

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of DIANA L. BEADY and SOCIAL SECURITY ADMINISTRATION,
Philadelphia, PA

*Docket No. 99-2378; Submitted on the Record;
Issued November 19, 2001*

DECISION and ORDER

Before MICHAEL E. GROOM, BRADLEY T. KNOTT,
A. PETER KANJORSKI

The issues are: (1) whether the Office of Workers' Compensation Programs met its burden of proof to terminate appellant's compensation effective March 28, 1999; and (2) whether appellant met her burden of proof to establish that she had any disability after March 28, 1999 causally related to her employment injury.

On February 11, 1998 appellant, then a 40-year-old service contact representative, filed an occupational disease claim, alleging that factors of employment caused bilateral carpal and cubital tunnel syndromes. By letter dated May 11, 1998, the Office accepted that she sustained employment-related carpal tunnel syndrome and right cubital tunnel syndrome. On February 16 and July 20, 1998 appellant underwent authorized surgery and she was placed on the periodic roll.

The Office continued to develop the claim and on October 22, 1998 referred appellant, along with the medical record, a set of questions and a statement of accepted facts, to Dr. Richard J. Mandel, a Board-certified orthopedic surgeon, for a second opinion evaluation. By letter dated February 5, 1999, the Office informed appellant that it proposed to terminate her compensation, based on the opinion of Dr. Mandel. In a February 11, 1999 letter, appellant disagreed with the proposed termination and submitted additional evidence. By decision dated March 17, 1999, the Office terminated her benefits, effective March 28, 1999, on the grounds that she no longer experienced residuals of the employment injuries. On April 24, 1999 appellant requested reconsideration and submitted additional evidence. In a May 6, 1999 decision, the Office denied modification of the prior decision. The instant appeal follows.

The Board finds that the Office met its burden of proof to terminate appellant's compensation.

Once the Office accepts a claim it has the burden of justifying termination or modification of compensation. After it has determined that an employee has disability causally

related to his or her employment, the Office may not terminate compensation without establishing that the disability has ceased or that it was no longer related to the employment.¹

The medical evidence relevant to the termination of appellant's compensation includes reports from appellant's treating Board-certified orthopedic surgeon, Dr. Easwaran Balasubramanian. In a disability slip dated October 28, 1998, he advised that appellant could return to light duty. In a report that date Dr. Balasubramanian stated:

"[Appellant] has been under my care since [February 6, 1998] for a diagnosis of bilateral carpal tunnel syndrome and on the right cubital tunnel syndrome. She had surgery done on [February 6, 1998] for the carpal tunnel and cubital tunnel. Subsequently she had the left carpal tunnel done in July. She underwent a physical therapy program and she has reached a plateau in physical therapy.

"At the present time I feel that she can return to light-duty work. I feel that she cannot return to her work, but she can return to work with no repetitive hand work and no lifting over five pounds."

In a report dated November 19, 1998, Dr. Richard J. Mandel, a Board-certified orthopedic surgeon, who provided a second opinion evaluation for the Office, noted the history of injury, described appellant's past treatment and her complaint of grip weakness. Examination of the hands and upper extremities revealed no visible atrophy or deformity with surgical scars present. Provocative maneuvers for carpal tunnel syndrome, including Phalen's, reverse Phalen's, Tinel's and carpal tunnel compression tests were all negative. Tinel's over the ulnar nerves was negative. Grip strength was nonphysiologic. He concluded:

"There were no objective findings on today's examination to suggest any ongoing carpal tunnel syndrome or ulnar neuropathies. There were no objective findings whatsoever. The grip strength measurements, a subjective test, were nonphysiologic. That is to say the grip strengths demonstrated represented a submaximal effort. The combination of normal sensory perception at 2.83 and the absence of all positive provocative maneuvers for ongoing neuropathy, as well as the natural history of these conditions, leads me to conclude that [she] is fully recovered from any carpal tunnel and cubital tunnel syndromes from which she may have suffered. In my opinion, she can resume normal activities and can return to regular duty work. I do not feel that the typing or data entry activities that are required represent any sort of contraindication to her returning to work. She is not in need of further formalized treatment."

In an attached work capacity evaluation, Dr. Mandel advised that appellant had no restrictions to physical activity.

¹ See Patricia A. Keller, 45 ECAB 278 (1993).

By report dated November 30, 1998, Dr. Balasubramanian stated:

“[Appellant] spoke with me today, November 30, 1998, regarding the job that has been offered to her. From the description ... I do not feel that she can return to that specific job because of the amount of writing that is involved in doing the job which she is not able to do at the present time. She will be seen again by me in January for further care.”

In a report dated January 8, 1999, Dr. Shwe Zin Tun, who is Board-certified in psychiatry and neurology, advised that electromyographic (EMG) and nerve conduction studies were abnormal, stating:

“There is electrodiagnostic evidence of a left median focal neuropathy at the wrist consistent with a clinical diagnosis of carpal tunnel syndrome. This is of mild degree in severity and better compared to the previous study done on January 1998. In addition, there is electrodiagnostic evidence suggestive but not conclusive of a bilateral cervical radiculopathy predominantly involving C8 nerve roots. Previously documented right focal ulnar neuropathy findings are also improved.”

In a treatment note dated January 28, 1999, Dr. Balasubramanian stated that the EMG “reveals that the cubital tunnel and the carpal tunnel are better, but she apparently has bilateral cervical radiculopathy with a C8 distribution.” He advised that she continued to have problems clinically with very weak grip strength. Dr. Balasubramanian concluded:

“She maintains that the way the job description is she cannot do the job. I will keep her out of work until I get more information on that.”

In assessing medical evidence, the weight of such evidence is determined by its reliability, its probative value and its convincing quality. The factors which enter in such an evaluation include the opportunity for and thoroughness of examination, the accuracy and completeness of the physician’s knowledge of the facts and medical history, the care of the analysis manifested and the medical rationale expressed in support of the physician’s opinion.²

The Board finds that the weight of the medical evidence regarding the termination of appellant’s compensation rests with the opinion of Dr. Mandel. While Dr. Balasubramanian advised that appellant could not return to the job that she described,³ he failed to provide specific findings on testing. Furthermore, Dr. Balasubramanian noted findings regarding cervical radiculopathy which is not an accepted employment-related condition. His opinion is, therefore, of decreased probative value while the EMG administered by Dr. Tun demonstrated mild carpal tunnel syndrome, he did not provide an opinion regarding appellant’s ability to return to work. On examination, Dr. Mandel elicited no positive findings on testing for carpal tunnel syndrome

² Gary R. Sieber, 46 ECAB 215 (1994).

³ The position description for a contact representative indicates that the position is primarily sedentary that “provides a full range of assistance to beneficiaries and inquirers in person, by telephone or by correspondence regarding all programs” administered by the employing establishment. The position specifically entails interviewing, completing applications, computer data entry and telephoning.

and concluded that appellant could return to her regular work. As he provided comprehensive, well-rationalized reports, in which he explained his findings and conclusions, the Board finds that the weight of the medical evidence rests with his opinion and, therefore, finds that appellant had no employment-related disability on or after March 28, 1999 and the Office met its burden of proof to terminate her compensation benefits on that date.

The Board further finds that appellant failed to establish that she had an employment-related disability after March 28, 1999.

As the Office met its burden of proof to terminate appellant's compensation benefits, the burden shifted to her to establish that she had disability causally related to her accepted injury.⁴ To establish a causal relationship between the condition, as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence, based on a complete factual and medical background, supporting such a causal relationship.⁵ Causal relationship is a medical issue,⁶ and the medical evidence required to establish a causal relationship is rationalized medical evidence. Rationalized medical evidence is medical evidence which includes a physician's rationalized medical 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.⁷

The evidence submitted by appellant subsequent to the March 17, 1999 Office decision terminating her compensation includes⁸ a magnetic resonance imaging (MRI) scan of the cervical spine dated February 16, 1999, which demonstrated minimum degenerative changes at the C5-6 level and no evidence of spinal canal stenosis. In a treatment note dated March 26, 1999, Dr. Balasubramanian noted examination findings of pain in the shoulder, which appeared to be C8 radiculopathy. He stated that the hand was "feeling better" with tenderness along the MCP joint and painful range of motion. Dr. Balasubramanian concluded:

"I feel she cannot return back to full work because of the amount of repetitive work that is needed but I feel that she can return back to work on a four hour a day basis to start with, with no repetitive work and no lifting over 5 pounds. She will return to see me in two months."

In a report dated April 7, 1999, Dr. Tun noted a history of right shoulder and neck pain that began in August 1998 and worsened in January 1999 and that appellant reported lack of hand strength and occasional numbness in both hands. He noted findings on examination and

⁴ See *George Servetas*, 43 ECAB 424 (1992).

⁵ See 20 C.F.R. § 10.110(a); *Kathryn Haggerty*, 45 ECAB 383 (1994).

⁶ *Mary J. Briggs*, 37 ECAB 578 (1986).

⁷ *Gary L. Fowler*, 45 ECAB 365 (1994); *Victor J. Woodhams*, 41 ECAB 345 (1989).

⁸ Appellant also submitted evidence previously of record.

diagnosed chronic pain syndrome, cervical radiculopathy and myelopathy, right greater than left, carpal tunnel syndrome, ulnar neuropathy and probable sleep apnea.

In a treatment note dated April 8, 1999, Dr. Balasubramanian stated:

“On examination today she still continues to have the same symptomatology and it is my opinion at this time that after the surgery that she has had and the physical therapy that she has had, she has plateaued in her recovery and I feel that what she has would be a permanent disability at this time. I do not think she can return to work on a repetitive hand work basis and her lifting is to be limited to 5 pounds and also she cannot do repetitive hand work because of the carpal tunnel and ulnar nerve entrapment. It is my opinion it is permanent and partial disability.”

In this case, after the Office properly terminated appellant’s compensation benefits, she submitted additional medical evidence. Dr. Balasubramanian, however, merely reiterated his conclusion that appellant continued to have symptomatology and restrictions due to carpal tunnel syndrome but provided no objective rationale in this regard. While Dr. Tun diagnosed carpal tunnel syndrome and noted findings on examination, he provided no opinion regarding appellant’s ability to work.⁹

As the record contains no evidence that appellant continued to be disabled after March 28, 1999 due to an employment-related condition, the Office properly determined that she was not entitled to compensation benefits after that date.

The May 6 and March 17, 1999 decisions of the Office of Workers’ Compensation Programs are hereby affirmed.

Dated, Washington, DC
November 19, 2001

Michael E. Groom
Alternate Member

Bradley T. Knott
Alternate Member

A. Peter Kanjorski
Alternate Member

⁹ Both Drs. Balasubramanian and Tun noted complaints and findings regarding cervical spine radiculopathy and shoulder complaints. These conditions have not been accepted as employment related.