

**United States Department of Labor  
Employees' Compensation Appeals Board**

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C.B., Appellant

and

U.S. POSTAL SERVICE, POST OFFICE,  
Des Moines, IA, Employer

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**Docket No. 08-2364  
Issued: June 17, 2009**

*Appearances:*  
*Appellant, pro se*  
*Office of Solicitor, for the Director*

*Case Submitted on the Record*

**DECISION AND ORDER**

Before:

ALEC J. KOROMILAS, Chief Judge  
DAVID S. GERSON, Judge  
JAMES A. HAYNES, Alternate Judge

**JURISDICTION**

On August 28, 2008 appellant filed a timely appeal of the Office of Workers' Compensation Programs' decision dated May 9, 2008 denying his request to expand his claim to include bilateral cubital tunnel syndrome and an August 22, 2008 decision denying his request for reconsideration without a merit review. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

**ISSUES**

The issues are: (1) whether appellant has established that he sustained bilateral cubital tunnel syndrome due to his accepted employment injury; and (2) whether the Office properly denied appellant's request for reconsideration without a merit review pursuant to section 8128(a) of the Federal Employees' Compensation Act.

**FACTUAL HISTORY**

On August 28, 2004 appellant, then a 47-year-old mail handler, filed an occupational injury claim alleging that he developed carpal tunnel syndrome in both hands from repetitive

lifting and moving mail with his hands. He first realized that his condition was caused or aggravated by his employment on January 1, 1991. Appellant did not stop work. On November 26, 2004 the Office accepted the claim for bilateral carpal tunnel syndrome.<sup>1</sup>

On October 24, 2003 Dr. Farhana Asad, appellant's treating physician, diagnosed postoperative residuals from the left middle finger, secondary to debridement of infection. He indicated that bilateral carpal tunnel syndrome was likely secondary to appellant's repetitive work. The report also noted that Dr. Eugene Cherny, a Board-certified plastic surgeon, indicated possible cubital tunnel syndromes with triggering of the left long finger.

In an August 10, 2004 report, Dr. John Gregory Ganske, a Board-certified plastic surgeon, noted appellant's 10-year history of carpal tunnel syndrome symptoms. He stated that appellant's job required heavy repetitive hand labor including pushing and unloading a hand truck. Dr. Ganske diagnosed carpal tunnel syndrome and ulnar nerve compression at the wrist. He recommended carpal tunnel and ulnar nerve releases at the wrists.

On November 23, 2004 Dr. Cherny diagnosed bilateral carpal tunnel syndrome and ulnar nerve compression at the wrist for at least 10 years with symptoms getting worse. He noted that appellant was losing sensation in his fingers and had lost significant grip strength. Dr. Cherny advised that appellant needed bilateral carpal tunnel release and ulnar nerve releases at the wrist. In a December 9, 2004 report, he noted upon examination that the right hand had decreased protection sensation to the thumb, index and small digit and decreased tactile sensation in the long and ring finger. Dr. Cherny also noted that the left hand had decreased protective sensation in the thumb, index, long and small fingers and decreased tactile sensation in the ring digit. He diagnosed bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome.

On November 29, 2007 appellant inquired about whether he could expand his case to include cubital tunnel syndrome. The Office explained that his case had only been accepted for carpal tunnel syndrome.

Appellant submitted a December 26, 2007 report from Dr. Cherny, who noted a fixed sensory deficit in both hands through the ulnar and median nerve distribution and some symptoms involving the radial nerve along the dorsal aspect of the wrist. Dr. Cherny indicated a positive Tinel's test for bilateral cubital tunnel syndrome. He diagnosed bilateral nerve compression syndromes involving the medial nerve at the wrist consistent with carpal tunnel in the ulnar nerve at the levels of the wrist and elbow consistent with ulnar and cubital tunnel. Dr. Cherny also noted symptoms involving the radial nerve due to sensory deficits over the dorsal aspect of the wrist and hands. He recommended an electromyogram (EMG) and nerve conduction study.

On February 19, 2008 the Office advised appellant of the factual and medical evidence necessary to expand his claim. In particular, it requested a description of job activities that appellant believed contributed to his condition and a medical report with a diagnosis and physician's opinion as to whether employment activities caused or contributed to his condition.

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<sup>1</sup> On July 12, 2005 the Office issued a schedule award for 23 percent impairment of the right upper extremity and 24 percent impairment of the left upper extremity, entitling appellant to 146.64 weeks of compensation.

Appellant submitted an undated statement describing the type of equipment he used at work and the amount of weight each held. He also noted continued pain, swelling, tenderness, weakness and throbbing of elbow in 2003. Appellant indicated that he had not received any effective treatment. He also submitted several physical therapy notes and several medical reports.

In an EMG report dated February 1, 2008, Dr. Charles Denhart, a Board-certified physiatrist, noted appellant's history of hand pain, paresthesias and bilateral medial elbow pain. Upon examination, he noted that appellant's upper extremity deep tendon reflexes were symmetrical and his upper extremity strength and sensation were grossly intact. Dr. Denhart found that the right and left median motor and sensory distal latencies were prolonged, consistent with mild bilateral carpal tunnel syndrome. He also found that the right and left ulnar nerve conduction study was normal. Dr. Denhart diagnosed bilateral carpal tunnel syndrome.

On February 12, 2008 Dr. Cherny found fixed sensory deficits through both medial and ulnar nerve distribution, with ulnar nerve symptoms greater than median nerve symptoms. He diagnosed bilateral carpal tunnel syndrome, cubital tunnel and ulnar tunnel syndrome. Dr. Cherny recommended open carpal tunnel release, ulnar tunnel release and cubital tunnel release bilaterally.

On April 17, 2008 the Office requested that an Office medical adviser determine whether there was sufficient medical evidence to establish cubital tunnel syndrome causally related to appellant's federal employment, and if so, whether the medical evidence established the need for surgery for the condition. On April 20, 2008 the Office medical adviser advised that the Office not accept a claim for cubital tunnel syndrome or surgery for this condition. He asserted that Dr. Cherny's reports were based on the subjective results of the Tinel's test and that his reports were repeatedly generic in discussing his findings. He also advised that Dr. Denhart's EMG was negative for cubital tunnel syndrome.

By decision dated May 9, 2008, the Office denied appellant's request to expand his claim to accept bilateral cubital tunnel syndrome finding that the medical evidence did not demonstrate that the claimed medical condition was related to the established work-related events.

Appellant requested reconsideration on May 14 and July 21, 2008. He submitted a July 2, 2008 operative report from Dr. Cherny, in which the physician performed a neuroplasty of the median nerve at the left carpal tunnel and empiric ulnar nerve release at the left wrist. Appellant also submitted several work restriction forms from Dr. Cherny regarding his return to work after the carpal tunnel surgery. On July 8, 2008 Dr. Cherny diagnosed status post left carpal tunnel release. He noted reduced numbness and tingling in the left hand. In a report dated July 29, 2008, Dr. Cherny noted appellant's complaint of numbness and tingling in the left ring and small fingers and the ulnar aspect of the left hand. He also noted continued partial sensory loss in the left small finger and into the hypothenar region and ulnar aspect of the left forearm. Dr. Cherny indicated that appellant continued to be limited by symptoms in the left hand involving ulnar nerve distribution. He also reported right hand symptoms involving the median nerve and ulnar nerve compression. Dr. Cherny noted that he would seek authorization for surgery on the ulnar nerve at the level of the wrist and elbow. In an August 1, 2008 operative report, he performed a neuroplasty of the median nerve at the right carpal tunnel.

Appellant also submitted several physical therapy reports, including a July 8, 2008 report noting that appellant had decreased protective sensation through the ulnar nerve distribution at the left hand.

By decision dated August 22, 2008, the Office denied appellant's request for reconsideration without a merit review finding that the evidence submitted was cumulative and not relevant.

### **LEGAL PRECEDENT -- ISSUE 1**

Where appellant claims that a condition not accepted or approved by the Office was due to his employment injury, he bears the burden of proof to establish that the condition is causally related to the employment injury.<sup>2</sup> To establish a causal relationship between the condition, as well as any attendant disability, claimed and the employment event or incident, the employee must submit rationalized medical opinion evidence, based on a complete factual and medical background, supporting such a causal relationship.<sup>3</sup> Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is a causal relationship between the employee's diagnosed condition and the compensable employment factors. The opinion of the physician must be based on a complete factual and medical background of the employee, 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 employee.<sup>4</sup>

### **ANALYSIS -- ISSUE 1**

The Board finds that appellant has not established that his bilateral cubital tunnel syndrome is causally related to factors of his federal employment. The Office accepted bilateral carpal tunnel syndrome due to repetitive lifting and moving mail with his hands. Thereafter, appellant requested that the Office expand his claim to include bilateral cubital tunnel syndrome. However, the Board finds that the medical evidence is insufficient to establish that appellant's bilateral cubital tunnel syndrome is due to the accepted employment injury.

The reports from Dr. Cherny diagnosed bilateral cubital tunnel syndrome. In particular, his reports dated November 23, 2004 and February 12, 2008 recommended ulnar nerve releases and cubital tunnel releases bilaterally. Also, Dr. Cherny's December 26, 2007 report noted that appellant had a positive Tinel's test result for bilateral cubital tunnel syndrome as well as decreased sensation in both hands. However, none of his reports discuss whether particular employment activities caused or aggravated appellant's cubital tunnel condition. In particular,

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<sup>2</sup> *Jaja K. Asaramo*, 55 ECAB 200 (2004).

<sup>3</sup> *Jennifer Atkerson*, 55 ECAB 317 (2004).

<sup>4</sup> *I.J.*, 59 ECAB \_\_\_\_ (Docket No. 07-2362, issued March 11, 2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

Dr. Cherny did not provide any opinion about the cause of appellant's condition or address why he continued to diagnose cubital tunnel syndrome after Dr. Denhart's EMG indicated no evidence of that condition. The Board has held that medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.<sup>5</sup>

Dr. Asad's report dated October 24, 2003 diagnosed postoperative residuals from the left middle finger. He also noted that Dr. Cherny indicated possible cubital tunnel syndromes with triggering of the left long finger. However, Dr. Asad's report does not support appellant's claim as it contains no opinion on causal relationship, rather it is a mere reiteration of Dr. Cherny's findings. He did not provide his own opinion as to whether appellant had cubital tunnel syndrome or whether that condition was attributed to appellant's employment. Similarly, Dr. Ganske indicated that appellant performed heavy repetitive hand labor at work and diagnosed ulnar compression, but he did not specifically address whether appellant's ulnar condition was causally related by his job duties.

The record also contains an EMG report from Dr. Denhart indicating that the right and left ulnar nerve conduction study results were normal. This report does not support that appellant has cubital tunnel syndrome. The record also contains the April 20, 2008 report from an Office medical adviser who recommended that the Office not accept appellant's claim for cubital tunnel syndrome given that Dr. Cherny's reports were based on subjective and generic findings as well as the fact that the EMG indicated no evidence of cubital tunnel syndrome. Other medical reports of record do not provide any specific support for causal relationship between appellant's claimed cubital tunnel syndrome and particular employment activities.

Appellant also submitted physical therapy reports. However, the Board has held that reports from physical therapists are of no probative value as physical therapists are not considered physicians under the Act, and as a result, they are not competent to provide a medical opinion.<sup>6</sup> None of the other evidence of record addresses the issue of causal relationship.

Consequently, the medical evidence does not support that appellant sustained cubital tunnel syndrome in the performance of duty.

### **LEGAL PRECEDENT -- ISSUE 2**

To require the Office to reopen a case for merit review under section 8128(a), the Office's regulations provide that the evidence or argument submitted by a claimant must: (1) show that the Office erroneously applied or interpreted a specific point of law; (2) advance a relevant legal argument not previously considered by the Office; or (3) constitute relevant and pertinent new evidence not previously considered by the Office.<sup>7</sup> Section 10.608(b) of Office regulations provides that, when an application for reconsideration does not meet at least one of

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<sup>5</sup> *K.W.*, 59 ECAB \_\_\_ (Docket No. 07-1669, issued December 13, 2007).

<sup>6</sup> *See Barbara Williams*, 40 ECAB 649 (1989). *See* 5 U.S.C. § 8101(2) (defines the term "physician").

<sup>7</sup> *D.K.*, 59 ECAB \_\_\_ (Docket No. 07-1441, issued October 22, 2007).

the three requirements enumerated under section 10.606(b)(2), the Office will deny the application for reconsideration without reopening the case for a review on the merits.<sup>8</sup>

### **ANALYSIS -- ISSUE 2**

In support of his reconsideration request, appellant submitted additional medical evidence. However, none of the medical evidence submitted addressed the relevant issue of whether appellant sustained cubital tunnel syndrome causally related to his factors of employment.

Dr. Cherny's July 2, 2008 operative report indicated that Dr. Cherny performed an ulnar nerve release on appellant's left wrist. In a July 29, 2008 report, he noted appellant's complaint of numbness and tingling in the ulnar aspect of his left hand. Dr. Cherny also noted that appellant was limited by symptoms of ulnar nerve distribution. Although these reports reference appellant's ulnar condition, they do not constitute relevant evidence as neither addresses the issue of causal relationship.<sup>9</sup> The other reports from Dr. Cherny submitted upon appellant's reconsideration request also are not relevant as they only discuss appellant's carpal tunnel syndrome, which is not at issue.

Appellant also submitted several physical therapy reports in support of his reconsideration request. However, the underlying issue is medical in nature and, as noted, physical therapists are not physicians and their reports are not competent medical evidence. Therefore, the physical therapy notes do not constitute relevant evidence.

None of the evidence submitted upon reconsideration constituted new and relevant evidence not previously considered by the Office. Appellant also did not advance a legal argument not previously considered by the Office or assert that the Office erroneously applied or interpreted a specific point of law. Consequently, the Office properly denied appellant's request for reconsideration without a merit review.

### **CONCLUSION**

The Board finds that appellant did not meet his burden of proof in establishing that he sustained cubital tunnel syndrome causally related to his factors of employment. The Board further finds that the Office properly denied his request for reconsideration without a merit review.<sup>10</sup>

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<sup>8</sup> *K.H.*, 59 ECAB \_\_\_ (Docket No. 07-2265, issued April 28, 2008).

<sup>9</sup> *See E.M.*, 60 ECAB \_\_\_ (Docket No. 09-39, issued March 3, 2009) (where the Board held that new evidence submitted upon a reconsideration request that does not address the pertinent issue is not relevant evidence); *Freddie Mosley*, 54 ECAB 255 (2002).

<sup>10</sup> Appellant submitted new evidence on appeal. However, the Board may only review evidence that was in the record at the time the Office issued its final decision. 20 C.F.R. § 501.2(c).

**ORDER**

**IT IS HEREBY ORDERED THAT** the Office of Workers' Compensation Programs' decisions dated August 22 and May 9, 2008 are affirmed.

Issued: June 17, 2009  
Washington, DC

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

David S. Gerson, Judge  
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge  
Employees' Compensation Appeals Board