United States Department of Labor
Employees' Compensation Appeals Board

M.G., Appellant	)	
and	)	**Docket No. 10-818**
	)	**Issued: March 21, 2011**
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, FEDERAL DETENTION CENTER, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 17, 2010 appellant filed a timely appeal from a November 2, 2009 decision of the Office of Workers' Compensation Programs. Pursuant to the Federal Employees' Compensation Act[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether appellant met her burden of proof to establish that she developed a right upper extremity condition as a consequence of her February 1, 2005 left upper extremity injury; and (2) whether the Office met its burden of proof to rescind acceptance of its authorization for right elbow surgery on April 12, 2007 and a subsequent period of disability from April 15 to May 11, 2007.

[1] 5 U.S.C. §§ 8101 *et seq.*

On appeal, appellant's attorney contends that the medical evidence of record establishes that appellant's right elbow and right shoulder conditions were a consequence of the February 1, 2005 left upper extremity injury.

FACTUAL HISTORY

On February 5, 2005 appellant, then a 44-year-old correctional officer, filed an occupational disease claim, alleging that she injured her left shoulder and arm while picking up boxes filled with logbooks on February 1, 2005. The Office accepted that she sustained aggravation of rotator cuff tear and adhesive capsulitis of the left shoulder.

In a February 23, 2005 report, Dr. Stuart Dubowitch, a Board-certified osteopath specializing in orthopedic surgery, noted that appellant was last seen on October 11, 2004 following left shoulder surgery for a rotator cuff tear and that she had recently reinjured her left shoulder picking up boxes at work. He reported a past medical history of multiple knee surgeries, two surgeries to the right shoulder, one surgery to the left shoulder and bilateral carpal tunnel releases. Dr. Dubowitch reported magnetic resonance imaging (MRI) scan and physical examination findings and diagnosed a recent possible rotator cuff and biceps tendon tear with prior adhesive capsulitis of the left shoulder. On August 25, 2005 he performed left shoulder subacromial decompression surgery with repair of rotator cuff tear. Appellant received compensation and returned to work on November 19, 2005.[2] A November 30, 2005 electromyographic (EMG) and nerve conduction studies (NCS) demonstrated chronic C8 radiculopathy with mild ulnar neuropathy at the elbow, right worse than left; chronic C6 radiculitis and mild residual carpal tunnel syndrome, right. On May 5, 2006 the Office accepted a lesion of the ulnar nerve at the left elbow.

On July 6, 2006 Dr. Dubowitch performed left elbow ulnar nerve exploration and decompression surgery. Appellant was placed on the periodic compensation rolls. She returned to full-time modified duty on October 2, 2006.[3]

In reports dated November 24, 2006 and January 5, 2007, Dr. Dubowitch described appellant's postoperative condition and advised that she had increasing problems with her left shoulder. On February 2, 2007 he listed her complaints of problems with her right arm, stating that she had increased stress and demands of her right arm while recovering from left arm injuries to the elbow and shoulder. Dr. Dubowitch noted that appellant previously had carpal tunnel decompressive surgery and advised that physical examination demonstrated a positive compressive maneuver at the right elbow. He diagnosed cubital tunnel of the right upper extremity, residual recurrent right carpal tunnel syndrome and cervical C8 radiculopathy and C6 radiculitis as found on a November 20, 2006 EMG study. Dr. Dubowitch recommended right elbow decompressive surgery. On February 12, 2007 surgery for a right revision of the ulnar nerve at the elbow was authorized by the fiscal agent services of the Office. A February 28,

[2] Appellant initially worked part time and on December 12, 2005 began full-time work.

[3] Appellant returned to administrative work. She was to have no contact with inmates and was to limit the use of her left arm with reaching above the shoulders and repetitive motion of her elbow limited to two hours each and a 15-pound lifting restriction. A January 9, 2007 MRI scan demonstrated questionable partial tears on the left.

2007 right elbow x-ray demonstrated mild spurring and no acute osseous changes since November 17, 2006.[4] On April 12, 2007 Dr. Dubowitch performed right elbow decompressive surgery. Appellant received wage-loss compensation for the period April 15 through May 11, 2007 and she did not return to work.

On June 12, 2007 the Office noted that a claims examiner had not authorized the right elbow surgery or expanded the accepted conditions to include right cubital tunnel syndrome. It forwarded the medical record to an Office medical adviser for review. In a June 30, 2007 report, an Office medical adviser found that there was no medical documentation to establish that appellant's right elbow complaints resulted from an injury to the left upper extremity. The first mention of right cubital tunnel syndrome was on February 2, 2007. The Office medical adviser opined that the April 12, 2007 surgery was not related to any employment-related condition and there was no clear indication for the surgery itself. He concluded that the accepted conditions should not be expanded to the right arm and the surgery should not be approved. Dr. Dubowitch submitted reports describing appellant's condition with continued problems referable to her left shoulder and right elbow. He advised that she could not return to work as a correctional officer.[5]

By letter dated August 15, 2007, the Office proposed to deny appellant's claim for compensation benefits for the period April 15 to May 11, 2007 and rescind authorization of the April 9, 2007 right elbow surgery. It noted that Dr. Dubowitch was advised in error that the surgery was approved and, based on the Office medical adviser's review of the medical record, there was no evidence that appellant's right cubital tunnel condition was employment related.

Appellant, through her attorney, disagreed with the proposed rescission. In a September 7, 2007 report, Dr. Dubowitch described appellant's complaints and his physical findings on February 2, 2007 with reference to her right elbow. He opined that the problems referable to her right upper extremity and right elbow were due to the employment-related trauma to her left arm that necessitated treatment of her left elbow and left shoulder. This required extensive rehabilitation, necessitating increasing stress and demands about the right arm, which caused appellant's right cubital tunnel to become more symptomatic and necessitated surgery. Dr. Dubowitch further opined that her cervical radiculopathy was somewhat aggravated for similar reasons. In subsequent reports, he reiterated the diagnoses and advised that appellant could not work.

By decision dated March 6, 2008, the Office rescinded authorization of the April 9, 2007 surgery and entitlement to wage-loss compensation from April 15 to May 11, 2007. It found that the notification of approval of the April 2007 surgery was an administrative error and that the

[4] Copies of the November 20, 2006 EMG study and November 17, 2006 x-ray are not found in the case record.

[5] Dr. Dubowitch also noted that appellant had employment-related osteofibrosis of the right knee. The Office adjudicated that claim under file number xxxxxx345 and Dr. Ronald M. Krasnick, a Board-certified orthopedic surgeon, provided reports regarding her right knee condition. On August 16, 2007 Dr. Krasnick advised that appellant was totally disabled due to her knee condition.

medical evidence did not support that the right elbow condition was causally related to the February 1, 2005 employment injury.[6]

On March 14, 2008 appellant, through her attorney, requested a hearing. She submitted an April 29, 2008 right shoulder x-ray that was interpreted as normal. In a May 14, 2008 report, Dr. John Ashby, a Board-certified orthopedic surgeon, noted that appellant had a long history of right shoulder, elbow, hand and wrist pain and tingling and a surgical history including bilateral carpal tunnel releases, right knee surgery, bilateral shoulder and bilateral elbow surgery. He provided physical examination findings noting diminished neck range of motion and right shoulder pain during abduction and internal rotation with a mildly positive impingement sign of the right shoulder, diminished right upper extremity sensation and a positive Tinel's sign at the wrist and over the ulnar nerve at the elbow. Dr. Ashby performed EMG and NCS tests on the right that demonstrated mild carpal tunnel syndrome and chronic C8, C6 radiculitis. A May 22, 2008 right shoulder MRI scan study demonstrated evidence of previous acromioplasty, bicipital tendinopathy and anterior labral tear.

On July 28, 2008 Dr. Dubowitch advised that appellant was being assessed for her right elbow and right shoulder. He noted her continued complaints of paresthesias and numbness involving the right ulnar nerve distribution with no intrinsic muscular atrophy and restricted range of motion with impingement and cuff weakness. Dr. Dubowitch opined that the need for treatment of the right shoulder and right elbow were related to the February 1, 2005 employment injury because her right upper extremity problems were due to overuse related to the left upper extremity injuries.

In an August 4, 2008 report, Dr. Michael Monte Carlo, an osteopath, noted the history of injury with subsequent surgeries on appellant's left shoulder. He stated that, due to the February 2005 injury, appellant was placed on light duty in an administrative rule and that, due to the repetitive nature of the clerical activity in this position, she developed right ulnar nerve neuropathy secondary to right cubital tunnel syndrome and right carpal tunnel syndrome, as demonstrated on MRI scan, EMG and clinical examination. Dr. Monte Carlo opined that her right elbow and wrist conditions were a direct result of overuse activity related to the increased clerical-type work when she could not use her left arm, to additional to periods of immobilization of the left shoulder from the initial injury and to lack of immediate treatment following the injury.[7]

At the August 28, 2008 hearing, appellant testified that she injured her right shoulder and right knee while in the Marine Corps and had bilateral carpal tunnel releases in 1994 and 1995 while at the employing establishment and had again injured her right knee in 1997 with additional knee surgery in 2000. She described the February 2005 left upper extremity injury and stated that following the July 2006 left elbow surgery she returned to work as an administrative lieutenant, describing work as 90 percent on the computer. At that time appellant

[6] Additional left shoulder surgery was authorized on March 7, 2008 and was performed by Dr. Dubowitch on March 27, 2008.

[7] Appellant also submitted additional reports from Dr. Krasnick describing her knee condition and reports dated April 2 and May 30, 2008 in which Dr. Dubowitch described her postoperative care for her left shoulder.

had very little use of her left upper extremity and began having problems with her right arm and elbow in late 2006 when she noticed tingling in the elbow and felt that she attributed to overuse. She received total disability compensation under her knee claim beginning in June 2007 and requested wage-loss compensation from May 15 to June 2007 and for medical treatment of her right upper extremity. Appellant was removed from employment on March 1, 2008 for inability to perform the duties of correctional officer. Her attorney argued that the medical evidence established that her right upper extremity condition was a consequence of the left upper extremity injury.

On December 12, 2008 Dr. Dubowitch diagnosed right shoulder rotator cuff tendinopathy, advised that the conditions were due to rehabilitating her left shoulder and elbow and recommended right shoulder surgery.

By decision dated April 17, 2009, an Office hearing representative found that the medical evidence did not establish that appellant's right upper extremity condition was causally related to the accepted left arm conditions or require the April 12, 2007 surgical and resultant surgical procedures and affirmed the May 6, 2008 decision.

On July 14, 2009 appellant, through her attorney, requested reconsideration and submitted the May 18 and July 10, 2009 reports of Dr. Dubowitch who noted diminished right shoulder range of motion with pain. Dr. Dubowitch diagnosed rotator cuff tendinopathy, adhesive capsulitis and partial rotator cuff tear of the right shoulder and status post ulnar nerve decompressive surgery of the right elbow with continued symptomatology of ulnar nerve irritation and some decreased sensation. On July 20, 2009 he described his care since February 23, 2005. Dr. Dubowitch stated that appellant was evaluated on October 27, 2006 for right elbow pain and noted the 2005 EMG findings. He stated that it was clear that she had right upper extremity problems since 2005 that were quiescent until aggravated secondary to repetitive use. Dr. Dubowitch reiterated his opinion that appellant's right upper extremity injuries and the need for surgery, were related to the February 1, 2005 employment injury to her left upper extremity that led to increased use of her right arm. In an August 6, 2009 report, Dr. Monte Carlo described her left and right upper extremity symptoms. Appellant developed right ulnar nerve neuropathy associated with overuse related to being unable to use her left upper extremity and that her right shoulder condition was also directly correlated to the right elbow and right wrist conditions related to the February 1, 2005 left shoulder injury. On August 6, 2009 Dr. Dubowitch performed arthroscopic surgery on appellant's right shoulder. In a September 14, 2009 report, he described her postoperative care. On October 5 and 14, 2009 Dr. Dubowitch noted appellant's complaint of severe left shoulder pain and diagnosed acute bursitis tendinitis of the left shoulder.

By decision dated November 2, 2009, the Office found that appellant did not establish that her right shoulder condition was caused by the February 1, 2005 employment injury and denied modification of the prior decisions regarding rescission of authorization for right elbow surgery and disability compensation for the period April 15 through May 11, 2007.

LEGAL PRECEDENT -- ISSUE 1

Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[8] Rationalized medical evidence is medical evidence which includes a physician's rationalized medical 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.[9] Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[10]

In discussing the range of compensable consequences, once the primary injury is causally connected with the employment, Larson notes that, when the question is whether compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury, the rules that come into play are essentially based upon the concepts of direct and natural results and of claimant's own conduct as an independent intervening cause. The basic rule is that, a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.[11] Aclaimant bears the burden of proof to establish a claim for a consequential injury.[12] As part of this burden, he or she must present rationalized medical opinion evidence, based on a complete factual and medical background, showing causal relationship.

ANALYSIS -- ISSUE 1

The Board finds that appellant did not meet her burden of proof to establish that she developed a right upper extremity condition that was either caused by or a consequence of the February 1, 2005 employment injury when she injured her left upper extremity lifting heavy boxes. The accepted conditions are aggravation of rotator cuff tear and adhesive capsulitis of the left shoulder and lesion of the ulnar nerve at the left elbow. Appellant underwent several surgical procedures to her left upper extremity and after July 6, 2006 decompression surgery to the left elbow, she returned to full-time modified administrative duties.

None of the physicians of record related appellant's right upper extremity conditions to the lifting incident on February 1, 2005. There is therefore no medical evidence to support that her right upper extremity conditions were caused by the February 1, 2005 employment injury.

[8] *D.G.*, 59 ECAB 734 (2008).

[9] *Id.*

[10] *Roy L. Humphrey*, 57 ECAB 238 (2005).

[11] Larson, *The Law of Workers' Compensation* § 1300; *see Charles W. Downey*, 54 ECAB 421 (2003).

[12] *J.J.*, Docket No. 09-0027 (issued February 10, 2009).

Appellant contended that her right elbow and shoulder conditions were a consequence of the injuries to her left upper extremity sustained on February 1, 2005. While she had right shoulder MRI scan findings on May 22, 2008 of previous acromioplasty, bicipital tendinopathy and anterior labral tear, this was more than one year after she stopped work on April 12, 2007. Dr. Ashby did not provide an opinion regarding the cause of appellant's right upper extremity conditions. Medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[13]

Dr. Dubowitch first reported problems with appellant's right arm on February 2, 2007, stating that her right elbow condition was caused by increased stress and demands of her right arm while recovering from left arm injuries to the elbow and shoulder. He diagnosed cubital tunnel syndrome, residual recurrent right carpal tunnel syndrome and cervical C8 radiculopathy and C6 radiculitis and recommended right elbow decompressive surgery. On September 7, 2007 Dr. Dubowitch opined that the problems referable to appellant's right upper extremity were due to the trauma she sustained to her left arm as extensive rehabilitation, placed increasing stress and demands about the right arm. This caused her right cubital tunnel to become more symptomatic, which led to the need for the right elbow surgery and postoperative management and therapy. The Board finds that Dr. Dubowitch's opinion is not sufficiently rationalized to meet appellant's burden of proof to establish that her right upper extremity conditions are a consequence of the February 1, 2005 employment injury to her left upper extremity. Dr. Dubowitch did not explain adequately the basis for his conclusions on causal relationship as he did not address the mechanics of how a left rotator cuff tear or adhesive capsulitis of the shoulder would give rise to right-sided cubital tunnel syndrome. His February 23, 2005 report acknowledged that appellant had a previous injury with surgery to her right shoulder and she testified at the hearing that she had a service-related injury to her right shoulder. Dr. Dubowitch's opinion is insufficient to establish that her right upper extremity conditions are a consequence of the February 1, 2005 injury.

In an August 4, 2008 report, Dr. Monte Carlo advised that appellant's right cubital and carpal tunnel syndrome were caused by overuse when performing the clerical duties of her modified position. On August 6, 2009 he advised that she developed right ulnar nerve neuropathy because she was unable to use her left upper extremity and that her right shoulder condition was also directly correlated to the right elbow and right wrist conditions related to the February 1, 2005 left shoulder injury. These reports are somewhat contradictory regarding the cause of the right upper extremity conditions. Dr. Monte Carlo did not mention the history of appellant's previous service-related right shoulder injury or surgery. His opinion was not based on a complete medical history. It is well established that medical opinions based on an incomplete history or which are speculative or equivocal are of diminished probative value.[14] Dr. Monte Carlo's opinion on causal relationship did not adequately address how appellant's left shoulder injury caused her right upper extremity conditions. His reports are insufficient to meet her burden of proof.

[13] *Willie M. Miller*, 53 ECAB 697 (2002).

[14] *Cecelia M. Corley*, 56 ECAB 662 (2005).

The opinion of a physician supporting causal relationship must be one of reasonable medical certainty that the condition for which compensation is claimed is causally related to federal employment and such relationship must be supported with affirmative evidence, explained by medical rationale and be based upon a complete and accurate medical and factual background of the claimant.[15] The Board finds that the reports of Dr. Dubowitch and Dr. Monte Carlo are insufficient to establish appellant's claim for a consequential right upper extremity injury because they do not provide sufficient medical rationale explaining the mechanics of how her right upper extremity elbow and shoulder conditions were a consequence of her accepted left upper extremity injuries and, contrary to her assertion on appeal, are insufficient to require further development of the case. As the record does not contain an opinion by a physician, supporting causal relationship that was of reasonable medical certainty and supported with affirmative evidence that explained with medical rationale that her right elbow and shoulder conditions were caused by or were a consequence of the February 1, 2005 left upper extremity injuries,[16] she did not establish a consequential right upper extremity condition.

LEGAL PRECEDENT -- ISSUE 2

Section 8128 of the Act[17] provides that the Secretary of Labor may review an award for or against payment of compensation at any time on her own motion or on application.[18] Office regulations on rescission state that, if the Director determines that a review of the award is warranted (including, but not limited to circumstances indicating a mistake of fact or law or changed conditions), the Director (at any time and on the basis of existing evidence) may modify, rescind, decrease or increase compensation previously awarded or award compensation previously denied.[19] The Board has upheld the Office's authority to reopen a claim at any time on its own motion under 5 U.S.C. § 8128 and, where supported by the evidence, set aside or modify a prior decision and issue a new decision. The power to annul an award, however, is not an arbitrary one and an award for compensation can only be set aside in the manner provided by the compensation statute. The Office's burden of justifying termination or modification of compensation holds true where the Office later decides that it has erroneously accepted a claim for compensation. In establishing that its prior acceptance was erroneous, the Office is required to provide a clear explanation of its rationale for rescission.[20]

Section 8103 of the Act provides that the United States shall furnish to an employee who is injured while in the performance of duty, the services, appliances and supplies prescribed or recommended by a qualified physician, which the Office considers likely to cure, give relief,

[15] *Patricia J. Glenn*, 53 ECAB 159 (2001).

[16] *See Conard Hightower*, 54 ECAB 796 (2003).

[17] 5 U.S.C. §§ 8101-8193.

[18] *Id*. at § 8128.

[19] 20 C.F.R. § 10.610; *see A.W.*, 59 ECAB 593 (2008).

[20] *Amelia S. Jefferson*, 57 ECAB 183 (2005).

reduce the degree or the period of disability or aid in lessening the amount of the monthly compensation.[21] While the Office is obligated to pay for treatment of employment-related conditions, the employee has the burden of establishing that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[22]

Under the Act, the term "disability" means the incapacity, because of an employment injury, to earn the wages that the employee was receiving at the time of injury. Disability is thus not synonymous with physical impairment, which may or may not result in incapacity to earn wages. An employee who has a physical impairment causally related to a federal employment injury, but who nevertheless has the capacity to earn the wages he or she was receiving at the time of injury, has no disability as that term is used in the Act.[23] Furthermore, whether a particular injury causes an employee to be disabled for employment and the duration of that disability are medical issues which must be proved by a preponderance of the reliable, probative and substantial medical evidence.[24]

ANALYSIS -- ISSUE 2

The Board finds that the Office properly considered a new rationale to support rescission of the April 12, 2007 right elbow surgery. It found that the Office's fiscal unit made an administrative error by authorizing right elbow surgery without review or approval by an Office claims examiner. Workers' compensation authorities generally recognize that compensation awards may be corrected, in the discretion of the compensation agency and in conformity with statutory provision, where there is good cause for so doing, such as mistake or fraud.[25] In the August 15, 2007 notice of proposed rescission, the Office found that appellant's accepted conditions involved the left upper extremity not the right. It explained that authorization for the right elbow surgery was an administrative error without review by the claims examiner or medical adviser. The Office provided a clear explanation to establish that its authorization was erroneous and properly rescinded authorization of the April 12, 2007 right elbow surgery.[26] As it properly rescinded authorization for the April 12, 2007 right elbow surgery, appellant would not be entitled to disability compensation for surgical recovery and the Office rescinded to disability compensation for the period April 15 through May 11, 2007.

The Board finds that the Office properly reopened appellant's claim for further review. As a right upper extremity condition had not been accepted as employment related, the April 12, 2007 right elbow surgery should not have been authorized.

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[21] 5 U.S.C. § 8103; *see L.D.*, 59 ECAB 648 (2008).

[22] *Kennett O. Collins, Jr.*, 55 ECAB 648 (2004).

[23] *See* 20 C.F.R. § 10.5(f); *Cheryl L. Decavitch*, 50 ECAB 397 (1999).

[24] *Fereidoon Kharabi*, 52 ECAB 291 (2001).

[25] *D.G., supra* note 8.

[26] *Amelia S. Jefferson, supra* note 20. The Board, however, notes that the authorization for appellant to obtain medical examination and/or treatment created a contractual obligation to pay for the cost of the authorized treatment regardless of the action taken on the claim. *See Kimberly Kelly*, 51 ECAB 582 (2000).

CONCLUSION

The Board finds that appellant did not establish that she had a right upper extremity condition causally related to the February 1, 2005 employment injury and that the Office properly rescinded authorization for the April 12, 2007 right elbow surgery and entitlement to wage-loss compensation for the period April 15 through May 11, 2007.

ORDER

IT IS HEREBY ORDERED THAT the November 2, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 21, 2011
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board