United States Department of Labor
Employees' Compensation Appeals Board

SHIRLEY J. HIGGS, Appellant	)	
and	)	**Docket No. 05-1722**
	)	**Issued: July 11, 2006**
DEPARTMENT OF LABOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, Dallas, TX, Employer	)	

Appearances:
Shirley J. Higgs, pro se
Office of the Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On August 15, 2005 appellant filed a timely appeal from an Office of Workers' Compensation Programs' August 3, 2005 merit decision. Under 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant sustained bilateral cubital tunnel syndrome, shoulder, foot, leg, neck or lower back conditions in the performance of duty.

FACTUAL HISTORY

Appellant has had several prior appeals to the Board. On September 14, 2000 appellant filed a claim for bilateral carpal tunnel syndrome as a result of her federal work activities. The claim was accepted by the Office. In an August 2, 2002 decision, the Board reversed decisions of the Office, which suspended her compensation benefits for failure to participate in vocational

rehabilitation.[1] Appellant subsequently filed a claim for an employment-related emotional condition, which was denied by the Office. In a December 4, 2003 decision, the Board found that appellant established a compensable work factor under *Cutler* and remanded the case for further development of the medical evidence.[2] The Office terminated appellant's compensation as it pertained to her accepted bilateral carpal tunnel syndrome and denied her request to expand the acceptance of her claim to include neck pain, bilateral elbow pain and numbness in both legs. In an August 13, 2004 decision, the Board found that the Office did not meet its burden of proof to terminate compensation benefits.[3] Following further development of the emotional condition claim, the Office denied it finding that the medical evidence did not establish that it was related to factors of her federal employment. In an April 13, 2005 decision, the Board reversed the Office finding that the medical evidence established that appellant sustained depression which was contributed to by the accepted work factor.[4] Appellant subsequently contended that her accepted emotional condition should be expanded to include the diagnoses of anxiety and multiple phobias, which was denied by the Office. In an April 3, 1996 decision, the Board affirmed the Office finding that the medical evidence was not sufficient to establish these emotional conditions as causally related to the compensable work factor.[5] The facts of the case are set forth in the Board's prior decisions and are incorporated herein by reference.

Following the Board's August 13, 2004 decision in Docket No. 03-1592, appellant filed a claim on August 23, 2004 alleging bilateral cubital tunnel syndrome, neck shoulder, foot, leg and lower back conditions as result of her repetitive duties as a claims examiner. She submitted a January 26, 2001 treatment note from Dr. Thomas C. DiLiberti, an attending Board-certified orthopedic surgeon. He listed the onset of appellant's bilateral arm and neck pain with upper and lower extremity numbness as December 2, 1999. Dr. DiLiberti noted her employment history as a claims examiner and noted that she had been diagnosed with median nerve compromise consistent with carpal tunnel syndrome. He noted that x-rays of the wrists did not show any abnormality and the cervical spine did not show any spondylolisthesis with disc spaces well maintained with no acute abnormalities. Dr. DiLiberti listed an impression of bilateral cubital tunnel syndrome and attribute appellant's neck symptoms to the possible positioning of her computer monitor at work.

In a report dated March 27, 2002, Dr. E. Olayinka Ogunro, a Board-certified orthopedic surgeon, stated that appellant developed pain in both hands from working as a claims examiner, which consisted of a burning sensation with proximal migration. Appellant also related symptoms of neck, elbow and lower extremity pain. He diagnosed carpal tunnel syndrome, cubital tunnel syndrome and myofascial pain.[6]

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[1] Docket No. 02-0127 (issued August 2, 2002).

[2] Docket No. 03-1447 (issued December 4, 2003).

[3] Docket No. 03-1592 (issued August 13, 2004). The Board noted that appellant could file a claim for these conditions.

[4] Docket No. 04-1197 (issued April 13, 2005).

[5] Docket No. 05-1623 (issued April 3, 2006).

[6] Appellant's claim for a bilateral carpal tunnel condition was adjudicated in a separate claim.

In a report dated May 25, 2001, Dr. Robert G. Viere, a Board-certified orthopedic surgeon, noted appellant's history of overuse and claim of December 2, 1999 and that she had been followed by Dr. DiLiberti for bilateral carpal tunnel syndrome. He noted her complaint of cervical and lumbar radicular pain into the lower extremities that was becoming progressively worse and that she was not presently working. Cervical x-rays were described as showing normal disc height at all levels with slight reversal of the normal lordosis between C3 and C5. Lumbar x-rays revealed a spina bifida occulata of S1 with narrowing of the L5-S1 disc space and slight retrolisthesis at L5-S1. He recommended a magnetic resonance imaging (MRI) scan of the cervical and lumbar regions.[7] On January 24, 2003 Dr. Viere described left shoulder blade and anterior chest pain radiating to appellant's neck, again noting that she last worked in September 2001. She described cervical spine, left shoulder and left trapezial pain that was constant in nature. Appellant also experienced right-sided lumbar pain with tingling to her calves and her toes were numb on occasion. Dr. Viere noted that appellant had not undergone any surgical intervention. He diagnosed a central disc protrusion at L5-S1, with significant myofascial pain in her neck, inner scapular area with no clear evidence of radiculopathy. Dr. Viere stated that appellant had significant rotator cuff tendinitis and restricted motion of the left shoulder.

By letter dated September 7, 2004, the Office advised appellant to submit additional factual and medical evidence. It requested a comprehensive medical report from a treating physician describing her symptoms and providing an opinion as to whether her claimed conditions were causally related to her federal employment. She submitted additional treatment records in support of her claim.

In a July 17, 2001 report, Dr. Dayoush Kaboli, a Board-certified neurologist, noted that appellant underwent nerve conduction studies of both lower extremities, which were within normal range. He found no signs of neuropathy or tarso tunnel syndrome. He noted that the EMG of both lower extremities indicated bilateral lumbar radiculopathy, predominantly in the S1 distribution. Dr. Kaboli concluded that her symptoms of the paresthesias and tingling in both feet were consistent with a lumbar radiculopathy. He did not believe that appellant had a demyelinating disease.

In an April 22, 2002 report, Dr. Ogunro indicated that appellant continued to experience tingling and numbness in the digits of her hands. She had a positive Tinel's sign, bilaterally and a negative Phalen's test, with normal sensation. He diagnosed bilateral cubital tunnel syndrome. On May 12, 2003 Dr. Ogunro noted tenderness, numbness and tingling to both wrists with a positive Phalen's test on the right and on the left. On August 27, 2003 appellant complained of numbness in both hands and elbows, relating that her pain became more severe during the prior two months. Appellant had diminished sensation to light touch in both hands, with a positive Tinel's sign bilaterally over the transverse carpal ligament and a positive compression test.

In a September 6, 2001 report, Dr. DiLiberti stated that appellant had no significant change, with full symmetrical range of motion. She did not exhibit a positive Tinel's test and the median

[7] On August 10, 2001 Dr. Viere stated that MRI scan testing revealed a minimal disc bulge at L5-S1, which was not impinging on the thecal sac or the exiting nerve root. An electromyogram (EMG) was reported in normal limits with possible S1 radiculopathy.

nerve compression wrist flexion tests and elbow flexion tests were weak and positive. He diagnosed bilateral cubital tunnel syndrome and outlined work restriction on lifting no more than 25 pounds while pushing and pulling, for no more than four hours per day. On October 2, 2001 appellant had continued upper extremity symptoms and signs of median nerve compression at the wrists, bilaterally, as well as ulnar nerve compression at the elbow. Dr. DiLiberti stated that the types of repetitive motions and overuse syndrome which result in compression of the median nerve at the wrist level can also result in compression of the ulnar nerves at the elbow level, especially associated with prolonged elbow flexion such as in typing. He concluded that appellant had the clinical diagnoses of bilateral carpal and cubital tunnel syndromes since her initial office visit "and these would both be reasonably considered part of the occupationally[-]related injury."

In a May 30, 2003 report, Dr. Don Buford, an orthopedic surgeon, noted that Dr. Viere had referred appellant for evaluation of her left shoulder. He noted a history of worsening shoulder discomfort with no history of direct shoulder trauma. Dr. Buford stated that appellant denied any significant night pain or pain with overhead activity, but complained of pain in her upper back, anterior chest and lateral shoulder. Diagnostic testing of June 3, 2003 revealed a normal acromioclavicular joint with no extensive degenerative changes affecting the shoulder joint. Increased signal intensity was seen in the bursal half of the supraspinatous tendon, consistent with tendinitis. On June 6, 2003 Dr. Buford reviewed the results of the MRI scan and noted that appellant did not have any surgical pathology but would continue with conservative treatment.

On July 14, 2003 Dr. Kathleen Sisler, Board-certified in physical medicine and rehabilitation, noted that appellant had been referred by Dr. Viere for physical therapy and an assessment of her physical capacities. She noted that diagnostic testing revealed bursitis and tendinitis of the left shoulder and that Dr. Buford believed most of her pain was coming from the cervical region. Dr. Sisler noted that appellant had not worked since 2001 and was not performing repetitive activities but noted that any type of household activity aggravated appellant's wrist, elbow, neck and low back pain. Physical examination revealed a full range of motion of the lumbar and cervical regions, which was not painful and no muscle atrophy in the upper or lower extremities. Dr. Sisler diagnosed myofascial pain, impingement syndrome of the left shoulder, more consistent with bursitis, low back pain, cubital tunnel syndrome and bilateral carpal tunnel syndrome. She stated:

> "In terms of her vocational abilities, the upper extremity specialist has pretty much stated that she cannot do repetitive motion with the upper extremities. Subsequently, she really cannot do work that is secretarial, use a computer, filing, etc."

In a March 22, 2002 report, Dr. Viere diagnosed a central disc protrusion and symptoms consisting of S1 radiculopathy, which he attributed to an overuse syndrome stemming from appellant's work injury of December 2, 1999. On June 20, 2003 he reported that appellant complained of neck pain in the center of her cervical spine that radiated into the shoulder blades and trapezial region. Dr. Viere advised that appellant still had some numbness in both hands and impairment from her carpal tunnel syndrome and did not believe she could work with the level of pain she was experiencing. He diagnosed multilevel cervical disc bulges and reversal of lordosis but no nerve root impingement as the MRI scan showed supraspinatous tendinitis but no tendon impingement. Dr. Viere described appellant's pain as multifactorial, with some of it coming from

the disc, some from the mechanical process and the fact that she was little kyphotic and some of it myofascial in nature. He recommended that she continue with a rehabilitation program. In a September 30, 2004 report, Dr. Viere noted that there was tenderness with trigger points on the right side of the cervical spine with a mildly positive impingement sign in the left shoulder. Wright's maneuver was reported negative with trace weakness in the left deltoid and pain with resistance. He noted weakness of the left rotator cuff, bicep and tricep and pain with resistance. Distally, her strength is symmetrical in upper extremities. Dr. Viere stated:

> "[Appellant] has four level cervical disc disease with periodic nerve root irritation, which she manages with modification of activities and avoidance of flexed position and avoidance of any overhead activities and significant lifting. Her work required her to spend long hours with her neck in the flexed position looking at a computer screen and doing writing and typing as well as a lot of work on the telephone with her head in awkward positions. These activities would be expected and initiate and aggravate the cervical disc disease [appellant] has. Presently, I think from the standpoint of her neck if [she] could avoid having to spend more than 30 minutes at one time looking at a computer screen and avoid that flexed position, if her workstation could be positioned so she can be in a more ergonomically normal position. She may be able to work but she would still require frequent rest periods through the day.
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> "[Appellant] has a central disc herniation at L5-S1 with EMG documented radiculopathy. This is aggravated by any lifting or bending or sitting for more than short periods of time. [Her] job requires her to sit for long periods of time and this would be expected to aggravate and initiate her back pain and her radiculopathy…. [She] also has other problems related to her carpal tunnel syndrome, cubital tunnel syndrome and her shoulder, which added together with her neck problems may make it impossible for her to work a full eight[-]hour day but these comments are related to her cervical and lumbar spine only."

The Office referred appellant for a second opinion evaluation by Dr. Robert M. Chouteau, a Board-certified orthopedic surgeon. In a report dated July 16, 2002, he noted a history of injury and medical treatment and listed his findings on physical examination. Dr. Chouteau noted that examination of the upper extremities revealed negative Tinel's and Phalen's signs in the wrist areas, with good grip strength and no neurological or circulatory defect. He stated that there was no evidence of cubital tunnel syndrome or any other diagnosis other than bilateral carpal tunnel syndrome that resulted from the cumulative effect of repetitive typing and use of her hands at work and documented by positive EMG findings. Dr. Chouteau noted that cubital tunnel syndrome did not result from repetitive activities and did not believe that the December 2, 1999 work injury caused cubital tunnel syndrome. He opined that appellant did not require surgery as she did not exhibit symptoms of ulnar nerve compression of the elbows. Appellant did not have any preexisting condition and her work activities did not aggravate or precipitate any preexisting condition. She was able to return to work subject to specified restrictions on repetitive activities.

By decision dated December 6, 2004, the Office denied appellant's claim, finding that she failed to submit medical evidence sufficient to establish that her claimed conditions were caused by her federal employment. This decision was appealed to the Board which, by order

dated July 19, 2005, remanded the case to the Office as the record submitted on appeal did not contain Dr. Chouteau's July 16, 2002 report.[8]

The Office secured a copy of Dr. Chouteau's report for the case file and, on August 3, 2005, denied appellant's claim.

LEGAL PRECEDENT

An employee seeking benefits under the Federal Employees' Compensation Act[9] has the burden of establishing that the essential elements of his or her claim including the fact that the individual is an "employee of the United States" within the meaning of the Act, that the claim was timely filed within the applicable time limitation period of the Act, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury.[10] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[11] A claimant has the burden of establishing by the weight of the substantial, reliable and probative evidence, a causal relationship between her claimed cervical condition and her federal employment. This burden includes providing medical evidence from a physician who concludes that the disabling condition is causally related to employment factors and supports that conclusion with sound medical reasoning.[12]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the employment factors identified by the claimant were the proximate cause of the condition for which compensation is claimed or, stated differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant. The medical evidence required to establish causal relationship is usually rationalized medical evidence. 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

[8] Docket No. 05-455 (issued July 19, 2005).

[9] 5 U.S.C. §§ 8101-8193.

[10] *Joe D. Cameron*, 41 ECAB 153 (1989); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[11] *Victor J. Woodhams*, 41 ECAB 345 (1989).

[12] *See Nicolea Bruso*, 33 ECAB 1138, 1140 (1982).

nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[13]

ANALYSIS

The Board finds that appellant failed to submit sufficient medical evidence to establish that the claimed medical conditions were caused or aggravated by her federal employment work duties. As noted, appellant's claim for carpal tunnel syndrome was adjudicated under a separate claim. In the current appeal, she contends that her bilateral cubital tunnel condition, cervical, shoulder, leg and feet numbness and low back conditions were caused by her work duties. Appellant submitted copies of treatment records from various attending physicians and diagnostic test results, however, the medical evidence fails to provide a rationalized opinion that explains how appellant's work duties caused or contributed to her various claimed conditions.

As to her diagnosed bilateral cubital tunnel condition, Dr. DiLiberti made the diagnosis in several reports dating from 2001 and noted a full and symmetrical range of motion of the upper extremities. He provided work restrictions and noted that appellant had stopped work in September 2001. Dr. DiLiberti stated that the types of repetitive motions and overuse syndrome which resulted in compression of the median nerve at the wrist level could also result in compression of the ulnar nerves at the elbow level, especially associated with prolonged elbow flexion such as in typing. He advised that appellant's bilateral cubital tunnel syndrome could reasonably be considered part of the occupationally-related injury. In 2002, Dr. Ogunro related that appellant continued to experience tingling and numbness in both hands, both elbows and wrists and opined that her symptoms were caused by working as a claims examiner. He also advised that appellant had symptoms of neck, elbow and lower extremity pain. Dr. Ogunro diagnosed cubital tunnel syndrome bilaterally and myofascial pain. In 2003, Dr. Sisler also diagnosed cubital tunnel syndrome and advised that any type of household activity aggravated appellant's wrist and elbow pain.

The reports from Drs. Ogunro, Sisler and DiLiberti do not establish that appellant's claimed bilateral cubital tunnel condition was caused or aggravated by factors of her federal employment. These reports are of limited probative value as the physicians did not provide sufficient medical rationale explaining how the work duties appellant performed would cause or contribute to her bilateral cubital tunnel condition.[14] The treatment records consist largely of noting appellant's symptoms and complaints of tingling and numbness but do not provide any discussion of the issue of causal relationship. The weight of medical opinion is determined by the opportunity for and thoroughness of examination, the accuracy and completeness of physician's knowledge of the facts of the case, the medical history provided the care of analysis manifested and the medical rationale expressed in support of stated conclusions.[15] The reports from Drs. Ogunro, Sisler and DiLiberti are generalized in nature and equivocal. The physicians did not adequately state the basis for concluding that appellant's cubital tunnel condition was

[13] *Id.*

[14] *William C. Thomas*, 45 ECAB 591 (1994).

[15] *See Anna C. Leanza*, 48 ECAB 115 (1996).

related to her duties as a claims examiner. This is essential, as the record indicates that appellant last worked in September 2001 and Dr. Sisler noted in 2003 that general housework activities could produce symptoms. The Office properly found that appellant did not establish that her cubital tunnel condition was causally related to her employment.

Appellant also attributed her cervical, shoulder and upper extremity conditions to her work activities. Dr. Viere noted that appellant experienced pain for several years and obtained diagnostic testing. He described neck pain in the cervical spine that radiated into the shoulders and trapezial regions. Dr. Viere diagnosed multilevel cervical disc bulges and reversal of the cervical lordosis but noted there was no nerve root impingement. He described appellant's complaints of pain as multifactorial, originating in part from four-level cervical disc disease and also myofascial in nature. Dr. Buford noted that appellant had a history of shoulder discomfort with no history of direct trauma and that and MRI scan showed evidence of supraspinatous tendinitis without any tendon tearing. Dr. Sisler addressed appellant's complaints of neck and left shoulder pain and diagnosed myofascial pain with impingement syndrome in her left shoulder consistent with bursitis. She stated that appellant had been restricted from doing repetitive motion activities, such as secretarial work or computer filing with the upper extremities.

Again, the treatment records do not provide a physician's opinion on the issue of how appellant's cervical disc disease or shoulder tendinitis or bursitis conditions were caused or aggravated by factors of her work. In a September 30, 2004 narrative report, Dr. Viere addressed the issue of causal relationship by stating that "her work requires her to spend long hours with her neck in the flexed position looking at a computer screen and doing writing and typing as well as a lot of work on the telephone with her head in awkward positions." He noted that these activities would be expected to "initiate and aggravate the cervical disc disease." As noted, however, appellant last worked in September 2001 and Dr. Viere's report indicates a history that appellant was presently engaged in such duties. His report did not adequately explain how her work duties prior to September 2001 would aggravate any degenerative disease process of the cervical spine, explain how any such aggravation was temporary or permanent in nature or distinguish why such degenerative process would not be consistent with aging.

With regard to appellant's low back and lower extremities, on May 25, 2001 Dr. Viere noted that diagnostic testing revealed an abnormality at L5-S1 and described right-sided lumbar pain due to a central disc protrusion. Following additional diagnostic testing, he noted that an MRI scan found the disc bulge was not impinging significantly on the thecal sac or exiting nerve root and diagnosed symptoms consistent with S1 radiculopathy. In a 2002 report, he attributed appellant's S1 radiculopathy to an overuse syndrome. Dr. Kaboli, a neurologist, noted that appellant underwent nerve conduction studies of both lower extremities, which were reported as within the normal range with no sign of neuropathy or tarso tunnel syndrome. He also indicated that appellant's symptoms of paresthesias and tingling to both feet was a lumbar radiculopathy in the S1 distribution. He found no evidence of any demyelinating disease. The medical reports do not provide a well-rationalized opinion explaining how the central disc protrusion at L5-S1 and any resulting radiculopathy into the lower extremities was caused or aggravated by appellant's duties at work. While generally supportive of the claim, the reports of record are of diminished probative value as they lack an explanation, with supporting rationale, as to how the low back

conditions relate to factors of appellant's employment.[16] Dr. Viere did not explain the basis for his conclusion attributing the S1 radiculopathy to an overuse syndrome or explain why such condition would be present after appellant stopped work in September 2001.

Dr. Chouteau examined appellant at the request of the Office and stated that there was no evidence of a cubital tunnel syndrome or any other diagnosis other than bilateral carpal tunnel syndrome. He further opined that appellant did not have any preexisting condition and did require surgery for any ulnar nerve compression at the elbows. Dr. Chouteau advised that she did not have any preexisting condition and found that her work activities did not aggravate or precipitate any preexisting condition.

An award of compensation may not be based on surmise, conjecture or speculation. Neither the fact that appellant's condition became apparent during a period of employment nor her belief that her condition was caused or aggravated by her employment is sufficient to establish causal relationship.[17] Causal relationship must be established by rationalized medical opinion evidence and appellant failed to submit such evidence. Consequently, she has not met her burden of proof to establish that her bilateral cubital tunnel, neck, shoulder, low back and lower extremity conditions are causally related to her employment. The Board will affirm the Office's August 3, 2005 decision.

CONCLUSION

The Board finds that appellant has failed to meet her burden of proof in establish that her claimed conditions were caused or aggravated by factors of her federal employment.

[16] *William C. Thomas, supra* note 14.

[17] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the August 3, 2005 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: July 11, 2006
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board