United States Department of Labor
Employees' Compensation Appeals Board

M.D., Appellant	)	
and	)	**Docket No. 11-494**
	)	**Issued: November 25, 2011**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Philadelphia, PA, Employer	)	

Appearances:
Aaron B. Aumiller, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 21, 2010 appellant, through her representative, filed a timely appeal from the Office of Workers' Compensation Programs (OWCP) decision dated July 22, 2010 which denied modification of a decision dated October 28, 2009. Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has met her burden of proof in establishing that her carpal tunnel syndrome and brachial plexus condition are employment related.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On September 9, 2008 appellant, then a 41-year-old supervisory medical support assistant, filed an occupational disease claim alleging that she developed a cervical strain, herniated disc, bilateral carpal tunnel syndrome and brachial plexopathy as a result of performing repetitive duties at work. She did not initially stop work.

Appellant came under the treatment of Dr. Scott M. Fried, an osteopath, on October 8, 2008 for bilateral hand pain, numbness and weakness progressing over the past year. She reported working as a medical support supervisor and performing repetitive keying duties and using a mouse and subsequently having symptoms of numbness and tingling bilaterally in the upper extremities and intermittent dysesthetic pain ascending into the paracervical area. Dr. Fried noted findings of positive Tinel's test at the bilateral median nerve and radial nerve at the left elbow, positive Phalen's test at the median nerve bilaterally and synovitis bilaterally at the wrist and carpal tunnel consistent with flexor tenosynovitis. He diagnosed tendinitis, bilateral flexor tenosynovitis, left radial neuropathy, brachial plexopathy/cervical radiculopathy with long thoracic neuritis bilaterally and carpal tunnel median neuropathy secondary to work activities. In a May 1, 2009 report, Dr. Fried noted that appellant's repetitive job duties including regular keying and use of a mouse caused a direct injury to the median nerve at the carpal tunnel and strain on the flexor tendons and the medial nerve. He noted that the repetitive activity resulted in inflammation and scarring of the nerves and carpal tunnel syndrome at the hands and wrists and brachial plexus injury with cervical radiculopathy. Dr. Fried indicated that the diagnosed flexor tenosynovitis was secondary to use of the keyboard. He opined that appellant's carpal tunnel, flexor tenosynovitis, radial neuropathy and brachial plexopathy were directly related to appellant's work activities including use of a computer, keyboard, mouse and prolonged head and neck posturing. Dr. Fried recommended work modifications. On May 28, 2009 he stated that appellant's symptoms were worsening. Dr. Fried opined that appellant was totally disabled from work.

A July 10, 2009 electromyogram (EMG) revealed moderate to significant right brachial plexus nerve compromise with no other abnormalities. July 28, 2009 magnetic resonance imaging (MRI) scan of the cervical spine revealed a small focal left paramedian disc herniation at C5-6, moderate desiccation with small focal left paramedian disc herniation at C4-5 and mild disc bulging with distinct focal disc herniation at C3-4.

On June 25, 2009 OWCP referred appellant to Dr. Raoul G. Biniaurishvili, a Board-certified neurologist, for a second opinion evaluation. In a report dated August 3, 2009, Dr. Biniaurishvili discussed appellant's work history. He noted findings upon physical examination of normal muscle strength and tone, sensory examination was intact, reflexes were normal and positive Tinel's sign bilaterally. Dr. Biniaurishvili opined that appellant's neurological examination was suggestive of carpal tunnel syndrome which correlated with appellant's reported work duties which involved extensive typing and use of a mouse. In an addendum report dated September 9, 2009, he reviewed the EMG and noted findings of right brachial plexus. Dr. Biniaurishvili noted that the EMG did not show any electrophysiological signs of carpal tunnel syndrome although his neurological examination indicated possible carpal tunnel syndrome. He opined that based upon appellant's clinical history it was difficult to say whether the brachial plexus was work related. Dr. Biniaurishvili opined that appellant's job

duties involved typing and the use of a mouse and this repetitive activity frequently leads to carpal tunnel syndrome. He recommended an additional MRI scan of the right brachial plexus.

On September 3, 2009 Dr. Fried treated appellant for neck pain in the bilateral plexus area with pain, numbness and tingling in the hands and wrist.

OWCP referred the matter to an OWCP medical adviser who, on September 29, 2009, noted that the findings of the MRI scan revealed cervical strain superimposed upon degenerative disc disease and herniated cervical disc. The medical adviser stated that the EMG and nerve conduction studies were definitive for a diagnosis of carpal tunnel syndrome. He noted that a diagnosis of carpal tunnel syndrome could not be made without electrodiagnostic evidence and in this case the EMG was normal. The medical adviser suggested a repeat EMG.

On October 28, 2009 OWCP accepted the claim for cervical sprain/strain superimposed on degenerative disc disease and cervical herniated disc but it denied the claim for carpal tunnel syndrome and brachial plexus condition.

On January 6 and April 20, 2010 appellant requested reconsideration. She submitted reports from Dr. Fried dated November 12, 2009 to April 15, 2010 who noted her progressive symptoms of tingling and burning in both arms with dysesthesias. Dr. Fried diagnosed bilateral paracervical pain, bilateral thoracic and paracervical, numbness and bilateral hand numbness and opined that appellant was totally disabled from work. In an April 1, 2010 report, he diagnosed bilateral flexor tenosynovitis, left radial neuropathy, brachial plexopathy, cervical radiculopathy and bilateral carpal tunnel median neuropathy secondary to work activities with brachial plexus involvement. Dr. Fried noted appellant performed repetitive keying activities and worked at a nonergonomic workstation which put significant strain on her neck irritating the cervical strain, median nerve carpal tunnel, flexor tenosynovitis and brachial plexus nerves causing inflammation in the tendons and the carpal canal. He opined that appellant's work activities directly resulted in the strain in these areas, tenosynovitis, median nerve compression and carpal tunnel. Dr. Fried noted that appellant could perform sedentary work with restrictions.

Appellant was also treated by Dr. Steven J. Valentino, an osteopath, from September 15, 2009 to February 24, 2010, for neck pain and radiation into the upper back and bilateral arm with paresthesias and weakness. He noted findings of weakness and decreased sensation of the upper extremities and positive Tinel's sign over the thoracic outlet. Dr. Valentino diagnosed cervical herniated nucleus pulposus, radiculitis, facet syndrome, brachial plexopathy and carpal tunnel syndrome and recommended a series of cervical medial branch blocks and transforaminal epidural steroid injections. In a February 24, 2010 report, Dr. Valentino opined that appellant's bilateral carpal tunnel syndrome was secondary to her work activities. An MRI scan of the cervical spine dated February 15, 2010 revealed small- to moderate-sized focal left paramedian disc herniations at C5-6 and C3-4 and C4-5. An EMG dated March 15, 2010 revealed no abnormalities with no evidence of neuropathy or radiculopathy affecting the bilateral upper extremities.

On June 16, 2010 OWCP referred appellant to Dr. Robert Draper, a Board-certified orthopedist, for a second opinion evaluation. In a report date July 1, 2010, Dr. Draper discussed appellant's work history. Examination of the upper extremities revealed normal motor function

of the deltoids, biceps, triceps, wrist extensors and flexors and grip strength, normal reflexes and normal light touch sensation at the C2-C8 and T1 dermatomes. Dr. Draper noted negative Tinel's sign over the median and ulnar nerve of the right and left wrist and elbow, no thenar or hypothenar atrophy and normal light touch sensation over the fingers. He diagnosed cervical strain, degenerative cervical disc disease, small focal left paramedian disc herniation at C5-6, focal left paramedian disc herniation at C4-5 and mild disc bulging with focal herniation at C3-4. Dr. Draper noted the clinical examination was not consistent with the findings of Dr. Fried, specifically, he found no evidence of brachial plexitis, carpal tunnel syndrome, thoracic neuritis or thoracic outlet syndrome. He advised that appellant sustained a cervical strain and has degenerative cervical disc disease. Dr. Draper indicated that he found no evidence of peripheral nerve root impingement syndromes involving the upper extremities. He recommended physical therapy and traction and noted appellant could return to work full time with restrictions.

On July 12, 2010 OWCP requested Dr. Draper clarify that he reviewed both statement of accepted facts dated September 29, 2009 and June 13, 2010 and address whether appellant could return to her regular job and whether she required further treatment due to her accepted work injuries. In a July 16, 2010 report, Dr. Draper noted he reviewed both statement of accepted facts and opined that appellant's diagnosed degenerative cervical disc disease and disc herniations were not traumatic or caused by appellant's employment duties rather these conditions were part of the degenerative process and associated with aging. He noted appellant continued to have residuals of her accepted injuries and could return to a sedentary position with restrictions.

In a decision dated July 22, 2010, OWCP denied modification of the October 28, 2009 decision.

LEGAL PRECEDENT

Where an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.[2]

Causal relationship is a medical issue that must be established by rationalized medical opinion evidence.[3] Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized 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.[4] The weight of medical evidence is determined by its reliability, its

[2] *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[3] *Elizabeth H. Kramm (Leonard O. Kramm)*, 57 ECAB 117 (2005).

[4] *Leslie C. Moore*, 52 ECAB 132 (2000).

probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.[5]

ANALYSIS

Appellant alleges that she developed bilateral carpal tunnel syndrome and a brachial plexus condition as a result of performing repetitive keying, data entry and lifting duties at work. OWCP accepted the claim, as noted, for cervical sprain/strain superimposed on degenerative disc disease and cervical herniated disc but did not accept bilateral carpal tunnel syndrome or a brachial plexus condition. OWCP based its determination on the opinion of Dr. Draper, an OWCP referral physician, who found that these conditions were not employment related.

The Board finds that there is a conflict in the medical opinion between Dr. Draper, for OWCP, and Drs. Fried and Valentino, for appellant.

In reports dated July 1 and 16, 2010, Dr. Draper found no evidence of brachial plexitis, carpal tunnel syndrome, thoracic neuritis or thoracic outlet syndrome. He noted normal motor function, reflexes and sensation and negative Tinel's sign over the median and ulnar nerve bilaterally. Dr. Draper diagnosed cervical strain, degenerative cervical disc disease, small focal left paramedian disc herniation at C5-6, focal left paramedian disc herniation at C4-5 and mild disc bulging with focal herniation at C3-4. By contrast, in an April 1, 2010 report, Dr. Fried diagnosed bilateral flexor tenosynovitis, left radial neuropathy, brachial plexopathy, cervical radiculopathy and bilateral carpal tunnel median neuropathy secondary to work activities. He opined that appellant's work duties included repetitive keying which directly resulted in the development of the cervical strain, carpal tunnel syndrome of the median nerve, flexor tenosynovitis and brachial plexopathy. Similarly, in reports dated September 15, 2009 to February 24, 2010, Dr. Valentino noted clinical findings consistent with carpal tunnel syndrome including decreased sensation of the upper extremities and positive Tinel's sign over the thoracic outlet. He diagnosed cervical herniated nucleus pulposus, radiculitis, facet syndrome, brachial plexopathy and carpal tunnel syndrome. On February 24, 2010 Dr. Valentino opined that appellant's carpal tunnel syndrome was work related. The Board therefore finds that a conflict in medical opinion has been created with regard to appellant's diagnosis and whether any carpal tunnel syndrome and brachial plexus condition are causally related to her employment.

Section 8123 of FECA[6] provides that if there is a disagreement between the physician making the examination for the United States and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[7]

The case, therefore, requires remand for an impartial medical specialist to resolve the conflict in the medical opinions. On remand, OWCP should refer appellant, the case record and

[5] *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value); *Jimmie H. Duckett*, 52 ECAB 332 (2001).

[6] 5 U.S.C. §§ 8101-8193.

[7] 5 U.S.C. § 8123(a); *see also Charles S. Hamilton*, 52 ECAB 110 (2000); *Leonard M. Burger*, 51 ECAB 369 (2000); *Shirley L. Steib*, 46 ECAB 39 (1994).

a statement of accepted facts to an appropriate Board-certified physician to examine appellant and render a reasoned medical opinion that resolves the medical conflict pursuant to section 8123(a). Following this and such further development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the July 22, 2010 decision of Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this decision.

Issued: November 25, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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