

FACTUAL HISTORY

OWCP accepted that on April 29, 2010 appellant, then a 41-year-old rural carrier, sustained bilateral carpal tunnel syndrome, enesopathy of the elbow region, and other peripheral enesopathies.² Following intermittent absences, she stopped work on August 16, 2010. OWCP paid wage-loss compensation from October 1 through November 27, 2010 and continuing.³

December 27, 2010 electromyography (EMG) and nerve conduction velocity (NCV) studies demonstrated bilateral carpal tunnel syndrome and mild bilateral cubital tunnel syndrome.⁴ On March 14, 2011 Dr. Ivica Ducic, an attending Board-certified plastic surgeon, performed right ulnar nerve neurolysis at the elbow, right partial medial epicondylectomy, and right endoscopic carpal tunnel release. Appellant received compensation for work absences through January 14, 2012.⁵

Dr. Ducic submitted January 24 and October 3, 2012 reports diagnosing pain and paresthasias of the right arm. He prescribed medication.⁶

Dr. Suneetha Budampati, an attending Board-certified physiatrist, provided June 24 and October 24, 2012 reports diagnosing chronic pain syndrome, carpal tunnel syndrome, and ulnar nerve entrapment of the right upper extremity. She prescribed medication.

Following a rehabilitation effort, appellant accepted a modified-duty assignment on January 22, 2013 and returned to work that day. She stopped work a few hours into her shift. Appellant received emergency room treatment on January 22, 2013 from Dr. Lisa K. Malloy, an attending Board-certified family practitioner, who diagnosed brachial neuritis or radiculitis. A January 22, 2013 venous Doppler study of the right upper extremity was normal. OWCP accepted a recurrence of disability from January 23 to March 24, 2013 due to accepted bilateral carpal tunnel syndrome, enesopathy of the right elbow, and other peripheral enesopathies.

² By decision dated August 3, 2010, OWCP denied appellant's claim for bilateral carpal tunnel syndrome, finding that causal relationship was not established. Appellant requested a review of the written record. By decision dated and finalized November 18, 2010, an OWCP hearing representative reversed OWCP's August 3, 2010 decision and accepted bilateral carpal tunnel syndrome as work related.

³ OWCP initially denied appellant's claims for wage-loss compensation by decision dated October 27, 2011, based on a lack of medical evidence. Appellant requested reconsideration. By decision dated December 28, 2011, OWCP affirmed the October 27, 2011 decision. Appellant requested reconsideration on March 29, 2012. By decision dated November 2, 2012, OWCP vacated the prior decisions and approved appellant's claims for wage-loss compensation.

⁴ In reports from August 16, 2010 to April 11, 2011, Dr. Richard L. Layfield, III, diagnosed a left wrist sprain/strain. Appellant participated in physical therapy from January through September, 2011.

⁵ On October 5, 2011 the employing establishment offered appellant a modified-duty assignment. Appellant refused the offer on October 5, 2011, as it required lifting 10 pounds, whereas her physicians limited her to lifting five pounds. On October 24, 2011 Dr. Ducic opined that the offered position exceeded her physical limitations.

⁶ June 24, 2012 EMG and NCV studies showed bilateral carpal tunnel syndrome, right greater than left, mild left cubital tunnel syndrome, and improvement in right median nerve conduction after decompression.

Dr. Naurang S. Gill, an attending neurologist, held appellant off work from February 6 to March 31, 2013 due bilateral carpal tunnel syndrome and upper extremity neuropathies. He ordered February 11, 2013 EMG and NCV studies, which demonstrated bilateral median nerve entrapment consistent with carpal tunnel syndrome, right greater than left. Dr. Gill released appellant to work as of March 25, 2013. In a March 25, 2013 report, Dr. Christopher G. Scharenbrock, an attending physician Board-certified in emergency medicine, released appellant to light duty as of March 26, 2013. He restricted lifting to five pounds through March 30, 2013.

Appellant stopped work on March 25, 2013 and remained off work through April 8, 2013. The employing establishment noted that she was on full duty as of March 25, 2013. Appellant worked 1 hour and 15 minutes, then stopped work, asserting that she needed to seek emergency room treatment for right hand pain.

Dr. Ashish Shanbhag, an attending Board-certified physiatrist, released appellant to sedentary duty on April 3, 2013. He submitted reports through July 19, 2013 diagnosing complex regional pain syndrome in the median and ulnar nerve distributions, unspecified reflex sympathetic dystrophy, carpal tunnel syndrome, ulnar nerve impairment, and chronic pain syndrome of mixed etiology.

In an April 5, 2013 letter, the employing establishment advised appellant that there was no sedentary work available within her medical restrictions.

In an April 9, 2013 letter, appellant requested that OWCP expand her claim to accept reflex sympathetic dystrophy syndrome/complex regional pain syndrome of the right upper extremity. She presented to a hospital emergency room on April 10, 2013. Nurses' notes indicate that appellant was seen by a pain clinic and that her medications were changed.

On April 24, 2013 appellant claimed a recurrence of disability from March 25 to April 10, 2013 (Form CA-2a). She asserted that after she returned to full-duty work on March 25, 2013 she had a flare-up of right carpal tunnel syndrome, ulnar nerve pain, swelling, and color changes of the right hand. Appellant attributed the flare-up to repetitive hand and arm movements while casing mail and lifting mail containers.⁷ On July 25, 2013 OWCP advised her of the additional evidence needed to establish her claim, including a statement from her physician explaining why the accepted conditions or other work factors would disable her for work for the claimed period. It afforded appellant 30 days to submit such evidence.

June 14, 2013 x-rays, bone scans, and venous testing of the upper extremity were normal. An OWCP medical adviser opined on July 6, 2013 that the test for reflex sympathetic dystrophy syndrome/complex regional pain syndrome was normal.

Appellant submitted an August 12, 2013 statement, explaining that, while on regular duty with a lifting restriction, she had a flare-up of bilateral hand and arm pain. She asserted that repetitive arm motions at work caused nerve damage.

⁷ The employing establishment advised that appellant was offered limited-duty assignments, but she turned them down.

On August 16, 2013 Dr. Malloy provided a history of injury and treatment, noting appellant's complaints of pain and paresthesias in her right hand and arm. She diagnosed unspecified reflex sympathetic dystrophy, carpal tunnel syndrome, ulnar nerve impairment, and chronic pain syndrome of mixed etiology. Dr. Malloy prescribed medication.

By decision dated September 13, 2013, OWCP denied appellant's claim for a recurrence of disability from March 25 to April 10, 2013, finding that the medical evidence of record was insufficient to establish that the accepted conditions disabled her from work on the claimed dates. It further found that she had not established reflex sympathetic dystrophy syndrome or complex regional pain syndrome due to the accepted conditions.

Counsel requested a telephonic hearing, held March 19, 2014. At the hearing, appellant contended that she was disabled for work from March 25 to April 10, 2013 due to a combination of accepted carpal tunnel syndrome and enesopathy, and reflex sympathetic dystrophy syndrome. She asserted that she sustained reflex sympathetic dystrophy syndrome as a consequence of the accepted bilateral conditions. Appellant submitted additional evidence.

Dr. Malloy provided reports from September 26, 2013 to April 17, 2014, diagnosed neuritis, and complex regional pain syndrome in the ulnar and median nerve distributions of the right forearm, with "minimal symptomatology."⁸ In an October 15, 2013 report, Dr. Ducic diagnosed "right arm pain."

In a June 3, 2014 decision, an OWCP hearing representative affirmed the September 13, 2013 decision, finding that the additional medical evidence submitted was insufficiently rationalized to expand the claim to include complex regional pain syndrome/reflex sympathetic dystrophy consequential to the accepted bilateral carpal tunnel syndrome, and upper extremity enesopathies. The hearing representative further found that the medical evidence of record did not establish that disability from work on March 25 and April 10, 2013, either due to the accepted conditions or reflex sympathetic dystrophy.

Counsel requested reconsideration by letter dated July 19, 2014. He submitted additional evidence. Dr. Malloy noted in a September 8, 2014 report that appellant was formally diagnosed with reflex sympathetic dystrophy/complex regional pain syndrome, and required treatment by a neurologist.

Dr. Jason S. Wong, an attending neurologist, provided a July 16, 2014 report relating a history of injury and treatment. He noted appellant's complaints of numbness and paresthesias in the right upper extremity of unknown etiology. Dr. Wong prescribed a transcutaneous electrical stimulation (TENS) unit. Also submitted were occupational therapy notes.

⁸ On February 28, 2014 appellant claimed a schedule award. Counsel obtained an impairment rating from Dr. Stuart J. Goodman, a Board-certified neurologist, who opined on February 24, 2014 that appellant had attained maximum medical improvement. He assessed 18 percent impairment of the right upper extremity according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, based on ulnar and median nerve deficits.

By decision dated October 16, 2014, OWCP denied modification of the June 3, 2014 decision, finding that appellant had not submitted sufficient medical evidence to establish disability for work from March 25 to April 10, 2013 due to consequence of the accepted conditions.⁹

In a September 8, 2015 letter, counsel again requested reconsideration. He submitted March 28 and June 26, 2014 reports from Dr. Wong diagnosing chronic nerve damage of the right arm and holding appellant off work. On January 6, 2015 Dr. Wong opined that complex regional pain syndrome was “the most likely cause” of her right arm symptoms. In a July 11, 2015 report, he diagnosed type 1 complex regional pain syndrome caused by “continuous, repetitive activity using her hands while working for [the employing establishment] for years.” The report contains a preprinted paragraph attributing the diagnosed condition named on the form to the work activities described. Dr. Wong did not provide his own analysis of causal relationship.¹⁰

By decision dated December 3, 2015, OWCP denied modification of the October 16, 2014 decision, finding that appellant had failed to establish a causal relationship between reflex sympathetic dystrophy syndrome and the accepted upper extremity conditions. It further found that she had not submitted sufficient medical evidence to establish disability for work from March 25 to April 10, 2013 due to accepted right upper extremity conditions.

LEGAL PRECEDENT -- ISSUE 1

OWCP’s implementing regulations define a recurrence of disability as “an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition which has resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness.”¹¹ This term also means an inability to work when a light-duty assignment made specifically to accommodate an employee’s physical limitations due to his or her work-related injury or illness is withdrawn (except when such withdrawal occurs for reasons of misconduct, nonperformance of job duties, or a reduction-in-force), or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations.¹²

When an appellant claims a recurrence of disability due to an accepted employment-related injury, he or she has the burden of establishing by the weight of reliable, probative, and substantial evidence that the recurrence of disability is causally related to the original injury. This burden includes the necessity of furnishing evidence from a qualified physician, who, on the basis of a

⁹ In a November 14, 2014 letter, appellant advised OWCP that she began a seasonal retail job at \$9.00 an hour.

¹⁰ Dr. Robert Macht, an attending general surgeon, submitted a January 13, 2015 impairment rating pursuant to appellant’s schedule award claim. He did not diagnose complex regional pain syndrome or address causal relationship.

¹¹ 20 C.F.R. § 10.5(x); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Recurrences*, Chapter 2.1500.2.b (June 2013). See also *Philip L. Barnes*, 55 ECAB 426 (2004).

¹² *Id.* at § 10.5(x).

complete and accurate factual and medical history, concludes that the condition is causally related to the employment injury. Moreover, sound medical reasoning must support the physician's conclusion.¹³ An award of compensation may not be based on surmise, conjecture or speculation or on appellant's unsupported belief of causal relation.¹⁴

ANALYSIS -- ISSUE 1

OWCP accepted that appellant sustained bilateral carpal tunnel syndrome, enesopathy of the right elbow, and other peripheral enesopathies. Appellant was off work from August 16, 2010 through January 14, 2012 and thereafter. Following a brief return to work in January 2013, she remained off work through March 25, 2013, when she returned to full-duty work with a temporary lifting limitation through March 30, 2013. Appellant again stopped work on March 25, 2013 and claimed a recurrence of disability through April 10, 2013. The employing establishment advised that it had made available light-duty work.

Appellant has the burden of providing sufficient evidence, including rationalized medical evidence, to establish the causal relationship asserted between the accepted right upper extremity conditions, and a spontaneous worsening of her condition as claimed.¹⁵ However, she attributed a flare-up of right arm and hand symptoms to casing mail and lifting containers of mail at work on March 25, 2013. Appellant thus identified an intervening cause, breaking the chain of causation from the original injury.¹⁶ This effectively negates her claim for a recurrence of disability.

Additionally, appellant's physicians did not opine that she was disabled from work for the claimed period. Dr. Gill, an attending neurologist, released appellant to work as of March 25, 2013. Dr. Scharenbrock, an attending physician Board-certified in emergency medicine, found appellant able to work as of March 26, 2013. Dr. Shanbhag found appellant able to perform sedentary duty as of April 3, 2015, but did not explain the reasoning behind this limitation.

OWCP advised appellant in a July 25, 2013 letter of the type of evidence needed to establish her claim for a recurrence of disability. As appellant did not submit such evidence, it properly issued its December 3, 2015 decision denying her recurrence claim.

On appeal counsel asserts that OWCP's December 3, 2015 decision was not rationalized and did not explain how the decision was reached. He contends that it appears that OWCP did not consider any evidence appellant submitted. As set forth above, appellant did not submit

¹³ *Ricky S. Storms*, 52 ECAB 349 (2001).

¹⁴ *Alfredo Rodriguez*, 47 ECAB 437 (1996).

¹⁵ *Supra* note 13.

¹⁶ *See Carlos A. Marrero*, 50 ECAB 117 (1998) (the Board found that the claimant's use of an exercise machine constituted an intervening cause of appellant's disability and thus OWCP properly denied appellant's claim for recurrence of disability); *Clement Jay After Buffalo*, 45 ECAB 707 (1994) (the Board found that the claimant's knee injury sustained while playing basketball broke the legal chain of causation from an accepted knee injury sustained in the performance of his duties as a firefighter).

sufficient rationalized medical evidence to establish that she was disabled for work from March 25 to April 10, 2013.

LEGAL PRECEDENT -- ISSUE 2

It is an accepted principle of workers' compensation law that when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause which is attributable to the employee's own intentional conduct. The Board has held that, once the work-connected character of any injury has been established, the subsequent progression of that condition remains compensable so long as the worsening is not shown to have been produced by an independent nonindustrial cause and so long as it is clear that the real operative factor is the progression of the compensable injury, associated with an exertion that in itself would not be unreasonable under the circumstances.¹⁷

A claimant bears the burden of proof to establish a claim for a consequential injury. As part of this burden, he or she must present rationalized medical opinion evidence, based on a complete factual and medical background, showing causal relationship. Rationalized medical evidence is evidence which relates a work incident or factors of employment to a claimant's condition, with stated reasons of a physician. The opinion must be one of reasonable medical certainty and must be supported by medical reasoning explaining the nature of the relationship of the diagnosed condition and the specific employment factors or employment injury.¹⁸

ANALYSIS -- ISSUE 2

Appellant claimed that she sustained reflex sympathetic dystrophy syndrome/complex regional pain syndrome of the right upper extremity, consequential to carpal tunnel syndrome and entropathies. OWCP denied the claim, finding that the medical evidence did not contain sufficient rationale supporting a causal relationship between work factors and the claimed condition.

In support of her claim, appellant provided reports dated from April to July 2013 from Dr. Shanbhag, an attending Board-certified physiatrist, who diagnosed complex regional pain syndrome of the right upper extremity. However, he did not address whether the accepted conditions or other work factors caused the claimed condition. Therefore, Dr. Shanbhag's opinion is insufficient to meet appellant's burden of proof.¹⁹

Dr. Malloy, an attending Board-certified family practitioner, initially diagnosed brachial neuritis on January 22, 2013, then changed her diagnosis to reflex sympathetic dystrophy from

¹⁷ *Clement Jay After Buffalo, id.*

¹⁸ *Charles W. Downey, 54 ECAB 421 (2003).*

¹⁹ *Deborah L. Beatty, 54 ECAB 340 (2003).*

August 16, 2013 through September 8, 2014. The equivocal aspect of this opinion diminishes its probative quality.²⁰

Dr. Wong, an attending neurologist, opined on January 6, 2015 that complex regional pain syndrome was the “most likely cause” of appellant’s right arm pain and paresthesias. He opined on July 11, 2015 that repetitive upper extremity motions at work caused complex regional pain syndrome. Dr. Wong’s report contains a preprinted paragraph attributing the claimed condition to work factors. However, he did not offer an independent explanation supporting causal relationship. In the absence of such rationale, Dr. Wong’s report is insufficient to meet appellant’s burden of proof.²¹

The Board finds that appellant has not submitted sufficient rationalized medical evidence supporting causal relationship between the claimed complex regional pain syndrome/reflex sympathetic dystrophy and the accepted bilateral carpal tunnel syndrome or upper extremity enesopathies. OWCP’s December 3, 2015 decision denying the claim is therefore proper under the law and facts of this case.

On appeal, counsel asserts that OWCP’s December 3, 2015 decision was not rationalized and did not explain how the decision was reached. He contends that it appears that OWCP did not consider any evidence appellant submitted. As set forth above, the Board found that appellant failed to submit sufficient rationalized medical evidence to establish a causal relationship between the claimed complex regional pain syndrome and the accepted conditions.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish a recurrence of disability from March 25 to April 10, 2013 due to accepted right upper extremity conditions. The Board further finds that she has not met her burden of proof to establish reflex sympathetic dystrophy syndrome or complex regional pain syndrome of the right upper extremity, consequential to accepted upper extremity conditions.

²⁰ *D.D.*, 57 ECAB 734 (2006).

²¹ *Supra* note 19.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated December 3, 2015 is affirmed.

Issued: July 5, 2016
Washington, DC

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

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board