

**United States Department of Labor  
Employees' Compensation Appeals Board**

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**M.G., Appellant**

**and**

**U.S. POSTAL SERVICE, POST OFFICE,  
Bellmawr, NJ, Employer**

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**Docket No. 19-1860  
Issued: March 15, 2021**

*Appearances:*

*Thomas R. Uliase, Esq., for the appellant<sup>1</sup>*

*Office of Solicitor, for the Director*

*Case Submitted on the Record*

**DECISION AND ORDER**

Before:

CHRISTOPHER J. GODFREY, Deputy Chief Judge

JANICE B. ASKIN, Judge

VALERIE D. EVANS-HARRELL, Alternate Judge

**JURISDICTION**

On September 10, 2019 appellant, through counsel, filed a timely appeal from a March 18, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act<sup>2</sup> (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

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<sup>1</sup> 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.

<sup>2</sup> 5 U.S.C. § 8101 *et seq.*

## ISSUE

The issue is whether appellant has met her burden of proof to establish a chest injury causally related to the accepted February 25, 2017 employment incident.

## FACTUAL HISTORY

On March 3, 2017 appellant, then a 54-year-old mail handler in a modified-duty status, filed a traumatic injury claim alleging that on February 25, 2017 she was working on a tray sorter machine to containerize trays while in the performance of duty when she felt chest pain and tingling in her right wrist, aggravating a previously accepted employment-related condition of carpal tunnel syndrome (CTS).<sup>3</sup> She explained that she experienced symptoms from CTS on a daily basis and on the evening of February 25, 2017, the tingling and numbness in her hands woke her up out of her sleep. Initially, appellant had some tingling in her right wrist, but by the following day her left hand was causing problems, including pain and swelling in her ring finger. On the reverse side of the claim form the employing establishment noted that, following appellant's original injury, she was on limited duty until returning to full-duty work. It indicated that she stopped work on February 25, 2017.

In a March 2, 2017 report, Dr. Scott M. Fried, an osteopath Board-certified in orthopedic surgery, noted appellant's employment duties and her medical history of bilateral CTS. Appellant continued to have symptoms of bilateral numbness, tingling, swelling, and pain in her hands radiating into her fingers. She noted that she was working overtime in January and February on tray sorter machines and experienced pain in her left axilla, spreading across her left chest. On physical examination appellant was found to have left trapezius muscle spasms of the cervical spine; positive Phalen's and Tinel's tests of the median and ulnar nerve of the right wrist and right elbow, and positive Roos and Hunter testing indicative of inflammation and scarring about the nerves of the brachial plexus at the thoracic outlet level. Dr. Fried diagnosed bilateral median neuropathy, left radial neuropathy, carpal tunnel median neuropathy of the bilateral upper extremities, and right and left flexor tenosynovitis. He advised that appellant remained symptomatic and limited and was unable to perform her usual job duties.

On March 13, 2017 Dr. Knic Rabara, an osteopath and family practitioner, treated appellant for a recent onset of left upper chest pain, which began in February. Appellant underwent a cardiac workup, which was unremarkable. She attributed her condition to repetitive use of her arms, chest, and shoulders while performing her mail handler duties. Dr. Rabara diagnosed left chest pain, likely musculoskeletal, and left shoulder and neck pain due to pectoral major/minor strain.

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<sup>3</sup> On December 13, 2007 appellant, then a 44-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that she developed bilateral CTS as a result of repetitive lifting, bending, pushing, and pulling tubs of flat mail while in the performance of duty. On April 7, 2008 OWCP accepted her claim for bilateral CTS under OWCP File No. xxxxxx484. On March 21, 2017 it notified appellant that it administratively converted the recurrence claim under OWCP File No. xxxxxx484 to a new traumatic injury claim occurring on February 25, 2017 under OWCP File No. xxxxxx880.

An attending physician's report (Form CA-20) from Dr. Michael Goldis, a Board-certified internist, dated March 13, 2017, diagnosed atypical chest pain possibly due to lifting. Dr. Goldis indicated by checking a box marked "Yes" that the condition was caused or aggravated by an employment activity and opined that appellant was totally disabled from February 28 to April 1, 2017. In a work capacity evaluation (Form OWCP-5c), dated March 3, 2017, he noted that appellant reported pain in the left chest with lifting and returned her to work full time with no lifting.

In a development letter dated March 24, 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. OWCP afforded appellant 30 days to respond.

Appellant was treated by Dr. Bryan Saia, a Board-certified cardiologist, on March 9, 2017 for chest pain and essential hypertension. Dr. Saia noted a cardiac catheterization was negative. He diagnosed chest pain, likely musculoskeletal, left axillary area mildly tender to palpation, hypertension controlled, and dyslipidemia. Dr. Saia recommended weight loss and lifestyle modifications.

OWCP also received March 9, 2017 x-rays of the lumbar, thoracic, and cervical spine, which revealed no acute bony abnormality, mild dextrosciosis of the thoracolumbar spine, and degenerative changes at the L5-S1 level.

In a follow-up note dated March 20, 2017, Dr. Rabara diagnosed improving left chest, left shoulder, and neck pain. He noted that x-rays for the neck and shoulders revealed disc narrowing at C5-6 and degenerative changes of the left shoulder.

In a narrative statement dated April 4, 2017, appellant indicated that on February 25, 2017 she was working on a high-speed tray sorter, containerizing the trays, putting them in the all-purpose containers (APC), labeling the APC's, and pushing the full APC's out, and replacing them with another one. She reported pushing about six APC's and lifting over 300 trays when she noticed pain in the left side of her chest.

In a report dated April 6, 2017, Dr. Fried diagnosed bilateral median and radial neuropathy, left brachial plexopathy/cervical radiculopathy with long thoracic neuritis and scapular winging, carpal tunnel median neuropathy of the left upper extremity with brachial plexus involvement secondary to work activities, overuse syndrome of bilateral upper extremities, right and left flexor tenosynovitis, pectoralis minor strain with brachial plexus involvement left secondary to work injury, and left shoulder rotator cuff strain and sprain. He opined that there was no doubt appellant sustained a significant acute injury secondary to her work duties on February 25, 2017 when she was reaching, grasping, pulling, pushing, and lifting while at work. Dr. Fried explained that the lifting of trays and placing them on APC's, reaching, grasping, and awkward posturing resulted in a significant acute pectoral strain, paracervical strain, and brachial plexus injury. He noted that appellant described an acute onset of pain with radiation symptomology while performing her work duties consistent with a pectoral injury. Dr. Fried indicated that the pectoralis is located over the plexus and the lower plexus travels through the axilla and shoulder area and down the arm,

which correlated with appellant's specific work activities and the acute injury. He concluded that this was an acute injury separate and additive to her previous bilateral CTS injuries. In a disability certificate dated April 6, 2017, Dr. Fried found that appellant was disabled from work.

By decision dated May 4, 2017, OWCP denied the claim, finding that the medical evidence of record failed to establish causal relationship between appellant's diagnosed chest condition and the accepted February 25, 2017 employment incident.

In a duty status report (Form CA-17) dated May 4, 2017, Dr. Fried diagnosed bilateral CTS and noted that appellant was totally disabled. In reports dated May 18 and July 11, 2017, he again noted her extensive diagnoses. Dr. Fried noted some improvement in appellant's condition as her off-work status continued, but she remained significantly symptomatic and limited. He opined that there was no doubt she sustained a significant acute injury secondary to her work duties on February 25, 2017 when reaching, grasping, pulling, pushing, and lifting. Dr. Fried explained that the lifting of trays and placing these on APC's, reaching, grasping, and awkward posturing resulted in a significant acute pectoral strain, paracervical strain, and brachial plexus injury. He again noted that appellant described an acute onset of pain with radiation symptomology while performing her work duties, consistent with a pectoral injury.

On May 17, 2017 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

By decision dated July 18, 2017, an OWCP hearing representative vacated the decision dated May 4, 2017 and remanded the case for further medical development. He found that Dr. Fried provided an affirmative opinion that appellant's work activities on February 25, 2017 caused or contributed to her diagnosed acute pectoral strain, paracervical strain, and brachial plexus injury, which merited further development by a second opinion evaluation. The hearing representative further instructed OWCP to administratively combine OWCP File Nos. xxxxxx880 and xxxxxx484 as correct adjudication depended on cross-referencing these files.

An electromyogram (EMG) dated August 16, 2017 revealed severe bilateral median nerve impairments at the bilateral wrists, moderate right posterior interosseous nerve impairment at the dorsal elbow, and borderline/mild left ulnar nerve impairment at medial elbow level.

Appellant attended physical therapy treatment from August 28 to September 13, 2017.

On February 16, 2018 OWCP referred appellant for a second opinion evaluation with Dr. Stanley Askin, a Board-certified orthopedic surgeon, to determine whether appellant sustained a diagnosed medical condition causally related to the accepted February 25, 2017 employment incident.

In a March 2, 2018 report, Dr. Askin noted appellant's medical history included bilateral CTS. Physical examination of appellant's neck, bilateral shoulders, scapulothoracic area, elbows, forearms, wrists, trapezius, pectoralis major, and deltoids was unremarkable, with intact sensation and strength, and positive Phalen's and Tinel's signs. Dr. Askin diagnosed bilateral carpal tunnel syndrome. He found no disabling residuals of any condition associated with appellant's current claim, rather he opined that her difficulty persisted from the earlier accepted CTS. Dr. Askin

advised that carpal tunnel release was expected to be therapeutic for CTS, but appellant chose not to have surgery. He noted that there were no objective findings that she suffered an aggravation or had current disability. Dr. Askin indicated that appellant reached maximum medical improvement (MMI) and there was no work-related reason referable to OWCP File No. xxxxxx880 that precluded her from returning to work full duty with lifting limited to 100 pounds occasionally.

By decision dated May 16, 2018, OWCP denied appellant's claim, finding the medical evidence of record was insufficient to establish causal relationship between the diagnosed medical conditions and the accepted February 25, 2017 employment incident. It found the weight of the medical opinion evidence rested with Dr. Askin's opinion. OWCP mailed the decision to appellant and counsel at their last known addresses of record.

OWCP continued to receive evidence. A magnetic resonance imaging (MRI) scan of the right shoulder dated February 25, 2018 revealed a longitudinal split tear of the long head tendon of the biceps and mild subacromial/subdeltoid bursitis. An MRI scan of the cervical spine revealed chronic disc osteophyte complex at C5-6 resulting in partial effacement to the anterior subarachnoid space, and posterior annular bulging in the upper thoracic region at T1-2, T2-3, and T3-4.

In a March 22, 2018 report, Dr. Robert Falconiero, an osteopath, noted that appellant presented with right shoulder pain, which began after lifting a heavy object. He diagnosed biceps tendinitis of the right shoulder, longitudinal tear of the right biceps tendon, subacromial bursitis/impingement of the right shoulder, degenerative disc disease of the cervical spine, osteophyte disc complex at C5-6, and possible right cervical radiculopathy.

On December 17, 2018 appellant, through counsel, requested reconsideration. Counsel asserted that neither he nor the employing establishment received the May 16, 2018 decision and, thus, it did not issue to the interested parties. He requested that the decision be reissued with full appeal rights.

By decision dated March 18, 2019, OWCP denied modification of the decision dated May 16, 2018.

### **LEGAL PRECEDENT**

An employee seeking benefits under FECA<sup>4</sup> 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,<sup>5</sup> 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

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<sup>4</sup> 5 U.S.C. § 8101 *et seq.*

<sup>5</sup> *S.C.*, Docket No. 18-1242 (issued March 13, 2019); *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

to the employment injury.<sup>6</sup> 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.<sup>7</sup>

To determine if an employee sustained a traumatic injury in the performance of duty, OWCP begins with an analysis of whether fact of injury has been established.<sup>8</sup> There are two components that must be considered in conjunction with one another. The first component is whether the employee actually experienced the employment incident that allegedly occurred.<sup>9</sup> The second component is whether the employment incident caused a personal injury.<sup>10</sup>

Causal relationship is a medical question that requires rationalized medical opinion evidence to resolve the issue.<sup>11</sup> A physician's opinion on whether there is causal relationship between the diagnosed condition and the implicated employment incident must be based on a complete factual and medical background.<sup>12</sup> Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition, and appellant's specific employment incident.<sup>13</sup>

Section 8123(a) of FECA provides that, if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.<sup>14</sup> This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.<sup>15</sup> When there exists opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of

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<sup>6</sup> *T.H.*, Docket No. 18-1736 (issued March 13, 2019); *J.M.*, Docket No. 17-0284 (issued February 7, 2018); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

<sup>7</sup> *T.E.*, Docket No. 18-1595 (issued March 13, 2019); *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).

<sup>8</sup> *S.S.*, Docket No. 18-1488 (issued March 11, 2019); *T.H.*, 59 ECAB 388, 393-94 (2008).

<sup>9</sup> *E.M.*, Docket No. 18-1599 (issued March 7, 2019); *Elaine Pendleton*, 40 ECAB 1143 (1989).

<sup>10</sup> *E.M.*, *id.*; *John J. Carlone*, 41 ECAB 354 (1989).

<sup>11</sup> *S.S.*, *supra* note 8; *Robert G. Morris*, 48 ECAB 238 (1996).

<sup>12</sup> *C.F.*, Docket No. 18-0791 (issued February 26, 2019); *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

<sup>13</sup> *Id.*

<sup>14</sup> 5 U.S.C. § 8123(a); *M.W.*, Docket No. 19-1347 (issued December 5, 2019); *C.T.*, Docket No. 19-0508 (issued September 5, 2019); *R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

<sup>15</sup> 20 C.F.R. § 10.321.

such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.<sup>16</sup>

### ANALYSIS

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

Dr. Fried, appellant's treating physician, diagnosed bilateral median and radial neuropathy, left brachial plexopathy/cervical radiculopathy, thoracic neuritis, scapular winging, carpal tunnel median neuropathy of the left upper extremity with brachial plexus involvement secondary to work activities, overuse syndrome of bilateral upper extremities, right and left flexor tenosynovitis, pectoralis minor strain with brachial plexus involvement left secondary to work injury, and left shoulder rotator cuff strain and sprain. He opined that there was no doubt appellant sustained a significant acute injury secondary to her work duties on February 25, 2017 when reaching, grasping, pulling, pushing, and lifting while at work. Dr. Fried explained that lifting trays and placing them on APC's, reaching, grasping, and awkward posturing resulted in a significant acute pectoral and paracervical strains and brachial plexus injury. He found appellant to be totally disabled from work.

By contrast, Dr. Askin, a second opinion physician, opined in his March 2, 2018 report that appellant had no disabling residuals of any condition associated with her current claim, rather her difficulty persisted from the earlier accepted CTS. He advised that there were no objective findings that she suffered an aggravation or had any current disability. Dr. Askin noted that appellant reached MMI and opined that there was no work-related reason referable to OWCP File No. xxxxxx880 that precluded her from returning to work full duty with lifting limited to 100 pounds occasionally.

Dr. Fried provided a rationalized description of how the accepted work factors caused or contributed to the diagnosed conditions. Dr. Askin, however, opined that there was no causal relationship between the identified employment factors and appellant's chest condition. The Board, therefore, finds that a conflict in medical opinion exists regarding whether she sustained a chest injury in the performance of duty on February 25, 2017.

OWCP's regulations provide that, if a conflict exists between the medical opinion of the employee's physicians and the medical opinion of a second-opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination.<sup>17</sup> The Board will, thus, remand the case to OWCP for referral to an impartial medical examiner regarding whether appellant has met her burden of proof to establish that she sustained a chest injury due to the

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<sup>16</sup> *M.W.*, *supra* note 14; *C.T.*, *supra* note 14; *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

<sup>17</sup> 5 U.S.C. § 8123(a); *M.W.*, *supra* note 14.

accepted employment incident.<sup>18</sup> Following this and any such further development as may be deemed necessary, OWCP shall issue a *de novo* decision.<sup>19</sup>

**CONCLUSION**

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

**ORDER**

**IT IS HEREBY ORDERED THAT** the March 18, 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.<sup>20</sup>

Issued: March 15, 2021  
Washington, DC

Janice B. Askin, Judge  
Employees' Compensation Appeals Board

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

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<sup>18</sup> *Id.*

<sup>19</sup> On appeal counsel asserts the May 16, 2018 decision was not properly served on appellant, appellant's representative, or the employing establishment. Under the mailbox rule, it is presumed, absent evidence to the contrary, that a notice mailed to an individual in the ordinary course of business was received by that individual. *See D.R.*, Docket No. 18-0232 (issued October 2, 2018); *A.C. Clyburn*, 47 ECAB 153 (1995). The record supports that OWCP's decision dated May 16, 2018 was sent to appellant and appellant's counsel at the address of record and does not indicate that it was returned as undeliverable.

<sup>20</sup> Christopher J. Godfrey, Deputy Chief Judge, was no longer a member of the Board effective January 20, 2021.