

and arm while lifting mail crates weighing over 50 pounds onto a shelf. OWCP accepted her claim for right wrist sprain and later expanded the claim to include right shoulder sprain, right rotator cuff tendinitis, and right wrist scaphoid ligament tear. Appellant did not initially stop work.

Appellant came under the treatment of Dr. Raphael Darvish, a Board-certified internist, from February 4 to April 28, 2011, for right wrist sprain and right forearm contusion which occurred after lifting boxes at work. Dr. Darvish recommended physical therapy and returned her to work full time with restrictions on February 4, 2011.

On July 6, 2011 Dr. Daniel Kharrazi, a Board-certified orthopedic surgeon, noted appellant's symptoms of radiating numbness and tingling down the right arm with weakness. Appellant had full and painless range of motion of the cervical spine with a negative head compression test. Dr. Kharrazi diagnosed work-related right wrist and right shoulder injury on February 2, 2011. He returned appellant to regular unrestricted duty.²

On September 14, 2011 Dr. Steven Shin, a Board-certified orthopedic surgeon, noted a history of injury and advised that a right wrist magnetic resonance imaging (MRI) scan showed a probable pinhole tear in the dorsal aspect of the scapholunate ligament. On January 19, 2012 he performed an authorized right wrist arthroscopy, debridement of severely attenuated partial torn scapholunate ligament, and synovectomy in the ulnar gutter.³

A cervical spine January 11, 2012 MRI scan showed no evidence of vertebral subluxation, a slight loss of disc height, age-related disc desiccation, disc protrusion with mild compression at C3-4, mild age-related degenerative change at C4-5, C5-6, and C6-7, minimal age-related disc degeneration without bulge, and degenerative facet arthritis at C7-T1. A May 16, 2012 right brachial plexus MRI scan showed mild supraclavicular edema that could be identified in plexitis, traumatic injury, and/or compression-neurapraxia.

On May 25, 2012 OWCP referred appellant to Dr. G.B. Ha'Eri, a Board-certified orthopedic surgeon, for a second opinion evaluation to determine the nature and extent of appellant's injury-related disability, her current diagnoses, and whether her diagnoses were caused or aggravated by the February 2, 2011 work injury.

On May 31, 2012 appellant was treated by Dr. Vernon Williams, a Board-certified neurologist, for cervical, right wrist, and shoulder pain. Dr. Williams noted moderate tenderness over the infraclavicular, supraclavicular, and scapular areas, restricted range of motion, and altered posture due to right shoulder decompression. He diagnosed chronic pain, her joint pain and shoulder region, adhesive capsulitis of the shoulder, and neurovascular compression syndrome. Dr. Williams noted that a cervical spine MRI scan revealed mild abnormalities that

² Dr. Kharrazi continued treating appellant. In December 21, 2011 and May 30, 2012 reports, he treated her for radiating radiculopathy and paresthesia symptoms from the right shoulder to the right arm. Dr. Kharrazi noted that a December 16, 2011 electromyogram and nerve conduction study revealed right carpal tunnel syndrome.

³ Appellant received wage-loss compensation beginning on January 19, 2012. In an undated letter, the employing establishment indicated that she was removed from the employing establishment on July 7, 2011 and the removal was unrelated to her injury. Appellant continued to receive wage-loss compensation.

did not correlate or explain with appellant's symptoms. An MRI scan of the brachial plexus correlated well with appellant's symptom complex and suggested a neurovascular compression syndrome arising from the plexus/thoracic outlet based on an altered shoulder girdle position and her posture.

In a report dated June 13, 2012, Dr. Ha'Eri discussed appellant's work history and stated that she had current complaints of right wrist pain radiating to the forearm as well as right shoulder pain and stiffness. Examination revealed right shoulder subacromial tenderness, limited range of motion, mild diffuse tenderness of the right wrist, and intact neurological examination of the right upper extremity. Dr. Ha'Eri noted a right wrist MRI scan revealed degenerative changes at the triangular fibrocartilage with right brachial plexus, and noted the MRI scan was normal. He diagnosed right shoulder rotator cuff tendinitis based on clinical examination and MRI scan, right wrist sprain, and status post arthroscopic right wrist debridement. Dr. Ha'Eri opined that appellant's physical limitations and disability were causally related to the February 2, 2011 work injury. He noted that she had not reached maximum medical improvement with regard to the right shoulder and wrist, and recommended physical therapy, nonnarcotic analgesics, and daily exercise. Dr. Ha'Eri opined that appellant continued to have residuals of the work injury including right wrist pain with radiation into the forearm, weakness of grip of the right hand, pain and stiffness of the right shoulder, and object MRI scan studies of the right shoulder and wrist. In a work capacity evaluation, he noted that she could return to work full time with restrictions.

Appellant continued seeing Dr. Shin, from February 15 to July 9, 2012, who diagnosed incompetent and attenuated scapholunate ligament of the right wrist and recommended a partial fusion.⁴ Reports from Dr. Williams dated July 24 to September 25, 2012 noted her treatment for scalene muscle spasm and tenderness in the supraclavicular region. Dr. Williams noted that appellant's physical examination was unchanged and diagnosed chronic pain, pain in shoulder region, adhesive capsulitis, and neurovascular compression syndrome. He recommended stellate ganglion blocks.

On October 25, 2012 Dr. Shin performed a limited four corner fusion with autograph of the right wrist and excision of the right wrist scaphoid. He diagnosed painful and incompetent scapholunate ligament of the right wrist.⁵

Reports from Dr. Kharrazi from August 22 and November 14, 2012 noted appellant's treatment for pain in the right shoulder, wrist, and cervical spine, numbness, neck stiffness, and radicular symptoms. Dr. Kharrazi noted findings of tenderness over the cervical spine paraspinal muscle and subacromial bursal space. He diagnosed history of industrial injury to right shoulder, right wrist, and cervical spine on February 2, 2011. Dr. Kharrazi advised that appellant was disabled from work. In reports dated December 26, 2012 to November 14, 2013, he noted

⁴ On September 1, 2012 an OWCP medical adviser opined that with the lack of improvement with extensive nonoperative measures, excision of the scaphoid and four corner fusion was medically necessary and reasonable. He further advised that appellant's claim should be expanded to include right wrist scaphoid ligament tear with incompetency with post-traumatic degenerative changes.

⁵ On March 1, 2013 Dr. Shin removed a deep pin in the right wrist.

appellant's complaints of cervical spine and right shoulder pain. Dr. Kharrazi opined that the adhesive capsulitis of the right shoulder had not improved despite conservative treatment and recommended right shoulder arthroscopic surgery.

Appellant was treated by Dr. Williams on November 20, 2012 for cervical pain. Dr. Williams diagnosed chronic pain, traumatic arthropathy of the hand, adhesive capsulitis of the shoulder, rotator cuff syndrome, and radial styloid tenosynovitis. On January 22, 2013 he noted appellant's complaints of pain in the neck, upper back, left arm, left hand, right upper extremity, and low back. Dr. Williams opined that her neck and upper extremity symptoms were related to her work injury. He noted that appellant had myofascial pain with a neuropathic or sympathetic component and recommended a stellate ganglion block. On May 7, 2013 Dr. Williams diagnosed chronic pain, pain in the shoulder region, and neurovascular compression syndrome. He noted that an MRI scan of the right plexus revealed findings consistent with right neurovascular compression syndrome and recommended a scalene block. A March 13, 2013 MRI scan of the right brachial plexus revealed extrinsic vascular compression with a vascular sling in the infraclavicular plexus region as well as a normal size and signal intensity of the infraclavicular plexus and major nerves with no evidence of neural edema or enlargement.

In a letter dated June 25, 2013, OWCP noted that appellant's request for authorization of a nerve block injection in the brachial plexus and spinal cord anesthesia were not covered under her accepted conditions. It requested that her physician provide a comprehensive medical report addressing the relationship between her current medical condition and the original injury.

In a letter dated August 30, 2013, appellant requested that her cervical spine and brachial plexus injuries be accepted. She indicated that test results and physicians' narrative reports documented her injuries and correlated them to her work injury. In reports dated March 7 to November 14, 2013, Dr. Kharrazi noted appellant's complaints of pain in the cervical spine and stiffness in her right shoulder. He opined that the adhesive capsulitis of the right shoulder had not improved despite conservative treatment and recommended right shoulder arthroscopic surgery. On January 15, 2014 Dr. Kharrazi noted that appellant was scheduled for right shoulder arthroscopic surgery, but she had an allergic reaction to latex requiring hospitalization before the surgery could be performed. Appellant was treated by Dr. Williams on September 6, 2013 who noted a history of the February 2, 2011 work injury to her right wrist and right shoulder. Dr. Williams opined that her neck and upper extremity symptoms and myofascial pain were related to her work injury. He advised that there was a potential for sympathetically maintained pain and neuropathic pain. Dr. Williams noted for this reason he recommended stellate ganglion blocks, an MRI scan of the brachial plexus, scapular stabilization brace, and ultrasound guided injections.

In a decision dated February 4, 2014, OWCP denied appellant's request to expand her claim to include the cervical spine and right brachial plexus.

LEGAL PRECEDENT

Where an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.⁶

Causal relationship is a medical issue that must be established by rationalized medical opinion evidence.⁷ 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.⁸ 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.⁹

ANALYSIS

Appellant alleges that she developed a work-related cervical spine and right brachial plexus condition on February 2, 2011 as a result of repetitively lifting files onto a shelf. OWCP accepted the claim, as noted, for right wrist sprain and later expanded the claim to include right shoulder sprain, right rotator cuff tendinitis, and right wrist scaphoid ligament tear. It did not accept a cervical spine or right brachial plexus condition.

OWCP referred appellant to Dr. Ha'Eri and sought an opinion from him regarding the nature and extent of appellant's injury-related disability, the current diagnoses, whether an aggravation was present, any injury-related factors of disability, and current physical limitations. However, it did not specifically request that Dr. Ha'Eri address whether the diagnosed cervical spine and right brachial plexus conditions were causally related to the accepted February 2, 2011 work injury. In a report dated June 13, 2012, Dr. Ha'Eri discussed appellant's work history and stated that she had current complaints of right wrist pain radiating to the forearm as well as right shoulder pain and stiffness. Examination revealed right shoulder subacromial tenderness, limited range of motion, mild diffuse tenderness of the right wrist, and intact neurological examination of the right upper extremity for sensory, motor, and reflexes. Dr. Ha'Eri noted that a right wrist MRI scan revealed degenerative changes at the triangular fibrocartilage while a right brachial plexus and the MRI scan was normal. He diagnosed right shoulder rotator cuff tendinitis based on clinical examination and MRI scan, and right wrist sprain, status post arthroscopic right wrist debridement and opined that the conditions were causally related to the February 2, 2011 work

⁶ *Jaja K. Asaramo*, 55 ECAB 200 (2004).

⁷ *Elizabeth H. Kramm (Leonard O. Kramm)*, 57 ECAB 117 (2005).

⁸ *Leslie C. Moore*, 52 ECAB 132 (2000).

⁹ *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value); *Jimmie H. Duckett*, 52 ECAB 332 (2001).

injury. Dr. Ha'Eri advised that appellant's current physical limitations and subsequent disability arose from the work-related injury. He noted that her prognosis was guarded with regard to the right shoulder and wrist as these conditions had not reached maximum medical improvement. Dr. Ha'Eri recommended physical therapy, nonnarcotic analgesics, and daily exercise. He opined that appellant continued to have residuals of the work injuries. In a work capacity evaluation, Dr. Ha'Eri noted that she could return to work fulltime with restrictions.

The Board finds that, as OWCP sought the opinion of Dr. Ha'Eri, it has the responsibility to obtain an opinion that adequately addresses the matters presented in the case.¹⁰ On remand OWCP should secure a medical report containing a reasoned medical opinion on the relevant issue of whether appellant's cervical spine and right brachial plexus conditions were caused or aggravated by the accepted work-related injury.

On appeal appellant asserts that OWCP improperly denied her request to expand her accepted injuries to include right brachial plexus and cervical spine injuries. The Board finds that it is unnecessary to address this argument in view of the Board's disposition in this case.

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 this case is not in posture for decision.¹¹

¹⁰ See *Mae Z. Hackett*, 34 ECAB 1421 (1983).

¹¹ The Board will not rule on the June 25, 2015 OWCP's decision accepting appellant's claim for aggravation of brachial plexus lesions/thoracic outlet syndrome.

ORDER

IT IS HEREBY ORDERED THAT the February 4, 2014 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for further action consistent with this decision.

Issued: June 11, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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