United States Department of Labor
Employees' Compensation Appeals Board

S.S., Appellant	)	
and	)	**Docket No. 14-211**
	)	**Issued: May 1, 2014**
DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF INVESTIGATION, Los Angeles, CA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On November 4, 2013 appellant filed a timely appeal from a June 26, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 case.

ISSUE

The issue is whether appellant established a recurrence of a medical condition on May 3, 2012 due to the accepted May 1, 2006 occupational injury.

FACTUAL HISTORY

On December 4, 2006 appellant, then a 43-year-old occupational health nurse, filed an occupational disease clam (Form CA-2) alleging a hand condition from use of her keyboard. She

[1] 5 U.S.C. § 8101 *et seq.*

first became aware of her condition on May 1, 2006, and of its relationship to her employment on August 14, 2006. On March 2, 2007 OWCP accepted appellant's claim for bilateral radial styloid tenosynovitis, also known as de Quervain's tenosynovitis. Appellant did not claim wage loss as a result of her condition. She received authorization for payment of medical procedures, including surgery and physical therapy. Appellant returned to full-time limited-duty work on May 22, 2008.

In a form report dated June 7, 2007, Dr. George A. Macer, Jr., a Board-certified orthopedist, diagnosed appellant with carpal tunnel syndrome. In a report dated August 13, 2007, Dr. Fred H. Batkin, Board-certified in physical medicine and rehabilitation, stated that an electromyogram/nerve conduction velocity (EMG/NCV) study of appellant's bilateral upper extremities revealed normal sensory nerve conduction and bilateral median motor conduction with no evidence of median nerve neuropathy across the wrist and no evidence of peripheral polyneuropathy.

In a February 20, 2008 record of a telephone conversation, appellant requested that carpal tunnel syndrome be added to her accepted conditions. On March 5, 2008 Dr. Macer called OWCP by telephone. OWCP informed him that appellant's claim was not accepted for carpal tunnel syndrome or a shoulder condition; but he could provide a supplemental report discussing the diagnoses of carpal tunnel syndrome in light of the negative EMG/NCV test. Dr. Macer submitted additional reports listing a diagnosis of carpal tunnel syndrome, but did not provide the requested opinion addressing causal relation. On May 6, 2008 Dr. Macer stated that he believed nearly all of her symptoms were due to her accepted de Quervain's tenosynovitis and recommended surgery, which was performed on May 19, 2008.

In a report dated August 16, 2008, Dr. Sangarapillai Manoharan, Board-certified in emergency medicine, diagnosed appellant with bilateral carpal tunnel syndrome, status post left de Quervain's tendon release and left shoulder tendinitis. Appellant reported that she developed pain in both wrists and hands in May 2006, and that her position involved prolonged writing, typing and data entry. On examination, Dr. Manoharan noted slight to moderate pain with flexion and extension of the left wrist and bilaterally negative Finklestein's, Tinel's and Phalen's tests. He stated that scar tissue resulting from surgery to correct appellant's left de Quervain's tenosynovitis caused her symptoms. Dr. Manoharan referred her to a hand specialist and noted that her carpal tunnel syndrome appeared mostly on the left side.

On August 20, 2008 Dr. Robert Sundstrom, a Board-certified orthopedic surgeon, diagnosed appellant with a superficial left radial nerve neuritis secondary to her radial wrist surgery and probable left carpal tunnel syndrome. While the radial neuritis was related to the previous surgery, the carpal tunnel syndrome "may have been present to some degree before the de Quervain's surgery" and "was more likely than not aggravated by the surgery and had been a result of previous work experience." On examination, he noted a positive Finklestein's test and a positive Phalen's test. Dr. Sundstrom reviewed appellant's history of injury, stating that she had worked at the employing establishment for three years in a position that involved typing and prolonged writing and data entry. He noted that in May 2006, she developed pain in both wrists and hands without any acute event. Appellant's pain was aggravated by typing and writing activity at work. Dr. Sundstrom stated that on initial discussion regarding her carpal tunnel syndrome, appellant described only numbness on the volar aspect of her thumb, but that, after he

informed her about typical carpal tunnel syndromes, she became aware of some parasthesias in the index, long and radial ring fingers.

In a diagnostic report dated October 9, 2008, Dr. Arnold S. Rappoport, a Board-certified radiologist, obtained a magnetic resonance imaging (MRI) scan of appellant's left wrist. He noted no abnormality in the flexor and extensor tendons; normal components of the carpal tunnel, including normal extensor pollicis brevis and abductor pollicis longus tendons; no evidence of increased signal, thickening, or abnormality in the surrounding soft tissue of these tendons; articulations within normal limits; normal intracarpal ligaments; and a normal triangular fibrocartilaginous complex. Dr. Rappoport concluded that no abnormality had been demonstrated.

In a progress report dated November 14, 2008, Dr. Manoharan reviewed the results of a bilateral bone scan study and the MRI scan of appellant's left hand. The bone scan study revealed no evidence for reflex sympathetic dystrophy and the MRI scan was normal. Dr. Manoharan stated that most of appellant's bilateral carpal tunnel syndromes were localized over the left wrist, particularly over the site where she had a surgical excision for her de Quervain's tendinitis. He recommended continuing modified duty under the prior restrictions.

On January 16, 2009 Dr. Joshua Sussman, Board-certified in physical medicine and rehabilitation, conducted an EMG/NCV study of appellant's hands and wrists. He stated that appellant's study was abnormal, finding evidence suggestive of a right ulnar motor neuropathy with relative slowing across the elbow.

On April 9, 2009 Dr. Manoharan reviewed appellant's history of injury, stating that she worked as a registered nurse at the employing establishment. Her usual duties involved prolonged writing, typing and data entry. Dr. Manoharan noted that she had developed pain in the wrists and hands in May 2006 and was diagnosed with bilateral carpal tunnel syndrome and left de Quervain's tenosynovitis. She underwent surgery for her left de Quervain's tenosynovitis and, following surgery, she noticed increased pain as well as weakness and numbness in her left hand and thumb. Dr. Manoharan diagnosed bilateral carpal tunnel syndrome, status post left de Quervain's tendon release and left shoulder tendinitis. He treated appellant by prescribing bilateral wrist braces and medication for the surgical incision site. Dr. Manoharan stated that her pain was mainly coming from the surgical site of her left de Quervain's tendon release. Even though she had carpal tunnel syndrome, appellant's pain was mainly confined and localized to the left thumb. Dr. Manoharan recommended a bone scan to rule out reflex sympathetic dystrophy. The study showed findings consistent with a prior surgery to the left wrist and subsequent dystrophic changes involving only the left thumb. On referral to Dr. Sundstrom, he found that appellant had superficial left radial nerve neuritis secondary to radial wrist surgery, and recommended physical therapy. Her symptoms slowly ameliorated and appellant worked modified duty. Dr. Manoharan stated that appellant had slight pain at rest bilaterally at the wrist and hand, and that, after prolonged movements, it would increase to moderate pain, which was mostly localized over the left thumb. On examination, he noted a positive Tinel's sign bilaterally and a positive Finkelstein's sign on the left. Dr. Manoharan stated that "[B]ased on the history, measureable objective findings, review of the medical records, it is the opinion of this examiner more likely than not [that] the repetitive/repetitive cumulative trauma that the patient sustained at work is the cause of her symptoms in both wrists/hands." Dr. Manoharan recommended work

restrictions of no lifting over 30 to 40 pounds, no prolonged gripping or grasping, and no typing or data entry for more than 45 minutes every hour.

On May 3, 2012 Dr. Manoharan noted that appellant complained of thumb pain, neuritis and bilateral carpal tunnel syndrome. He requested authorization for occupational therapy for appellant's wrists and an ergonomic work station evaluation.

In a report dated May 24, 2012, Dr. Manoharan stated that appellant was seen for complaint of slight dull intermittent bilateral wrist pain. On examination of the wrists and hands, he noted tenderness bilaterally. Appellant was referred to occupational therapy and attended for one session. Dr. Manoharan noted that she had reached maximum medical improvement as of May 24, 2012 and that she had permanent work restrictions.

On June 19, 2012 Dr. Manoharan noted that appellant's slight dull intermittent bilateral wrist pain improved with rest and medication and worsened with typing. Appellant had other symptoms, such as numbness and tingling of the first three fingers. Dr. Manoharan advised her to continue with a wrist brace.

On September 5, 2012 Dr. Manoharan noted that appellant had completed the treatment modalities of taking nonsteroidal anti-inflammatory drugs, physical therapy and bracing, with good improvement upon each. He observed no tenderness to the wrists or hands upon physical examination. Dr. Manoharan released appellant from care as of that date and noted that she continued with her permanent work restrictions. He stated that she had reached maximum medical improvement as of September 5, 2012, diagnosing her with bilateral carpal tunnel syndrome, aftercare following surgery for left de Quervain's tenosynovitis and resolved bilateral wrist pain.

Appellant submitted October 5, 2012 requests for authorization for durable medical equipment and further physical therapy for treatment of her bilateral radial styloid tenosynovitis, bilateral carpal tunnel syndrome and limb pain. The dates of service were from August 13 through September 4, 2012. Appellant had also submitted requests for authorization of physical therapy on June 22, 2012, noting a diagnoses of bilateral carpal tunnel syndrome and wrist pain, and on August 15, 2012, noting a diagnosis of carpal tunnel syndrome. Payment for physical therapy on appellant's claim had last been authorized on February 6, 2009.

On May 17, 2013 appellant filed a claim for recurrence of medical condition. She noted that she continued to perform her regular duties after surgery because she was the only nurse at the employing establishment. The employing establishment noted that appellant was removed from its rolls effective February 20, 2013. Appellant did not claim wage loss and stated that she had not worked since leaving the employing establishment.

By letter dated May 23, 2013, OWCP requested additional medical evidence from appellant to support her claim for a recurrence of her medical condition. It noted that the evidence she had submitted was insufficient to support her claim because it contained no medical explanation of how her diagnosis of bilateral carpal tunnel syndrome was the result of a material change or worsening of her accepted bilateral radial tenosynovitis.

In a report dated June 12, 2013, Dr. Manoharan noted that appellant had been declared permanent and stationary as to her bilateral wrist condition. Appellant's diagnoses at the time of the declaration were carpal tunnel syndrome and wrist pain. Dr. Manoharan noted that she had a flare-up of her symptoms of carpal tunnel syndrome, and noted tenderness of the wrists and hands bilaterally. He stated that appellant had intermittent slight dull pain in her wrists bilaterally. Dr. Manoharan diagnosed her with bilateral carpal tunnel syndrome and wrist pain and released her from his care.

By decision dated June 26, 2013, OWCP denied appellant's claim for a recurrence of her medical condition. It noted that she had not provided a medical report from a physician explaining how her carpal tunnel syndrome was related to her accepted condition of radial styloid tenosynovitis.

LEGAL PRECEDENT

A claimant has the burden of establishing that she sustained a recurrence of a medical condition[2] that is causally related to her accepted employment injury. To meet her burden, she must furnish medical evidence from a physician who, on the basis of a complete and accurate factual and medical history, concludes that the condition is causally related to the employment injury and supports that conclusion with sound medical rationale.[3] Where no such rationale is present, the medical evidence is of diminished probative value.[4]

OWCP regulations define a recurrence of medical condition as the documented need for further medical treatment after release from treatment of the accepted condition when there is no work stoppage. Continued treatment for the original condition is not considered a renewed need for medical care, nor is examination without treatment.[5]

OWCP's procedure manual provides that, after 90 days of release from medical care (based on the physician's statement or instruction to return as needed (PRN), or computed by the claims examiner from the date of last examination), a claimant is responsible for submitting an attending physician's report which contains a description of the objective findings and supports causal relationship between the claimant's current condition and the previously accepted work injury.[6]

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[2] Recurrence of medical condition means a documented need for further medical treatment after release from treatment for the accepted condition or injury when there is no accompanying work stoppage. Continuous treatment for the original condition or injury is not considered a need for further medical treatment after release from treatment, nor is an examination without treatment. 20 C.F.R. § 10.5(y).

[3] *Ronald A. Eldridge*, 53 ECAB 218 (2001).

[4] *Mary A. Ceglia*, 55 ECAB 626 (2004); *Albert C. Brown*, 52 ECAB 152 (2000).

[5] 20 C.F.R. § 10.5(y).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Recurrences*, Chapter 2.1500.5(b) (September 2003). The procedure manual provides, with certain exceptions, that, within 90 days of release from medical care (as stated by the physician or computed from the date of last examination or the physician's instruction to return PRN), a claims examiner may accept the attending physician's statement supporting causal relationship between appellant's current condition and the accepted condition, even if the statement contains no rationale. *Id.* at Chapter 2.1500.5(a).

ANALYSIS

The Board finds that appellant has not established that she sustained a recurrence of her medical condition. OWCP accepted her occupational disease claim for bilateral radial styloid tenosynovitis on March 2, 2007, for which she underwent surgery. Appellant has claimed compensation for medical treatment of her condition. She failed, however, to submit sufficient rationalized medical evidence to establish that she required further medical treatment for her employment-related condition.

In a report dated September 5, 2012, Dr. Manoharan stated that he released appellant from care as of that date but that she should continue with her permanent work restrictions. He listed the diagnoses of bilateral carpal tunnel syndrome, aftercare following surgery for left de Quervain's tenosynovitis and resolved bilateral wrist pain. Dr. Manoharan noted that appellant had completed the recommended treatment modalities of taking nonsteroidal anti-inflammatory drugs, physical therapy and bracing, with good improvement upon each. Appellant's last physical therapy visit was on September 4, 2012, according to an authorization request dated October 5, 2012. There is no evidence of record documenting that she received medical treatment for her accepted condition between September 5, 2012, the date she was released from Dr. Manoharan's care, and June 12, 2013, when she was again examined by Dr. Manoharan. Appellant's examination on June 12, 2013 was more than 90 days after her release from medical care. Therefore, she must submit an attending physician's report on the causal relationship of her current medical condition to her accepted bilateral radial styloid tenosynovitis.[7] Appellant had the burden of submitting sufficient medical evidence to document the need for further medical treatment.[8] She did not submit such evidence as required and failed to establish a need for continuing medical treatment.[9]

Dr. Manoharan's reports are insufficient to establish appellant's claim. In a report dated June 12, 2013, he diagnosed her with carpal tunnel syndrome and wrist pain, noting that he had previously declared her condition permanent and stationary. Dr. Manoharan noted that appellant had a flare-up of her symptoms of carpal tunnel syndrome, and noted tenderness of the wrists and hands bilaterally. He stated that she had intermittent slight dull pain in her wrists bilaterally. This is the only report of record submitted by Dr. Manoharan after he released appellant from his care on September 5, 2012. It does not contain an opinion addressing the causal relationship between appellant's current condition or need for continuing medical treatment and her accepted injury. It does not contain any reference to appellant's accepted condition. Medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value.[10] The Board notes that appellant's claim was not accepted for carpal tunnel syndrome, but for radial styloid tenosynovitis, or de Quervain's tenosynovitis. To establish a recurrence, appellant must submit a rationalized medical opinion addressing the causal

[7] Federal (FECA) Procedure Manual, *supra* note 6.

[8] *Supra* note 5.

[9] *See J.F.*, 58 ECAB 331 (2006).

[10] *Michael E. Smith*, 50 ECAB 313 (1999).

relationship between her current condition and her accepted condition of radial styloid tenosynovitis.

Appellant also submitted notes from physical therapists. Physical therapy notes do not constitute probative medical evidence, as a physical therapist is not a "physician" under FECA.[11] The reports of diagnostic studies, magnetic resonance imaging and x-rays, do not provide any opinion as to the cause of appellant's condition. These are also of diminished probative value and are insufficient to establish her claim.[12]

The medical evidence of record must be supported by rationalized medical evidence explaining the nature of the relationship between appellant's current condition and her accepted injury.[13] An award of compensation may not be based on surmise, conjecture, speculation or upon appellant's own belief that there was a causal relationship between her claimed condition and her employment.[14] The Board finds that OWCP properly denied appellant's claim, as she did not meet her burden of proof to establish that she sustained a recurrence of a medical condition.

On appeal, appellant contends that OWCP misunderstood the nature of her claim, and that she was not claiming monetary compensation for time lost from work, but rather only for additional medical treatment in the form of physical therapy. As noted, however, the medical evidence submitted to the record is not sufficient to establish that her need for physical therapy on or after May 3, 2012 is due to residuals of her accepted de Quervain's tenosynovitis or the surgery performed in 2008.

Section 8103(a) of FECA states in pertinent part: 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 Secretary of Labor considers likely to cure, give relief, reduce the degree or the period of disability or aid in lessening the amount of the monthly compensation.[15] The Board has found that OWCP has great discretion in determining whether a particular type of treatment is likely to cure or give relief.[16] The only

[11] Section 8101(2) of FECA provides as follows: (2) "physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law."

[12] *See Mary E. Marshall*, 56 ECAB 420 (2005).

[13] While the medical opinion of a physician supporting causal relationship does not have to reduce the cause or etiology of a disease or condition to an absolute certainty, neither can such opinion be speculative or equivocal. 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. *See Thomas A. Faber*, 50 ECAB 566 (1999); *Samuel Senkow*, 50 ECAB 370 (1999).

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

[15] 5 U.S.C. § 8103.

[16] *Vicky C. Randall*, 51 ECAB 357 (2000).

limitation on OWCP's authority is that of reasonableness.[17] Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment, or actions taken which are contrary to both logic and probable deductions from established facts. It is not enough to merely show that the evidence could be construed so as to produce a contrary factual conclusion.[18] In order to be entitled to reimbursement of medical expenses, it must be shown that the expenditures were incurred for treatment of the effects of the employment-related injury or condition.[19] Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[20]

The Board finds that OWCP did not abuse its discretion in denying authorization for physical therapy. Appellant did not establish that the expenditures claimed were incurred for treatment of the residuals arising from her accepted condition or surgery. OWCP did not abuse its discretion by denying authorization for payment of physical therapy.

The Board notes that appellant submitted evidence after the issuance of the June 26, 2013 decision. The Board lacks jurisdiction to review evidence for the first time on appeal.[21] Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant did not meet her burden of proof to establish that she sustained a recurrence of a medical condition causally related to her accepted injury.

[17] *Lecil E. Stevens*, 49 ECAB 673, 675 (1998).

[18] *Rosa Lee Jones*, 36 ECAB 679 (1985).

[19] *Bertha L. Arnold*, 38 ECAB 282, 284 (1986).

[20] *Zane H. Cassell*, 32 ECAB 1537, 1540-41 (1981); *John E. Benton*, 15 ECAB 48, 49 (1963).

[21] 20 C.F.R. § 501.2(c).

ORDER

IT IS HEREBY ORDERED THAT the June 26, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 1, 2014
Washington, DC

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

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

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