U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ROBERT ZARILLO and U.S. POSTAL SERVICE,
POST OFFICE, Brooklyn, NY

Docket No. 97-1528; Submitted on the Record;
Issued March 13, 2000

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether appellant met his burden of proof to establish that he sustained a recurrence of disability commencing June 6, 1995, causally related to his accepted August 18, 1988 cervical and upper back strain and sprain, such that he can no longer perform his light-duty job.

In this case, the Office of Workers' Compensation Programs accepted that on August 18, 1988 appellant, then a 32-year-old letter carrier, sustained cervical and upper back sprains and strains in the course of his employment. Appellant stopped work on August 24, 1988, briefly returned until October 15, 1988, when he stopped work again and then returned to a light-duty clerical position, four hours a day, on July 6, 1994.[1]

On June 27, 1995 appellant filed a notice of recurrence of disability alleging that his condition had been steadily aggravated since his return to light-duty work and that on June 6, 1995 he developed a severe pain in his left shoulder. Appellant stopped work on June 6, 1995 and did not return.

In an August 22, 1995 decision, the Office denied appellant's claim on the grounds that the medical evidence was insufficient to establish that he sustained a recurrence of disability beginning on June 6, 1995 causally related to the August 18, 1988 accepted employment injury.

By letter dated September 15, 1995, appellant requested an oral hearing before an Office representative. After the hearing, at which appellant testified and submitted additional medical

[1] Appellant's job duties as a modified carrier, four hours a day, consisted of general office work which involved but was not limited to, answering the telephones, stamping mail for return to senders and processing routine paperwork. The tasks could be performed with no lifting, pushing, pulling, squatting, reaching above the shoulder or use of the left hand and no prolonged standing or walking.

evidence, the Office hearing representative issued a decision dated December 24, 1996, which affirmed the Office's prior decision.

The Board has duly reviewed the case record in the present appeal and finds that this case is not in posture for a decision, as there remains a conflict in the medical opinion evidence.

When an employee, who is disabled from the job he or she held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence establishes that the employee can perform the light-duty position, the employee has the burden to establish by the weight of the reliable, probative and substantial evidence, a recurrence of total disability and to show that he or she cannot perform such light duty. As part of this burden, the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the light-duty job requirements.[2]

In support of his claim, appellant has submitted medical reports from his treating physicians Dr. Juan A. Olivera, a general practitioner and Dr. Howard Weintraub, a Board-certified internist. In a report dated October 13, 1994, written while appellant was still performing his light-duty job, Dr. Olivera discussed the history of appellant's injury and treatment and noted that an electromyogram (EMG) performed on March 1, 1994 showed findings compatible with C5-6 radiculopathy of the left upper extremity. He diagnosed severe spasm of the paravertebral muscles with torticollis over the left side, guarding position with deformity of the spine curvature, numbness of the number three, four and five fingers of the right hand, poliantralgia of the right side and depression. On an accompanying work restrictions evaluation form, Dr. Olivera indicated that appellant could perform intermittent siting three hours a day, intermittent walking for one-half hour a day and no bending, climbing, squatting or kneeling. He further indicated that appellant could perform intermittent twisting and standing for one hour a day and could lift no more than ten pounds. Dr. Olivera indicated that within these restrictions appellant could work up to four hours a day. In support of his claim for a recurrence of disability, appellant submitted several more reports from Dr. Olivera. In a report dated June 10, 1995, Dr. Olivera noted that appellant had been working part time, but that his symptoms had continually worsened in the last few weeks and that he was now unable to continue working. He explained that there had been no history of any recent injury, only a worsening of appellant's residual pain from the prior injury. Dr. Olivera diagnosed severe muscle spasm of the cervical and thoracic spinal muscles, cervical radiculopathy, poliantralgia affecting the number three, four and five fingers of the right hand, anxiety and depression. He expressed a hope that with rest and treatment, appellant's condition would stabilize and he would be able to resume his part-time work. In a follow-up report dated August 5, 1995, Dr. Olivera reiterated that on June 6, 1995 appellant had returned complaining of excruciating pain precipitated by his job. He stated that appellant was totally disabled due to all his symptoms that were not improving, and that he would not be able to work anymore because this could cause an aggravation and a worsening of his condition. Dr. Olivera diagnosed spasm of the paravertebral muscles, cervical radiculopathy, poliantralgia and torticollis of the left shoulder with deformity. In each of these reports, Dr. Olivera listed the same diagnoses as prior to appellant's claimed June 6, 1995 recurrence, but emphasized that appellant's symptoms had worsened.

[2] *Richard E. Konnen*, 47 ECAB 388 (1996); *Terry R. Hedman*, 38 ECAB 222, 227 (1986).

In a report dated October 24, 1995, written after additional testing, Dr. Olivera offered an additional explanation for his opinion that appellant had suffered a recurrence of disability. Dr. Olivera explained that an EMG performed in 1989, shortly after appellant's original injury, revealed bilateral C5-6-7 radiculopathy with bilateral carpal tunnel syndrome and right ulnar neuropathy, but that a follow-up EMG, performed on March 1, 1994 after appellant had been off work for several years, revealed only C5-6 radiculopathy of the left upper extremity, with no evidence of peripheral neuropathy and normal right side findings. Dr. Olivera stated that these decreased findings may have played a part in appellant's ability to return to light duty in July 1994. He further stated that, in March 1995, appellant again complained of increased pain and was taken off work for approximately three weeks of rest. After he returned, appellant reported that tension at work was building up, as he was afraid of minimal touch over the affected areas by his co-workers, which caused him panic. He also complained that his job required too much motion and that his pain was getting worse. Dr. Olivera again noted that on June 6, 1995 appellant presented complaining of severe pain and spasms and upon examination was found to have spasms of the neck shoulder and back, paresthesia of the left side of the head and face with bilateral numbness of the fingers and a guarded lock of the left shoulder and surrounding areas on the left side at minimal touch. He then noted that while a recent computerized tomography scan taken on October 5, 1995 had negative results and an EMG taken on October 13, 1995 revealed bilateral cervical radiculopathy C5-6-7 and bilateral carpal tunnel syndrome. Dr. Olivera concluded:

> "This patient's condition has been steadily deteriorating since the last report. He has not improved enough in the last seven years to allow him to return to full duties. The last EMG clearly demonstrated that his job precipitated the recurrence of his disability. Several doctors have the same opinion as I do that he is totally disabled and his condition is permanent in nature. Pain and tension are building up in this man that I fear his mental health would become impaired if he returned to work. If any future examiners believe that he can work they will have to bear the responsibility of the aggravation of his condition and future injury at work."

On an accompanying work restrictions evaluation form, Dr. Olivera indicated that appellant could perform sitting for two hours a day, and walking and standing for one hour a day, but could not lift, bend, squat, climb, kneel or twist. He restricted appellant from lifting more than 10 pounds and indicated that he could not work at all.

In a short follow-up letter dated May 11, 1996, Dr. Olivera stated, in pertinent part, that appellant had been working part time within his limitations, but that his condition had worsened and it was recommended that he stop work. He added that appellant's condition was aggravated by fear of somebody touching him, which exacerbated his pain.

In his most recent report of record dated September 26, 1996, Dr. Olivera stated:

> "The precipitation of the recurrence of this patient's disability on June 6, 1995 was caused by the working condition at his job and is directly related to the original injury of his neck and back on August 18, 1988.
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> "The original injury has left this patient in chronic pain limiting his abilities and he had complained to me about the difficulties he faced at work. Appellant told me that he had to strain to reach around his desk so I had written a request for him to have an armchair with adjustable height. Appellant claims that after several months he had not been able to get one. Appellant seemed troubled about being touched by his fellow employees around the sensitive parts of his shoulders and back, this caused him stress. He was frustrated by having to get up every time the telephone rang at work causing him pain and exhaustion to the point where he could do nothing but stay in bed by the end of his workday. I believe that the constant and repetitive stamping of mail caused the numbness in his fingers known as carpal tunnel syndrome.
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> "The medical criteria I base my opinion on besides physical examination can be demonstrated by nerve conduction studies (EMG's) done both before and after his return to work. The EMG performed on March 1, 1994 basically indicated that he had C5-6 cervical radiculopathy of the upper extremities. The EMG on October 13, 1995 indicated that he had C5-6-7 cervical radiculopathy bilaterally with carpal tunnel syndrome.
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> "This patient is totally and permanently disabled. Please refer to my full report dated October 24, 1995."

Appellant also submitted reports dated July 12 and November 15, 1995 from Dr. Weintraub, who noted, in pertinent part, that appellant's recent EMG performed on October 13, 1995 revealed C5-6-7 cervical radiculopathy and bilateral carpal tunnel syndrome affecting both hands and that physical examination revealed swelling over the left clavicle and spasm of the upper back. He added that there had been no improvement in appellant's condition in the past seven years to warrant a recovery and that he continues to have chronic pain in his neck, shoulder, arms, hands and upper back triggered by minimal physical activity. Dr. Weintraub concluded that appellant had developed cervical radiculopathy, which is permanent in nature and the cause for his total disability.

The record also contains a July 7, 1995 report from Dr. Joel Teicher, a Board-certified orthopedic surgeon and Office second opinion physician, who reviewed the history of appellant's employment, injury and treatment, as well as all available test results, including the August 16, 1989 EMG showing C5-6-7 radiculopathy. After performing a complete physical examination,

Dr. Teicher diagnosed acute cervical sprain with left cervical radiculitis, adhesive capsulitis left shoulder and dorsolumbar sprain, by history. Dr. Teicher stated:

> "Objective physical findings present at the time of today's examination consist of mild hypesthesias and subjective paresthesias of the right middle, ring and little fingers, deltoid muscle atrophy and restriction of abduction, internal rotation and forward flexion of the left shoulder, residual paresthesias and hypesthesia of the right hand consistent with old resolved cervical radiculitis; no evidence of active residual cervical pathology. Findings referable to the left shoulder are consistent with an adhesive capsulitis with secondary disuse atrophy of the deltoid musculature. There are no objective physical findings referable to the dorsolumbar spine and there are no objective findings to suggest any carpal tunnel syndrome of either hand or ulnar tunnel syndrome. Based on the history as elicited from the patient, his cervical radiculitis must be considered to be causally related to the injuries of August 18, 1988 and the adhesive capsulitis of the left shoulder sequentially related to the cervical radiculitis and voluntary positioning and disuse of the left shoulder. At the present time he has a mild partial disability referable to the cervical spine and left shoulder. He is capable of performing activities which do not require the strenuous use of the left upper extremity. He is capable of performing clerical and sedentary work eight hours a day, five days weekly. With a reasonable degree of medical certainty, it is unlikely he will be able to return in the future to his regular duties of employment as a mail carrier, which require carrying and lifting involving the left upper extremity as well as abduction and stretching positions of the left shoulder. He has reached maximum benefit from active treatment and his condition has stabilized."

On an accompanying work restrictions evaluation form, Dr. Teicher indicated that appellant could work eight hours a day as long as he did not lift more than ten pounds, performed only occasional reaching and avoided pulling and pushing using his left upper extremity.

Finally, the record contains a medical report from Dr. Henry M. Tischler, an orthopedic surgeon who performed a fitness-for-duty examination on behalf of the employing establishment. Dr. Tischler reviewed the medical and factual evidence of record and noted that an EMG revealed radiculopathy at C5-6-7. Following a physical examination, he diagnosed cervical radiculopathy on the right, torticollis and adhesive capsulitis of the shoulder. Dr. Tischler concluded that appellant could return to limited duty not involving strenuous activities of the affected upper extremity or repetitive twisting of the neck and added that appellant could answer telephones and perform clerical-type duties within these guidelines eight hours a day, five days a week.

Section 8123(a) of the Federal Employees' Compensation Act provides: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[3]

[3] 5 U.S.C. § 8123(a); *see also Brady L. Fowler*, 44 ECAB 343 (1992); *George A. Johnson*, 43 ECAB 712 (1992);

In the present case, appellant's treating physicians, Drs. Olivera and Weintraub, repeatedly opined in several reports that appellant's employment-related conditions had steadily deteriorated to the point where he was no longer capable of performing his light-duty job; however, the Office referral physician, Dr. Teicher, offered as a rationalized second opinion that appellant was capable of performing a sedentary, light-duty job, with restrictions, for eight hours a day, more than the four he had been performing.

The Board finds that the reports of appellant's physicians, Drs. Olivera and Weintraub, and the reports of the Office physician, Dr. Teicher, are of approximately equal value and are in conflict on the issue of whether appellant sustained a recurrence of disability commencing June 6, 1995, causally related to his accepted August 18, 1988 cervical and upper back strain and sprain, such that he can no longer perform his light-duty job. This requires resolution by referral to a Board-certified impartial medical specialist, accompanied by a statement of accepted facts and the complete case record, for a rationalized medical opinion addressing this issue.

Melvina Jackson, 38 ECAB 443 (1987).

Consequently, the decision of the Office of Workers' Compensation Programs dated December 24, 1996 is hereby set aside and the case is remanded for further development in accordance with this decision.[4]

Dated, Washington, D.C.
March 13, 2000

David S. Gerson
Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member

[4] The Board notes that the record contains two additional decisions issued by the Office, a June 13, 1997 decision issued by the Office after reconsideration, and a July 1, 1997 decision terminating appellant's compensation benefits for failure to accept suitable work. As appellant filed his appeal on March 28, 1997, the only decision properly before the Board is the December 24, 1996 decision of the Office hearing representative. The Board's jurisdiction to consider and decide appeals from final Office decisions extends only to those final decisions issued within one year prior to the filing of an appeal. With respect to the Office's June 13, 1997 decision on reconsideration, finding the additional evidence submitted by appellant insufficient to warrant modification of the prior decision, the Board notes that as appellant's notice of appeal was received by the Board on March 28, 1997, and as the Board and the Office may not simultaneously have jurisdiction over the same issue in the same case, the Office did not have the authority to issue the June 13, 1997 decision and it is null and void. *Russell E. Lerman*, 43 ECAB 770 (1992); *Douglas E. Billings* 41 ECAB 880 (1990). With respect to the Office's July 1, 1997 decision, as this decision was not issued in the one year prior to the filing of appellant's appeal, the Board does not have jurisdiction to consider this decision. 20 C.F.R. § 501.3(d)(2).