

FACTUAL HISTORY

On July 19, 2001 appellant, then a 40-year-old modified distribution clerk, filed an occupational disease claim (Form CA-2) alleging that she sustained injuries due to her federal employment. She alleged that she first became aware of her medical condition and its relation to her federal employment on February 1, 2001. OWCP accepted the claim for entrapment bilateral neuropathy of the elbows. It assigned the claim OWCP File No. xxxxxx400. Previously on April 1, 1992 appellant filed an occupational disease claim for pain in her hands due to her federal work duties. OWCP assigned the claim File No. xxxxxx966 and accepted right carpal tunnel syndrome and bilateral lesion of the ulnar nerve. It also accepted that appellant sustained calcifying tendinitis of the right shoulder due to factors of her employment.³ Appellant worked modified duty intermittently and received wage-loss compensation for hours in which the employing establishment was unable to accommodate her work restrictions. Effective June 4, 2010 the employing establishment was unable to provide her any work. Appellant received appropriate wage-loss compensation thereafter and was placed on the periodic compensation rolls.

Medical evidence of record includes an April 15, 1992 report from Dr. Douglas Swift, Board-certified in occupational medicine, who advised that an x-ray revealed no evidence of injury and that a nerve conduction study was within normal limits bilaterally with no evidence of carpal tunnel syndrome. Dr. Swift noted that her previous problems could have been tenosynovitis secondary to repetitive digital action on a letter sorting machine, but there was no reason to restrict appellant's activities at that time. Appellant's physicians continued to note her status.

In a March 21, 2003 report, Dr. Stephen Kishner, a Board-certified physiatrist, conducted a second opinion examination. Examination of both arms revealed full range of motion in all joints, normal tendon reflexes, normal sensation, no swelling, normal motor strength, no tenderness of the ulnar nerves across the elbows, and negative Tinel's and Phalen's signs. Appellant had tenderness almost everywhere Dr. Kishner touched over her hand, wrists, and forearms. He noted that he was unable to provide an impairment rating as he did not believe that appellant had carpal tunnel syndrome or ulnar neuropathy of the elbow. Dr. Kishner reiterated that other than subjective diffuse tenderness, his neurological examination of appellant's upper extremities was normal and opined that she possibly had fibromyalgia or connective tissue disease. Appellant's physicians continued to support that appellant had restrictions or was unable to work for intermittent period due to her employment conditions.

In an October 2, 2007 report, Dr. Raymond Fletcher, a Board-certified orthopedic surgeon, provided a second opinion examination. Examination of the arms revealed no muscle atrophy, no joint line tenderness of the elbows, negative Tinel's and Phalen's, mild paresthesia with pressure at both carpal tunnels, and unreliable results for two-point discrimination in both

³ In a July 5, 2002 memorandum, OWCP recommended that File No. xxxxxx966, accepted for the January 4, 1991 right carpal tunnel syndrome and bilateral lesion of the ulnar nerve, and File No. xxxxxx400, accepted for a February 1, 2001 entrapment neuropathy of the elbows, be doubled under File No. xxxxxx966. In a March 14, 2008 memorandum, OWCP recommended that File No. xxxxxx966 and File No. xxxxxx060, accepted for a November 22, 2006 right shoulder condition, also be doubled under File No. xxxxxx966.

hands. Dr. Fletcher opined that appellant's bilateral cubital tunnel and bilateral carpal tunnel were not resolved and provided permanent work restrictions attributable to the February 1, 2001 work injury.

Appellant continued to receive treatment from various physicians. In a June 25, 2010 report, Dr. Sofjan Lamid, a Board-certified physiatrist, advised that the effects of appellant's work injury persisted and her condition was worsening. In a June 20, 2012 report, Dr. Dwight McKenna, a general practitioner, indicated that appellant continued to complain of pain in the shoulder, bilateral elbows, right wrist, and hand. He opined that she was disabled and unable to work.

Appellant subsequently began treatment with Dr. Alain Cracco, a Board-certified orthopedic surgeon, in 2013. In an April 1, 2013 report, Dr. Cracco noted a history provided by appellant. He found that the right upper extremity examination was normal as compared to the left, but concluded that appellant could not return to work. Dr. Cracco diagnosed moderate adhesive capsulitis, moderate ulnar nerve lesion, and mild carpal tunnel syndrome. He continued submitting reports noting appellant's status.

In a September 4, 2014 report, Dr. Cracco advised that appellant complained of hand and elbow pain. Examination of the elbows revealed no joint tenderness, no swelling, 160 degrees of elbow flexion, elbow extension at 0 degrees, and positive Tinel's sign over the elbow. Examination of the hand revealed no thenar atrophy. Dr. Cracco advised that neurologically appellant was normal with the cranial nerves grossly intact. He advised that she had a normal electromyography (EMG) and nerve conduction studies. Dr. Cracco noted that appellant disagreed and that she insisted that in 10 percent of cases the diagnosis for carpal tunnel is clinical. He opined that she fully recuperated from the 2001 injury, noted that her complaints were subjective and not based on objective findings, and discharged her from his care.

In a September 11, 2014 report, Dr. Roy Berkowitz, a treating Board-certified surgeon, advised that appellant complained of right hand and wrist pain. He noted that she previously had a nerve conduction velocity (NCV) test which did not show carpal tunnel syndrome, but he advised that there was ample documentation that 10 percent of people with carpal tunnel syndrome had negative NCV's. Examination of the arms revealed grip strength of 10 pounds on the right, grip strength of 50 pounds on the left, and positive Tinel's and Phalen's sign on the right. Dr. Berkowitz assessed right carpal tunnel syndrome and right ulnar nerve entrapment by history. He noted that both these conditions were repetitive motion injuries attributable to her federal employment.

By letter dated October 21, 2014, OWCP advised appellant that it proposed to terminate wage-loss and medical benefits. It advised that the weight of the evidence was represented by Dr. Cracco who found that there were no residuals of her accepted conditions.

Appellant provided an October 15, 2014 report from Dr. Berkowitz who noted her complaints of right hand pain and weakness as well as a recent increase in right shoulder pain. Dr. Berkowitz diagnosed bilateral carpal tunnel syndrome and ulnar nerve lesion. He recommended physical therapy.

By decision dated December 1, 2014, OWCP terminated appellant's wage-loss and medical benefits, effective December 14, 2014.

Thereafter, appellant submitted a November 12, 2014 report from Dr. Berkowitz who advised that appellant continued to have pain in her right hand and wrist. On examination Dr. Berkowitz noted that appellant had good right radial pulse and negative Phalen's and Tinel's signs on the right. He assessed bilateral carpal tunnel syndrome and bilateral ulnar nerve lesion. Dr. Berkowitz opined that appellant was incapacitated and unable to work due to her work injury. He noted that he did not understand why Dr. Cracco strongly suggested that there was nothing wrong with appellant's right upper extremity when he prescribed her medication for right upper extremity pain and listed diagnoses.

In a December 17, 2014 report, Dr. Berkowitz, advised that appellant continued to complain of pain and weakness in the right upper extremity. On examination of the right he noted negative Tinel's and Phalen's and grip strength at 22 pounds. Examination of the left side revealed negative Tinel's and Phalen's, and grip strength at 20 pounds. Dr. Berkowitz opined that appellant was incapacitated and unable to work due to her decreased grip strength and her work-related repetitive motion injury.

Later, in a December 23, 2014 report, Dr. Berkowitz noted the history of appellant's injury. He advised that customary diagnostics were negative, but reiterated that 10 percent of patients with carpal tunnel syndrome do not have positive diagnostics. On examination Dr. Berkowitz noted that appellant had positive Phalen's and Tinel's on the right, weakness, reduced strength, and reduced range of motion. He opined that appellant's condition was not resolved. Dr. Berkowitz also questioned Dr. Cracco's sudden change of opinion in appellant's status and suggested that it was attributed to her request for a second opinion and electing to forego surgery.

On December 23, 2014 appellant requested reconsideration.

In a July 21, 2014 report, Dr. Kristina Lafaye, a Board-certified neurologist, advised that a nerve conduction study of the bilateral median and ulnar nerves was within normal limits. She noted that an EMG also showed no evidence of electrical instability.

By letter dated March 2, 2015, OWCP advised appellant that her claims examiner determined that a second opinion evaluation was necessary.

In a May 8, 2015 letter, appellant inquired about the status of her claim. She noted that her compensation benefits were terminated effective December 14, 2014. She explained that she was inquiring about the status of her claim as she received the March 2, 2015 letter informing her of an OWCP directed medical examination. By letter dated May 15, 2015, OWCP advised appellant that the second opinion examination was scheduled as part of the development of her reconsideration request.

On June 1, 2015 OWCP referred appellant, together with the medical record and a statement of accepted facts, to Dr. Douglas Lurie, Board-certified in orthopedics, for a second opinion regarding appellant's work-related conditions and work status. In his July 2, 2015 report, Dr. Lurie recounted the history of the work injury. Examination of the arms revealed

good muscle tone in both arms, 10 pounds of grip strength on the right, 20 pounds of grip strength on the left, 100 degrees of shoulder flexion, 90 degrees of abduction and internal rotation, normal sweat pattern on hands, calluses on the middle and ring finger, and pain with Tinel's, Phalen's, and Durkan compression test on both sides. Dr. Lurie noted that a nerve study and x-rays of both hands were normal without abnormality. He opined that there was no evidence that appellant had disabling residuals from her accepted conditions. Dr. Lurie reiterated that she had a normal nerve study and noted that it was extremely unlikely that she had carpal tunnel or cubital tunnel in either arm. He noted that appellant had normal sweat patterns, excellent muscle tone, and calluses which indicated that she used her hands. Dr. Lurie further noted that although she had pain with Tinel's, Phalen's, and Durkan compression tests for carpal tunnel, pain was not a typical response as those tests typically produced numbness or tingling. He noted that there was no interosseous atrophy to indicate an ulnar nerve lesion despite appellant's tenderness over the ulnar nerve of both elbows. Dr. Lurie opined that appellant had no disabling residuals and that there was major concern for symptom magnification. He further opined that appellant was capable of returning to full duty and reiterated that there were no objective findings to support an inability to work.

In a July 8, 2015 report, Dr. Berkowitz advised that appellant complained of right hand pain and numbness. On examination he noted positive Tinel's on the right, negative Phalen's on the right, 10 pounds grip strength of the right wrist, negative Tinel's and Phalen's of the left wrist, and 25 pounds of grip strength. Dr. Berkowitz opined that appellant could not work because of her inability to use her hands well which he attributed to work-related repetitive motion injuries.

By decision dated August 7, 2015, OWCP denied modification of its previous decision.

LEGAL PRECEDENT

Once OWCP accepts a claim and pays compensation, it has the burden of proof to justify modification or termination of an employee's benefits. After it has determined that an employee has disability causally related to his or her federal employment, it may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.⁴

ANALYSIS

OWCP accepted that appellant sustained entrapment neuropathy of the elbows, right carpal tunnel syndrome, and bilateral lesion of the ulnar nerve. As of December 14, 2014 it terminated compensation for wage-loss and medical benefits. OWCP found that the weight of the medical evidence was represented by Dr. Cracco, appellant's attending physician of record.

Dr. Cracco, in a September 4, 2014 report, advised that there was no joint tenderness, no swelling, 160 degrees of elbow flexion, elbow extension at 0 degrees, and no thenar atrophy. He indicated that appellant had a normal neurological examination and that she had a normal EMG. Dr. Cracco opined that appellant fully recuperated from the 2001 injury and noted that her

⁴ *Kenneth R. Burrow*, 55 ECAB 157 (2003).

complaints were subjective and not based on any objective finding. He discharged appellant from his care.

OWCP subsequently received a September 11, 2014 report from Dr. Berkowitz. Dr. Berkowitz who acknowledged that an NCV test failed to show carpal tunnel syndrome, but advised that there was ample documentation that 10 percent of people diagnosed with carpal tunnel syndrome have negative NCV studies. He noted that examination of the upper extremity revealed grip strength of 10 pounds on the right, grip strength of 50 pounds on the left, and positive Tinel's and Phalen's sign on the right. Dr. Berkowitz assessed right carpal tunnel syndrome and right ulnar nerve entrapment by history. He noted that both of these conditions were repetitive motion injuries attributable to her federal employment. On October 15, 2014 Dr. Berkowitz noted appellant's complaints of right hand pain and provided diagnoses, but did not address the cause of appellant's diagnoses.

The Board finds that OWCP improperly found that Dr. Cracco represented the weight of the medical evidence at the time that it terminated benefits. There is no indication that Dr. Cracco reviewed appellant's extensive medical record as he did not refer to the case record to show that he had formed his opinion based upon established facts. Furthermore, although Dr. Cracco opined that appellant fully recuperated from the 2001 injury, he did not provide sufficient medical rationale to serve as a basis for terminating appellant's benefits.⁵

The lack of an opinion based on an accurate medical and factual background, coupled with insufficient rationale, should have prompted OWCP to refer appellant for a second opinion examination prior to the termination of benefits. Instead, OWCP terminated appellant's compensation benefits based on Dr. Cracco's opinion without seeking further development. The Board notes that OWCP referred appellant for a second opinion examination after its termination of appellant's compensation benefits. However, this development of the medical evidence should have been conducted prior to the termination of benefits.

Thus, the Board finds that OWCP did not meet its burden of proof in terminating appellant's compensation benefits. As OWCP improperly terminated appellant's compensation, the second issue regarding whether she established continuing disability following the termination is moot.

CONCLUSION

The Board finds that OWCP did not meet its burden of proof to terminate appellant's compensation benefits for her, effective December 14, 2014. In light of the Board's disposition on the first issue, the second issue is moot.

⁵ See *L.P.*, Docket No. 08-1648 (issued August 28, 2009); *Harry T. Mosier*, 49 ECAB 688 (1988).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 7, 2015 is reversed.

Issued: July 11, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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