United States Department of Labor
Employees' Compensation Appeals Board

G.P., Appellant	)	
and	)	**Docket No. 14-395**
	)	**Issued: June 5, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Portland, ME, Employer	)	

Appearances:
Stephen L. Cusick, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On December 12, 2013 appellant, through her attorney, filed a timely appeal from a July 30, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether OWCP abused its discretion by denying authorization for bilateral cubital tunnel syndrome release.

FACTUAL HISTORY

On August 23, 2006 appellant, then a 43-year-old rural carrier, filed an occupational disease claim (Form CA-2) alleging that she developed rotator cuff tendinitis as a result of lifting telephone books. OWCP accepted her claim for right shoulder supraspinatus tendon tear, right

[1] 5 U.S.C. § 8101 *et seq.*

sprain of shoulder and rotator cuff, right rotator cuff tendinitis and right shoulder fibrous capsulitis.

Appellant initially sought treatment with Dr. John R. Johansson, an osteopath, and Dr. John F. Lawlis, a Board-certified orthopedic surgeon. She stopped work on March 9, 2010 and underwent arthroscopic right shoulder surgery on May 10, 2010. Appellant was released to return to work for four hours a day beginning November 1, 2010. The employing establishment was unable to accommodate her restrictions or provide light-duty work.

In a February 21, 2011 report, Dr. Rizwan U. Haq, a Board-certified neurologist, reported that appellant was referred to him by Dr. Lawlis for numbness and tingling in her right third, fourth and fifth fingers. Appellant noticed the numbness and tingling for some time before her right shoulder surgery but the condition became more noticeable since she had physical therapy postsurgery. She lifted weights and placed items in slots with frequent flexion of her right elbow that caused an increase in symptoms. Dr. Haq stated that appellant was a mail handler, which also required frequent flexion of the elbow when delivering mail. An electrodiagnostic study was completed and he speculated that appellant suffered from cubital tunnel syndrome.

OWCP referred appellant and the case file to Dr. Douglas Kirkpatrick, a Board-certified orthopedic surgeon, for a second opinion medical examination. In a March 4, 2011 report, Dr. Kirkpatrick provided findings on physical examination, a summary of appellant's past medical reports and a history of the July 26, 2006 employment duties of lifting heavy telephone books for delivery. He diagnosed rotator cuff tendinitis and fibrous capsulitis of the right shoulder causally related to the July 26, 2006 work injury. Dr. Kirkpatrick provided additional diagnoses of bilateral cubital tunnel syndrome and fibromyalgia which were not employment related. He noted that appellant's cubital tunnel syndrome was not well defined in the records and dated back to her 2006 work injury. It seemed to have developed largely in the absence of her work environment. Dr. Kirkpatrick concluded that the cubital tunnel syndrome did not have clear causal ties to the July 26, 2006 employment injury.

In a March 18, 2011 report, Dr. Seth Frenzen, a Board-certified orthopedic surgeon, reported that appellant was a new patient who was referred by Dr. Lawlis for consultation of right elbow symptoms. Appellant complained of having problems with her elbow for approximately two to three years. After having shoulder surgery, appellant's symptoms in her elbow did not cease. Dr. Frenzen diagnosed right medial and lateral epicondylitis and right cubital tunnel syndrome. He noted that a cubital tunnel release would probably relieve appellant of the numbness and tingling in her fingers but would not necessarily resolve her elbow pain. Dr. Frenzen opined that her elbow issues were related to work and predated her shoulder surgery.

On March 24, 2011 Dr. Frenzen requested authorization for bilateral cubital tunnel syndrome release.

OWCP provided Dr. Lawlis, Dr. Frenzen and Dr. Johansson with copies of Dr. Kirkpatrick's second opinion report. It requested that the physicians provide an opinion on the nature and extent of appellant's disability and whether they agreed with Dr. Kirkpatrick's assessment.

By letter dated March 28, 2011, Dr. Lawlis responded that he only treated appellant for her shoulder injury and agreed with Dr. Kirkpatrick's assessment. He further stated that he could not comment on appellant's elbow or wrist injuries as he was not involved in the evaluation or management of her other complaints.

In a May 16, 2011 response, Dr. Frenzen disagreed with Dr. Kirkpatrick's assessment pertaining to the cause of appellant's elbow injury. Based on his conversation with appellant that her elbow pain predated her shoulder surgery, he believed that appellant developed the elbow pain secondary to her work. Dr. Frenzen advised that he did not have any notes by Dr. Johansson who initially treated appellant. His office notes did not contain anything that would suggest that appellant had elbow pain when she was seen by Dr. Lawlis for treatment of her shoulder. Dr. Frenzen only had her description of her elbow pain and the period of time for which it developed to use in reaching his conclusion.

By letter dated July 6, 2011, Dr. Johansson reviewed Dr. Kirkpatrick's report and stated that appellant was initially treated for injuries to her shoulder and a repetitive stress injury. While there were some references to elbow pain, it was thought that such symptoms could conceivably have been arising from her shoulder. Dr. Johansson noted that, because new testing had been completed and surgery was proposed, there was a strong possibility that the elbow complaints were causally related to her federal employment duties.

OWCP found a conflict in medical opinion as to the cause of appellant's bilateral cubital tunnel syndrome and the need for surgery. It referred her, together with a statement of accepted facts (SOAF), to Dr. Marco Berard, a Board-certified orthopedic surgeon, for an impartial referee medical examination.

In a November 18, 2011 report, Dr. Berard evaluated appellant, reviewed previously taken diagnostic tests, provided a summary of past medical reports and noted findings on physical examination. He noted that per the review of the record, there was no documentation mentioning numbness of the fourth and fifth digit for the right and left hand on or about the time of the injury on July 26, 2006. Dr. Berard noted that even the postoperative following shoulder surgery failed to mention numbness over the fourth and fifth digits of the right and left hand and made no mention of chronic ongoing right or left elbow pain. He opined that appellant's bilateral cubital (sic) tunnel syndrome was not related to the right shoulder condition. Dr. Berard noted that her complaints of pain in the posterolateral aspect of the forearm going across the elbow and on the posterior aspect of the forearm were secondary and radiating from the right shoulder pain. He stated that those entities should be seen different as the cubital (sic) tunnel syndrome which would not give the symptoms mentioned above. Thus, Dr. Berard concluded that appellant's bilateral elbow condition and cubital (sic) tunnel syndrome were not related to the occupational incident on July 26, 2006 and that appellant did not injure her right and left elbow at the same time she injured her right shoulder.

By decision dated December 1, 2011, OWCP denied appellant's request for bilateral cubital tunnel syndrome release finding that the weight of medical evidence did not establish that the surgery was medically necessitated by any residuals or disability causally related to her accepted July 26, 2006 employment-related injuries.

On June 14, 2012 appellant, through counsel, requested reconsideration of OWCP's decision denying authorization for surgery. Counsel argued that Dr. Berard failed to consider appellant's elbow complaints as documented in her physical therapy notes and his report lacked credibility as he referred to "capital tunnel syndrome," a nonexistent diagnosis. He provided a report from Dr. Sikhar N. Banerjee, Board-certified in physical medicine and rehabilitation, who disagreed with Dr. Berard's assessment.

In a May 11, 2012 report, Dr. Banerjee provided detailed review of appellant's past medical reports and findings on physical examination. He diagnosed cubital tunnel syndrome which he opined was caused by her July 26, 2006 work injury. Dr. Banerjee reported that appellant worked for the postal service and suffered an injury to her right shoulder while delivering mail in July 2006, resulting in partial tear of the rotator cuff and labral tear requiring arthroscopic surgery. At the time of injury, appellant had pain in her right elbow but it was felt that this pain was referred from the shoulder and no investigation or treatment was carried out. She reported that her elbow pain was initially overshadowed by her shoulder pain because it was not as severe. However, during her physical therapy following arthroscopic surgery, appellant developed increased pain in her elbow along with tingling and numbness of her right fourth and fifth fingers which she attributed to the special physical therapy exercise of wall climbing to improve range of movement of her shoulder. She reported these complaints to her physical therapist which were recorded in physical therapy reports dated November 1, 2010 and subsequently from January 10 to 26, 2011. Appellant had also reported these complaints to Dr. Lawlis as recorded in his December 14, 2010 and January 27, 2011 reports. Dr. Banerjee had opined that based on her records and the information provided to him by appellant, her complaints of elbow pain and tingling and numbness of her fingers were attributable to bilateral cubital tunnel syndrome which resulted from her work injury on July 26, 2006 and subsequently aggravated by physical therapy following arthroscopic surgery of her right shoulder which was caused by her original work injury.

Dr. Banerjee noted that appellant's request for bilateral decompression of cubital tunnel was denied based on Dr. Berard's examination and report. He argued that Dr. Berard's rationale for denying surgery was incorrectly based on his assessment that the record lacked documentation pertaining to elbow complaints at the time of the initial injury on July 26, 2006. Dr. Banerjee stated that appellant's elbow complaints were in fact documented in the record and Dr. Berard failed to mention or account for the physical therapy notes or Dr. Lawlis' reports which indicated elbow pain post right shoulder surgery. He noted that Dr. Berard's report was confusing as he referred to "capital tunnel syndrome" and also discussed right carpal tunnel syndrome which was not a diagnosed condition.

On September 19, 2012 OWCP expanded appellant's claim to include right shoulder suprascapular neuropathy.

On December 17, 2012 OWCP requested Dr. Morley Slutsky, Board-certified in occupational medicine and a medical adviser, to review the case file and SOAF. Dr. Slutsky was asked to address whether appellant's work duties related to the July 26, 2006 injury caused or contributed to her elbow condition and if surgery for bilateral cubital tunnel syndrome release was medically necessary or warranted.

In a December 17, 2012 report, Dr. Slutsky reviewed the record and opined that appellant's cubital tunnel syndrome and elbow problems were not a result of the July 26, 2006 injury or her work-related duties. Therefore, surgery was not warranted. Dr. Slutsky noted that between the date of injury and May 10, 2007, there were no objective clinical findings or diagnostic tests consistent with clinically active bilateral cubital tunnel syndrome. Moreover, there was a large gap in the medical record from May 29, 2007 to May 10, 2010. Dr. Slutsky noted that there was mention that appellant first developed symptoms of cubital tunnel syndrome on November 1, 2010 but that the physician's assistant note from that date documented no such history of elbow/cubital tunnel related issues.

Dr. Slutsky stated that the first note by a physician where elbow symptoms were mentioned was dated December 14, 2010, almost four and a half years after the date of injury and seven months postshoulder surgery. Appellant noted some elbow pain with numbness to the small and ring finger (consistent with ulnar nerve irritation at the elbow). Her physician did not mention which elbow was involved, the cause of her condition or document examining her for this issue. Dr. Slutsky noted that appellant had not yet returned to work so her symptoms appeared to have developed outside of her work-related duties. Based upon the medical evidence of record, it was implausible that her cubital tunnel syndrome was related to her accepted injury or work-related duties. Dr. Slutsky's cubital tunnel symptoms were not present despite working in 2006 and appellant developed the condition in 2010 when she was not working. He concurred with Dr. Kirkpatrick's opinion that appellant's elbow problems did not develop as a result of the 2006 injury or associated with her work-related duties.

By decision dated December 28, 2012, OWCP affirmed the December 1, 2011 decision denying appellant's request for authorization of surgery. It found that the weight of the medical evidence rested with Dr. Berard's impartial report and supported by Dr. Slutsky.

On January 8, 2013 appellant, through counsel, requested an oral hearing before the Branch of Hearings and Review.

At the May 15, 2013 hearing, appellant described her employment duties prior to July 26, 2006 and problems arising from her elbow since the date of onset. Counsel contended that her physician's reports established that appellant's elbow condition was caused by the July 26, 2006 work injury. The record was held open for 30 days.

In a June 29, 2013 report, Dr. Slutsky again reviewed the medical record and opined that appellant's work duties related to the injury on July 26, 2006 did not cause, aggravate or contribute to her diagnosed elbow condition or cubital tunnel syndrome. As such, the requested surgery for bilateral cubital tunnel release should not be authorized as the condition was not work related.

In a report dated June 26, 2013, Dr. Carlos A. Pino, a Board-certified anesthesiologist, noted appellant's complaints of pain to the elbow which had been present since July 2006. He diagnosed shoulder region joint pain, neuropathic pain and fibromyalgia.

By decision dated July 30, 2013, the Branch of Hearings and Review affirmed the December 28, 2012 decision, finding that the medical evidence of record failed to support that

appellant's cubital tunnel conditions were causally related to her accepted injury in 2006 and denied authorization for surgery. It noted that the weight of the medical evidence rested with the opinion of Dr. Berard, the impartial medical examiner, and supported by Dr. Slutsky.

LEGAL PRECEDENT

Section 8103(a) of FECA provides for the furnishing of services, appliances and supplies prescribed or recommended by a qualified physician which OWCP, under authority delegated by the Secretary, considers likely to cure, give relief, reduce the degree or the period of disability or aid in lessening the amount of monthly compensation.[2] In interpreting section 8103(a), the Board has recognized that OWCP has broad discretion in approving services provided under FECA to ensure that an employee recovers from his or her injury to the fullest extent possible in the shortest amount of time.[3] OWCP has administrative discretion in choosing the means to achieve this goal and the only limitation on OWCP's authority is that of reasonableness.[4] Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment or actions taken which are contrary to both logic and probable deductions from established facts. It is not enough to merely show that the evidence could be construed so as to produce a contrary factual conclusion.[5]

While OWCP is obligated to pay for treatment of employment-related conditions, appellant has the burden of establishing that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[6] Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[7] Therefore, in order to prove that the surgical procedure is warranted, appellant must submit evidence to show that the procedure was for a condition causally related to the employment injury and that the surgery was medically warranted. Both of these criteria must be met in order for OWCP to authorize payment.[8]

ANALYSIS

OWCP accepted appellant's claim for right shoulder supraspinatus tendon tear, right sprain of shoulder and rotator cuff, right rotator cuff tendinitis, right shoulder fibrous capsulitis and right shoulder suprascapular neuropathy. On March 24, 2011 appellant requested authorization for bilateral cubital tunnel syndrome release. OWCP denied her request for

[2] *Id.* at § 8103(a).

[3] *See Dale E. Jones*, 48 ECAB 648, 649 (1997).

[4] *See Daniel J. Perea*, 42 ECAB 214, 221 (1990) (holding that abuse of discretion by OWCP is generally shown through proof of manifest error, clearly unreasonable exercise of judgment or administrative actions which are contrary to both logic and probable deductions from established facts).

[5] *See Minnie B. Lewis*, 53 ECAB 606 (2002).

[6] *See Kennett O. Collins, Jr.*, 55 ECAB 648 (2004); *Debra S. King*, 44 ECAB 203, 209 (1992).

[7] *Id.*; *see also M.B.*, 58 ECAB 588 (2007); *Bertha L. Arnold*, 38 ECAB 282 (1986).

[8] *See R.C.*, 58 ECAB 238 (2006); *Cathy B. Millin*, 51 ECAB 331, 333 (2000).

authorization of surgery. The Board finds that it did not abuse its discretion by denying authorization for bilateral cubital tunnel release.

OWCP determined that a conflict in medical opinion arose between Dr. Frenzen, appellant's treating physician, and Dr. Kirkpatrick, the second opinion physician, regarding whether the requested bilateral cubital tunnel release was causally related to the July 26, 2006 work injury. In order to resolve the conflict, it referred appellant, pursuant to section 8123(a) of FECA, to Dr. Berard for an impartial medical examination and an opinion on the matter.

In a November 18, 2011 report, Dr. Berard reviewed the medical evidence of record and noted that there was no documentation mentioning numbness of the fourth or fifth digits of the right or left hand on or about the time of the injury on July 26, 2006. He noted that even the right shoulder postoperative note failed to mention complaints of numbness or chronic bilateral elbow pain. Dr. Berard opined that appellant's bilateral cubital tunnel syndrome was not related to the right shoulder condition.[9] He stated that appellant's complaints of pain in the posterolateral aspect of the forearm going across the elbow and on the posterior aspect of the forearm were secondary and radiating from the right shoulder pain. Dr. Berard stated that those entities should be seen different as the cubital tunnel syndrome, which would not elicit the symptoms mentioned above. He determined that appellant's bilateral elbow condition was not related to the occupational claim of July 26, 2006 and that appellant did not injure her right or left elbow at the same time she injured her right shoulder.

The Board finds that, the opinion of Dr. Berard is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight. It establishes that appellant's bilateral cubital tunnel syndrome was not causally related to the July 26, 2006 injury. Further, authorization for surgery was properly denied. Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.[10]

The Board has carefully reviewed the opinion of Dr. Berard and finds that it has reliability, probative value and convincing quality with respect to its conclusions regarding the relevant issue in the present case. Dr. Berard's opinion is based on a proper factual and medical history. He accurately summarized the relevant medical evidence.[11] Dr. Berard provided medical rationale for his opinion by explaining that appellant's cubital tunnel syndrome was unrelated to the July 26, 2006 occupational exposure as the medical record contained no elbow complaints on or around July 26, 2006 or following her right shoulder surgery in postoperative notes.[12] He further explained that the symptoms which were noted were not indicative or related to cubital tunnel syndrome. Dr. Berard provided support for his conclusion noting that appellant

[9] The Board notes that, though Dr. Berard referenced capital tunnel syndrome in his report, this was a typographical error and does not diminish the reliability of his report.

[10] *Solomon Polen*, 51 ECAB 341 (2000). *See* 5 U.S.C. § 8123(a).

[11] *See Melvina Jackson*, 38 ECAB 443 (1987).

[12] *R.W.*, Docket No. 12-375 (issued October 28, 2013).

did not have elbow complaints until years after the 2006 injury. His opinion is entitled to special weight as the impartial medical examiner and OWCP was within its discretion to deny authorization for surgery.

Subsequent to Dr. Berard's report, appellant submitted a May 11, 2012 report from Dr. Banerjee, who advised that appellant's cubital tunnel syndrome was caused by her July 26, 2006 injury. He stated that at the time of her right shoulder injury, she complained of pain in her elbow but it was believed that it was caused by her shoulder condition and no investigation or treatment was carried out. Dr. Banerjee stated that following appellant's right shoulder arthroscopic surgery, she developed increased pain in her elbow which she attributed to her physical therapy exercises. He noted that these elbow complaints were reflected in the record. Dr. Banerjee also opined that this condition was subsequently aggravated by physical therapy following arthroscopic surgery of her right shoulder which was causally related to appellant's injury at work.

Dr. Banerjee generally supported that appellant's bilateral cubital tunnel syndrome was related to her work injury. The Board finds that his opinion on causal relationship was conclusory without adequate rationale.[13] Dr. Banerjee's report is insufficient to overcome the special weight of the medical evidence accorded to Dr. Berard as his opinion that her cubital tunnel syndrome was caused by the July 26, 2006 injury is based on medical reports documenting appellant's elbow complaints in November 2010 and January 2011, more than four and a half years after the initial injury. Moreover, Dr. Banerjee attributed appellant's symptoms pertaining to the elbow as having occurred during her physical therapy exercises postarthroscopic surgery. He did not specifically address how the claimed condition arose as a consequence of any exercise or physical therapy provided in treatment of the accepted condition. Dr. Banerjee also noted that his opinion on causation was based on information provided to him by appellant as she stated that her elbow bothered her since the 2006 injury. Findings on examination are generally needed to support a physician's opinion.[14] Dr. Banerjee did not provide a fully rationalized opinion based on medical documentation and objective evidence to establish that appellant's bilateral cubital tunnel syndrome is causally related to the July 26, 2006 injury or warranting authorization for surgery. Thus, his report is insufficient to overcome the opinion of Dr. Berard.[15]

OWCP referred medical records to Dr. Slutsky, a district medical adviser, for an opinion regarding whether appellant's July 26, 2006 work duties caused or contributed to her elbow condition and if the surgical procedure of bilateral cubital tunnel syndrome release was medically necessary or warranted.

In reports dated December 17, 2012 and June 29, 2013, Dr. Slutsky reviewed the case record and opined that appellant's cubital tunnel syndrome and elbow problems were not

[13] *See George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of little probative value).

[14] *G.T.*, 59 ECAB 447 (2008); *see Huie Lee Goal*, 1 ECAB 180,182 (1948).

[15] *See Michael Hughes*, 52 ECAB 387 (2001); *Howard Y. Miyashiro*, 43 ECAB 1101, 1115 (1992); *Dorothy Sidwell*, 41 ECAB 857 (1990).

causally related to the July 26, 2006 occupational claim or to her work-related duties. Thus, surgery was not warranted. He noted that from the date of injury on July 26, 2006 to December 14, 2010, there were no objective clinical findings or diagnostic tests consistent with clinically active bilateral cubital tunnel syndrome or any mention of elbow-related issues. The first note by a physician where elbow symptoms were mentioned was dated December 14, 2010, almost four and a half years after the date of injury and seven months postshoulder surgery. Dr. Banerjee noted that appellant had not yet returned to work so her symptoms appeared to have developed outside of her work-related duties. Based upon the medical record, it was medically implausible that appellant's cubital tunnel syndrome was related to her 2006 claim or work-related duties.

The Board notes that appellant argued that she had complaints of elbow pain since the onset of the 2006 injury. The record lacks documentation pertaining to issues involving her elbows. The March 28, 2011 report of Dr. Lawlis noted that he only treated appellant for her shoulder condition and could not comment on the evaluation or management of her elbow. On May 16, 2011 Dr. Frenzen acknowledged that he did not have any of Dr. Johansson's notes for review. Further, his office notes did not contain anything that would suggest appellant had elbow pain when she saw Dr. Lawlis for treatment of her shoulder. Dr. Frenzen only had appellant's description of her elbow pain and the period of time in which she stated it developed as the basis for concluding that it was causally related to the July 26, 2006 injury. Dr. Johansson's July 6, 2011 report noted that appellant had previously made some reference to elbow pain but it was thought that it arose from her shoulder condition. He provided no specific dates and failed to state a specific time period for which she referenced her prior elbow complaints. This medical evidence lacks adequate detail to establish that appellant's elbow condition arose on or around July 26, 2006.

For a surgical procedure to be authorized, a claimant must show that the surgery is for a condition causally related to an employment injury.[16] The weight of medical evidence, as represented by Dr. Berard and Dr. Slutsky support that the recommended surgery is not for an employment-related condition. The Board finds that OWCP properly exercised its discretion to deny authorization for the proposed surgery.[17] The Board finds that Dr. Berard provided a well-rationalized opinion based on a complete background, review of the accepted facts and the medical record.[18] Dr. Berard's opinion was supported by Dr. Slutsky.

The only limitation on OWCP's authority in approving or disapproving service under FECA is one of reasonableness.[19] OWCP obtained an impartial medical examination by Dr. Berard. It also routed the case to Dr. Slutsky for review. Dr. Slutsky also found the surgery

[16] 5 U.S.C. § 8103; *see also R.C.*, 58 ECAB 238 (2006) (where the Board found that, for a surgery to be authorized, a claimant must submit evidence to show that the requested procedure is for a condition causally related to the employment injury and that it is medically warranted).

[17] *K.D.*, Docket No. 11-1738 (issued March 27, 2012).

[18] *L.D.*, Docket No. 13-69 (issued June 4, 2013).

[19] *Daniel J. Perea*, 42 ECAB 214, 221 (1990).

unnecessary. Therefore, the Board finds that OWCP did not abuse its discretion under section 8103 in denying approval of surgery for bilateral cubital tunnel release.[20]

Appellant may submit additional evidence, together with a written request for reconsideration, to OWCP within one year of the Board's merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.606 and 10.607.

CONCLUSION

The Board finds that OWCP properly denied appellant's request for authorization of bilateral cubital tunnel release.

ORDER

IT IS HEREBY ORDERED THAT the July 30, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 5, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

[20] *K.B.*, Docket No. 12-1438 (issued March 27, 2013).