U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of CHRISTIAN S. ROWINS and DEPARTMENT OF THE AIR FORCE, HILL AIR FORCE BASE, UT

Docket No. 99-1940; Submitted on the Record;
Issued June 15, 2000

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
MICHAEL E. GROOM

The issues are: (1) whether the Office of Workers' Compensation Programs met its burden of proof to terminate appellant's compensation benefits effective September 13, 1996; and (2) whether appellant has met his burden of proof to establish that he is entitled to continuing compensation benefits on or after September 13, 1996.

The Board has reviewed the case record and finds that the Office met its burden of proof in terminating appellant's compensation effective September 13, 1996.

Once the Office accepts a claim, it has the burden of proving that the employee's disability has ceased or lessened before it may terminate or modify compensation benefits.[1] After it has determined that an employee has disability causally related to his or her federal employment, the Office may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.[2] To discharge its burden of proof, it is not sufficient for the Office to simply produce a physician's opinion negating causal relationship. As with the case where the burden of proof is upon a claimant, the Office must support its position on causal relationship with a physician's opinion which is based upon a proper factual and medical background and which is supported by medical rationale explaining why there no longer is, or never was, a causal relationship.[3] In assessing medical evidence, the number of physicians supporting one position or another is not controlling; the weight of such evidence is determined by its reliability, its probative value and its convincing quality. The factors that comprise the evaluation of medical evidence include the opportunity for and the

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[1] *Karen L. Mayewski*, 45 ECAB 219, 221 (1993); *Bettye F. Wade*, 37 ECAB 556, 565 (1986); *Ella M. Garner*, 36 ECAB 238, 241 (1984).

[2] *Jason C. Armstrong*, 40 ECAB 907 (1989).

[3] *Frank J. Mela*, 41 ECAB 115, 125 (1989).

thoroughness of, physical examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[4]

On February 9, 1994 appellant, then a 36-year-old electrical engineer, filed a claim alleging that he had radial nerve entrapment in his right arm due to overcompensation of his right arm after an earlier injury in August 1992 to his left arm. He alleged that he first realized his condition was caused or aggravated by his employment on February 4, 1994. The Office accepted the claim for a right elbow strain and paid appropriate benefits. Review of the file indicates that the Office paid bills for medical treatment of a right elbow ulnar lesion, right radial nerve lesion, tendintitis on the right and right elbow myositis. Appellant did not experience a work stoppage since reporting his condition February 4, 1994. On April 3, 1996 the Office issued a notice proposing to terminate appellant's medical and compensation benefits and by decision dated September 13, 1996 terminated benefits effective the same day, finding that the weight of the medical evidence rested with the opinion of Dr. Nathaniel M. Nord, a Board-certified neurologist and an Office referral physician, that appellant did not have any continuing work-related medical condition of the right upper extremity.

With respect to the Office's decision to terminate appellant's benefits effective September 13, 1996, the Board notes that, while the medical evidence supports that appellant has continuing subjective complaints to his right upper extremity, there was no objective medical evidence to support a medically diagnosable condition. In his March 19, 1994 report, Dr. Dennis D. Thoen, a Board-certified neurologist, noted that appellant had signs of irritability of the neurovascular bundle on both sides, but could not find any atrophy, focal weakness or sensory loss. In a January 18, 1994 report, Dr. John M. Provost, a Board-certified orthopedist, diagnosed tendinitis of appellant's right elbow (triceps tendon) due to an overuse of the right upper extremity since appellant's injury of his left elbow at work in August 1992, but failed to describe any objective findings on physical examination or provide objective evidence to support his diagnosis. In his February 7, 1994 medical report, Dr. Provost diagnosed radial nerve entrapment, but noted that the x-rays showed no significant findings. A March 17, 1994 nerve conduction study and electromyogram (EMG) showed no electrodiagnostic evidence of compressive neuropathy to account for appellant's clinical symptoms. In an undated report, Dr. William F. Brandt, a Board-certified physiatrist, diagnosed neurovascular bundle irritation at the elbow and a repetitive motion syndrome of both upper extremities, but provided no objective evidence to support his diagnosis. In his August 23, 1995 letter, Dr. Brandt continued to diagnose appellant with a repetitive motion disorder with myofascial symptoms secondary to his work as an electrical engineer and also diagnosed a resultant sleep deficit. He stated, however, that the numerous nerve conduction studies and EMG studies revealed no specific evidence of focal nerve entrapment in the upper extremities. No medical explanation was provided to support his recommendation that appellant's pain management program continue. In a February 1, 1996 report, Dr. Bradley R. Melville, a Board-certified physiatrist, diagnosed bilateral tenderness in the ulnar grove presumably due to repetitive motions/trauma and some right shoulder discomfort. The physical examination revealed a normal range of motion of both upper extremities including the shoulders. Although a focal tenderness in the ulnar groove

[4] *Connie Johns*, 44 ECAB 560, 570 (1993).

region bilaterally was noted, there was no subluxation of the ulnar nerve with repetitive flexion and extension. Discomfort was noted in the right shoulder region in the posterior axillary folder. In his April 24, 1996 medical report, Dr. Melville diagnosed appellant with bilateral upper extremity discomfort due to neurovascular bundle irritation at both elbows and repetitive motion syndrome of both upper extremities. He noted that appellant had extensive testing, including electrodiagnostic studies and a rheumatologic work up which was negative. Although Dr. Melville opined that appellant had significant symptoms and limitations of upper extremity function due to the above diagnoses, he did not provide any objective evidence to support his medical diagnoses or provide any medical rationale for his opinion that it would be inappropriate to close appellant's case with the assumption that there were no continuing residuals.

Alternatively, Dr. Nord's November 17, 1995 report has the reliability, probative value and convincing quality with respect to the issue of whether appellant has any residuals from his accepted right elbow strain and provides a proper basis for the Office's termination of appellant's compensation benefits and continuing medical treatments. In his November 17, 1995 report, Dr. Nord, the second opinion physician, stated that he found no objective evidence to support the conditions previously accepted by the Office, including appellant's claim that routine, daily living activities involving the right upper extremity resulted in a definable clinical syndrome. Dr. Nord found no evidence from the history provided, appellant's symptoms or the physical examination which indicated that appellant's right upper extremity symptoms occurred on the basis of neurologic or vascular dysfunction. He further stated that he could not define a pathogenic mechanism for the origination of appellant's right upper extremity symptoms and specifically disagreed with a diagnosis of neurovascular bundle irritation syndrome and that appellant had a repetitive use syndrome. Dr. Nord also concluded that he failed to see the requirement for continued physical therapy or the recommended psychological counseling. He had reviewed all the medical evidence in appellant's file and had the relevant objective testing of appellant's right upper extremity. Dr. Nord also had the benefit of an accurate and up-to-date statement of accepted facts, provided a thorough factual and medical history and accurately summarized the relevant medical evidence.

Thus, based on the evidence before the Office at the time of the September 13, 1996 decision terminating benefits was rendered, the Office's termination of appellant's compensation benefits and medical treatment was proper.

Subsequent to the termination of benefits, appellant requested reconsideration and in decisions dated February 24, 1998 and March 17, 1999, the Office denied modification of its previous decision.

As the Office met its burden of proof to terminate appellant's compensation benefits, the burden shifts to appellant to establish that he has a disability causally related to his accepted employment injury.[5] To establish a causal relationship between the condition, as well as any disability claimed and the employment injury, the employee must submit rationalized medical opinion evidence, based on a complete factual background, supporting such a causal relationship. Rationalized medical opinion evidence is medical evidence which includes a

[5] *George Servetas*, 43 ECAB 424, 430 (1992).

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. The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.[6]

In a February 12, 1997 report, Dr. Melville stated that appellant has carried the diagnosis of bilateral "neurovascular bundle irritation syndrome," more commonly referred to as thoracic outlet syndrome, and a triceps tendinitis bilaterally. He noted that appellant was sent to an occupational therapist to obtain objective evidence of an ongoing pathology. Dr. Melville stated that the study revealed that only muscles in the arm with a muscle grade below three were both triceps and on the left, some muscles about the elbow. He stated that this was consistent with the ongoing clinical diagnosis of a triceps tendinitis. The study also revealed weakness in an ulnar distribution of the intrinsic hand muscles, but no other hand muscles. Dr. Melville stated that this was consistent with a thoracic outlet syndrome bilaterally. He noted that sensory measurements were noncontributory. Dr. Melville opined that appellant's complaints have persistently been consistent with a bilateral triceps tendinitis and thoracic outlet syndrome (or neurovascular bundle irritation syndrome) and the measurements from the testing supported those diagnoses. Dr. Melville stated that the symptoms on the left side were a continuation of his work injury when he struck his left elbow against an object and that the symptoms on the right side developed due to over compensation of the right arm.

The Office directed appellant for a second opinion examination with Dr. Gary Jay, a neurologist. In a July 23, 1997 report, Dr. Jay obtained the history from appellant as well as from past medical records. After setting forth his examination findings, Dr. Jay found there was no sign of radicular pain nor of nerve entrapment, with the exception of a positive Tinel's test in the left upper extremity. He noted, however, that that had nothing to do with the questions he had been asked to evaluate. Dr. Jay stated that appellant has chronic cervical myofascial pain syndrome, left more so than right, associated with significant bilateral myogenic thoracic outlet syndromes. He noted that there was no evidence of radiculopathy, as sensation, motor, including strength and reflexes were within normal limits and symmetric bilaterally in the upper extremities. However, the history of numbness in the upper extremities when appellant carries heavy books or does repetitive motion was compatible with the diagnosis of throacic outlet syndrome. Dr. Jay noted that appellant has had numerous EMG's and nerve conduction velocities, revealing no specific evidence of focal nerve entrapment in the upper extremities. In addressing the Office's specific questions, Dr. Jay stated that, if the February 9, 1994 injury was identified as radial nerve entrapment and that alone, appellant does not have any evidence of residuals from that problem. Furthermore, the history of multiple EMG/nerve conduction studies are not positive for radial nerve deficits. The examination revealed no radial nerve deficit. Dr. Jay stated, however, that appellant does has a significant cervical myofascial pain syndrome associated with a significant myogenic thoracic outlet syndromes. He stated that the question

[6] *James Mack*, 43 ECAB 321 (1991).

which needs to be addressed is whether or not this diagnosis (which was mentioned at least once in review of the medical records) was present all along and missed. If that was the case, Dr. Jay opined that appellant may have had an injury of February 9, 1994 which was misdiagnosed as a radial nerve entrapment syndrome. He noted that diagnostic testing performed on March 17, 1994 for thoracic outlet syndromes or other compressive neuropathies was normal. Dr. Jay noted that Dr. Thoen noted no atrophy, focal weakness or sensory loss, but signs of irritability of the "neurovascular bundle on both sides." Dr. Jay stated that if this was indeed his description of or a name for myogenic thoracic outlet syndrome, then appellant's current diagnosis would extend back to 1994. He further noted that Dr. Kimball, in a May 18, 1994 report, noted a medical diagnosis by Dr. Brandt of "neurovascular bundle irritation at the elbow" and repetitive syndromes in both upper extremities. Dr. Jay stated that a myogenic thoracic outlet syndrome, which can be intermittent in terms of the degree, may not be positive on an EMG or nerve conduction velocity. Also, the records did not show any indication of a myogenic thoracic outlet syndrome being looked or, nor does the "neurovascular bundle irritation at the elbow" make sense in terms of a diagnosis for appellant. Accordingly, Dr. Jay opined that appellant did not have thorough treatment for a myogenic thoracic outlet syndrome, or if that is actually what was meant by the initial diagnosis of "neurovascular bundle irritation syndrome bilaterally" made in February 1994, then appellant continues to suffer residuals for the February 9, 1994 injury, but the injury in question is not radial nerve entrapment, but indeed myogenic thoracic outlet syndrome. Dr. Jay diagnosed cervical myofascitis and thoracic outlet syndrome, nondiscogenic and myogenic in nature and advised that appropriate treatment would include appropriate physical therapy and trigger point injections.

Upon receipt of Dr. Jay's July 23, 1997 report, the Office, in a letter dated August 13, 1997, referred the report to an Office medical adviser for interpretation. In an August 14, 1997 report, the Office medical adviser stated that in his opinion Dr. Jay was saying that the original diagnoses were incorrect, but it seemed to him that the alternative diagnoses suggested were quite subjective and speculative.

Upon receipt of the Office medical adviser's opinion, the Office refused to accept Dr. Jay's report as valid and referred appellant to Dr. Robert M. Miska, a Board-certified neurologist, for a second opinion evaluation along with an updated statement of accepted facts and set of questions to be resolved. In a December 12, 1997 report, Dr. Miska reviewed the medical evidence of file and noted that subsequent record review, historical analysis and clinical examination of several sorts by many doctors, failed to achieve a consistent diagnostic formulation of appellant's problem. He noted that findings of his clinical examination were relatively normal and that the nerve conduction and needle examination data were also within the normal range. Dr. Miska stated that appellant's normal electrodiagnostic study of the right upper limb demonstrated no evidence of potential brachial plexus injury, brachial mononeuropathy or brachial multiple mononeuropathy, or a cervical radiculopathy. He noted that normal results on the tests of this sort do not support or refute pain complaints. The ulnar nerve motor conduction study also fell within the normal range. Dr. Miska further noted that the clinical examination failed to demonstrate any neurologic abnormality. He stated that appellant's examination results and electrodiagnostic test results allow confident assertions about the integrity and continuity of motor and sensory fibers subserving right upper limb function and opined that there was no evidence of active or chronic nerve injury to the upper limb.

By letter dated January 14, 1998, the Office enclosed a copy of Dr. Miska's December 12, 1997 report to Dr. Melville and asked for comments. In a February 4, 1998 response, Dr. Melville stated that he did not disagree with Dr. Miska's report. He noted, however, that appellant had multiple somatic complaints over the two years he had been treating him and the complaints were not easily classified into a specific diagnosis. Dr. Melville stated that a case could be made for a number of different diagnoses which could be a myogenic, nonneurogenic thoracic outlet syndrome, as well as tricepts tendinitis, lateral epicondylitiis in the right arm, triceps tendinitis and extensor indicis proprius tendinitis in the left arm.

By letter dated February 2, 1998, the Office referred Dr. Melville's February 4, 1998 letter to an Office medical adviser for clarification. In a February 12, 1998 letter, the Office medical adviser opined that Dr. Miska demonstrated that there was no objective evidence by neurological examination or by electrical studies to support residuals of February 9, 1994 injury. Specifically, there was no evidence of cervical root disorder, no evidence of peripheral nerve disorder in arm and no evidence of reflex sympathetic dystrophy (RSD). The Office medical adviser noted that Dr. Melville agreed with Dr. Miska, but mentioned five "diagnoses" which are speculative and based on subjective patient complaints for which nothing is proven.

In a September 3, 1998 medical report, Dr. Melville advised that appellant requested that he mention the normal electrodiagnostic studies which were performed by Dr. Miska. He stated that it was his experience that patients sometimes have symptoms of numbness or tingling or discomfort in a classic distribution of an ulnar neuropathy or a thoracic outlet syndrome with normal electrodiagnostic studies. Dr. Melville stated that a certain threshold of abnormality needs to be reached for the electrodiagnostic studies to be abnormal. He stated that sometimes patients develop symptoms prior to the onset of abnormalities and that this may be the case with appellant.

In a January 14, 1999 report, Dr. Donald B. Doty, a Board-certified thoracic surgeon, advised that the question was whether or not appellant has thoracic outlet compression syndrome. Dr. Doty advised that appellant's symptoms strongly suggested evidence of the syndrome and there was a positive Allen test bilaterally. He noted that the right arm appeared to be a bit worse than the left and that appellant had responded well to physical therapy. Dr. Doty opined that the diagnosis of thoracic outlet compression syndrome fit appellant's signs and symptoms as he responded to physical therapy. He recommended that physical therapy be continued as he still has some residual symptoms even though he has improved.

The Board finds that appellant has not established any continuing disability or residuals after September 13, 1996 causally related to his accepted employment injury.

Although Dr. Jay opined in his July 23, 1997 report that appellant had chronic cervical myofascial pain syndrome associated with significant bilateral myogenic thoracic outlet syndromes causally related to the February 4, 1994 injury, his opinion is speculative and poorly rationalized. Although Dr. Jay attempts to distinguish the initial diagnosis of radial nerve entrapment syndrome and myogenic thoracic outlet syndrome, his opinion that these diagnoses are equivalent is speculative and not well rationalized given the lack of objective evidence to support his diagnosis. Moreover, Dr. Jay does not clearly explain how the negative objective evidence supports the diagnosis of myogenic thoracic outlet syndrome but not a radial nerve

entrapment diagnosis. Likewise, in his January 14, 1999 report, Dr. Doty's opinion that appellant's symptoms are suggestive of thoracic outlet syndrome is also speculative as the only rationale for the diagnosis was that appellant responds to physical therapy. Although Dr. Doty advised that appellant had a positive Allen's test, he failed to provide an explanation why this test was significant in light of the fact that appellant had normal electrical tests. Accordingly, the reports from Drs. Jay and Doty are insufficient to create a conflict or overcome the weight of the medical evidence as represented by Dr. Nash.

Dr. Miska's report is fully supportive of Dr. Nash's opinion that appellant has no residuals from his accepted condition. He opined that there was no objective evidence by neurological examination or by electrical studies to support any residuals of the February 9, 1994 injury. Dr. Miska found no evidence of cervical root disorder, no evidence of peripheral nerve disorder in the arm, and no evidence of reflex sympathetic dystrophy. His opinion is well rationalized as to his stated conclusions.

Although Dr. Melville opined in his February 12, 1997 report that appellant had bilateral "neurovascular bundle irritation syndrome," or thoracic outlet syndrome and a triceps tendinitis bilaterally and supported these diagnoses with objective evidence taken from appellant's December 3, 1996 testing, he stated in a February 4, 1998 report that he was in agreement with Dr. Miska's conclusions that there was no objective evidence to support any residuals of the February 1994 injury. Inasmuch as Dr. Miska specifically found that the ulnar nerve motor conduction study was within the normal range and his conclusion mirrors Dr. Nash's conclusion that appellant does not have any residuals from his accepted condition, the Board finds Dr. Melville's opinion to be of limited probative value. Furthermore, Dr. Melville's rationale that appellant might have developed symptoms prior to the onset of abnormalities to show up on electrodiagnostic studies is a speculative statement based upon subjective complaints. Thus, Dr. Melville's opinion is insufficient to create a conflict or to overcome the weight of the medical evidence as represented by Dr. Nash.

The decisions of the Office of Workers' Compensation Programs dated March 17, 1999 and February 24, 1998 are hereby affirmed.

Dated, Washington, D.C.
June 15, 2000

David S. Gerson
Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member