U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ALTON H. TREASE, JR. and U.S. POSTAL SERVICE,
ROBERTSVILLE STATION, San Jose, CA

Docket No. 00-838; Submitted on the Record;
Issued November 9, 2001

DECISION and ORDER

Before WILLIE T.C. THOMAS, BRADLEY T. KNOTT,
A. PETER KANJORSKI

The issue is whether appellant's right carpal tunnel syndrome or psychiatric condition is causally related to his November 10, 1987 employment injury.

On November 10, 1987 appellant, then a 34-year-old mailhandler, filed an occupational disease claim asserting that he had developed bilateral ulnar neuritis while in the performance of his duties. The Office of Workers' Compensation Programs accepted his claim for bilateral ulnar nerve irritation and bilateral elbow tendinitis. Appellant received compensation for periods of temporary total disability and a schedule award for permanent impairment to both upper extremities. He took disability retirement on September 25, 1990.

On February 28, 1990 appellant advised that he was experiencing a lot of depression because he had no control over his future or his medical condition. On May 22, 1990 he was seen at the employing establishment mental hygiene clinic complaining of depression, sleeping difficulties, crying spells and auditory hallucinations. Appellant was diagnosed with schizophrenia, chronic, undifferentiated, in partial remission and reactive depression secondary to job stress. On June 6, 1990 appellant filed an occupational disease claim asserting that his stress and depression were a result of his federal employment.

On March 22, 1990 Dr. Howard Belfer, a Board-certified neurologist, reported that nerve conduction studies were unremarkable. Right medial distal motor latency was slightly prolonged compared to the left but was within normal limits. In absolute terms sensory conduction was within normal limits. An electromyogram (EMG) failed to reveal any acute or chronic denervation changes. Dr. Belfer reported the following impression: "This EMG/nerve conduction study of both arms is considered to be unremarkable and without evidence of carpal tunnel syndrome or ulnar nerve entrapment."

On October 10, 1992 Dr. Victoria Pickering Edelstein, appellant's attending psychiatrist, reported that appellant's depression and the physical pain in his arms and shoulders were intimately connected: "Virtually all of his world is wrapped up in his experience of pain. He continues to deteriorate in terms of his ability to deal with day-to-day living issues such as family

life, sense of future and self-respect. His sleep patterns evidence interference as a result of the physical pain; his tolerance levels are markedly effected by his physical pain."

On March 1993 an Office medical adviser reported: "This claimant has had considerable difficulty dealing psychologically with his chronic bilateral elbow pain over the past several years. He has had considerable conservative care including steroid injections and restriction of his activities without significant or lasting improvement. Recommend authorization for the prescribed St. Helena Pain Management Program."

On April 13, 1993 Dr. Gary K. Mills, director of the pain rehabilitation program, diagnosed developing major depression, recurrent, secondary to chronic pain syndrome; history of post-traumatic stress disorder, secondary to military service; history of probable underlying thought disorder (atypical psychosis?); and history of bilateral, lateral humeral epicondylitis and ulnar neuritis with pain.

On June 29, 1993 Dr. Gregory A. Kersulis, a neurologist, reported that nerve conduction studies were consistent with mild right-sided carpal tunnel syndrome as well as mild right-sided cubital tunnel syndrome. Appellant's attending physician, Dr. Richard H. Jacobsen, an orthopedic surgeon, began reporting symptoms of right carpal tunnel syndrome in February 1994. On October 21, 1994 he reported: "In the past, [appellant] has been seen and evaluated on numerous occasions for ulnar neuritis and more recently he has had symptoms of carpal tunnel syndrome." Dr. Jacobsen requested authorization for a carpal tunnel release. On March 7, 1996 an Office medical adviser reported that there was electrodiagnostic evidence of carpal tunnel syndrome but noted that the relationship of this condition to the accepted employment injury was not well explained, as appellant had not worked since 1990.

On March 23, 1995 Dr. Edelstein reported that the interruption of appellant's physical therapy had resulted in a marked negative shift in his psychological functions, specifically his level of depression. She also reported that appellant's ability to tolerate and manage his physical pain was exhausting and debilitating. On November 8, 1995 Dr. Edelstein reported her concern about appellant's failure to progress: "He has reached an impasse of sorts with my practice due to the termination of physical therapy. As his chronic pain worsens in his upper extremities, his mood disorder deepens (DSM IV 293.83 with mixed features); furthermore, his weight gain due to inactivity and lack of therapy aggravates his knee conditions, blood pressure and stomach condition."

The Office referred appellant, together with the medical record and a statement of accepted facts, to Dr. Pramila R. Gupta, a Board-certified neurologist, Dr. Larry N. Magnussen, a Board-certified orthopedic surgeon, and Dr. Paul D. Michaels, a Board-certified psychiatrist, for a second opinion.

In a report dated May 23, 1996, Dr. Gupta related appellant's history and complaints and her findings on physical examination and neurologic evaluation. She reviewed appellant's medical record, including the electrodiagnostic reports of March 22, 1990 and June 29, 1993. Dr. Gupta reported that bilateral median nerve conduction studies revealed mild prolongation of

the distal latency of the mixed action potential indicative of mild carpal tunnel syndrome bilaterally. On the issue of causal relationship, she reported:

> "The patient's diagnosis of tendinitis and ulnar neuritis are due to cumulative trauma secondary to work activities requiring repetitive lifting. The patient's bilateral carpal tunnel syndrome could be caused by the repetitive lifting, but the patient's symptoms did not become evident until at least 1994 when the patient had been already off from the work for the last two or three years. Hence, I do not feel that the patient's carpal tunnel syndrome is caused or aggravated by the work activities."

Dr. Gupta found that appellant's bilateral carpal tunnel syndrome was of a mild magnitude and did not recommend surgical intervention.

In a report dated May 20, 1996, Dr. Magnussen related appellant's history and complaints and his findings on physical examination. He reviewed appellant's medical record, including the electrodiagnostic studies of March 22, 1990 and June 29, 1993. Dr. Magnussen's diagnosis included bilateral carpal tunnel syndrome, right more than left. On the issue of causal relationship, he reported:

> "The ulnar neuritis and elbow tendinitis are directly connected to the repetitive activities of his job. This is well documented, and he continues to have the same symptomatology that he was experiencing while he was working. As far as the carpal tunnel problem is concerned, this is a bit more obscure. According to his verbal history, as given on my evaluation, he repetitively indicates a painful condition of the right hand with stiffness. This is no doubt a form of tendinitis, but no where in the medical records is shown the typical symptoms of carpal tunnel syndrome, either by physical examination or by inference to history. However, based on the activity as described in his job description, and because of the demonstration of the onset of ulnar neuritis and tendinitis, also entrapment syndromes due to overuse, it is probable that there was irritation of the carpal tunnel area to some degree. It is also noted that he has engaged in physical therapy with the use of the hands and I believe that it is probable that the factors of his prior work, present activities of daily living and his physical therapy activities have ultimately produced the diagnosis of right carpal tunnel syndrome. It would, therefore, be reasonable to say that his employment with the [employing establishment] did accelerate the onset of this problem by producing significant contribution."

The Office requested that Dr. Magnusssen provide clarification in light of Dr. Gupta's opinion. In a supplemental report dated October 4, 1996, Dr. Magnussen stated:

> "I have reread my report, as well as Dr. Gupta's report, and historically, there is no specific evidence of numbness and tingling or diminished sensation or weakness nerve weakness (sic) during the time the patient was employed. Provocative testing of Phalen's test was also negative. Ulnar dysesthesias were noted. Evidence of carpal tunnel did not present itself until about 1994.

> "On further reflection, I cannot say with medically (sic) certainty that the patient's right carpal tunnel condition was caused by his employment. Because of his overall injury being that of 'overuse,' there is a high likelihood that there was some contribution from his wrist pain and tendinitis, compromising the carpal tunnel. This is based on a lack of history of other inciting factors after he left the [employing establishment]. Thus, although there is not a medical certainty, there are indications of overuse with bilateral hand and wrist pain, but up to the time that he left, the diagnosis of carpal tunnel syndrome was not a medical certainty."

In a report dated June 25, 1996, Dr. Michaels related appellant's history and complaints and reviewed appellant's medical records. He described his findings on psychological testing and mental status examination. Dr. Michaels gave a principal diagnosis of depressive disorder, not otherwise specified, history of schizophrenia (not confirmed) and history of post-traumatic stress disorder (not confirmed). On the issue of causal relationship he stated:

> "In my professional opinion, this patient's condition of depressive disorder, NOS, does not appear to be logically connected by direct causation, aggravation, acceleration or precipitation to the factors of employment as described in the statement of accepted facts. There is no evidence in the history as presented by the patient that he developed any type of symptoms of depression around the time that he developed his physical disability while working for the [employing establishment]. This patient's symptoms of depression appear to have developed more recently, in 1995, with reference to his alleged difficulties gaining access to adequate medical care."
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> "This patient's diagnosis of depressive disorder, NOS, appears to be intimately related to the resolution of his treatment-related conflicts with the Department of Labor. If the patient receives satisfactory access to medical care, in all likelihood, his alleged symptoms of depression will subside."

In a decision dated January 15, 1997, the Office denied compensation for carpal tunnel syndrome or any psychiatric condition on the grounds that the medical evidence failed to establish a causal relationship to accepted employment injury.

On March 3, 1998 Dr. Gary J. Rowe, a neurologist, reported that appellant had asked him to review his electrodiagnostic studies. Dr. Rowe reported:

> "In any case, I reviewed his nerve conduction studies and some of the tabulation data is a bit ambiguous, but the best I can determine is that this man has had borderline slightly prolonged median nerve motor latencies in his right hand on all three determinations in 1990 through 1996. They are consistent from that one time to another and I would say would all be interpreted the same way. In my laboratory, those latencies would be considered slightly prolonged and indicative of carpal tunnel syndrome on the right. They were indicative of that in 1990 and they remain so in 1996, albeit mildly prolonged but never the less, prolonged. I also explained to [appellant] that in some laboratories, these latencies would be considered at the absolute upper limits of normal so that different laboratories

have different standards of normal and abnormal. In any case, however, [appellant's] findings are consistent from 1990 through 1996 and would all bear, I believe, the same interpretation regardless of laboratory variations and interpretation."

In a decision dated, August 27, 1998, an Office hearing representative affirmed the denial of compensation for carpal tunnel syndrome and any psychiatric condition. The hearing representative noted that Dr. Edelstein, who testified at the June 23, 1998 hearing, expressed her disagreement with Dr. Michaels' conclusion.

On January 22, 1999 Dr. Belfer, who obtained appellant's first electrodiagnostic study on or about March 22, 1990, reported that appellant had presented for a second opinion about his arm pain, possible carpal tunnel syndrome, ulnar neuritis and tendinitis. He stated:

"These symptoms date back at least to 1987, when he had difficulty picking up things, noted aching and numbness, particularly in the fourth finger, and then spreading to the other digits. His hands significantly would go numb if he was holding a steering wheel. He has recently noted that it is sometimes hard to sleep. He gets aching in his forearms, both anterior and posterior aspects, but does not have true weakness or neck pain. He has had three EMGs in 1990, 1993 and 1996. He has been wearing a wrist splint for at least five years, and it does help him to sleep. The past history does not reveal anything of significance to contribute to neuritis or neuropathy. He has tried anti-inflammatory agents, but they have given him significant GI upset."

* * *

"I reviewed the nerve conduction studies, and they do show a mild right-sided carpal tunnel syndrome, present since 1990. The parameters do appear to be getting slowly worse with each succeeding test. The left median nerve, by these three tests, appears to me normal. There is mention of a possible right-sided cubital tunnel syndrome from the 1993 study, and the numbers do bear this out. However, this does not appear to be present on the 1996 study."

On July 21, 1999 Dr. Edelstein reported as follows:

"I have reviewed the report from the O[ffice] Hearing written by Ms. Woods. Her report misstates some facts involving my testimony.

"At no time did I agree with Dr. Michaels' evaluation of [appellant] or Dr. Michaels' recommendation regarding [appellant's] treatment. On the contrary, I stand by my statement to Dr. Jacobsen on August 19, 1997, which he refers to in his letter to you dated June 15, 1999. I have attached correspondence to Dr. Jacobsen from me dated August 19, 1997 that explains in detail what transpired in my presence between Dr. Michaels and [appellant]."[1]

[1] The August 19, 1997 correspondence to which Dr. Edelstein referred was not received by the Office until August 27, 1999. Because this evidence was not before the Office when it made its August 24, 1999 decision, the Board has no jurisdiction to review it. 20 C.F.R. § 501.2(c) (the Board's review of a case shall be limited to the

In a decision dated August 24, 1999, the Office found that the medical evidence was insufficient to warrant modification of the prior decision denying compensation for carpal tunnel syndrome or any psychiatric condition. The issue at hand, the Office stated, was whether sufficient rationalized medical opinion evidence was on file to support that appellant had a right carpal tunnel condition causally related to his employment of November 10, 1987. The Office noted that Dr. Belfer did not medically explain his change of opinion from March 22, 1990, when he opined that the study of both arms was considered unremarkable and without evidence of carpal tunnel syndrome. The Office further noted that Dr. Belfer provided no rationalized opinion on the causal relationship between any right carpal tunnel condition and his federal employment. The Office found that Dr. Edelstein's report of July 21, 1999 was of no probative value and that she had provided no sufficiently rationalized medical report to establish that appellant has a psychiatric condition or for that matter a right carpal tunnel condition, that was causally related to his prior federal employment.

The Board finds that this case is not in posture for a determination of whether appellant's right carpal tunnel syndrome or psychiatric condition is causally related to his November 10, 1987 employment injury. Further development is warranted on the carpal tunnel issue, and a conflict in medical opinion exists on the psychiatric issue.

A claimant seeking benefits under the Federal Employees' Compensation Act[2] has the burden of proof to establish the essential elements of his claim by the weight of the evidence,[3] including that he sustained an injury in the performance of duty and that any specific condition or disability for work for which he claims compensation is causally related to that employment injury.[4]

Because the Office accepted appellant's claim for bilateral ulnar nerve irritation and bilateral elbow tendinitis, it remains for appellant to establish that his right carpal tunnel syndrome and depression are causally related to the November 10, 1987 employment injury.

After appellant's attending orthopedic surgeon, Dr. Jacobsen, requested authorization for a carpal tunnel release, the Office referred appellant to a panel of specialists for a second opinion. Dr. Gupta, a neurologist, report that while appellant's bilateral carpal tunnel syndrome could be caused by the repetitive lifting in his federal employment, his symptoms did not become evident until at least 1994, when appellant had been off from work for two or three years. For this reason she did not feel that appellant's carpal tunnel syndrome was caused or aggravated by the work activities.

Dr. Gupta's associate, Dr. Magnussen, an orthopedic surgeon, felt differently. He reported that, although the medical records showed none of the typical symptoms of carpal tunnel syndrome, either by physical examination or by inference to history, it was probable that there was irritation of the carpal tunnel area to some degree based on the activity as described in

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evidence that was before the Office at the time of its final decision).

[2] 5 U.S.C. §§ 8101-8193.

[3] *Nathaniel Milton*, 37 ECAB 712 (1986); *Joseph M. Whelan*, 20 ECAB 55 (1968) and cases cited therein.

[4] *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

his job description and because of the demonstration of the onset of ulnar neuritis and tendinitis, which were also entrapment syndromes due to overuse. He concluded that it was probable that the factors of his prior work, present activities of daily living and his physical therapy activities had ultimately produced the diagnosis of right carpal tunnel syndrome. It was therefore reasonable to say, he reported, that appellant's federal employment did accelerate the onset of right carpal tunnel syndrome by producing a significant contribution.

When the Office requested clarification in light of Dr. Gupta's opinion, Dr. Magnussen maintained that, because appellant's overall injury was that of overuse, there was a high likelihood that there was some contribution from his wrist pain and tendinitis compromising the carpal tunnel. He based this likelihood on the lack of history of other inciting factors after he left his federal employment. Although it was not a medical certainty, he stated, there were indications of overuse with bilateral hand and wrist pain.

Thus, on further development of the evidence, the Office obtained opinions from two specialists who disagreed on whether appellant's right carpal tunnel syndrome was causally related to his federal employment. Although one specialist was a neurologist and the other an orthopedic surgeon, on balance the medical evidence obtained by the Office has only clouded the issue.[5] As the Office referred appellant to Dr. Gupta and Dr. Magnussen, it has the responsibility to obtain an evaluation that will resolve the issue involved in the case.[6] The Board will set aside the Office's August 24, 1999 decision on the issue of right carpal tunnel syndrome and remand the case for further development of the medical evidence and an appropriate final decision.

On the psychiatric issue, the Board finds that a conflict exists between appellant's attending psychiatrist and the Office referral psychiatrist. Dr. Edelstein explained that appellant's depression and the physical pain in his arms and shoulders were intimately connected. She stated that virtually all of his world was wrapped up in his experience of pain, that he continued to deteriorate in terms of his ability to deal with day-to-day living issues such as family life, sense of future and self-respect. She noted that his sleep patterns evidenced interference as a result of the physical pain, and that his tolerance levels were markedly affected by his physical pain. Consistent with this, Dr. Gary K. Mills, director of the pain rehabilitation program authorized by the Office, diagnosed developing major depression, recurrent, secondary to chronic pain syndrome.

Dr. Michaels, the Office referral physician, disagreed. He reported that appellant's depressive disorder did not appear to be logically connected by direct causation, aggravation, acceleration or precipitation to factors of employment. Dr. Michaels noted no evidence in the history as presented by appellant that he developed any type of symptoms of depression around the time that he developed his physical disability while working for the federal government. He reported that appellant's symptoms of depression appeared to develop more recently, in 1995, with reference to his alleged difficulties gaining access to adequate medical care.

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[5] Dr. Belfer's January 22, 1999 report that nerve conduction studies showed a mild right-sided carpal tunnel syndrome present since 1990 and Dr. Rowe's March 3, 1998 report that appellant's nerve conduction studies were consistent from one time to another and should all be interpreted the same way, have further muddied the waters.

[6] *Mae Z. Hackett*, 34 ECAB 1421, 1426 (1983); *see also Milton Lehr*, 45 ECAB 467 (1994) (where the Board remanded the case to the Office for a medical opinion and the opinion obtained from the attending physician was not sufficient to resolve the issue, the Board found that the Office should obtain a supplemental report from the attending physician curing the deficiency and resolving the issue in the case).

Although Dr. Edelstein also supported a connection between the termination of appellant's physical therapy and the deterioration of his condition, the issue to be resolved is whether a causal connection exists between the residuals of the accepted bilateral ulnar nerve irritation and bilateral elbow tendinitis and appellant's diagnosed psychiatric condition. On this issue, Dr. Edelstein disagreed with Dr. Michaels' conclusion.

Section 8123(a) of the Act provides in part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[7]

The Board will set aside the Office's August 24, 1999 decision on the psychiatric issue. To resolve the conflict in opinion between appellant's attending psychiatrist and the Office referral psychiatrist, the Office shall refer appellant, together with the medical record and a statement of accepted facts, to an appropriate referee medical examiner for an opinion on whether appellant's diagnosed psychiatric condition is causally related to the residuals of his accepted employment injuries.[8] After such further development of the evidence as may be necessary, the Office shall issue an appropriate final decision on this issue.

The August 24, 1999 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Dated, Washington, DC
November 9, 2001

Willie T.C. Thomas
Member

Bradley T. Knott
Alternate Member

A. Peter Kanjorski
Alternate Member

[7] 5 U.S.C. § 8123(a).

[8] As appellant's accepted employment injuries might include right carpal tunnel syndrome, the Office should first resolve the carpal tunnel issue.