

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of BARBARA SNYDER and DEPARTMENT OF THE TREASURY,
INTERNAL REVENUE SERVICE, Germansville, PA

*Docket No. 03-1467; Submitted on the Record;
Issued November 26, 2003*

DECISION and ORDER

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

The issue is whether the Office of Workers' Compensation Programs met its burden of proof in terminating appellant's compensation.

On September 13, 1999 appellant, then a 55-year-old secretary, filed a notice of occupational illness and claim for compensation (CA-2), alleging that she sustained a right wrist and arm injury as a result of her federal duties. In a September 13, 1999 report, Dr. Emil Diiorio, an orthopedist, wrote that appellant presented with joint pain and swelling in her right wrist and hand and that she had worn wrist braces after being seen for carpal tunnel in the past. On September 15, 1999 appellant underwent carpal tunnel release surgery. In an October 22, 1999 decision, the Office accepted appellant's claim for right flexor tendinitis and carpal tunnel syndrome and authorized the surgical release procedure.

In a November 12, 1999 report, Dr. Christine Hinke, a physiatrist, wrote that appellant's carpal tunnel symptoms have resolved, but she now experiences persistent pain in her right bicep radiating into her right dorsal forearm, the lateral volar forearm and down to her wrist. She stated that these symptoms were consistent with musculotaneous nerve injury which was consistent with the results of an electrodiagnostic (EKG) test. Dr. Hinke wrote that the EKG supported an incomplete injury to the musculocutaneous nerve that was affecting appellant's sensory fibers. She noted that the etiology of the injury was unknown, but may be related to tourniquet positioning during appellant's carpal tunnel release surgery.

In a December 20, 1999 report, Dr. Diiorio wrote that appellant returned to work on a limited part-time basis and experienced a great deal of pain in her right upper extremity and had to stop work. He noted that the grip strength in her right hand had decreased from 38 to 21 pounds. In a December 27, 1999 report, Dr. Hinke stated that appellant presented with increasing numbness and tingling and pain radiating from her upper right extremity where she found tightness and atrophy of the medial arm in the area of the brachialis. She noted that appellant had pain with compression over the median nerve at the elbow and over the median nerve at the right carpal tunnel. Dr. Hinke diagnosed post carpal tunnel release and

musculocutaneous nerve injury in her right elbow. She concluded that appellant had a neurapraxia injury that will heal overtime.

In a February 21, 2000 report, Dr. Nathan Schwartz, a specialist in pain management, wrote that since appellant's carpal tunnel release she has experienced numbness, burning pain, paresthesia and progressive musculocutaneous dependent atrophy in her right arm. His examination revealed a normal range of motion and atrophy at the brachialis muscle with weakness to supination associated with a weak grip in her right hand. Dr. Schwartz found decreased sensation to light touch over appellant's right dorsal forearm and later aspect of the forearm. He diagnosed suspected right musculocutaneous nerve injury and provided acupuncture treatments.

In a February 29, 2000 report, Dr. Thomas Ward, an orthopedic surgeon and Office referral physician, wrote that his physical examination of appellant was unremarkable except for her right arm, which revealed some muscle mass loss of the right brachialis and brachial radialis and decreased sensation over the lateral aspect of her left forearm. He stated that appellant has some peripheral neuropathy secondary to compression for the tourniquet that was used at the time of her carpal tunnel surgery. Dr. Ward opined that appellant could return to light duty, but the length of time on light duty would be dictated by the regeneration of the injured nerve and that could take up to two years. He added that appellant's arm condition was directly related to the work-related surgery.

In an April 4, 2002 report, Dr. Hinke wrote that appellant complains of right forearm pain and dysesthesias. She noted that an EMG confirmed evidence of a musculocutaneous nerve injury and noted that appellant complained of pain in the area of anatomic snuffbox and had a positive Finklestein's test for reproduction of this pain. Dr. Hinke found that appellant had some taut band formation in the extensor tendon mass consistent with the muscles of extension and abduction to the thumb. She also added right de Quervain's tenosynovitis to her diagnosis. In a May 2, 2000 report, Dr. Hinke opined that appellant was totally disabled writing:

“[P]ostoperatively [appellant] developed new symptoms including right arm weakness and right forearm numbness and tingling. Her symptoms were in the distribution of the musculocutaneous nerve and repeat EMGs confirmed an injury to the right musculocutaneous nerve. This has resulted in weakness of the musculature that is innervated by the musculocutaneous nerve including part of the biceps and the brachialis. [Appellant] has severe atrophy of the brachialis muscle because of this injury ... and has developed dysesthesia pain in the distribution of the lateral antebrachial cutaneous nerve which is the terminal branch of the musculocutaneous nerve. This condition is also known as causalgia and ... complex regional pain syndrome, Type 2.... [T]his dysesthesia pain and weakness of the right upper extremity limits her tolerance for activities with the right upper extremity. [Appellant] has undergone extensive treatment with occupational therapy including work simulation activities, but continues to tolerate only very low levels of activity [including] ... keyboarding for approximately 10 minutes at a time and ... for only 1 hour total.... I do not feel [appellant] has functional use of her right upper extremity to be used in gainful employment.”

In a May 15, 2000 treatment note, Dr. Schwartz wrote that appellant is unable to work at this time and her prognosis is poor.

In a September 6, 2000 letter, the Office found a conflict in the medical evidence and referred appellant, along with a statement of accepted facts for an impartial medical examination. In a November 24, 2000 report, Dr. Thomas DiBenedetto, a Board-certified orthopedic surgeon, wrote that appellant complained of pain, weakness and atrophy in her right arm. On physical examination he found restricted motion in the right shoulder, a well-healed carpal tunnel incision and negative Tinel's and Phalen's test. Appellant had good pulses in both upper extremities with normal coloration and sudo motor activity with no brawny edema, swelling or pain on light touch. Dr. DiBenedetto noted that an EMG taken on September 7, 1999 showed no evidence of plexopathy, myopathy or radiculopathy. He diagnosed right carpal tunnel syndrome with normal EMG/nerve conduction test. Dr. DiBenedetto stated that appellant had abnormal pain behavior in that she claimed to have atrophy in her right arm, but the circumferential measurements were equal bilaterally and she showed a nonanatomic response to strength testing in the right hand. He opined that appellant could return to full-time unrestricted work in regards to her carpal tunnel problem. Dr. DiBenedetto stated that he could find no indication that she had any residuals from an injury to the musculocutaneous nerve and no evidence of complex regional pain syndrome from the review of the records, the statement of accepted facts, the examination or history of appellant.

In an August 22, 2001 letter, the Office proposed terminating appellant's compensation, finding that the weight of the medical evidence rested with Dr. DiBenedetto as the impartial medical examiner. Dr. Hinke disagreed with the Office's proposed termination. In her September 4, 2001 report, she wrote that Dr. DiBenedetto selectively read the EMG results and ignored the fact that the duration of appellant's response in the nerve conduction study was very wide. In addition, Dr. Hinke wrote that appellant showed marked abnormalities in her EKG, further indication of an axonal type injury. She noted that, contrary to Dr. DiBenedetto's report, careful observation of appellant's arms shows atrophy in the brachialis muscle that lies underneath the biceps. Dr. Hinke repeated her diagnosis that appellant has chronic complex regional pain syndrome which is noted objectively as hyperesthesia and atrophy. Appellant, through her representative, argued that Dr. DiBenedetto's report was unrationalized as it failed to explain the atrophy in the brachial muscle and the wide response to the nerve studies.

In an October 23, 2001 letter, the Office again found a conflict in the medical evidence identifying Dr. DiBenedetto as an impartial medical examiner physician and referred appellant, along with a statement of accepted facts to Dr. David B. Yanoff, an orthopedic surgeon, for another impartial medical examination. In a February 12, 2002 report, Dr. Yanoff wrote that examination of appellant revealed slight atrophy of the right hypothenar muscle, but no atrophy at the thenar muscle. He found her axillary, radial, median, ulnar and musculocutaneous nerve muscle function and sensation intact and normal. Dr. Yanoff noted that a review of the medical records revealed that appellant tolerated physical therapy with few complaints of arm pain. He indicated that an electrodiagnostic study conducted on February 15, 2002 revealed evidence of right ulnar neuropathy at the elbow, but not for the right median nerve, radial sensory or cervical radiculopathy or brachial plexopathy. Dr. Yanoff noted no evidence of axonal loss or musculocutaneous neuropathy. Noting the diagnosis of musculocutaneous neuropathy secondary to tourniquet compression, he wrote that carpal tunnel release surgery typically requires only 10

to 15 minutes of tourniquet time and that it would seem a little unusual to develop an isolated musculocutaneous neuropathy in that period of time. Dr. Yanoff noted that appellant's current electrodiagnostic studies showed no evidence of musculocutaneous neuropathy, adding that the studies did show signs of ulnar neuropathy at the elbow which is a problem she had in her left arm and required surgery. Dr. Yanoff stated that, while her subjective symptoms were difficult to sort out, she does have objective evidence of hypothenar atrophy of the right hand and evidence of numbness in an ulnar nerve distribution with ulnar neuropathy at the elbow. He diagnosed right carpal tunnel syndrome resolved and right upper extremity ulnar neuropathy at the elbow consistent with cubital tunnel syndrome, unrelated to her occupational injury. Dr. Yanoff opined that appellant had no work restrictions attributable to her work-related injury and that she suffered no significant nerve injury subsequent to the surgery due to tourniquet compression.

In a March 4, 2002 decision, the Office proposed terminating appellant's compensation based on Dr. Yanoff's report as an impartial medical examiner. In a March 26, 2002 report, Dr. Hinke wrote that a careful analysis of the electrodiagnostic study done for Dr. Yanoff reveals that neither the right musculocutaneous motor nerve, nor the right lateral antebrachial cutaneous nerve were tested during the examination, only the brachialis muscle showed evidence of no abnormalities and that the test was done two years after the injury. She noted that her own recent electrodiagnostic study produced abnormal results consistent with right musculocutaneous nerve injury that was preferentially affecting the right lateral antebrachial cutaneous nerve, which is the terminal sensory branch of that nerve. Dr. Hinke noted that appellant had some high amplitude motor units noted, but these do not qualify as giant motor unit action potentials, which she wrote was consistent with a right musculocutaneous nerve injury that has evolved over the last two years.

In an April 2, 2002 report, Dr. Harry Doyle, a Board-certified psychiatrist and neurologist, wrote that appellant suffers from a dysthymia disorder as a result of her chronic pain and physical impairment causally related to complications from the carpal tunnel release. Dr. Doyle added that appellant has experienced significant impairment in her daily living, social functioning and adapting to her stress and that she was totally disabled from work.

In an April 3, 2003 report, appellant's representative argued that, as an orthopedic surgeon, Dr. Yanoff was not qualified to comment on neurological disorders. He also argued that the statement of accepted facts provided Dr. Yanoff was not accurate as he did not identify the upper extremity condition resulting from the surgery, which even the Office referral physician, Dr. Ward, acknowledged to exist.

In a June 17, 2002 decision, the Office finalized its termination of appellant's compensation, finding the weight of the medical evidence was with Dr. Yanoff as the impartial medical examiner and noted that Dr. Hinke's reports never discuss appellant's left ulnar problem and that Dr. Doyle's report was unrationalized.

Appellant requested a review of the written record arguing that the upper extremity condition should have been included in the statement of accepted facts provided the impartial medical examiner and that the Office has an obligation to further develop the emotional condition identified by Dr. Doyle. In a May 7, 2003 decision, the Office affirmed the June 17,

2002 termination, finding that the weight of the medical evidence rested with Dr. Yanoff as the impartial medical examiner.

The Board finds that the Office did not meet its burden of proof to terminate appellant's compensation.

Under the Federal Employees' Compensation Act,¹ once the Office has accepted a claim it has the burden of justifying termination or modification of compensation benefits.² The Office may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.³ The Office's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.⁴

In the present case, the Office properly found a conflict in the medical evidence between Dr. Hinke, appellant's treating physician, and Dr. Ward as an Office referral. As required by the Act the Office then forwarded appellant's medical record and the statement of accepted facts to an independent medical examiner to resolve the conflict. The statement of accepted facts represents the factual finding on which the impartial examiner's opinion must be based. In the present case, the statement of accepted facts provided to Dr. Yanoff for his February 12, 2002 report was created on December 15, 1999 with a minor update dated January 3, 2000. More important, the statement of accepted facts Dr. Yanoff and the Office relied on did not include all the medical conditions established by the evidence in the record. Specifically, the statement of accepted facts did not include appellant's upper extremity condition. At the time the conflict was declared, the record contained medical reports from Drs. Diiorio, Hinke, Schwartz and Ward, that all identified an upper extremity condition as a result of the carpal tunnel release surgery. Dr. Ward, the Office referral physician, stated that appellant had some peripheral neuropathy secondary to compression for the tourniquet that was used at the time of her carpal tunnel surgery. He opined that appellant could return to light duty, but the length of time on light duty would be dictated by the regeneration of the injured nerve and that could take up to two years. Dr. Ward added that appellant's arm condition was directly related to the work-related surgery. As the preponderance of the medical evidence supports an upper extremity condition and there was no opposing medical evidence, the condition should have been included in the statement of accepted facts provided the impartial medical examiners. Without this condition included in the statement of accepted facts, Dr. Yanoff's report was based on an inaccurate medical history and is insufficient for the Office to rely on in terminating appellant's compensation.

The only conflict in the medical evidence at the time of the referrals to the impartial medical examiners was between Drs. Hinke and Ward, on the issue of whether or not appellant was totally or partially disabled from work. In his February 12, 2002 report, Dr. Yanoff opined that appellant did not have an upper extremity injury, noting in particular that a typical tourniquet

¹ 5 U.S.C. §§ 8101-8193.

² *Charles E. Minniss*, 40 ECAB 708, 716 (1989); *Vivien L. Minor*, 37 ECAB 541, 546 (1986).

³ *Id.*

⁴ *See Del K. Rykert*, 40 ECAB 284, 295-96 (1988).

compression for a carpal tunnel release procedure lasts from 10 to 15 minutes, which was not long enough to cause the alleged injury, but as mentioned above, this was not the issue that Dr. Yanoff was appointed to resolve. Therefore, his opinion on appellant's upper extremity condition is that of referral physician and the Office erred in according it special weight. The Board finds that the Office has not met its burden of proof in terminating appellant's compensation.

The Board further finds that there is now a conflict in the evidence between Dr. Hinke and Dr. Yanoff on the issue of whether or not appellant has a consequential injury to her upper extremity and whether or not that condition is disabling. When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist pursuant to section 8123(a) of the Act, to resolve the conflict in the medical evidence.⁵

The decisions of the Office of Workers' Compensation Programs dated May 7, 2003 and June 17, 2002 are hereby reversed and the case record is remanded to the Office to resolve the existing conflict.

Dated, Washington, DC
November 26, 2003

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member

⁵ *William C. Bush*, 40 ECAB 1064, 1975 (1989); 5 U.S.C. 8123(a).