial left and right rotator cuff tears, herniation of the lumbar intervertebral disc with radiculopathy, lumbar radiculopathy, displacement of the cervical intervertebral disc without myelopathy, lumbosacral radiculopathy, cervical disc disorder with radiculopathy, lumbar sprain, bilateral knee sprains, bilateral carpal tunnel syndrome, neck sprain, and right rotator cuff strain.

On January 30, 2019 Dr. Skinner noted that appellant was working light duty with restrictions. He indicated that she experienced bilateral shoulder pain and right knee pain. Dr. Skinner examined appellant and diagnosed partial bilateral rotator cuff tears, herniation of the lumbar intervertebral disc with radiculopathy, lumbar radiculopathy, displacement of the cervical intervertebral disc without myelopathy, lumbosacral radiculopathy, cervical disc disorder with radiculopathy, lumbar sprain, bilateral knee sprains, bilateral carpal tunnel syndrome, neck sprain, and right rotator cuff strain.

In a report dated April 12, 2019, Dr. Skinner noted that appellant still experienced bilateral shoulder and hand pain. He further indicated that she reported worsening neck pain. Dr. Skinner examined appellant and diagnosed partial left and right rotator cuff tears, herniation of the lumbar intervertebral disc with radiculopathy, lumbar radiculopathy, displacement of the cervical intervertebral disc without myelopathy, lumbosacral radiculopathy, cervical disc disorder with radiculopathy, lumbar sprain, bilateral knee sprains, bilateral carpal tunnel syndrome, neck sprain, and right rotator cuff strain.

In a July 26, 2019 report, Dr. Skinner noted that appellant's bilateral shoulder and knee pain had improved since she began light-duty work. He examined her and diagnosed partial left

and right rotator cuff tears, herniation of the lumbar intervertebral disc with radiculopathy, lumbar radiculopathy, displacement of the cervical intervertebral disc without myelopathy, lumbosacral radiculopathy, cervical disc disorder with radiculopathy, lumbar sprain, bilateral right knee sprains, bilateral carpal tunnel syndrome, neck sprain, and right rotator cuff strain.

In a report dated November 14, 2019, Dr. Skinner noted that appellant developed severe pain in her bilateral hands, knees, shoulder, neck, and lower back due to the repetitive nature of her job duties. He examined her and diagnosed partial left and right rotator cuff tears, herniation of the lumbar intervertebral disc with radiculopathy, lumbar radiculopathy, displacement of the cervical intervertebral disc without myelopathy, lumbosacral radiculopathy, cervical disc disorder with radiculopathy, lumbar sprain, bilateral knee sprains, bilateral carpal tunnel syndrome in the left and right upper limbs, neck sprain, and right rotator cuff strain.

By decision dated February 12, 2020, OWCP denied modification of its January 16, 2019 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 the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was timely filed within the applicable time limitation period of FECA,[4] that an injury was sustained in the performance of duty as alleged, and that any disability or medical condition for which compensation is claimed is causally related to 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]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit 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 identified employment factors.[7]

[3] *Supra* note 1.

[4] *R.M.*, Docket No. 20-0342 (issued July 30, 2020); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

[5] *V.P.*, Docket No. 20-0415 (issued July 30, 2020); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[6] 20 C.F.R. § 10.115; *S.A.*, Docket No. 20-0458 (issued July 23, 2020); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

[7] *See B.H.*, Docket No. 18-1693 (issued July 20, 2020); *Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

Causal relationship is a medical question that requires rationalized medical opinion evidence to resolve the issue.[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 a December 21, 2018 report from Dr. Skinner, who described appellant's work activities with great detail. He reviewed x-rays and MRI scans and examined her. Dr. Skinner conducted multiple physical and neurological studies and evaluations. He diagnosed lumbosacral radiculopathy, cervical disc disorder with radiculopathy, lumbar sprain, left knee sprain, right knee sprain, bilateral carpal tunnel syndrome, neck sprain, and bilateral shoulder rotator cuff strains. Dr. Skinner opined that appellant's repetitive bending forward at the waist caused anterior pressure on the lumbar discs, which in turn, placed pressure on the nerve roots in the lumbar region causing radiculopathy. He further opined that her work activities caused repetitive forward flexion which led to disc displacement. Dr. Skinner also noted that appellant's flexing and rotating of her head placed prolonged stress on the anterior portion of her cervical discs, which stressed the disc beyond its normal physiological limits, causing the disc to bulge and place pressure on the cervical nerve roots. He opined that this prolonged pressure caused cervical radiculopathy. Dr. Skinner indicated that appellant's repetitive walking, bending, stooping, squatting, and standing for long periods of time stressed the ligaments of both of her knees beyond their normal physiological limits, leading to left and right knee sprains. He opined that her repetitive lifting, grasping, and squeezing caused wrist tendon inflammation. Dr. Skinner noted that over time, the swelling of appellant's wrist flexor tendons placed pressure on the median nerve passing through the carpal tunnel, which caused left and right carpal tunnel syndrome. He opined that her work activities also stressed her left and right rotator cuff ligaments beyond their normal physiological limits leading to sprains of the left and right rotator cuffs.

The Board finds that this report from Dr. Skinner is sufficient to require further development of the medical evidence. Dr. Skinner provided a comprehensive understanding of the medical record and case history. His affirmative opinion on causal relationship provides a pathophysiological explanation as to how appellant's work activities caused her diagnosed conditions. The Board has long held that it is unnecessary that the evidence of record in a case be

[8] *L.S.*, Docket No. 19-1769 (issued July 10, 2020); *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[9] *B.C.*, Docket No. 20-0221 (issued July 10, 2020); *Leslie C. Moore*, 52 ECAB 132 (2000).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013); *see S.M.*, Docket No. 19-1634 (issued August 25, 2020).

so conclusive as to suggest causal connection beyond all possible doubt. Rather, the evidence required is only that necessary to convince the adjudicator that the conclusion drawn is rational, sound, and logical.[11] Accordingly, Dr. Skinner's medical opinion is well-rationalized and logical and is therefore sufficient to require further development of appellant's claim.

It is well established that proceedings under FECA are not adversarial in nature, and that while appellant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. OWCP has an obligation to see that justice is done.[12] The nonadversarial policy of proceedings under FECA is reflected in OWCP's regulations at section 10.121.[13]

On remand OWCP shall refer appellant, a statement of accepted facts, and the medical record to a specialist in the appropriate field of medicine. The chosen physician shall provide a rationalized opinion as to whether appellant's diagnosed conditions are causally related to the accepted factors of her 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. Skinner. Following this and such other further development as deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim.

CONCLUSION

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

[11] *S.M., id.*

[12] *Id.*

[13] 20 C.F.R. § 10.121.

ORDER

IT IS HEREBY ORDERED THAT the February 12, 2020 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: October 27, 2020
Washington, DC

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

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

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