United States Department of Labor
Employees' Compensation Appeals Board

W.J., Appellant **and** **FEDERAL JUDICIARY, U.S. PROBATION OFFICE, Jacksonville, FL, Employer**	)	**Docket No. 12-1606** **Issued: August 5, 2013**

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On July 23, 2012 appellant filed a timely appeal from the July 6, 2012 merit decision of the Office of Workers' Compensation Programs. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this appeal.

ISSUE

The issue is whether appellant sustained right knee arthritis or a lesion of the right ulnar nerve due to his June 16, 2008 injury.

FACTUAL HISTORY

On June 16, 2008 appellant, then a 47-year-old probation officer, was injured in a motor vehicle accident. His claim was accepted by OWCP for a fracture of the right humerus, a closed

[1] 5 U.S.C. § 8101 *et seq.*

fracture of the fourth posterior rib on the right side; adhesive capsulitis of the right shoulder and other affections of the right shoulder not elsewhere classified. Appellant did not return to work.

In a June 24, 2008 report, Dr. Michael Suk, Board-certified in orthopedic surgery, reviewed a history of the accepted motor vehicle accident. He advised that appellant sustained a right shoulder dislocation with a greater tubercle fracture and had complaints of right knee pain without restricted motion. Dr. Suk noted that appellant would undergo conservative treatment of the knee.

The record reflects that on July 11, 2008 appellant underwent surgery by Dr. Mark E. Farmer, a Board-certified orthopedic surgeon. The procedure consisted of an open reduction and internal fixation of the right shoulder. Following surgery, appellant underwent physical therapy. He was restricted from use of the right arm and lifting. On January 5, 2009 Dr. Farmer found that appellant was capable of returning to modified duty with a maximum 10-pound lifting restriction; he noted that appellant was not at maximum medical improvement.

Appellant was referred by OWCP for examination by Dr. Jeffrey Fried, an orthopedic surgeon. In a July 16, 2009 report, Dr. Fried reviewed the history of injury, medical treatment and physical therapy. He advised that, following surgery, appellant had difficulty regaining range of motion of the right shoulder and a slight right curve of the acromion. Dr. Fried had most recently recommended that appellant undergo manipulation of the shoulder with subacromial decompression and capsule release in addition to hardware removal. On physical examination, Dr. Fried set forth range of motion measurements and noted diminished sensation of the small fingers. He advised that the current diagnosis was significant restriction of motion and probable adhesive capsulitis following surgery. Dr. Fried stated that appellant was disabled from work at his usual job as his limitations interfered with his ability to restrain clients, reaching and heavy lifting. He recommended arthroscopic evaluation of the shoulder joint with removal of the hardware and manipulation, if necessary. Dr. Fried noted that appellant was a candidate for vocational rehabilitation.

On December 8, 2009 diagnostic x-rays were obtained of the right shoulder. They were interpreted as showing a bone fragment adjacent to the greater tuberosity with a slight bony proliferation at the inferior glenoid rim. Two surgical screws were seen passing through the neck of the proximal right humerus. On February 26, 2010 Dr. Farmer obtained x-rays of the right knee. There was good bone density, no joint space narrowing and no evidence of tumors of other lesions or of any fracture. Dr. Farmer listed an impression of a normal knee, with old Osgood-Schlatters disease. On review of right shoulder x-rays obtained that day, Dr. Farmer noted a Type 2 B acromion with large spike and a healed fracture of the greater tuberosity. He listed an impression of moderate impingement.

On April 20, 2010 Dr. Farmer performed manipulation of the right shoulder under anesthesia with arthroscopy, lysis of adhesions and pan-capsular release followed by arthroscopic subacromial decompression.

In a June 7, 2010 report, Mary A. Amback, an associate of Dr. Farmer, who is Board-certified in physical medicine and rehabilitation, noted appellant's complaint of numbness with intermittent aching of the right arm, worse when raising the extremity. She advised that

diagnostic testing showed a mild carpal tunnel syndrome on the right and no ulnar neuropathy. There was good range of motion, no weakness or swelling. Appellant was continued on physical therapy.

On October 29, 2010 appellant asked OWCP to accept the conditions of right knee injury/knee pain and numbness and tingling of the fingers in his right hand.

By decision dated December 10, 2010, OWCP denied appellant's claim, finding that he failed to submit sufficient medical evidence to establish the causal relationship of his right knee or wrist conditions to the accepted injury.

By letter dated November 29, 2011, appellant requested reconsideration. He submitted a January 11, 2011 report by Dr. Mark D. Durden, a specialist in family practice, who stated that appellant had complaints of right arm pain with numbness, tingling and cold sensation since undergoing rotator cuff surgery. Dr. Durden attributed the symptoms to an accident at work. Appellant experienced decreased grip strength, biceps strength and deltoid strength in the right upper extremity. Dr. Durden noted that appellant might be experiencing radiculopathy.

In a March 22, 2011 report, Dr. Christina L. Mayville, a Board-certified neurologist, stated that appellant had a history of bilateral hand numbness with recent complaints of right hand numbness involving the second to fifth digits and loss of strength in the right hand. Appellant related that he experienced these symptoms since the June 16, 2008 automobile accident. Dr. Mayville found that he had a disturbance of skin sensation with a possible brachial plexus injury. On April 14, 2011 she stated that the results of a nerve conduction study showed a chronic lesion of the right ulnar nerve.

In a report dated May 9, 2011, Dr. William S. Hutchings, Board-certified in family practice, stated that appellant had injured his ribs, right shoulder and right knee as a result of the June 2008 injury. He advised that appellant had numbness in the fingers of his right hand due to a radial nerve injury, which caused symptoms in the palm and palmar surfaces of the right hand and fingers. Dr. Hutchings related that appellant's right knee stiffened up after sitting or standing for short periods of time and trouble walking. Appellant experienced a popping sensation in his right knee and had severe right leg pain while squatting; he walked with a limp favoring the right leg. Dr. Hutchings diagnosed arthritis of the right knee from trauma and partial ulnar and median nerve palsy.

An x-ray report of May 10, 2011 noted that two views of the right knee were essentially normal. There was no joint effusion, intact bones and the joint spaces were preserved. There was some calcification at the tibia patellar joint ligament and quadriceps insertion on the patella.

On January 12, 2012 Dr. James W. Dyer, an OWCP medical adviser, reviewed the medical evidence of record. He stated that the motor vehicle accident and right shoulder surgery were not competent to cause or contribute to the ulnar nerve lesion. Dr. Dyer noted that the ulnar and median nerves were anatomically well distal to the shoulder region. Ulnar nerve injuries occurred with elbow fractures or dislocations and median nerve injuries occurred with forearm fracture or dislocation. The shoulder region frequently involved the axillary or radial nerves of

the upper extremity. Appellant's shoulder surgery was not medically competent to cause or otherwise contribute to the ulnar nerve lesion in the right arm.

By decision dated January 18, 2012, OWCP denied appellant's claim of right knee arthritis and right ulnar nerve lesion. It found that he failed to submit sufficient medical evidence to establish these conditions as causally related to the June 16, 2008 employment injury or right shoulder surgery.

On April 11, 2012 appellant requested reconsideration. He submitted the February 12, 2012 report of Dr. Mayville, who noted ongoing complaints of numbness in the right hand and the second digit of the right hand. Dr. Mayville noted that appellant sustained a dislocated shoulder and fracture of the upper end of the humerus and adhesive capsulitis of the right shoulder. Appellant experienced a constant cold sensation in his right fingers, worse in cold weather, with different, paler coloration in the palms of his right hand as opposed to the left. He underwent electromyelogram studies which noted an ulnar nerve lesion on the right which was chronic and proximal. Dr. Mayville stated that there was no history of appellant having an ulnar lesion prior to the motor vehicle accident, which was not localized as was typical with elbow lesions. She opined that his right-sided neuropathy and right hand lesion were most likely caused by the upper extremity trauma he experienced at the time of the June 2008 injury.

Dr. Mayville advised that appellant was not diabetic or had hypothyroid or alcoholic conditions which might predispose him to neuropathies. In addition, not all of his symptoms were explainable on the basis of ulnar neuropathy. Dr. Mayville stated that the coldness and numbness of the second and third digits were not explainable on the basis of ulnar neuropathy, as these were in the distribution of the median nerve. These symptoms on examination and the pallor of the palm might be caused by a complex regional pain syndrome, which was usually caused by a proximal injury. Although appellant did not have objective findings of complex regional pain syndrome, he most likely had a mild case. Dr. Mayville advised that his condition was a result of the automobile accident and proximal arm and shoulder injury he sustained on June 16, 2008.

In a report dated April 10, 2012, Dr. Durden stated that he evaluated appellant for intermittent right knee pain experienced since the June 2008 accident. Appellant mentioned having right knee pain in several of the medical reports issued subsequent to the June 2008 injury. Dr. Durden stated that appellant had not experienced right knee pain prior to the June 2008 injury and concurred with the diagnosis of right knee arthritis due to traumatic injury. He noted that appellant experienced recurrent pain, inflammation, stiffness and weakness in the joint. Dr. Durden opined that arthritis was a chronic, recurrent and incurable condition which typically worsened over time. He administered a pain-killing injection to appellant's right knee.

By decision dated July 6, 2012, OWCP denied modification of the January 18, 2012 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[2] has the burden of proof to establish the essential elements of his or her claim by the weight of the evidence,[3] including that he or she sustained an injury in the performance of duty and that any specific condition or disability for work for which he or she claims compensation is causally related to that employment injury.[4] As part of his burden, the employee must submit rationalized medical opinion evidence based on a complete factual and medical background showing causal relationship.[5] The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of the analysis manifested and the medical rationale expressed in support of the physician's opinion.[6]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is a causal relationship between the employee's diagnosed condition and the compensable employment factors.[7]

ANALYSIS

Appellant was injured in a June 16, 2008 motor vehicle accident and his claim was accepted for a fracture of the right humerus, adhesive capsulitis of the right shoulder; other affections of the right shoulder region not elsewhere classified and closed fracture of fourth posterior rib on the right. He was initially treated on a conservative basis and underwent surgery on July 11, 2008 by Dr. Farmer for an open reduction and internal fixation of the right shoulder. On January 5, 2009 appellant was returned to modified duty by Dr. Farmer under specified work restrictions.

Appellant contends that he sustained right knee arthritis and an ulnar nerve lesion of the right wrist due to the June 16, 2008 employment incident. As these conditions were not accepted by OWCP, he has the burden to establish causal relationship to the accepted June 16, 2008 injury.[8]

Regarding the claimed right knee condition, on June 24, 2008 Dr. Suk listed that appellant had complaint of right knee pain without restricted motion following the June 16, 2008

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[2] 5 U.S.C. §§ 8101-8193.

[3] *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

[4] *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[5] *Id.*; *Nancy G. O'Meara*, 12 ECAB 67, 71 (1960).

[6] *Jennifer Atkerson,* 55 ECAB 317, 319 (2004); *Naomi A. Lilly*, 10 ECAB 560, 573 (1959).

[7] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[8] *Robert Broome,* 55 ECAB 339, 342 (2004).

motor vehicle accident. The Board notes that Dr. Suk did not provide a firm medical diagnosis for this complaint or address how the accepted injury caused or contributed to appellant's right knee complaints. Dr. Suk did not support a diagnosis of right knee arthritis. On February 26, 2010 Dr. Farmer obtained x-rays of the right knee that revealed good bone density, no joint space narrowing and no evidence of tumor or other lesions or of any fracture. He stated that appellant had a normal knee with evidence of old Osgood-Schlatters disease.[9] This evidence reflects that approximately a year and a half following the June 16, 2008 injury, Dr. Farmer did not find evidence of right knee arthritis or support such a diagnosis.

Following the December 10, 2010 denial of his claim for right knee arthritis, appellant submitted the May 9, 2011 report of Dr. Hutchings, who listed under the history of the 2008 accident that appellant had injured his right knee and related that it stiffened after sitting or standing for short periods of time. The Board notes that Dr. Hutchings provided a medical diagnosis of arthritis of the right knee from trauma; but did not address causal relationship. The history of injury recounted by Dr. Hutchings was not accurate as it pertained to the conditions accepted by OWCP in this case arising from the accepted motor vehicle accident. Moreover, Dr. Hutchings did not provide a review of the medical evidence of record or address the prior medical reports, such as the February 26, 2010 evaluation by Dr. Farmer. On May 10, 2011 additional x-ray studies were obtained of the right knee for Dr. Hutchings which were reported as essentially normal. There was no joint effusion, intact bones and joint spaces preserved. There was calcification at the tibia patellar ligament and the quadriceps insertion.[10] Dr. Hutchings did not address how the 2011 x-ray findings supported the diagnosis of arthritis, noted as a clinical indication. The calcification of the tibia patellar ligament conforms to the diagnosis by Dr. Farmer of old Osgood-Schlatters disease.

Following the January 18, 2012 decision denying his claim, appellant submitted the February 12, 2012 report of Dr. Durden, who evaluated appellant for complaint of right knee pain experienced since the 2008 injury. Dr. Durden stated that appellant did not experience right knee pain prior to the injury and diagnosed right knee arthritis. He administered an injection. The Board finds that Dr. Durden's report is not sufficient to establish appellant's claim. Dr. Hutchings did not provide a full or accurate history of appellant's right knee condition or address the old Osgood-Schlatters disease. Dr. Durden did not obtain any additional diagnostic testing or provide a review of the x-rays obtained of the right knee in 2010 and 2011 that were reported as essentially normal. Due to these deficiencies, his diagnosis and opinion on causal relationship is of diminished probative value. Based on the medical evidence of record, the Board finds that appellant has not established that he sustained right knee arthritis as a result of the accepted 2008 motor vehicle accident.

As to the claimed right ulnar nerve lesion, appellant was treated for the accepted fracture of the right humerus and his claim accepted for adhesive capsulitis and other conditions of the right shoulder region not elsewhere classified. Dr. Suk advised that appellant sustained a dislocation of the right shoulder with a fracture and he underwent surgery by Dr. Farmer on

[9] Osgood-Schlatters disease is inflammation or irritation of the patellar ligament at the tibial tuberosity, characterized by lumps just below the knee most often in adolescents.

[10] *Id.*

July 11, 2008. The medical reports contemporaneous to the accepted motor vehicle accident did not diagnose or address any ulnar nerve lesion. Following surgery, Dr. Farmer noted that appellant had difficulty with range of motion to the shoulder and he underwent physical therapy. In February, 2010, he obtained right shoulder x-rays which showed a healed fracture. Dr. Farmer listed an impression of moderate impingement and performed a manipulation of the shoulder on April 20, 2010.

On June 7, 2010 Dr. Amback, an associate of Dr. Farmer, noted appellant's complaint of numbness with aching of the right arm. She advised that diagnostic testing showed a mild carpal tunnel syndrome on the right with no ulnar neuropathy. This report did not support a lesion of the ulnar nerve, as claimed. On January 11, 2011 Dr. Durden listed appellant's complaint of right arm pain and noted decreased grip strength, biceps strength and deltoid strength. He stated that appellant might be experiencing radiculopathy. This report did not diagnose a lesion of the ulnar nerve.

On March 22, 2011 Dr. Mayville noted appellant's complaint of bilateral hand numbness. She found a disturbance of skin sensation with a possible brachial plexus injury. On April 14, 2011 Dr. Mayville stated that a nerve conduction study showed a chronic lesion of the right ulnar nerve, but she did not address the causal relationship of this finding to the accepted motor vehicle accident of 2008. Dr. Hutchings noted that appellant had numbness in the fingers of his right hand, but stated that this was due to a radial nerve injury causing symptoms in the palm and palmar surfaces of the right hand. He also diagnosed partial ulnar and medial nerve palsy but did not explain how such conditions related to the accepted injury.

The medical evidence was reviewed by an OWCP medical adviser. On January 12, 2012 Dr. Dyer stated that the motor vehicle accident caused a right shoulder injury and was not competent to cause or contribute to an ulnar nerve lesion. He stated that most ulnar nerve injuries occurred in the region of the elbow and were due to fracture or dislocation while medial nerve injuries occurred with forearm fracture or dislocation. Dr. Dyer noted that the shoulder region was enervated by the axillary and radial nerves and that the surgery performed by Dr. Farmer would not cause or contribute to an ulnar nerve lesion.

Dr. Mayville reiterated on April 11, 2012 that appellant underwent diagnostic testing that showed an ulnar nerve lesion on the right. She stated that he had no history of a lesion prior to the motor vehicle accident and stated that his condition was most likely caused by the upper extremity trauma he experienced. The Board finds that the opinion of Dr. Mayville on causal relationship is speculative in nature and not stated to a reasonable degree of medical certainty.[11] Dr. Mayville relied largely on the fact that an ulnar nerve lesion had not been diagnosed prior to the 2008 motor vehicle accident.[12] The Board also notes that the diagnostic testing obtained in 2011 was almost three years following the accepted injury. It is well established that, when diagnostic testing is delayed, the uncertainty mounts regarding the cause of the diagnosed condition and a question arises as to whether such testing documents an injury as claimed by the

[11] *See Elizabeth H.Kramm (Leonard O. Kramm)*, 57 ECAB 117 (2006).

[12] *See Michael S. Mina*, 57 ECAB 379 (2006) the fact a condition arises after an injury and was not present before injury is not sufficient to support causal relationship.

employee.[13] Moreover, Dr. Mayville noted that not all of appellant's symptoms were explainable by the diagnosis of ulnar neuropathy, as the coldness and numbness experienced at certain fingers was in the distribution of the median nerve. She listed the possibility of a complex regional pain syndrome, but noted that he did not have objective findings to support such diagnosis or, at best, only a mild case. The Board finds that Dr. Mayfield did not adequately describe how the accepted motor vehicle accident in 2008 was competent to cause appellant's symptoms. Dr. Mayfield's opinion is of limited probative value for the further reason that it is generalized on the issue of causal relation and equivocal in nature.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he sustained right knee arthritis or a right ulnar nerve lesion due to the June 16, 2008 injury.

ORDER

IT IS HEREBY ORDERED THAT the July 6, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 5, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[13] *See Thomas R. Horsfall*, 48 ECAB 180 (1996).