United States Department of Labor
Employees' Compensation Appeals Board

E.N., Appellant	)	
and	)	**Docket No. 20-1171**
	)	**Issued: April 20, 2022**
U.S. POSTAL SERVICE, DOMINICK V. DANIELS PROCESSING & DISTRIBUTION CENTER, Kearny, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On May 19, 2020 appellant, through counsel, filed a timely appeal from a December 18, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP). 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.

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.[3]

ISSUE

The issue is whether appellant has met her burden of proof to expand the acceptance of her claim to include right shoulder impingement syndrome, a right knee medial meniscus tear, lumbar disc displacement, cervical radiculopathy, and bilateral carpal tunnel syndrome causally related to her accepted June 2, 2017 employment injury.

FACTUAL HISTORY

On June 2, 2017 appellant, then a 45-year-old mail handler, filed a traumatic injury claim (Form CA-1) alleging that on that date she injured her knees, neck, and back when she tripped over a postal container (post con) and fell on the floor while in the performance of duty. She stopped work on June 2, 2017.

In a report dated June 5, 2017, Dr. Mark A.P. Filippone, a Board-certified physiatrist, provided a history of the June 2, 2017 employment incident. He noted that appellant complained of pain in her right shoulder, right elbow, hands and wrists, right knee, and in her neck radiating into the upper extremities (worse on the right). Dr. Filippone diagnosed cervical derangement and radiculitis, bilateral shoulder internal derangement worse on the right, internal derangement of the right elbow and both wrists, and internal derangement of the right knee and patellofemoral joint, low back derangement, and lumbosacral radiculitis. He further provided diagnoses to rule out, including carpal tunnel syndrome. Dr. Filippone attributed the diagnosed conditions to appellant's fall at work on June 2, 2017. He advised that she had hyperextended her neck at the time of her fall and sustained compression contusions of the wrists and hands. Dr. Filippone found that appellant was totally disabled from employment.

A magnetic resonance imaging (MRI) scan of the right knee, obtained on June 6, 2017, revealed a tear of the posterior horn of the lateral meniscus, grade two signal intensity in the posterior horn of the medial meniscus, a partial tear of ligamentous strain of the lateral collateral ligament, prepatellar bursitis, joint effusion, a popliteal cyst, and erosive chondromalacia of the lateral patella facet.

In a progress report dated June 16, 2017, Dr. Filippone reviewed the results of diagnostic studies and found appellant disabled from work.

[2] 5 U.S.C. § 8101 *et seq*.

[3] The Board notes that, following the December 18, 2019 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*.

On June 19, 2017 appellant received treatment for pain management from Dr. Joseph Ibrahim, a Board-certified physiatrist.

In a report dated June 29, 2017, Dr. Gabriel L. Dassa, an osteopath, discussed appellant's complaints of pain in her cervical and lumbar spine, right shoulder, elbow, and wrist, and right knee after a June 2, 2017 employment injury. He provided findings on examination and diagnosed cervical and lumbar sprain/strain, a multiligamentous injury of the cervical and lumbar spine, right shoulder impingement syndrome, right elbow lateral epicondylitis, and right wrist and knee sprain/strain. Dr. Dassa attributed the diagnosed conditions to the employment injury and opined that appellant was totally disabled from work.

By decision dated July 17, 2017, OWCP denied appellant's traumatic injury claim, finding that she had not established a diagnosed condition causally related to the accepted June 2, 2017 employment incident.

A July 19, 2017 MRI scan of the right wrist showed a partial tear of the triangular fibrocartilage complex (TFCC).[4]

On July 24, 2017 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review.

In a progress report dated August 10, 2017, Dr. Dassa advised that a July 19, 2017 MRI scan showed impingement syndrome and a partial rotator cuff tear and that an MRI scan of the right knee showed tears of the medial and lateral meniscus.[5] He diagnosed cervical and lumbar sprain/strain, impingement syndrome of the right shoulder with a partial rotator cuff tear, a right wrist TFCC tear, a tear of the medial and lateral meniscus of the right knee, and right elbow sprain/strain.

Following a preliminary review, by decision dated October 11, 2017, OWCP's hearing representative set aside the July 17, 2017 decision. He found that the medical evidence was sufficient to warrant further development and instructed OWCP to refer appellant for a second opinion examination.

Thereafter, OWCP received an October 5, 2017 report from Dr. Dassa. Dr. Dassa provided a history of the June 2, 2017 employment injury. He diagnosed musculoligamentous injuries to the cervical and lumbar spine, impingement syndrome of the right shoulder with a partial rotator cuff tear, a right wrist TFCC tear, a tear of the medial and lateral meniscus of the right knee, and right elbow sprain/strain. Dr. Dassa found that the conditions were "directly caused by the accident."

On October 13, 2017 OWCP referred appellant to Dr. Timothy Henderson, a Board-certified orthopedic surgeon, for a second opinion examination.

[4] The record contains progress reports from Dr. Filippone dated July 3 and 25, 2017.

[5] On September 15, 2017 Dr. Dassa requested authorization for a right knee synovectomy and partial medial and lateral meniscectomy.

In an October 27, 2017 report, Dr. Filippone explained the mechanism by which appellant had injured her neck, right shoulder, low back, right elbow, and right knee on June 2, 2017. He indicated that she had a positive Tinel's sign and Phalen's test at the median nerve bilaterally, more on the right, and a positive Tinel's sign at the right tarsal tunnel.

In a report dated October 30, 2017, Dr. Henderson discussed the history of the June 2, 2017 employment injury and provided findings on examination. He related:

> "The claimant's current diagnoses causally connected to the work injury are a fall at work with blunt force trauma to the right knee, [a] possible cervical herniated disc with right[-]sided cervical radiculopathy, lumbar back sprain with right[-]sided radiculopathy, right wrist sprain with TFCC tear, and partial tear of the supraspinatus tendon of the right shoulder. These injuries are causally related to the claimant's workplace injury."

Dr. Henderson found that appellant was disabled from her usual employment, but could perform sedentary duties.

A December 21, 2017 MRI scan of the cervical spine showed straightening of the cervical lordosis possibly due to muscle spasm and a diffuse disc bulge at C5-6 causing compression of the ventral aspect of the thecal sac.

On January 18, 2018 OWCP accepted the claim for lumbar sprain, a sprain of the right wrist with a TFCC tear, a partial tear of the supraspinatus tendon of the right shoulder, and right lumbar radiculopathy. It paid appellant wage-loss compensation on the supplemental rolls retroactive to July 18, 2017 and on the periodic rolls as of April 1, 2018.

Thereafter, OWCP received a July 19, 2017 MRI scan of the right shoulder, which showed a tear of the supraspinatus tendon, glenohumeral joint effusion, subdeltoid bursa fluid, and impingement of the rotator cuff.[6]

On March 14, 2018 OWCP referred appellant to Dr. Andrew Farber, an osteopath, for a second opinion examination.

In a report dated March 29, 2018, Dr. Faber reviewed appellant's history of injury and the medical evidence of record, including the results of diagnostic testing. On examination he found possible symptom magnification or less than full cooperation. Dr. Faber advised that the "subjective complaints do correspond with the objective findings. The claimant sustained a right knee contusion and a right shoulder tear in the supraspinatus tendon." Dr. Faber attributed the left knee contusion and right shoulder supraspinatus tendon tear to the accepted employment injury. He found that appellant could work in a sedentary position.

[6] The record contains progress reports from Dr. Dassa dated November 16, 2017 and February 1, March 15, August 9, and September 20, 2018 and from Dr. Filippone dated November 27, 2017 and March 12, 2018. The record also contains reports describing appellant's treatment by Dr. Ibrahim, for pain management.

In a progress report dated May 30, 2018, Dr. Filippone noted that appellant had shoulder surgery scheduled for June 16, 2018. He discussed appellant's complaints of pain in her low back, right wrist, and right shoulder with radiation to the upper and lower extremities. Dr. Filippone opined that appellant was totally disabled from employment.

On June 7, 2018 OWCP expanded the acceptance of appellant's claim to include right knee sprain, right elbow sprain, and cervical sprain.

On June 14, 2018 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

On June 22, 2018 Dr. Dassa performed a right shoulder arthroscopy.

OWCP determined that a conflict in the medical opinion evidence existed between Dr. Farber and Dr. Filippone regarding causal relationship, continuing disability, and the need for further medical treatment. It referred her to Dr. Dean L. Carlson, a Board-certified orthopedic surgeon, for an impartial medical examination. OWCP requested that Dr. Carlson address whether OWCP should expand the acceptance of appellant's claim to include any additional conditions causally related to her accepted June 2, 2017 employment injury.

In a report dated November 1, 2018, Dr. Carlson reviewed appellant's history of injury and current complaints of right knee pain and weakness, lumbosacral pain and stiffness, cervical pain radiating into the proximal trapezial muscles, and right wrist and right medial humeral epicondyle pain. On examination he found tenderness to palpation of the lumbar spine from L1 to S1 and the cervical spine at the proximal trapezial muscles. Dr. Carlson found negative Neer and Hawkin's signs of the right shoulder, negative Phalen's and Finkelstein's test of the wrists bilaterally, and tenderness at the medial and lateral femorotibial joint lines of the right knee with no collateral ligament instability and negative McMurray and Lachman signs. He diagnosed a tear of the right lateral meniscus, a partial TFCC tear of the right wrist, status post right shoulder surgery, chronic lumbosacral and cervical strain, and chronic right elbow medial humeral epicondylitis. Dr. Carlson advised that the accepted right knee sprain should have resolved, but that the June 6, 2017 MRI scan had shown a posterior horn tear of the lateral meniscus. He related, "The sprains of ligaments of the cervical and lumbar spine have become chronic. The right lumbar radiculopathy had resolved by the date of the electromyogram (EMG)/nerve conduction velocity (NCV) study on March 12, 2018. The elbow sprain has continued as a chronic medial humeral epicondylitis. The tear of the supraspinatus tendon, right shoulder, was treated at the time of the right shoulder arthroscopy of June 22, 2018." Dr. Carlson opined that appellant had continued disability due to her partial TFCC tear and torn right lateral meniscus. He opined that OWCP should expand acceptance of the claim to provide surgical treatment for both conditions. Dr. Carlson attributed the right posterior lateral meniscus horn tear and chronic TFCC of the right wrist to the accepted June 2, 2017 employment injury. He found that appellant was disabled from work and required surgery on her right knee and right wrist.

A telephonic hearing was held on November 16, 2018.

By decision dated January 22, 2019, OWCP's hearing representative affirmed the June 7, 2018 decision, finding that appellant had not demonstrated that the acceptance of her claim should

be expanded to include right shoulder impingement syndrome, right elbow lateral epicondylitis, lumbar disc displacement, cervical radiculopathy, and bilateral carpal tunnel syndrome. He found, however, that OWCP should expand the acceptance of her claim to include right elbow medial humeral epicondylitis and a right knee lateral meniscus tear based on Dr. Carlson's opinion.

Thereafter, appellant submitted a September 7, 2017 MRI scan of the lumbar spine, which showed a mild disc bulge causing compression of the ventral aspect of the thecal sac. A September 27, 2017 MRI scan of the cervical spine revealed straightening of the cervical lordosis possible due to spasms and a diffuse bulge at C5-6 with compression of the ventral aspect of the thecal sac.

In an undated supplement to his October 5, 2017 report, Dr. Dassa advised that a July 19, 2017 MRI scan of appellant's right shoulder had demonstrated impingement syndrome as well as a supraspinatus tendon tear. He related, "The rotator cuff impingement was caused by direct injury to the shoulder as well as further dysfunction of the rotator cuff after it was torn as it does cause high riding of the humeral head and does contribute to impingement syndrome." Dr. Dassa further noted that a June 6, 2017 MRI scan of the right knee had showed a tear of the right medial meniscus in addition to a tear of the posterior horn of the lateral meniscus. He attributed the meniscus tears to appellant's accepted employment injury. Dr. Dassa asserted that appellant had also sustained lumbar disc displacement based on a September 7, 2017 MRI scan showing a disc bulge at L4-5 causing compression of the ventral aspect of the thecal sac and attributed the condition to the June 2, 2017 employment injury, noting that the MRI scan was obtained based on symptoms of radiculopathy after the accident. He further noted that appellant had symptoms of "neck pain with numbness and tingling down the upper extremities subsequent to this accident. The description of radiating pain that developed subsequent to a cervical sprain, which was the condition approved is termed radiculopathy. I believe that [appellant's] current radicular symptoms are causally related to the cervical sprain and disc injuries that were noted on MRI."

In a report dated May 24, 2019, Dr. Filippone advised that a January 12, 2018 EMG had showed bilateral carpal tunnel syndrome, right and left cervical radiculopathy at C5-6, and partial denervation in the cervical paraspinals. He related, "The lower extremities gave evidence of a bilateral L5-S1 lumbosacral radiculopathy, but no suggestion of any systemic neuromuscular disease, all of which in the opinion of this examiner are directly and solely the result of injuries sustained in the worker's compensation injury of June 2, 2017."

On June 26, 2019 appellant, through counsel, requested reconsideration.

An MRI scan of the cervical spine dated September 13, 2019 revealed posterior disc herniations at C3-4 and C5-6 exerting pressure on the ventral aspect of the thecal sac and reversal of the lordoctic curvature of the cervical spine most likely resulting from muscle spasm.

An MRI scan of the lumbar spine dated September 13, 2019 found straightening of the lordotic curvature suggesting muscle spasm and lumbar myalgia and a small hernia. It further found a posterior disc herniation at L5-S1 with pressure on the ventral epidural adipose tissue. An MRI scan of the even date of the right knee showed a tear of the posterior horn of the medial meniscus, an interosseous ganglion in the posterior inner aspect, mild chondromalacia of the outer

aspect of the medial patella facet, joint effusion, a small popliteal cyst, and prepatellar and infrapatellar bursitis.

In an October 31, 2019 attending physician's report (Form CA-20), Dr. Ibrahim diagnosed a cervical disc herniation, lumbar radiculitis, and tendinitis of the right shoulder and elbow. He checked a box marked "Yes" indicating that the condition was caused or aggravated by the employment activity.

On November 4, 2019 Dr. Alexander J. Visco, a Board-certified physiatrist, discussed appellant's history of a fall on June 2, 2017. He diagnosed cervical disc herniations, right shoulder impingement syndrome, right lateral epicondylitis, a right knee meniscal tear, and lumbar disc herniations.

In form reports dated November 3 and 24, 2020, Dr. Ibrahim diagnosed elbow epicondylitis and a meniscus tear of the right knee. He checked a box marked "Yes" indicating that the condition was caused or aggravated by the employment activity of appellant tripping over a post con and landing on her right knee and hands.

On December 18, 2019 OWCP expanded acceptance of appellant's claim to include a right knee lateral meniscus tear and right elbow medial humeral epicondylitis.

By decision dated December 18, 2019, OWCP denied modification of its January 22, 2019 decision. It found that the medical evidence of record was insufficient to establish that the acceptance of appellant's claim should be expanded to include right shoulder impingement syndrome, a right knee medial meniscus tear, lumbar disc displacement, cervical radiculopathy, and bilateral carpal tunnel syndrome.

LEGAL PRECEDENT

When an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.[7]

Causal relationship is a medical question that requires rationalized medical opinion evidence to resolve the issue.[8] A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factor(s) must be based on a complete factual and medical background.[9] Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty and must be supported by medical

[7] *J.R.*, Docket No. 20-0292 (issued June 26, 2020); *W.L.*, Docket No. 17-1965 (issued September 12, 2018); *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004).

[8] *E.M.*, Docket No. 18-1599 (issued March 7, 2019); *Robert G. Morris*, 48 ECAB 238 (1996).

[9] *F.A.*, Docket No. 20-1652 (issued May 21, 2021); *M.V.*, Docket No. 18-0884 (issued December 28, 2018); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

rationale, explaining the nature of the relationship between the diagnosed condition and appellant's employment injury.[10]

Section 8123(a) of FECA which provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, OWCP shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[11] Where a case is referred to an impartial medical examiner (IME) for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background must be given special weight.[12]

ANALYSIS

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

In reports beginning June 5, 2017, Dr. Filippone provided multiple diagnoses that he found causally related to the accepted employment injury, including cervical derangement and radiculitis, internal derangement of the right knee, low back derangement, and lumbosacral radiculitis, and carpal tunnel syndrome. Dr. Dassa, in reports beginning June 29, 2017, diagnosed right shoulder impingement syndrome as employment related. On August 10, 2017 he diagnosed a tear of the medial and lateral meniscus of the right knee.

OWCP referred appellant to Dr. Henderson for a second opinion examination. On October 30, 2017 Dr. Henderson found that she had sustained, among other conditions, a possible cervical herniated disc with right radiculopathy and lumbar sprain with radiculopathy causally related to her accepted employment injury.

OWCP subsequently referred appellant to Dr. Faber for a second opinion examination. It properly determined that a conflict arose between Dr. Faber and Dr. Filippone regarding appellant's disability from employment, need for medical treatment, and the causal relationship between the additional diagnosed conditions and her accepted employment injury. In order to resolve the conflict, OWCP properly referred her, pursuant to 5 U.S.C. § 8123(a), to Dr. Carlson for an impartial medical examination.

When a case is referred to an IME for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[13]

In its December 18, 2019 decision, OWCP found that appellant had not submitted sufficient evidence to support expansion of the acceptance of her claim to include right shoulder impingement syndrome, a medial meniscus tear of the right knee, lumbar disc displacement,

[10] *Id*.

[11] 5 U.S.C. § 8123(a); *L.S.*, Docket No. 19-1730 (issued August 26, 2020); *M.S.*, 58 ECAB 328 (2007).

[12] 20 C.F.R. § 10.321; *T.D.*, Docket No. 17-1011 (issued January 17, 2018).

[13] *Id*.

cervical radiculopathy, and bilateral carpal tunnel syndrome. However, it failed to discuss the findings of its referral physician, Dr. Henderson, who diagnosed a possible cervical herniated disc with cervical radiculopathy due to the June 2, 2017 employment injury or the findings of Dr. Carlson, the IME who addressed the issue of claim expansion.

In a report dated November 1, 2018, Dr. Carlson found that OWCP should expand acceptance of appellant's claim to include a posterior horn tear of the lateral meniscus and a partial TFCC tear of the right wrist. He did not, however, directly address the issue of whether her claim should be expanded to include right shoulder impingement syndrome, a medial meniscus tear of the right knee, lumbar disc displacement, cervical radiculopathy, and bilateral carpal tunnel syndrome or explain why these additional diagnosed conditions were unrelated to the June 2, 2017 employment injury.

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares the responsibility in the development of the evidence to see that justice is done.[14] Once OWCP undertakes development of the medical evidence, it must produce medical evidence that will resolve the relevant issues in the case.[15] When it obtains an opinion from an IME for the purpose of resolving a conflict in the medical evidence and the IME's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to correct the defect in the original report.[16]

On remand, OWCP should prepare an updated statement of accepted facts and request a supplemental report from Dr. Carlson to determine whether the acceptance of appellant's claim should be expanded to include right shoulder impingement syndrome, a medial meniscus tear of the right knee, lumbar disc displacement, cervical radiculopathy, and bilateral carpal tunnel syndrome. If Dr. Carlson fails to respond or does not provide an adequate response, OWCP should refer appellant to a new IME for examination.[17] Following 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.

[14] *See T.B.*, Docket No. 20-0182 (issued April 23, 2021).

[15] *T.K.*, Docket No. 20-0150 (issued July 9, 2020); *T.C.*, Docket No. 17-1906 (issued January 10, 2018).

[16] *B.J.*, Docket No. 18-1186 (issued July 9, 2019); *Harold Travis*, 30 ECAB 1071 (1979).

[17] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.11(e) (September 2010); *Harold Travis, id*.

ORDER

IT IS HEREBY ORDERED THAT the December 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.

Issued: April 20, 2022
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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