United States Department of Labor
Employees' Compensation Appeals Board

W.Q., Appellant	)	
and	)	**Docket No. 07-250**
	)	**Issued: August 8, 2007**
U.S. POSTAL SERVICE, REMOTE ENCODING CENTER, Glendale, AZ, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge

JURISDICTION

On November 7, 2006 appellant timely appealed the August 11, 2006 merit decision of the Office of Workers' Compensation Programs, which accepted her occupational disease claim for left radial tunnel syndrome and left lateral epicondylitis. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of the claim.[1]

ISSUE

The issue is whether appellant sustained a cervical condition in the performance of duty on or about February 22, 2005.

FACTUAL HISTORY

Appellant, a 39-year-old data conversion operator, has an accepted occupational disease claim for bilateral wrist tendinitis and bilateral carpal tunnel syndrome, which arose on or about

[1] The record on appeal contains evidence that was received after the Office issued its August 11, 2006 decision. The Board may not consider evidence that was not in the case record when the Office rendered its final decision. 20 C.F.R. § 501.2 (2007).

August 2, 1999, file number 13-1195763.[2] She also has an accepted claim for aggravation of bilateral cubital tunnel syndrome, arising on or about September 15, 2001, file number 13-2042446. With respect to this latter claim, appellant underwent bilateral ulnar nerve transposition and cubital tunnel release in August 2002. She returned to full-time, regular duty on October 5, 2002.

On June 10, 2005 appellant filed an occupational disease claim for pain in her wrists, elbows and neck, file number 13-2131743. Her claimed condition was allegedly due to continuous keying at work, which she performed for 55 minutes each hour during an 8-hour shift. Appellant identified February 22, 2005 as the date she was first aware of her employment-related condition.

By letter dated July 7, 2005, the Office advised appellant that, because her prior claims for bilateral upper extremity conditions remained open, it would only address the newly claimed cervical condition.

The relevant medical evidence regarding appellant's cervical condition included a May 10, 2005 magnetic resonance imaging (MRI) scan that revealed a minimal disc bulge and facet hypertrophy at C6-7, with minimal left neural foraminal stenosis. Dr. Mark Whitaker, a family practitioner, examined appellant on May 17, 2005 and diagnosed cervical disc disease and cervicothoracic strain. He believed that appellant's condition was aggravated by her employment, but did not otherwise explain the basis for his opinion.[3] Dr. Whitaker saw appellant on several occasions between July and August 2005 and continued to diagnose cervicothoracic strain, cervical disc disease and cervical radiculopathy. He explained that appellant's duties at work involved data entry and keying all day, which can aggravate her symptoms.

Dr. Edward J. Dohring, a Board-certified orthopedic surgeon, examined appellant on behalf of the employing establishment. In his July 15, 2005 report, he found no evidence of an injury having occurred on February 22, 2005. Dr. Dohring explained that, although appellant complained of cervical paraspinal muscle myofascial-type pain, as well as aching pain in the forearms, she had no imaging or examination evidence whatsoever that she has a diagnosable condition relating to the cervical spine or to the upper extremities. With regard to appellant's cervical spine, he stated: "she has a *normal* cervical spine." (Emphasis in the original.) Dr. Dohring also noted that the May 10, 2005 cervical MRI scan was within normal limits for someone of appellant's age and the disc bulge identified was so small as to be barely noticeable. He further explained that there was certainly no evidence of sufficient degenerative changes to explain appellant's symptoms.

In a decision dated September 20, 2005, the Office denied appellant's claim for an employment-related cervical condition. On December 6, 2005 she requested reconsideration.

[2] She underwent right and left carpal tunnel releases on November 17, 1999 and January 5, 2000, respectively.

[3] Dr. Whitaker reported his findings on (Form CA-20) and checked the "Yes" box on item number eight, which asks whether the diagnosed condition was caused or aggravated by an employment activity.

Dr. Christopher A. Yeung, a Board-certified orthopedic surgeon, examined appellant on September 13, 2005 for complaints of neck and bilateral wrist pain. In addition to appellant's prior bilateral upper extremity conditions, he noted a history of a motor vehicle accident some 18 years prior, which caused a whiplash injury. Physical examination of the cervical spine revealed good range of motion without apparent limitations. However, appellant exhibited some discomfort with neck range of motion and tenderness was noted at the base of the cervical spine and the trapezium. Her x-ray showed good alignment of the cervical spine and appellant's MRI scan showed only mild spondylosis and a mild disc protrusion on the left at C6-7, with some mild foraminal stenosis. The cervical MRI scan also revealed a benign appearing syrinx from the C5-6 level down to C7. Dr. Yeung diagnosed mild cervical spondylosis with left C6-7 foraminal stenosis and syrinx in the cervical spine from C5 to 7. He noted that appellant had some spondylosis, but no current radiculopathy or radiculitis. Dr. Yeung also explained that, with bilateral cubital tunnel and carpal tunnel surgeries, it was difficult to tell if appellant had any residual symptoms from this or from the syrinx. He further explained that appellant certainly could have some wrist and hand symptoms from the syrinx, which most likely occurred after her motor vehicle accident 18 years ago.

The Office denied modification by decision dated February 15, 2006.

Appellant filed another occupational disease claim on January 30, 2006, with a date of injury of January 24, 2006, file number 13-2145667. She stated that she recently began experiencing pain in her elbows and forearms. While appellant's neck pain seemed to have resolved, her forearms and elbows were very painful, which prevented her from working.

On March 7, 2006 appellant filed a request for reconsideration of the Office's February 15, 2006 decision under file number 13-2131743. She also asked the Office to combine that file with her January 30, 2006 file number 13-2145667 for bilateral elbow and forearm injuries. Appellant explained that she initially believed that her arm pain was caused by her neck pain, but now she believed her neck pain was caused by her arm pain. According to her, she had radial tunnel syndrome, which was responsible for both her neck pain and her bilateral arm pain.

On January 26, 2006 Dr. Whitaker referred appellant to an orthopedist to rule out radial tunnel syndrome. In a February 2, 2006 report, Dr. Kishore Tipirneni, a Board-certified orthopedic surgeon, diagnosed radial tunnel syndrome, which he attributed to repetitive motion and keying. He also recommended obtaining a cervical MRI scan and additional diagnostic studies to rule out cervical radiculopathy.

A February 9, 2006 MRI scan revealed a small central disc protrusion at C6-7, with an annular tear. The MRI scan also showed partial disc desiccation at C3-4 to C5-6, straightened cervical lordosis and no abnormal signal characteristics within the cervical cord.

The Office denied file number 13-2145667 in a decision dated March 16, 2006. Appellant requested reconsideration on April 6, 2006.

On March 21, 2006 Dr. Peter J. Campbell, a Board-certified orthopedic surgeon, examined appellant on behalf of the employing establishment. He indicated that her clinical

symptoms were consistent with radial tunnel syndrome. However, it was unclear whether appellant's repetitive employment duties caused her symptoms. Dr. Campbell noted that there were no specific activities at work which seem to aggravate her condition, nor had appellant's second-month absence from work significantly improved her symptoms. He advised that appellant could resume her full employment duties.

A March 21, 2006 electromyogram and nerve conduction study showed a mild median nerve lesion on the right at the wrist and mild slowing of the radial nerve on both sides.

On March 30, 2006, after reviewing the recent diagnostic studies, Dr. Tipirneni diagnosed possible radial tunnel syndrome. On April 6, 2006 he provided a definitive diagnosis of radial tunnel syndrome and administered corticosteroid injections on both sides. Dr. Tipirneni saw appellant again on April 27, 2006 and noted that he had reviewed Dr. Campbell's report. He indicated that appellant's radial tunnel syndrome may be related to her keying at work. In light of appellant's improved symptoms following corticosteroid injections, Dr. Tipirneni released her to return to her regular employment duties. However, he advised that, if her symptoms returned, she might be a candidate for a radial tunnel release. Within a week's time, appellant returned to Dr. Tipirneni with complaints of bilateral forearm pain. She attempted to resume working, but after two hours her arms were reportedly too painful. On May 4, 2006 Dr. Tipirneni referred appellant to Dr. Kent H. Chou, a Board-certified orthopedic surgeon, for a surgical consultation.

Dr. Chou saw appellant on May 12, June 9 and July 18, 2006. He diagnosed lateral epicondylitis and radial tunnel syndrome, with the left side being much more symptomatic than the right. In his July 18, 2006 report, Dr. Chou explained that appellant's symptoms were exacerbated by lifting and keyboarding, both of which she performed on a regular basis at work. Because of the past failure of conservative treatment, he recommended surgical intervention to treat appellant's left lateral epicondylitis and left radial tunnel syndrome. On August 2, 2006 Dr. Chou performed a left radial tunnel release and left lateral epicondylar release with ostectomy.

By decision dated August 11, 2006, the Office modified the February 15, 2006 decision in file number 13-2131743. The Office accepted appellant's claim for left radial tunnel syndrome and left lateral epicondylitis. Additionally, the Office found that she failed to establish that she sustained an employment-related cervical condition.[4]

LEGAL PRECEDENT

A claimant seeking benefits under the Federal Employees' Compensation Act[5] has the burden of establishing the essential elements of her claim by the weight of the reliable, probative and substantial evidence, including that an injury was sustained in the performance of duty as

[4] In a September 1, 2006 letter, the Office advised appellant that file numbers 13-2145667 and 13-2131743 were combined under the latter file number. The Office also stated that the August 11, 2006 decision was equally applicable to appellant's request for reconsideration of the March 16, 2006 decision in file number 13-2145667.

[5] 5 U.S.C. § 8101 *et seq* (2000).

alleged and that any specific condition or disability claimed is causally related to the employment injury.[6]

To establish that an injury was sustained in the performance of duty, a claimant must submit: (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 diagnosed condition is causally related to the employment factors identified by the claimant.[7]

ANALYSIS

The Office accepted appellant's claim for left radial tunnel syndrome and left lateral epicondylitis. Additionally, the Office found that she had not established an employment-related cervical condition. On appeal, the only issue specifically raised was whether the Office should have also included right radial tunnel syndrome as an accepted condition. However, this issue is not currently before the Board because the Office has yet to render a specific finding and a final decision on whether appellant has employment-related right radial tunnel syndrome.[8]

The only adverse finding in the Office's August 11, 2006 decision was that appellant had not established an employment-related cervical condition. The Board notes that she did not specifically challenge this finding on appeal. Moreover, the medical evidence of record does not establish an employment-related cervical condition. Dr. Whitaker, a family practitioner, was the only physician of record to diagnose an employment-related cervical condition. He authored a series of reports between May and August 2005, in which he diagnosed cervicothoracic strain, cervical disc disease and cervical radiculopathy. Dr. Whitaker indicated that data entry and keying, which appellant performed all day at work, aggravates her symptoms. However, despite his ultimate finding, his various reports offer little or no support for his opinion on causal relationship.[9] Furthermore, beginning in January 2006, Dr. Whitaker appeared to have

[6] 20 C.F.R. § 10.115(e), (f) (2007); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996). Causal relationship is a medical question that can generally be resolved only by rationalized medical opinion evidence. *See Robert G. Morris*, 48 ECAB 238 (1996). A physician's opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors must be based on a complete factual and medical background of the claimant. *Victor J. Woodhams*, 41 ECAB 345, 352 (1989). Additionally, in order to be considered rationalized, the opinion must be expressed in terms of a reasonable degree of medical certainty and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factors. *Id.*

[7] *Victor J. Woodhams*, *supra* note 6.

[8] The Board's jurisdiction is limited to reviewing final decisions issued by the Office's 20 C.F.R. § 501.2(c).

[9] On May 17, 2005 Dr. Whitaker reported his findings on a Form CA-20 and checked the "Yes" box on item number eight, which asks whether the diagnosed condition was caused or aggravated by an employment activity. He also underscored the word "aggravated," but offered no explanation for his opinion on causal relationship. Dr. Whitaker's July 19, 2005 report on a Form CA-20 similarly provides no explanation regarding causal relationship. But even in the two reports where he mentioned appellant's repetitive keying and data input responsibilities as aggravating factors, Dr. Whitaker still failed to provide a rationalized opinion on causal relationship.

abandoned his previous cervical-related diagnoses in favor of a diagnosis of radial tunnel syndrome. Additionally, Drs. Dohring and Yeung, both of whom are Board-certified orthopedic surgeons, did not identify an employment-related cervical condition. Dr. Dohring found that appellant had a normal cervical spine. Dr. Yeung noted a benign syrinx from C5-6 to C7, which likely developed after a whiplash injury appellant sustained in motor vehicle accident 18 years ago. The Board finds that the Office properly determined that appellant had not demonstrated the presence of an employment-related cervical condition.

CONCLUSION

Appellant has not established that she sustained an employment-related cervical condition.

ORDER

IT IS HEREBY ORDERED THAT the August 11, 2006 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 8, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board