United States Department of Labor
Employees' Compensation Appeals Board

S.K., Appellant	)	
and	)	**Docket No. 14-520**
	)	**Issued: July 18, 2014**
DEPARTMENT OF HOMELAND SECURITY, IMMIGRATION & CUSTOMS ENFORCEMENT, Long Beach, CA, Employer	)	

Appearances:
Max Gest, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On January 8, 2014 appellant, through his representative, filed a timely appeal from the Office of Workers' Compensation Programs' (OWCP) decision dated September 26, 2013. 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 claim.

ISSUE

The issue is whether appellant established that his brachial plexus condition, bilateral ulnar neuropathy or right carpal tunnel syndrome are causally related to his accepted November 17, 1999 employment injury.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On November 17, 1999 appellant, then a 42-year-old supervisory special agent, sustained injury to his neck and left arm pain as a result of being kicked, shoved and pushed during baton and pepper spray training. He stopped work on January 14, 2000. OWCP accepted appellant's claim for cervical strain, aggravation of cervical degenerative disc diseases, herniated discs L4-5 and L5-S1, major depression and psychogenic pain disorder. Appellant received disability compensation.

Appellant underwent an authorized cervical discectomy and fusion on March 27, 2008, which was performed by Dr. Sam Bakshian, a Board-certified orthopedic surgeon. In a report dated April 8, 2009, Dr. Bakshian related that appellant was one-year post cervical fusion. He conducted a physical examination and reviewed electromyogram (EMG) studies. Dr. Bakshian diagnosed bilateral cubital tunnel syndrome, right carpal tunnel syndrome, which were superimposed on appellant's cervical radiculopathy and were a direct consequence of the November 17, 1999 employment injury.

On April 9, 2009 Dr. Lawrence R. Miller, Board-certified in internal medicine, pain management and anesthesiology, examined appellant. He diagnosed post cervical laminectomy pain syndrome, lumbar post laminectomy pain syndrome, left shoulder impingement/adhesive capsulitis, right cubital tunnel syndrome and left thoracic outlet syndrome.

To determine appellant's permanent impairment, OWCP referred him to Dr. Joan Sullivan, a Board-certified orthopedic surgeon. In a report dated March 24, 2010, Dr. Sullivan related that her examination on that day did not reveal cubital tunnel symptoms, but that EMG findings were consistent with cubital tunnel entrapment neuropathy. OWCP thereafter referred appellant to Dr. John S. Wendt, a Board-certified neurologist for a second opinion evaluation. In a report dated July 7, 2010, Dr. Wendt related that appellant had electrodiagnostic evidence of bilateral cubital tunnel syndrome and mild right carpal tunnel syndrome. He concluded that appellant had no clear objective neurologic deficits with respect to the upper extremities on an objective basis that were injury related.

Appellant was evaluated by Dr. Jacob E. Tauber, a Board-certified orthopedic surgeon, on November 4, 2010. Dr. Tauber explained that appellant had undergone extensive cervical and lumbar surgery, which were clearly failed surgical procedures. He stated that appellant had a left thoracic outlet syndrome confirmed on ultrasound, bilateral cubital tunnel syndrome and a right carpal tunnel syndrome each confirmed by objective testing. Dr. Tauber explained that appellant's physical examination would not follow specific dermatomal findings because appellant had so many levels of involvement.

On July 20, 2012 OWCP referred appellant, together with a statement of accepted facts and the medical record, to Dr. Robert Lang, a Board-certified neurological surgeon, for a second opinion examination regarding his upper extremity symptoms. In an August 22, 2012 report, Dr. Lang reviewed appellant's history and accurately described the November 17, 1999 employment injury. Upon examination of the upper extremities, he observed +1 triceps and biceps reflexes on the left. Tinel's test at the elbow was mildly positive on the right and strongly positive on the left. Dr. Lang diagnosed a brachial plexus injury, bilateral ulnar neuropathy at

the elbow and right carpal tunnel syndrome. He stated that appellant sustained injury to both upper extremities related to the accepted work injury and continued to have residuals of the injury. Dr. Lang explained that the brachial plexus and bilateral ulnar neuropathy injuries were likely related to the cervical condition and subsequent surgeries. He recommended further electrodiagnostic testing. In a November 19, 2012 addendum report, Dr. Lang noted that he reviewed an October 29, 2012 EMG report which confirmed findings of bilateral cubital tunnel syndrome, right carpal tunnel syndrome and chronic left C7-T1 radiculopathy. He reiterated that appellant's brachial plexus injury and bilateral ulnar neuropathy were likely related to his ongoing cervical and lumbar conditions from the industrial injury. Dr. Lang reported that the EMG study confirmed that appellant had right carpal tunnel syndrome and opined that this condition was likely related to appellant's claim. He concluded that appellant sustained an injury to both upper extremities related to the original work injury and continued to suffer residuals of the injury.

In a February 8, 2013 report, Dr. Kenneth D. Sawyer, a Board-certified surgeon and the district medical adviser, reviewed the medical record, including Dr. Lang's second opinion reports. He opined that appellant's carpal tunnel syndrome, cubital tunnel syndrome, brachial plexus pathology and thoracic outlet syndrome were not likely related to the November 17, 1999 employment injury.

In a letter dated March 7, 2013, appellant's representative requested that OWCP accept appellant's claim for brachial plexus injury, bilateral ulnar neuropathy and right carpal tunnel syndrome.

In a May 6, 2013 report, Dr. Sawyer again reviewed the record. He opined that appellant's brachial plexus injury, bilateral ulnar neuropathy at the elbow and right carpal tunnel syndrome were most likely not related to the accepted injury. Dr. Sawyer advised that none of the conditions should be accepted under this claim. He noted that the conditions developed months or years after the accepted injury. Dr. Sawyer stated that Dr. Lang provided no explanation for his opinion that appellant's upper extremity conditions were consequential to the original November 17, 1999 employment injury.

In a decision dated May 30, 2013, OWCP denied appellant's claim for brachial plexus injury, bilateral ulnar neuropathy at the elbow and right carpal tunnel syndrome based on the opinion of Dr. Sawyer, the district medical adviser.

By letter dated June 11, 2013, appellant's representative requested a hearing, which was held on August 12, 2013. He alleged that Dr. Lang's second opinion reports represented the weight of medical opinion. Appellant's representative had physically examined appellant while Dr. Sawyer only reviewed the medical record. He also contended that there was an unresolved conflict in medical opinion that existed between Dr. Sawyer and Dr. Lang.

In a June 14, 2013 report, Dr. Tauber reviewed appellant's history and his previous evaluation of appellant. He diagnosed thoracic outlet syndrome, bilateral ulnar neuropathy, right carpal tunnel syndrome and brachial plexus injury. Dr. Tauber noted that these diagnoses were confirmed by electrodiagnostic studies. He agreed with Dr. Lang that appellant's upper extremity conditions were attributable to his employment injury. Dr. Tauber explained that

appellant had a history of failed spine surgery syndrome and had diffuse weakness and sensory losses which would have been consistent with his failed symptoms. He also stated that it remained his opinion that appellant's claim should be accepted for all of the diagnosed conditions because appellant's employment duties were strenuous, involving repetitive motion and were a known cause of his conditions. Dr. Tauber disagreed with Dr. Sawyer's finding that appellant's thoracic outlet syndrome was temporary, because it had existed a period of nine years.

By decision dated September 26, 2013, OWCP's hearing representative affirmed the May 30, 2013 denial 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, including that any specific condition or disability for work is causally related to the employment injury.[3]

The evidence generally required to establish causal relationship is rationalized medical opinion evidence. The medical opinion must be based on a complete factual and medical background with an accurate history of the employment injury and must explain from a medical perspective how the current condition is related to the injury.[4]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[5] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[6] When there exists opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[7]

[2] *Id*.

[3] *T.B.*, Docket No. 13-799 (issued March 5, 2014).

[4] *D.U.*, Docket No, 10-144 (issued July 27, 2010); *D.G.*, 59 ECAB 734 (2008); *Donald W. Wenzel*, 56 ECAB 390 (2005).

[5] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[6] 20 C.F.R. § 10.321.

[7] *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

ANALYSIS

The Board has duly reviewed the matter and finds that this case is not in posture for a decision as there is an unresolved conflict in a medical opinion between appellant's treating physicians, Drs. Bakshian and Tauber who found that his upper extremity conditions were related to his November 17, 1999 employment injury. Dr. Sawyer determined that these conditions were not causally related to appellant's accepted injury.

The Board notes that appellant was referred for several evaluations to determine the degree of his permanent impairment, after Dr. Bakshian, appellant's treating orthopedic surgeon, performed a cervical discectomy and fusion in March 2008. In 2009, Dr. Bakshian diagnosed bilateral cubital tunnel syndrome, right carpal tunnel syndrome, superimposed upon appellant's cervical radiculopathy, which he opined were the direct consequence of appellant's accepted employment injury. During the second opinion evaluations related to the permanent impairment question, the issue arose regarding the proper diagnosis of appellant's cervical and upper extremity conditions. As noted by Drs. Bakshian and Miller, appellant's electrodiagnostic studies evidenced bilateral cubital tunnel syndrome and right carpal tunnel syndrome. OWCP second opinion physicians, Drs. Sullivan and Wendt noted appellant's electrodiagnostic studies, but could not confirm the diagnoses on physical examination. Appellant was then examined by Dr. Tauber, who advised that appellant's physical examination would not follow specific dermatomal findings because appellant had so many levels of involvement. Dr. Tauber related that appellant's diagnoses, based upon objective findings, were left thoracic outlet syndrome, bilateral cubital tunnel syndrome and right carpal tunnel syndrome.

Appellant was then referred by OWCP for a second opinion evaluation with Dr. Lang, who related that appellant had confirmed findings of bilateral cubital tunnel syndrome, right carpal tunnel syndrome and brachial plexus injury. Dr. Lang opined that the conditions were causally related to appellant's work injury and his cervical surgery. Dr. Tauber subsequently agreed with Dr. Lang's opinion that the diagnoses were causally related to appellant's work injury. He explained that appellant's diffuse weakness and his sensory losses were due to his failed surgery. Dr. Tauber also opined that appellant's strenuous work activities, which caused the accepted conditions, were a known cause of his other diagnosed conditions.

The record was reviewed by Dr. Sawyer, an OWCP medical adviser, who opined that appellant's conditions were not work related, as they developed months or years subsequent to the injury.

The Board finds that a conflict exists between Drs. Sawyer, Bakshian and Tauber. OWCP should refer appellant to an impartial medical examiner to resolve the medical conflict. The Board will set aside the September 26, 2013 decision and remand the case to OWCP for referral to an impartial medical examiner for further medical development. Following this and any further development as deemed necessary, OWCP shall issue an appropriate final decision on appellant's claim.

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the September 26, 2013 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: July 18, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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