U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of CHARLES R. BONDURANT and U.S. POSTAL SERVICE,
GULF BREEZE POST OFFICE, Gulf Breeze, FL

Docket No. 98-711; Submitted on the Record;
Issued September 15, 1999

DECISION and ORDER

Before WILLIE T.C. THOMAS, MICHAEL E. GROOM,
BRADLEY T. KNOTT

The issue is whether the Office of Workers' Compensation Programs properly terminated appellant's compensation and medical benefits.

On October 12, 1995 appellant, then a 50-year-old rural letter carrier, filed a claim for recurrence of disability due to carpal tunnel syndrome and fibromyositis. On October 18, 1995 appellant filed a claim for arthritis, thoracic outlet syndrome and fibromyalgia. The employing establishment indicated that appellant had stopped working on October 3, 1995. In an April 1, 1996 letter, the Office accepted appellant's claim for aggravation of carpal tunnel syndrome and began payment of temporary total disability compensation effective November 21, 1995.

In a September 27, 1996 letter, the Office notified appellant that it was proposing to terminate his compensation on the grounds that he was no longer disabled due to the effects of his employment injury. In an October 28, 1996 decision, the Office terminated appellant's compensation effective November 9, 1996 on the grounds that he was no longer disabled from his date-of-injury job. In a December 12, 1996 decision, the Office terminated appellant's medical benefits on the grounds that the medical evidence of record established that appellant had no objective work-related residuals of his injury. Appellant requested a hearing before an Office hearing representative. In a December 9, 1997 decision, an Office hearing representative affirmed the Office's decisions.

The Board finds that the Office properly terminated appellant's compensation and medical benefits.

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation benefits. After it has determined that an employee has disability causally related to his or her federal employment, the Office may not terminate compensation

without establishing that the disability has ceased or that it is no longer related to the employment.[1]

Appellant indicated that he had carpal tunnel syndrome previously for which he underwent surgery on his left arm in 1988. He noted that after the surgery he adapted to his job. He worked as a letter carrier until August or September 1994 when he became an acting supervisor. He returned to his carrier route in June 1995 and began to have severe pain in his arms and shoulders which would intensify when he worked and subsided when he stopped working. Eventually the pain became continuous. He sought treatment in September 1995 and received a diagnosis of fibrositis. He commented that carpal tunnel syndrome was first diagnosed in December 1980, arthritis in December 1986 and thoracic outlet compression syndrome in 1988.

In an October 24, 1995 report, Dr. Joseph D. Howard, a Board-certified family practitioner, stated that appellant had seen him for osteoarthritis, fibrositis, carpal tunnel syndrome and thoracic outlet syndrome. He indicated that appellant was disabled for work due to these conditions. In a February 23, 1996 letter, the Office informed Dr. Howard that it had accepted that appellant's job aggravated his carpal tunnel syndrome due to the repetitive motion of his job. The Office, however, did not accept appellant's claims of fibrositis, osteoarthritis and thoracic outlet syndrome.

In a February 27, 1996 report, Dr. Howard related that appellant had a diagnosis of fibrositis of a minor degree in 1986. He noted that the diagnosis was silent for several years but in July 1995 the fibrositis returned in its most severe instance with substantial complaints of pain in the hands, arms, shoulders and neck. Dr. Howard indicated that the pain functionally inhibited appellant from carrying out his duties as a mail carrier and sorter. He commented that appellant's daily repetitive activity aggravated the underlying fibrositis process. Dr. Howard concluded that appellant had intermittent fibrositis of a minor degree over the prior decade which had been markedly aggravated by his job to the point that he was unable to work. He attributed appellant's condition to repetitive cumulative neuro-trauma events. Dr. Howard stated that there was no x-ray or laboratory tests to establish a diagnosis of fibrositis. He indicated that the diagnosis depended on clinical presentation alone. Dr. Howard commented that appellant demonstrated on a permanent, consistent basis the findings for fibrositis. He noted that appellant had a positive Tinel's sign, less on the right than the left.

In a March 12, 1996 report, Dr. Shane VerVoort, a Board-certified physiatrist, performing a fitness-for-duty examination for the employing establishment, related that examination of the neck showed a full range of motion without pain. He noted some discomfort on extension and some tenderness to pressure in the right lower cervical paraspinal muscles. Dr. VerVoort indicated that appellant had some firmness to palpation of the levator scapula muscle but otherwise no discreet trigger points were noted. He stated that both arms showed a full range of motion in all joints with general pain on abduction of the right shoulder beyond 160 degrees. Dr. VerVoort noted that appellant complained of some tenderness and moderate pain with palpation of the acromioclavicular joint, more on the right than the left. He reported that there

[1] *Jason C. Armstrong*, 40 ECAB 907 (1989)

was a negative impingement sign bilaterally. He indicated that appellant had a positive Tinel's sign over the wrists and the elbows bilaterally. Dr. VerVoort stated that appellant's examination was essentially normal except for his complaints of tenderness over the right acromioclavicular joint and the biceps tendon bilaterally. Dr.VerVoort commented that appellant also showed evidence of peripheral neuropathy of the ulnar and median nerves suggesting that his condition was not limited to carpal tunnel compression. He recommended electrodiagnostic testing. He indicated that shoulder x-rays were unremarkable and physical examination revealed no evidence of rotator cuff injury. Dr. Vervoort concluded that appellant had a subacromial bursitis or acromioclavicular arthritis that resulted in shoulder pain with repetitive arm motions, especially overhead activities. He stated that appellant could perform the majority of the duties of his job with no lifting over 50 pounds and avoiding over shoulder activity.

In a July 15, 1996 report, Dr. Richard Westbrook, a Board-certified orthopedic surgeon, noted that appellant was complaining of pain in both arms. He reported that appellant had no muscle atrophy, a negative Phalen's sign bilaterally and a positive Tinel's sign bilaterally. Dr. Westbrook indicated that motor strength was normal and equal bilaterally. He noted appellant had decreased sensation in the distribution of the median, ulnar and radial nerves distally which was a glove-type distribution bilaterally. Dr.Westbrook found no evidence of thoracic outlet syndrome. He referred appellant for an electromyogram (EMG) and nerve conduction studies. In a July 16, 1996 report, Dr. Angelo Romagosa, a physiatrist, stated that the nerve conduction studies showed no evidence of nerve entrapment syndrome in the arms while the EMG showed no evidence of cervical radiculopathy or myopathy. He concluded that the studies were normal. In an August 21, 1996 report, Dr. Westbrook indicated that appellant had a full range of motion of his arms with no significant muscle weakness and no atrophy. He stated that he could not find any cause specifically for appellant's discomfort and did not find any reason why appellant could not go back to sedentary work. Dr. Westbrook commented that appellant might have trouble casing mail because of the complaints of chronic arm discomfort but noted that the EMG showed no evidence of any problems.

The Office referred appellant, together with the statement of accepted facts and the case record, to Dr. Octavio Licon, a Board-certified orthopedic surgeon, for a second opinion. In a September 12, 1996 report, Dr. Licon indicated that appellant had no weakness or atrophy of the arm. He noted that appellant had a full range of motion with pain at the maximum abduction as well as internal and external rotation. Dr. Licon reported that impingement and apprehension signs were negative. He indicated that the elbow and wrist joints were unremarkable. He noted that x-rays of both shoulders showed signs of early degeneration of both acromioclavicular articulations while x-rays of both hands were normal. Dr. Licon stated that current objective findings, including the most recent EMG studies, indicated that appellant did not have a bilateral carpal tunnel syndrome. He noted by history that appellant had carpal tunnel syndrome. He indicated that his examination, supported by the July 16, 1996 EMG tests indicated that the conditions had resolved satisfactorily. Dr. Licon concluded that appellant had no work restrictions due to carpal tunnel syndrome but cautioned that such a condition could be triggered by repetitive motions of the hands and wrists.

In a November 21, 1996 report, Dr. Robert J. Abresch, a Board-certified rheumatologist, stated that appellant had musculoskeletal pain associated with findings of widespread tenderness.

He commented that this finding seemed to fit best with fibromyalgia. Dr. Abresch indicated that appellant's paresthesia, aching, stiffness, sleep disturbance would be compatible with that diagnosis. He stated that appellant's examination showed multiple areas of tender points in the neck, in the medial areas of scapulae, the anterior chest region, the trapezoidal areas, the gluteal areas in the lower back and the trochanteric areas of the hip, all consistent with fibromyalgia. He diagnosed fibromyalgia.

In a June 27, 1997 report Dr. Abresch stated appellant continued to show widespread pain in numerous locations, particularly in the lower back, hips and neck but also in his shoulders, elbows and from the hips to the knees. He indicated that appellant's problems in the neck and shoulders limited repetitive use of the arms. He commented that appellant's repetitive motions of his arms in his work as a letter carrier would significantly increase his pain and markedly limit his activities. He noted that the pain in the hips and lower back work would prevent appellant from performing repetitive bending and lifting. He commented that fibromyalgia was a well-established rheumatologic diagnosis and clearly was a problem associated with very significant pain and limitation. He noted that there were no objective blood tests or x-ray studies which would definitively diagnosis fibromyalgia but clinically it was very typical and straight forward in terms of his diagnosis to rheumatologists. He concluded that appellant's extreme discomfort and marked tenderness, taken with the diagnosis of fibromyalgia indicated that appellant was not able to perform repetitive tasks as a letter carrier.

The only condition accepted by the Office as caused by appellant's employment was aggravation of carpal tunnel syndrome. Dr. Westbrook and Dr. Licon noted that appellant's electrodiagnostic testing was normal. Both physicians indicated that appellant had no objective evidence of any condition that explained his symptoms of pain and numbness in the arms and shoulders. Dr. Licon indicated that appellant's carpal tunnel syndrome had fully subsided. The reports of Dr. Westbrook and Dr. Licon showed that appellant's accepted employment-related condition had ceased to disable him and left no residuals. Their well-rationalized medical reports provided a sufficient basis for the Office's decision to terminate appellant's compensation and medical benefits.

Dr. Howard diagnosed fibrositis and Dr. Abresch diagnosed fibromyalgia. Both physicians indicated that their diagnoses could not be established by objective evidence such as x-rays. Both related appellant's condition to repetitive motion at work. Neither, however, gave a physiological explanation on how appellant's employment would caused the diagnosed condition in the absence of any objective evidence of physiological changes or damage. Also, neither physician explained how appellant's symptoms would persist after he stopped working, even two years after he stopped working. The reports of Dr. Howard and Dr. Abresch, therefore, are insufficiently rationalized and as a result have diminished probative value. The Board finds that appellant has failed to meet his burden of proof.

The decision of the Office of Workers' Compensation Programs, dated December 9, 1997, is hereby affirmed.

Dated, Washington, D.C.
September 15, 1999

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

Bradley T. Knott
Alternate Member