United States Department of Labor
Employees' Compensation Appeals Board

S.M., Appellant	)	
and	)	**Docket No. 20-1527**
	)	**Issued: March 29, 2022**
U.S. POSTAL SERVICE, DOMINICK V. DANIELS PROCESSING & DISTRIBUTION CENTER, Kearney, NJ, Employer	)	

Appearances:
Michael D. Overman, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On August 20, 2020 appellant, through counsel, filed a timely appeal from a March 24, 2020 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the 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]

[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] 5 U.S.C. § 8101 *et seq*.

[3] The Board notes that appellant submitted additional evidence to OWCP following the March 24, 2020 decision. 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 his burden of proof to establish expansion of the acceptance of his claim to include bilateral carpal tunnel syndrome, bilateral knee arthritis, and internal derangement of the right knee.

FACTUAL HISTORY

On November 9, 2010 appellant, then a 53-year-old mail handler, filed a traumatic injury claim (Form CA-1) alleging that on November 3, 2010 he sustained low back and right knee injuries when loading a postal container onto a truck while in the performance of duty. He explained that the truck pulled away without warning, causing the container to roll backward. Appellant stopped work on November 3, 2010. On November 4, 2010 he received treatment in a hospital emergency department.

In a November 13, 2010 report, Dr. F. Kennedy Gordon, Board-certified in internal and sports medicine, provided a history of injury and treatment. He noted that appellant underwent arthroscopic right meniscal repair in January 2010. Dr. Gordon diagnosed right-sided cervical strain, right superior trapezius strain, paralumbar sprain/strain, lower right abdominal strain, right groin strain, right medial collateral ligament sprain, and history of right meniscal tear.[4]

On November 23, 2010 OWCP accepted the claim for lumbar, thoracic, and cervical spine sprains, sprain of the right lateral collateral ligament, and a groin sprain.[5] It paid appellant wage-loss compensation on the supplemental rolls commencing December 26, 2010 and on the periodic rolls commencing September 25, 2011.[6]

On July 1, 2011 OWCP referred appellant for a second opinion evaluation and report from Dr. Jeffrey F. Lakin, a Board-certified orthopedic surgeon. In a July 22, 2011 report, Dr. Lakin opined that the accepted right knee injury remained active. He recommended right knee arthroscopy.

On July 7, 2013 appellant returned to modified duty as a mail handler for two hours a day. OWCP paid appellant wage-loss compensation for the remaining hours on the supplemental rolls commencing July 7, 2013.

In an August 1, 2013 report, Dr. Mark A.P. Filippone, a Board-certified physiatrist, reviewed a history of injury and treatment. He noted a January 2010 right knee arthroscopy prior to the accepted injury and a 2003 nonoccupational left knee arthroscopy. On examination, Dr. Filippone noted: bilaterally-positive Tinel's and Phalen's signs over the median nerve at the wrists; diminished pinprick sensation in the right thumb, index, and middle fingers; decreased

[4] Dr. Gordon provided periodic reports dated from December 6, 2010 through May 31, 2013 noting continued right medial collateral ligament pain and a right meniscal tear requiring surgical repair. A December 30, 2010 magnetic resonance imaging (MRI) scan of the right knee demonstrated prior meniscal surgery, tear or retear of the posterior horn, joint effusion, chondromalacia of the patella, diffuse thickening of the patellar tendon, spurring of the patellar poles, and a posterior popliteal cyst.

[5] Appellant underwent right inguinal hernia repair in February 2016.

[6] From June 23, 2011 through February 14, 2013, appellant underwent a series of OWCP-authorized cervical and lumbar injections, and stereotactic radiofrequency neurotomy of the right L3, L4, L5, S1, S2, and S3 nerve roots.

pinprick sensation over the distal volar aspect of all five left fingers and hypothenar eminence; limited range of motion throughout the spine; right knee swelling; an equivocally-positive drawer sign in the right knee; and crepitation over the right medial meniscus. He diagnosed cervical and thoracic radiculitis, right inguinal hernia. and internal derangement of the right knee. Dr. Filippone opined that all of these diagnoses "need to be accepted by [OWCP]."[7]

In a September 12, 2013 report, Dr. David Deramo, a Board-certified orthopedic surgeon, provided a history of January 2010 right knee surgery and the accepted November 3, 2010 employment injury. He diagnosed right knee pain, acute right medial meniscus tear, internal derangement of the right knee, and patellar chondromalacia.

In a September 13, 2013 report, Dr. Filippone opined that electromyography/nerve conduction velocity (EMG/NCV) studies of the bilateral upper extremities demonstrated bilateral carpal tunnel syndrome.[8]

Appellant stopped work on March 7, 2014 and did not return.

On June 17, 2014 Dr. Marc S. Arginteanu, a Board-certified neurosurgeon, performed OWCP-authorized partial L5 laminectomy, partial S1 laminectomy, and L5-S1 discectomy.

By decision dated June 25, 2014, OWCP accepted a recurrence of disability and a need for medical treatment commencing March 7, 2014. It expanded the acceptance of the claim to include lumbosacral spondylosis without myelopathy.

By decision dated July 9, 2014, OWCP accepted another recurrence of disability effective June 17, 2014. It authorized payment of wage-loss compensation for partial disability from May 31 through June 16, 2014. OWCP placed appellant on the periodic compensation rolls retroactive to June 29, 2014.

Dr. Filippone provided periodic reports dated from September 5, 2014 through June 30, 2015 diagnosing cervical,[9] thoracic, and lumbar radiculopathy; bilateral carpal tunnel syndrome with positive Tinel's and Phalen's signs; and internal derangement of the right knee. He opined that these conditions were causally related to the accepted November 3, 2010 employment injury.[10]

[7] An August 19, 2013 MRI scan of the right knee demonstrated mild tricompartmental osteoarthritis, chronic thickening of the medial collateral ligament and patellar tendon, persistent tear of the posterior horn of the medial meniscus, persistent radial tear of the lateral meniscus, chondromalacia, and a popliteal cyst and a focal area of inflammation in the superolateral aspect of Hoffa's fat pad. August 21, 2013 MRI scans of the cervical and thoracic spine demonstrated disc bulges at C5-6, C6-7, and C7-T1, thoracic kyphosis and spondylosis deformans, and multiple Shmorl's nodes in the lower thoracic region.

[8] In November and December 2013 appellant underwent a series of OWCP-authorized lumbar and lumbosacral injections.

[9] A January 13, 2015 MRI scan of the cervical spine demonstrated a C4-5 broad-based posterior disc bulge, C5-6 broad-based midline disc herniation with mild spinal stenosis, board-based posterior disc bulge at C6-7, and C7-T1 asymmetric disc bulge to the right. A May 20, 2015 MRI scan of the right knee demonstrated postoperative changes from prior partial medial meniscectomy, increased cartilage loss, and patellar tracking disorder.

[10] Appellant underwent a series of OWCP-authorized epidural steroid injections from March 26 through August 13, 2015.

In a June 8, 2015 report, Dr. Yaser El-Gazzar, an orthopedic surgeon, noted the onset of right knee pain after the November 3, 2010 employment injury. On examination, he observed crepitance of both knees. Dr. El-Gazzar diagnosed patellofemoral syndrome, a right meniscal tear, acquired genu varum deformity, and synovitis status postemployment injury. He administered a series of cortisone injections and prescribed a knee brace.

Thereafter, OWCP referred appellant to a second opinion physician. In a July 2, 2015 report, Dr. Timothy Henderson, a Board-certified orthopedic surgeon, reviewed a statement of accepted facts (SOAF) and the medical record and noted findings on examination. He opined that the accepted cervical spine injury caused "double crush" bilateral carpal tunnel syndrome due to compression of cervical nerve roots superimposed on mild compression of the median nerve at the wrists.

Dr. Filippone submitted reports dated July 31, 2015 through September 26, 2017 finding appellant totally disabled from work due to cervical,[11] thoracic, and lumbar radiculopathy, bilateral carpal tunnel syndrome, and internal derangement of the right knee. He opined that these conditions were caused by the accepted November 3, 2010 employment injury.

Thereafter, OWCP referred appellant for a second opinion report to Dr. Stanley Askin, a Board-certified orthopedic surgeon. In an October 6, 2017 report, Dr. Askin reviewed a SOAF and the medical records. On examination, he observed bilaterally-positive Tinel's sign at the wrist, and limited active range of motion throughout the spine. Dr. Askin opined that the accepted employment conditions had resolved without residuals. He attributed appellant's spinal and musculoskeletal complaints to obesity "and not consequential to the fact that he fell on November 3, 2010." Dr. Askin concluded that the acceptance of appellant's claim "should not be expanded to include any other conditions for the November 3, 2010, incident."

In reports dated November 20, 2017, Dr. Filippone noted bilateral hand numbness secondary to the use of a cane.[12] In reports dated December 19, 2017, he noted that both knees were tender and effused. Dr. Filippone opined that appellant urgently required right knee arthroscopy.

In a January 26, 2018 letter, appellant, through counsel, requested that OWCP expand the acceptance of the claim to include bilateral carpal tunnel syndrome, based on Dr. Henderson's July 2, 2015 opinion.

In a February 14, 2018 report, Dr. Paul M. Brisson, a Board-certified orthopedic surgeon, related appellant's complaints of increased numbness and weakness in both hands. He opined that appellant had sustained cervical and lumbar spine injuries in the November 3, 2010 employment incident. In a March 14, 2018 report, Dr. Brisson diagnosed bilateral radiculopathy at C5, C6, C7, and L5-S1.

[11] In an October 20, 2015 report, Dr. Filippone noted that a May 6, 2015 EMG/NCV study of the bilateral upper extremities demonstrated right C5, C6, and C7 cervical radiculopathy and left C5-6 cervical radiculopathy.

[12] A November 29, 2017 MRI scan of the right knee demonstrated status post partial lateral meniscectomy, "[r]ecurrent tear within the posterior horn of the lateral meniscus, "[n]ew vertical tear within the body and posterior horn" of the medial meniscus, and a small ganglion cyst.

OWCP found a conflict of medical opinion between Dr. Filippone, for appellant, and Dr. Askin, for the government, regarding whether acceptance of the claim should be expanded to include additional spinal conditions, bilateral carpal tunnel syndrome, and derangement of the right knee, and whether appellant had continuing work-related disability or required further medical treatment. It referred appellant, an updated statement of accepted facts (SOAF), and the medical record to Dr. Dean Carlson, a Board-certified orthopedic surgeon, to resolve the conflict of opinion as the impartial medical examiner (IME).

In a February 15, 2018 report, Dr. Carlson diagnosed resolved cervical, thoracic, and lumbar sprains, status post lumbar discectomy, a resolved L5-S1 disc herniation, resolved right lateral collateral ligament sprain, nonoccupational bilateral carpal tunnel syndrome, and nonoccupational osteoarthritis of both knees.

In a June 4, 2018 report, Dr. Imran Ashraf, a Board-certified orthopedic surgeon, diagnosed a work-related right knee injury and post-traumatic osteoarthritis. He recommended right knee surgery.

By notice dated July 18, 2018, OWCP proposed to terminate appellant's wage-loss compensation and medical benefits as the accepted employment conditions had ceased. It afforded him 30 days to submit additional evidence or argument.

Appellant, through counsel, contended in an August 13, 2018 statement that Dr. Carlson provided insufficient medical rationale. He submitted reports from Dr. Filippone dated from July 18 through August 16, 2018 reiterating previous diagnoses.

By decision dated August 29, 2018, OWCP denied expansion of the acceptance of appellant's claim to include bilateral carpal tunnel syndrome, internal derangement of the right knee, bilateral knee arthritis, right inguinal hernia, herniated/bulging discs of the cervical and lumbar spine, and cervical and lumbar degenerative disc disease, based on Dr. Carlson's opinion as the special weight of the medical evidence.

By decision dated September 7, 2018, OWCP terminated appellant's wage-loss compensation and medical benefits effective that day, based on Dr. Carlson's opinion as the special weight of the medical evidence.

Appellant, through counsel timely requested a hearing before a representative of OWCP's Branch of Hearings and Review with regard to both the expansion and termination decisions. During the hearing, held on February 21, 2019, counsel contended that OWCP should have accepted bilateral carpal tunnel syndrome/double crush syndrome based on Dr. Henderson's July 2, 2015 opinion instead of posing the same question to Dr. Askin. He submitted additional reports from Dr. Filippone dated September 13, 2018 through April 25, 2019, which reiterated that the November 3, 2010 employment injuries caused bilateral carpal tunnel syndrome and internal derangement of the right knee.

By decision dated May 8, 2019, OWCP's hearing representative reversed the September 7, 2018 termination decision, set aside the August 29, 2018 expansion decision, and remanded the case for additional development.

On remand, OWCP referred appellant, an updated SOAF, and the medical record to Dr. Howard M. Pecker, Board-certified in orthopedic surgery and sports medicine, for an impartial medical opinion. In an August 6, 2019 report, Dr. Pecker reviewed the medical record and SOAF. On examination of appellant, he observed triggering of the index and long fingers of the right hand, and a palpable medial osteophyte of the right knee. Dr. Pecker noted that there was no evidence of carpal tunnel syndrome. He diagnosed degenerative cervical and lumbar disc disease, and osteoarthritis of both knees. Dr. Pecker opined that all conditions present on examination were age-related, without contribution by physical trauma. He returned appellant to full-time medium duty.

By decision dated September 5, 2019, OWCP terminated appellant's wage-loss compensation and medical benefits effective that day based on Dr. Pecker's August 6, 2019 report as the special weight of the medical evidence.

By separate decision also dated September 5, 2019, OWCP denied expansion of the acceptance of appellant's claim to include bilateral carpal tunnel syndrome, internal derangement of the right knee, bilateral knee arthritis, herniated/bulging cervical and lumbar discs, cervical and lumbar degenerative disc disease, and inguinal hernia based on Dr. Pecker's opinion as the special weight of the medical evidence.

On September 12, 2019 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review with regard to both September 5, 2019 decisions. The hearing was held on January 17, 2020.

OWCP subsequently received a July 24, 2019 report, wherein Dr. Serge Menkin, Board-certified in physiatry and pain medicine, provided a history of injury and treatment. On examination, he noted positive cervical, thoracic, and lumbar facet loading maneuvers, positive Apley's maneuver and McMurray's sign in the right knee, and a positive right patellofemoral grind test. He diagnosed lumbar radiculopathy, lumbar facet pain, cervicalgia, thoracic pain, and right knee pain. Dr. Menkin reiterated these diagnoses in reports through December 18, 2019.

By decision dated March 24, 2020, OWCP's hearing representative reversed the September 5, 2019 termination decision. He remanded the case to obtain a supplemental report from Dr. Pecker on whether the accepted November 3, 2010 employment injury had caused or contributed to herniated/bulging cervical and lumbar discs, cervical and lumbar degenerative disc disease, and right inguinal hernia. The hearing representative affirmed the September 5, 2019 denial of expansion of the acceptance of appellant's claim to include bilateral carpal tunnel syndrome, internal derangement of the right knee, and bilateral knee arthritis, based on Dr. Pecker's report as the special weight of the medical evidence.

LEGAL PRECEDENT

Where 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.[13]

[13] *D.B.*, Docket No. 20-1280 (issued March 2, 2021); *R.R.*, Docket No. 19-0086 (issued February 10, 2021); *K.T.*, Docket No. 19-1718 (issued April 7, 2020); *Jaja K. Asaramo*, 55 ECAB 200 (2004).

Causal relationship is a medical question that requires medical opinion evidence to resolve the issue.[14] The opinion of the physician must be based on a complete factual and medical background, must be one of reasonable certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the accepted employment injury.[15]

To establish causal relationship between the condition as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence.[16] 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.[17] The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[18]

In discussing the range of compensable consequences, once the primary injury is causally connected with the employment, the question is whether compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury. The rules that come into play are essentially based upon the concepts of direct and natural results and of the claimant's own conduct as an independent intervening cause. The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.[19]

In a 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.[20]

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 IME) who shall make an examination.[21] This is called a referee examination and OWCP will select a physician who is

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

[15] *Id*.

[16] *T.K.*, Docket No. 18-1239 (issued May 29, 2019); *M.W.*, 57 ECAB 710 (2006); *John D. Jackson*, 55 ECAB 465 (2004).

[17] *D.S.*, Docket No. 18-0353 (issued February 18, 2020); *T.K.*, *id*.; *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[18] *See P.M.*, Docket No. 18-0287 (issued October 11, 2018).

[19] *D.B.*, *supra* note 14; *see V.K.*, Docket No. 19-0422 (issued June 10, 2020).

[20] *B.P.*, Docket No. 19-1376 (issued January 4, 2021); *M.O.*, Docket No. 18-0229 (issued September 23, 2019); *J.F.*, Docket No. 19-0456 (issued July 12, 2019); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013).

[21] 5 U.S.C. § 8123(a); *L.S.*, Docket No. 19-1730 (issued August 26, 2020); *M.S.*, 58 ECAB 328 (2007).

qualified in the appropriate specialty and who has no prior connection with the case.[22] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an IME for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[23]

ANALYSIS

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

Dr. Pecker, the IME**,** opined in his August 6, 2019 report that appellant's bilateral knee conditions were age-related with no contribution from physical trauma. However, he did not identify the conditions that necessitated the prior bilateral knee surgeries, or explain whether the accepted right medial collateral ligament sprain would have had any effect on those degenerative processes or caused an acute meniscal tear. Additionally, in contrast to appellant's treating physicians, Dr. Pecker opined that there were no objective findings of carpal tunnel syndrome. He did not address the reports of Dr. Filippone or Dr. Henderson, which documented the presence of bilateral carpal tunnel syndrome and supported causal relationship. As Dr. Pecker did not provide medical rationale, his opinion requires clarification.[24]

In a situation where OWCP secures an opinion from an IME for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification and/or elaboration, OWCP has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[25]

For the above-described reasons, the opinion of Dr. Pecker requires clarification. Therefore, in order to address the unresolved conflict in the medical opinion evidence, the Board will remand the case to OWCP for a supplemental opinion regarding whether OWCP should expand its acceptance of the claim to include bilateral carpal tunnel syndrome, internal derangement of the right knee, and bilateral knee osteoarthritis. If Dr. Pecker is unable to clarify his opinion or if his requested supplemental report is also lacking rationale, OWCP shall refer appellant to a new IME for the purpose of obtaining a rationalized medical opinion on the issue.[26] After 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 a decision.

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[22] 20 C.F.R. § 10.321; *P.B.*, Docket No. 20-0984 (issued November 25, 2020); *R.C.*, 58 ECAB 238 (2006).

[23] *R.R.*, *supra* note 14; *see Y.I.*, Docket No. 20-0263 (issued November 30, 2020); *Darlene R. Kennedy*, 57 ECAB 414 (2006).

[24] *B.P.*, *supra* note 21.

[25] *T.C.*, Docket No. 20-1170 (issued January 29, 2021); *S.R.*, Docket No. 17-1118 (issued April 5, 2018); *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232 (1988).

[26] *M.D.*, Docket No. 19-0510 (issued August 6, 2019); *Harold Travis*, 30 ECAB 1071 (1979).

ORDER

IT IS HEREBY ORDERED THAT the March 24, 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: March 29, 2022
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

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