

**United States Department of Labor
Employees' Compensation Appeals Board**

C.C., Appellant)	
)	
and)	Docket No. 09-963
)	Issued: April 19, 2010
SOCIAL SECURITY ADMINISTRATION,)	
REGIONAL OFFICE, Greeley, CO, 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
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On March 3, 2009 appellant filed a timely appeal from a February 20, 2009 merit decision of the Office of Workers' Compensation Programs which denied modification of a decision terminating her compensation benefits. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUES

The issues are: (1) whether the Office met its burden of proof to terminate appellant's compensation benefits for her accepted bilateral carpal tunnel syndrome and bilateral wrist tendinitis effective June 18, 2008; and (2) whether appellant established that she had any continuing disability or residuals relating to her accepted conditions after June 18, 2008.

FACTUAL HISTORY

On April 29, 1996 appellant, then a 41-year-old service representative alleged that she developed pain in her hands and fingers while performing her work duties. The Office accepted the claim for bilateral carpal tunnel syndrome and bilateral wrist tendinitis. Appellant did not stop work but returned to a light-duty part-time position on April 24, 1996. She took an early retirement effective July 1, 2001.

Appellant came under the care of Dr. Charles H. Lehman, a family practitioner, from December 2, 1997 to June 23, 1999. Dr. Lehman diagnosed fibromyalgia, chronic pain syndrome, tenosynovitis of the wrist and hand and depression. On May 8, 1998 appellant underwent an electromyogram (EMG) which revealed no evidence of carpal tunnel syndrome or cervical radiculopathy. She was treated by Dr. Harlan R. Ribnik, a Board-certified orthopedist, on June 29, 1999 for chronic pain in the neck, shoulders and arm, myofascial pain syndrome and fibromyalgia. Reports from Dr. Ribnik dated December 21, 2005 to March 7, 2006, noted appellant's complaints of persistent bilateral wrist pain related to her diagnosed bilateral carpal tunnel syndrome.

Appellant was treated by Dr. Mark D. Grossnickle, a Board-certified orthopedic surgeon, from November 29, 2004 to September 20, 2006, for bilateral carpal tunnel syndrome, paresthesias and bilateral hand pain. He noted findings of positive Phalen's and Tinel's sign bilaterally with a lump over the first dorsal compartment of the left wrist. Dr. Grossnickle diagnosed bilateral carpal tunnel syndrome and ganglion cyst and recommended surgical intervention. In a December 9, 2004 operative report, he performed a de Quervain's release on the left wrist and diagnosed tendon cyst with de Quervain's of the left wrist. On February 17, 2005 Dr. Grossnickle performed a de Quervain's release of the first dorsal compartment of the right wrist and trigger finger release and diagnosed de Quervain's tendinitis of the right wrist with trigger fingers. The surgeries were authorized by the Office. In reports dated August 3, 2005 to September 20, 2006, he noted that appellant continued to have bilateral wrist pain with radiation into the epicondyles. Dr. Grossnickle diagnosed medial epicondylitis and residual tendinitis and indicated that appellant could not perform repetitive duties.

On September 11, 2007 the Office granted appellant schedule awards for 21 percent impairment of the left upper extremity and 22 percent impairment of the right upper extremity.

On October 1, 2007 appellant claimed wage-loss compensation from July 2000 to April 10, 2007. In a June 20, 2001 report, Sarah West, a therapist, treated appellant for depression. In reports dated June 27 and July 16, 2007, Dr. Grossnickle saw appellant in follow-up for left arm pain radiating into the medial epicondyle. He noted normal range of motion of the elbow, intact strength and negative Tinel's sign. Dr. Grossnickle diagnosed bilateral chronic tendinitis of the wrists, carpal tunnel syndrome, ulnar neuropathy, lupus and fibromyalgia. He advised that appellant was unable to do any repetitive motion activity with either hand. On June 29, 2007 appellant was treated by Dr. Greg Reichhardt, Board-certified in physical medicine and rehabilitation. He provided an impairment rating for the arms.

On March 26, 2008 the Office referred appellant to Dr. John D. Douthit, a Board-certified orthopedic surgeon, for a second opinion. In an April 19, 2008 report, Dr. Douthit reviewed the medical records provided and examined appellant. He diagnosed chronic pain syndrome, oral narcotic habituation, probable degenerative disease of the thoracic and cervical spine consistent with appellant's age, and a history of diabetes and obesity. Examination revealed full range of motion of the shoulders, no muscle atrophy or swelling around the joints or tendons of the elbows and wrists and full range of motion of the elbows. With regard to appellant's wrists and hands, he noted two well-healed scars from surgeries, no atrophy of the hands with good thenar and hypothenar musculature, normal two-point discrimination bilaterally and no evidence of arthritis, crepitation, loss of motion, locking, swelling or pain in the fingers and thumbs. Dr. Douthit noted moderately restricted motion of the neck and back, negative straight leg raises and full range of motion of the hips, knees, ankles and feet. He concluded that there were no

objective physical findings of carpal tunnel syndrome present and advised that appellant had excellent sensation in her hands and fingers, no neurologic deficits and no evidence of loss of motion, skin lesions, arthritis, median neuropathy or tendinitis. Dr. Douthit stated that subjective findings supported a diagnosis of chronic pain syndrome which was not work related. He opined that appellant's work-related injuries resolved and she required no further medical treatment. There were no objective physical findings to support that she remained totally disabled from her preinjury job; however, because of her subjective complaints of hand pain, he would restrict repetitive duties to four hours a day. In an accompanying work capacity evaluation, he noted that appellant could return to full-time work with permanent restrictions on repetitive movements of the wrist and elbow limited to four hours per day.

On May 8, 2008 the Office issued a notice of proposed termination of compensation benefits. It advised that Dr. Douthit's opinion established that appellant had no residuals of the work-related bilateral carpal tunnel syndrome or bilateral wrist tendinitis.

Appellant submitted a May 19, 2008 report from Dr. William J. Oligmueller, a Board-certified family practitioner, who treated her for hypertension, diabetes, hypercholesterolemia, fibromyalgia, hyperthyroidism, osteoarthritis, depression, chronic neck pain and carpal tunnel syndrome. Dr. Oligmueller noted appellant was on multiple medications and had difficulty performing any activity secondary to an aggravation of her fibromyalgia. He reviewed the most recent medical evaluation and advised that he could not relate appellant's diagnoses to the injuries sustained in 1996. Dr. Oligmueller opined that appellant was totally disabled secondary to her chronic pain syndrome and depression. Due to her intolerance of activity and difficulty in controlling her symptoms, she was precluded her from any type of gainful employment.

In a June 18, 2008 decision, the Office terminated appellant's compensation benefits that date, finding that the weight of the medical evidence established that she no longer had any disability or residuals of her accepted employment injuries.

On June 19, 2008 appellant requested reconsideration. She resubmitted the April 11, 2007 report of Dr. Reichhardt and the June 5, 2008 report of Ms. West. Also submitted were reports from Dr. Grossnickle dated June 11 and July 16, 2008. Dr. Grossnickle noted appellant's most recent EMG studies were unremarkable. He diagnosed chronic tendinitis, lateral epicondylitis and medial epicondylitis. In a prescription note dated June 11, 2008, Dr. Grossnickle advised that appellant would be off work indefinitely due to fibromyalgia, carpal tunnel syndrome, chronic tendinitis and could not perform repetitive motion with her hands.

In a decision dated October 7, 2008, the Office denied modification of the June 18, 2008 decision.

On October 11, 2008 appellant requested reconsideration and resubmitted reports from Dr. Grossnickle dated April 5 to September 20, 2006. On October 29, 2008 Dr. Grossnickle diagnosed chronic mild myofascial pain, chronic tendinitis in both arms due to her work and overuse syndrome. In a November 3, 2008 report, Dr. Reichhardt treated appellant for chronic upper extremity pain in her hands, upper trapezius, shoulder and low back. He diagnosed bilateral upper extremity pain, carpal tunnel syndrome, bilateral de Quervain's tenosynovitis, right hand trigger finger, bilateral lateral epicondylitis, diabetes, hypertension, fibromyalgia and chronic neck pain. Dr. Reichhardt recommended a pain management consultation, pool therapy and oral medication for fibromyalgia.

In a decision dated February 20, 2009, the Office denied modification of the prior decisions.

LEGAL PRECEDENT -- ISSUE 1

Once the Office accepts a claim, it has the burden of justifying termination or modification of 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 The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability. To terminate authorization for medical treatment, the Office must establish that a claimant no longer has residuals of an employment-related condition, which requires further medical treatment.³

ANALYSIS -- ISSUE 1

The Office accepted appellant's claim for bilateral carpal tunnel syndrome and bilateral wrist tendinitis. It authorized a left de Quervain's release which was performed on December 9, 2004 and a right de Quervain's release which was performed on February 17, 2005.

On March 26, 2008 the Office referred appellant for a second opinion evaluation to Dr. Douthit, a Board-certified orthopedic surgeon. On April 19, 2008 Dr. Douthit diagnosed chronic pain syndrome, oral narcotic habituation, probable degenerative disease of the thoracic and cervical spine consistent with appellant's age, diabetes and obesity. He noted examination of the wrists and hands revealed two well-healed scars from surgeries, no atrophy of the hands with good thenar and hypothenar musculature, normal two-point discrimination bilaterally and no evidence of arthritis, crepitation, loss of motion, locking, swelling or pain in the fingers and thumbs. Dr. Douthit noted appellant exhibited no motor, sensory or neurologic deficits in the hands and fingers with no evidence of median neuropathy or tendinitis. He concluded that there were no objective physical findings to support residuals of the accepted carpal tunnel syndrome. Dr. Douthit advised that subjective findings supported a diagnosis of chronic pain syndrome which was not a work-related condition. He found that appellant's work-related injuries had resolved and she did not require further medical treatment. There was no objective physical evidence to support that she remained totally disabled from her preinjury job and could return to work full time with restrictions on repetitive duties limited to four hours a day due to conditions not related to her federal employment.

Appellant submitted reports from Dr. Grossnickle dated June 27 and July 16, 2007, who treated her in follow-up for left arm pain radiating into the medial epicondyle. He diagnosed bilateral chronic tendinitis of the wrists, carpal tunnel syndrome, ulnar neuropathy, lupus and fibromyalgia and advised that she was unable to perform repetitive motion activity with either hand. In a June 29, 2007 report, Dr. Reichhardt provided an impairment rating for the upper extremities. The Board notes that neither Dr. Grossnickle nor Dr. Reichhardt specifically

¹ *Gewin C. Hawkins*, 52 ECAB 242 (2001); *Alice J. Tysinger*, 51 ECAB 638 (2000).

² *Mary A. Lowe*, 52 ECAB 223 (2001).

³ *Id.*; *Leonard M. Burger*, 51 ECAB 369 (2000).

addressed how appellant's continuing symptoms or conditions were causally related to the accepted employment injury. Their reports do not provide a rationalized opinion regarding the causal relationship between appellant's current ulnar neuropathy, lupus and fibromyalgia conditions and her accepted conditions.⁴ For this reason they are of diminished probative value.

After issuance of the pretermination notice, appellant submitted a May 19, 2008 report from Dr. Oligmueller who diagnosed hypertension, diabetes, hypercholesterolemia, fibromyalgia, hyperthyroidism, osteoarthritis, depression, chronic neck pain and carpal tunnel syndrome. Dr. Oligmueller reviewed the medical evidence of record and advised that he could not relate appellant's diagnoses to the injuries sustained in 1996. He opined that appellant was totally disabled secondary to chronic pain syndrome and depression and advised that her intolerance for activity precluded her from doing any type of gainful employment. Dr. Oligmueller did not support that appellant's conditions or medical restrictions were causally related to the accepted employment injury. Instead, he stated that he could not relate appellant's diagnoses to the work injury of 1996 and attributed her condition to chronic pain syndrome and depression which are not conditions accepted by the Office as work related.

The Board finds that the opinion of Dr. Douthit represents the weight of the evidence and establishes that appellant's work-related conditions have resolved. Dr. Douthit found that appellant did not have residuals of bilateral carpal tunnel syndrome or bilateral wrist tendinitis and that she could return to her preinjury job. He found no basis on which to attribute any continuing condition or disability to her employment. Appellant submitted a report from Ms. West, a therapist, dated June 20, 2001, who treated her for depression related to her medical problems. The Board has held that a medical opinion, in general, can only be given by a qualified physician and treatment notes signed by a therapist are not considered medical evidence as a therapist is not a physician under the Act.⁵ Additionally, the Office has not accepted that appellant developed an emotional condition as a result of her 1996 work injury.⁶

For these reasons, the Office met its burden of proof to terminate appellant's compensation for the accepted bilateral carpal tunnel syndrome and bilateral wrist tendinitis.

LEGAL PRECEDENT -- ISSUE 2

After termination or modification of compensation benefits, clearly warranted on the basis of the evidence, the burden for reinstating compensation shifts to appellant. In order to prevail, appellant must establish by the weight of the reliable, probative and substantial evidence that she had an employment-related disability, which continued after termination of

⁴ See *George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of little probative value).

⁵ See 5 U.S.C. § 8101(2) (this subsection defines a "physician" as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. See also *Charley V.B. Harley*, 2 ECAB 208, 211 (1949) (where the Board has held that a medical opinion, in general, can only be given by a qualified physician).

⁶ For conditions not accepted by the Office as being employment related, it is the employee's burden to provide rationalized medical evidence sufficient to establish causal relation, not the Office's burden to disprove such relationship. *Alice J. Tysinger*, 51 ECAB 638 (2000).

compensation benefits.⁷ 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 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 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.⁸

ANALYSIS -- ISSUE 2

The Board finds that appellant has not established that she has any continuing residuals of her resolved bilateral carpal tunnel syndrome and bilateral wrist tendinitis causally related to her accepted employment conditions on or after June 18, 2008.

On reconsideration appellant submitted an April 11, 2007 report from Dr. Reichhardt and a June 5, 2008 report from Ms. West, both previously of record. Reports from Dr. Grossnickle dated June 11 and July 16, 2008 diagnosed chronic tendinitis, lateral epicondylitis and medial epicondylitis. He also diagnosed bilateral carpal tunnel syndrome, fibromyalgia, chronic mild myofascial pain, chronic tendinitis and overuse syndrome and advised that she could not perform repetitive motion activities with her hands and wrists. On November 3, 2008 Dr. Reichhardt diagnosed bilateral upper extremity pain, carpal tunnel syndrome, bilateral de Quervain's tenosynovitis, right hand trigger finger, bilateral lateral epicondylitis, diabetes, hypertension, fibromyalgia and chronic neck pain. Drs. Grossnickle and Reichhardt did not explain how any continuing condition or medical restrictions were causally related to the accepted employment injury.⁹ Their reports do not include a rationalized opinion regarding the causal relationship between appellant's current bilateral/lateral epicondylitis, diabetes, hypertension, fibromyalgia and chronic neck pain and her accepted conditions.¹⁰ Therefore, these reports are insufficient to establish appellant's claim.

CONCLUSION

The Board finds that the Office met its burden of proof to terminate benefits effective June 18, 2008. The Board further finds that appellant failed to establish that she had any continuing work-related condition or disability after June 18, 2008.

⁷ See *Joseph A. Brown, Jr.*, 55 ECAB 542 (2004); *Virginia Davis-Banks*, 44 ECAB 389 (1993); *Joseph M. Campbell*, 34 ECAB 1389 (1983).

⁸ See *Connie Johns*, 44 ECAB 560 (1993); *James Mack*, 43 ECAB 321 (1991).

⁹ *A.D.*, 58 ECAB 149 (2006) (medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

¹⁰ See *George Randolph Taylor*, *supra* note 6 (where the Board found that a medical opinion not fortified by medical rationale is of little probative value).

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated February 20, 2009, October 7 and June 18, 2008 are affirmed.

Issued: April 19, 2010
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