U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ROBERT WELLS and U.S. POSTAL SERVICE
POST OFFICE, Kentwood, Mich.

Docket No. 96-710; Submitted on the Record;
Issued November 10, 1998

DECISION and ORDER

Before GEORGE E. RIVERS, WILLIE T.C. THOMAS,
MICHAEL E. GROOM

The issues are: (1) whether appellant has met his burden of proof in establishing that he sustained an injury in the performance of duty, as alleged; and (2) whether the Office of Workers' Compensation Programs, by its November 30, 1995 decision, abused its discretion by refusing to reopen appellant's case for further review on the merits of his claim under 5 U.S.C. § 8128(a).

The Board has duly reviewed the case record in the present appeal and finds that the case is not in posture for decision.

An employee seeking benefits under the Federal Employees' Compensation Act[1] has the burden of establishing 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 the Act, that the claim was filed within the applicable time limitations of the Act, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed is causally related to the employment injury.[2] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or occupational disease.[3]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the

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[1] 5 U.S.C. § 8101.

[2] *Joe Cameron*, 41 ECAB 153 (1989); *Elaine Pendleton*, 40 ECAB 1143, 1154 (1989).

[3] *Victor J. Woodhams*, 41 ECAB 345 (1989).

presence or occurrence of the disease or condition; and (3) medical evidence establishing that the employment factors identified by the claimant were the proximate cause of the condition for which compensation is claimed or, stated differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by claimant.

The medical evidence required to establish causal relationship, generally, is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. 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.[4]

In this case, appellant filed an occupational disease claim on November 12, 1993, alleging that as a result of performing his duties as a letter carrier he developed left shoulder rotator cuff syndrome due to "repetition of the movements used in sorting the mail and moving trays from the back of the truck to the front to put it in the racks for delivery, beginning August 10, 1993 and continuing. On the reverse side of the form, the employing establishment indicated that appellant was last exposed to the conditions alleged to have caused the illness on October 9, 1993 and stopped work on October 13, 1993. The Office denied appellant's claim on May 25, 1994, finding that the evidence of record failed to establish that the claimed medical condition or disability was causally related to federal work factors on and prior to August 10, 1993. By letter dated June 15, 1994, appellant requested reconsideration of the May 25, 1994 decision. By decision dated August 15, 1994, the Office denied appellant's request for reconsideration, finding that the evidence of record was insufficient to warrant modification of the prior decision. By letter dated September 29, 1994, appellant requested reconsideration of the August 15, 1994 decision. By decision dated December 19, 1994, the Office denied appellant's request for reconsideration finding that the evidence of record was insufficient to warrant modification of the prior decision. By letter dated August 23, 1995, appellant, through his representative, requested reconsideration of the December 19, 1994 decision. By decision dated September 25, 1995, the Office denied appellant's request for reconsideration, finding that the evidence of record was insufficient to warrant modification of the prior decision. By letter dated October 9, 1995, appellant's representative requested reconsideration of the September 25, 1995 decision. By decision dated November 30, 1995, the Office found that the evidence submitted was repetitious or irrelevant and immaterial and insufficient to warrant review of the prior decision.

The medical evidence in support of appellant's claim includes a December 30, 1993 report by Dr. Darrel J. Rosen, a Board-certified radiologist; a January 12, 1994 report by Dr. Brian C. Fedeson, a Board-certified radiologist; December 23, 1993 and January 21, 1994 office notes by Dr. Gregory A. Peters, a Board-certified orthopedic surgeon; February 9, 16, and 21, 1994 reports by Dr. Kevin E. Fitzgerald, a Board-certified anesthesiologist, who performed suprascapular nerve blocks on appellant; March 30 and June 8, 1994 reports by Dr. Michael W.

[4] *Id.*

Grof, a Board-certified neurologist; June 7 and August 31, 1994 reports by Dr. David G. Carr, an osteopath; and March 21, April 7, and June 9, 1994 reports by Dr. David Frye.

In a December 15, 1993 unsigned report, Dr. Rosen, interpreted a radionuclide bone scan of the shoulders and a left shoulder arthrogram. Dr. Rosen stated that the bone scan revealed mildly increased activity in the left glenohumeral area consistent with hyperemia from inflammation and the arthrogram revealed no demonstration of a rotator cuff tear.

In office notes dated December 23, 1993 and January 21, 1994, Dr. Peters noted that he saw appellant for his left shoulder. On December 23, 1993, Dr. Peters stated that x-ray revealed increased activity about the left shoulder consistent with degenerative arthritis and an arthrogram revealed no rotator cuff tear. Dr. Peters diagnosed recalcitrant work-related left shoulder pain, etiology to be determined, left shoulder pain secondary to adhesive capsulitis and to rule out a mysterious cause. ON January 21, 1994 Dr. Peters also diagnosed recalcitrant left shoulder pain, and adhesive capsulitis, as well as reflex sympathetic dystrophy.

In a January 12, 1994 report, Dr. Fedeson interpreted an MRI (magnetic resonance imaging) of the shoulder, performed to rule out osteomyelitis versus tumor. Dr. Fedeson stated that appellant gave a history of therapy for a frozen shoulder, pain from shoulder to wrist, and repetitive movement at work. Dr. Fedeson's diagnosed rotator cuff tear, possible glenoid labral tear, which needed to be correlated clinically and a small glenoid cyst.

In February 9, 16, and 21, 1994 reports, Dr. Fitzgerald stated that he saw appellant for pain management of left arm and shoulder pain. Dr. Fitzgerald initially noted that appellant was referred by Dr. Peters who felt appellant needed physical therapy to increase the range of motion in his left arm prior to having surgery. Dr. Fitzgerald's diagnosis was possible frozen shoulder. He described the procedure, suprascapular nerve blocks, performed on appellant on each date mentioned above and noted a dramatic decrease in pain and greater range of motion.

In a March 30, 1994 report, Dr. Grof, stated that he saw appellant for evaluation of neurological problems in the left arm and cervical spine. Dr. Grof related a history as given by appellant of a mail carrier who carried his bag over his left shoulder for years. He noted that appellant developed some pain off and on for years but last summer when delivering mail from a truck and reaching back behind him appellant felt a sudden strain and felt that he had pulled a muscle. The pain was severe over the back of the left shoulder just over the top of the left shoulder blade. The pain gradually progressed over the next several weeks and appellant stopped using his arm. Dr. Grof went on to say that appellant stated that during October and November it was so painful that he did not use his arm at all and finally saw a doctor who felt he had a frozen shoulder at that time. Dr. Grof stated that appellant told him that he underwent testing and since winter he has had continued pain in the left shoulder with a pulling sensation when he tries to fully extend at the elbow. Dr. Grof stated that an EMG (electromyography) nerve conduction study revealed several mild abnormalities. After further testing and examination, Dr. Grof found:

> "[M]ild weakness of the left upper extremity secondary to disuse atrophy of this arm which occurred last fall. He still favors the arm significantly and is not fully rehabilitated in the use of the arm and shoulder. There is abnormal carriage and

> posturing and persistent pain on the left side involving the shoulder and arm. This most likely is secondary to arthritis of the shoulder and his frozen shoulder condition. There is no evidence by clinical examination or myelogram that he has a cervical radiculopathy to account for any of the problems there."

Dr. Grof suggested metabolic testing to rule out several possible reasons for appellant's problems. Hestated that "[appellant's] main problem is that of shoulder pain which hopefully will be helped with physical therapy and pain medication."

In a June 8, 1994 report, Dr. Grof stated that an EMG evidenced polyradiculoneuropathy with abnormal neuromuscular findings in all muscles of both upper extremities. Dr. Grof stated that an MRI was performed showing mild anterior impression at L4-5 and C3-4 level of cervical spine, however, that did not explain appellant's painful shoulder syndrome, so additional tests were done, *i.e.*, MRI of the brain, blood tests and a lumbar puncture. He stated that he later became aware that Dr. Carr believed there was a pinched nerve in the neck and performed surgery which helped appellant. Dr. Grof further stated, "This letter is to state that the testing performed on [appellant] was necessary as part of the work up for a problem which had occurred through [appellant's] course of work and should be covered by his workmen's compensation insurance."

In a May 5, 1994 report, Dr. Steven P. Klegman interpreted an MRI of the cervical spine and gave his impression as a herniated disc at the C6-7 level and a mild annular bulge at the C3-4 level.

In a June 7, 1994 report, Dr. Carr stated that he first saw appellant on April 27, 1994 for left arm pain. Dr. Carr gave a history of injury as provided by appellant. Dr. Carr referred to Dr. Klegman's MRI report which revealed a large herniated disc at C6-7 level for which surgery was performed on May 26, 1994, and after which appellant experienced immediate relief of his arm pain. Dr. Carr stated that appellant had a pinched nerve in the cervical spine and an EMG revealed peripheral neuropathy generalized. In an August 31, 1994 report, Dr. Carr stated that appellant related that he had been working full time for several years and one day when he turned, reached around behind him to get some mail, he felt a pop in his neck followed by pain. Dr. Carr stated:

> "Since [appellant] was working with no left arm pain but then reached to get some mail from behind him and experienced the onset of severe pain that forced him to quit working, and in view of his dramatic response to the surgery with resolution of his pain upon awakening, it is my opinion that the herniated disc was related to his work for the [employing establishment] and was indeed due to turning around, lifting up the parcels in the back seat and any other maneuvers he describes in relation to the onset of his pain.
>
> "I am unable to provide you with any opinions concerning his shoulder or the diffuse findings on the EMG from Dr. Grof."

In a March 21, 1994 report, Dr. Frye stated that he saw appellant on March 16, 1994 for pain in his left shoulder, with intermittent pain in his neck and arm. Dr. Frye related a history of

left shoulder complaint as given by appellant of "it began in August of 1993. He states that he was in his truck delivering mail and he turned around to get something from the back seat and he had immediate onset of pain in the shoulder, neck and down into the hand. The pain that initially was in the forearm has dissipated and now it is primarily located in the shoulder and the left neck region and along the medial scapular border. It will awake him at night. He states that it aggravates with overhead activities. Denies any history of previous trauma, such as fractures or dislocation to the extremity." Dr. Frye diagnosed adhesive capsulitis of the left shoulder and rule out cervical radiculopathy or other upper motor neuron lesions. Dr. Frye ordered an EMG, nerve conduction studies and chest x-rays. In an April 7, 1994 report, Dr. Frye stated that appellant underwent an extensive workup to evaluate his left shoulder pain, which revealed no metabolic reasons to explain what at this time appears to be a polyneuropathy. Dr. Frye scheduled appellant for manipulation of the shoulder under anesthesia.

In a June 9, 1994 report, Dr. Frye stated that he saw appellant for complaints of neck, arm and left shoulder pain. Dr. Frye repeated the history of injury he described in his March 21, 1994 report which had been provided by appellant. Dr. Frye also stated that appellant related that he had no prior history of trauma to his cervical spine or shoulder. Dr. Frye reported his findings on examination and diagnosed adhesive capsulitis of the left shoulder and possible cervical radiculopathy. Dr. Frye also mentioned previous test performed by other physicians which revealed a tear of the left rotator cuff and possible glenolabral tear. Dr. Frye stated that he referred appellant to Dr. Carr for evaluation of the cervical spine.

In a March 3, 1994 report, an Office medical adviser stated:

> "I have reviewed the file and find that there is not enough evidence to show that the man's problem is due to work. Also there is no medical definitive history and physical examination reviewing the patients problems and findings of the doctor with a clinical impression. MRI on January 12, 1994 suggests a rotator cuff tear and a glaniod labral tear but there is no clinical correlation. There is a P.T. [physical therapy] evaluation but not that by a physician. Bone scan and arithrograms were inconclusive. Please obtain this information and when it returns, return file to me for further evaluation."

Appellant's pain and problems started with an employment incident on August 10, 1993. The medical evidence of record suggests that his problems got progressively worse, requiring physical therapy, bone scan, arthrogram, myelogram, blood studies and MRI. Dr. Grof stated that he believed all the testing was necessary to diagnose appellant's problems.

On remand the Office should prepare a statement of accepted facts and refer it and appellant for a second opinion evaluation by a panel consisting of a neurologist and orthopedist for a reasoned opinion as to whether the employment incident caused an injury resulting in the need for medical treatment he received, including the diagnostic testing, physical therapy, surgery; and if so, the period or periods of disability associated with the injury.

After such further development as is necessary, the Office should issue a *de novo* decision.

The decisions of the Office of Workers' Compensation Programs dated November 30, and September 25, 1995 are set aside and the case is remanded for further development consistent with this decision.[5]

Dated, Washington, D.C.
November 10, 1998

George E. Rivers
Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

[5] In view of the Board's decision on the first issue, it is unnecessary for the Board to address the second issue in this case.