United States Department of Labor
Employees' Compensation Appeals Board

J.V., Appellant	)	
and	)	**Docket No. 15-0389**
	)	**Issued: October 5, 2015**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION REGIONAL OFFICE, INSURANCE 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:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 10, 2014 appellant, through counsel, filed a timely appeal from an August 26, 2014 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 met his burden of proof to establish that he developed carpal tunnel syndrome causally related to factors of his federal employment.

On appeal appellant, through counsel, alleged that OWCP improperly weighed the medical evidence, engaged in doctor shopping, and did not follow proper procedures when it referred appellant to an impartial medical examiner.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On December 14, 2001 appellant, then a 43-year-old lead claims adjustment technician, filed an occupational disease claim alleging that during the course of his federal employment, he had been involved with numerous clerical duties and, as a result, has developed bilateral carpal tunnel syndrome.

In a March 16, 2002 report, Dr. Scott M. Fried, appellant's treating osteopath specializing in orthopedic and hand surgery, noted that appellant had repetitive strain injury with flexor tenosynovitis and bilateral median neuropathy at wrist level secondary to keying activities; moderate radial neuropathy bilateral forearms secondary to same; and possible radiculitis with disc space C5-6 and narrowing C6-7. He opined that the injuries were directly and causally related to his repetitive work activities of appellant's job for the employing establishment.

On September 20, 2002 OWCP referred appellant to Dr. Anthony Salem, a Board-certified orthopedic surgeon, for a second opinion. In an opinion dated October 10, 2002, Dr. Salem indicated that Dr. Fried's opinion of appellant was totally not indicated and nonproductive. He noted that appellant's symptoms have persisted significantly despite treatment, and the fact that appellant was sent to Dr. Fried by his lawyer speaks for itself. Dr. Salem opined that the significant treatment of appellant by a physical therapist, massage therapists, and Dr. Fried was abuse of the system. He noted that he only agreed with Dr. Fried's assessment about the disc space narrowing at C5-6 with compression at C6-7. Dr. Salem opined that the electromyelogram (EMG) was performed by a physical therapist and should be repeated by a reputable physiatrist. He opined that appellant's diagnosis was cervical spondylitis with cervical cord and nerve root compression. Dr. Salem opined that the diagnosed condition was not necessarily related to the employment injury by direct cause, but by aggravation or acceleration of holding his head in an improper way while performing his work. He noted that appellant was capable of performing his usual job and that modifications could be made to relieve the aggravation and get him back to normal. Dr. Salem further found that appellant was neurologically able to perform his job and that he did not have true carpal tunnel syndrome.

On March 13, 2003 OWCP accepted appellant's claim for aggravation of cervical disc degeneration. However, in a separate decision of the same date, it rejected appellant's claim that he was disabled from work commencing March 12, 2002.

On March 17, 2003 appellant, through counsel, requested a hearing before an OWCP hearing representative.

In an April 3, 2003 summary report, Dr. Fried discussed his findings and opined that appellant remained with an ongoing and significant disability and that his severe disability is secondary to his work injuries. He noted that appellant's accepted work condition is an aggravation of cervical disc degeneration. Dr. Fried indicated that appellant did have significant objective positive findings including narrowed disc space in his cervical spine on x-ray and a magnetic resonance imaging (MRI) scan. He also noted objective evidence of proximal radiculopathy with EMG studies showing positivity at the brachial plexus and nerve roots which emanate from the same cervical discogenic levels. Dr. Fried noted that this indicated that there was evidence of neck and nerve root injury at the neck level. He also noted that appellant had

repetitive strain in his upper extremities secondary to his work and secondarily has distal neuropathies which are also involved with this problem but were secondary. Based on his objective findings, Dr. Fried opined that appellant has continued dysfunction and disability and severe limitations on functional capacity testing and positive EMG nerve conduction studies as well as radiographs, MRI scans, and clinical examination. He noted ongoing evidence of his employment-related problem. Dr. Fried further opined that appellant had ongoing disabilities secondary to the same and was unable to perform his regular work activities. He noted that, if appellant's condition worsened consideration of operative intervention may be reasonable, although the inherent risks of proximal surgery were significant. Dr. Fried indicated that appellant's disability was ongoing and causally related to his work injuries.

At the hearing held on October 27, 2003, appellant testified that when he was first hired by the employing establishment, he was the clerk and typed eight hours a day putting in notice of deaths for veterans. He noted that he was first diagnosed with carpal tunnel syndrome while in the military and received disability benefits from military for neck and arms, but that he believed that his problems with his neck and arms got worse while with the employing establishment. Appellant's counsel argued that the medical evidence established not only a neck problem but also median nerve neuropathy as it relates to the job, and asked for a referee examination.

In a January 2, 2004 decision, an OWCP hearing representative remanded the case, noting the conflict in medical opinion between Drs. Fried and Salem, and ordering that appellant must be referred for an impartial medical examination.

On February 18, 2004 OWCP referred appellant to Dr. John Hogan, a Board-certified orthopedic surgeon, for an impartial medical examination. It asked Dr. Hogan to resolve the conflict between Drs. Fried and Salem concerning appellant's exact diagnosis related to his employment, whether he suffered any disability as a result of his employment-related conditions, and, if so, the extent of this disability. In a March 19, 2004 opinion, Dr. Hogan listed the diagnosis as degenerative disease of the cervical spine, especially C5-6, with radiculopathy to upper limbs. He noted no evidence whatsoever of carpal tunnel syndrome. Dr. Hogan opined that the symptoms started gradually in about 1991 and probably originated from his duties as a military policeman, during which time he was frequently involved in altercations. He noted that over the years these gradually became worse, and when he had to do all the keying activities for nine years he worked for the employing establishment, the constant position of his head and arms slowly caused the symptoms to be aggravated. Dr. Hogan indicated that appellant's symptoms were not caused by his work at the employing establishment, but were an aggravation of his long-standing cervical degenerative arthritis. He did not believe that appellant could go back to his previous job because of the radiculopathy. Dr. Hogan noted that while there were many jobs he could do, keying and filing were beyond him at this stage.

In a May 9, 2005 report, Dr. Fried noted that he commenced treatment of appellant on March 13, 2002. He noted that appellant's diagnoses remained repetitive strain injury with flexor tenosynovitis and bilateral median neuropathy at wrist level secondary to keying activities, moderate radial neuropathy bilateral forearms secondary to same, and possible radiculitis with disc space C5-6 and narrowing C6-7. Dr. Fried opined that appellant continued to have ongoing evidence of bilateral upper extremity injuries with repetitive strain injury and a resultant neuropathy secondary to his work for the military. He noted that appellant continued to work for

the employing establishment through 2002, and that his repetitive activities, including answering telephones, filing, computer work, writing, keying, and repetitive hand, wrist, and arm activities, exacerbated and further aggravated his condition. Dr. Fried explained that each day appellant worked caused new injury, thereby causing new inflammation and exacerbation and further scarring about his nerves resulting in his permanent nerve injuries. He also noted multiple objective findings corroborating his clinical complaints, including positive Phalen's test, Roos test, Tinel's test, Hunters test, and compression testing. Dr. Fried further noted positive EMG nerve conduction velocity (NCV) studies which corroborate his clinical complaints. He noted objective evidence of significant dysfunction and disability in function and capacity testing as well, objectively documenting his limitations. Dr. Fried noted that appellant was not capable of performing his previous job and has been permanently disabled since 2002 directly caused by his development of repetitive strain and upper extremity nerve injuries developing in 1991 and ongoing.

On December 5, 2006 OWCP referred appellant to Dr. Joseph J. Mesa, a Board-certified orthopedic surgeon, for an impartial medical examination. It asked Dr. Mesa to resolve the conflict between Dr. Fried and Dr. Salem concerning the exact diagnoses which are related to appellant's factors of employment, whether appellant suffered any disability as a result of the employment-related condition, and the extent of such disability. In a February 7, 2007 report, Dr. Mesa noted that appellant had degenerative arthritis of the cervical spine with radicular symptoms. He opined that the symptoms most likely began or started when he was involved in military activity and progressed and aggravated by his clerical work at the employing establishment. Dr. Mesa noted that appellant still had persistent secondary to degenerative changes. He placed limitations on appellant.

By decision dated October 31, 2008, OWCP denied appellant's claim for bilateral carpal tunnel syndrome and also denied appellant's claim for compensation for the period March 12, 2002 through January 24, 2008. However, on February 3, 2009 the hearing representative vacated the October 31, 2008 decision, instructed OWCP to exclude the report of Dr. Mesa, and to refer appellant back to Dr. Hogan who should give an updated medical opinion specifically answering OWCP's questions.

In a May 18, 2009 medical conflict statement, OWCP noted that Dr. Fried, appellant's treating physician, diagnosed appellant with bilateral carpal tunnel syndrome and stated that he was unable to work whereas several other physicians did not concur with this assessment. It also noted a difference in opinion as to whether the employee was totally disabled due to an aggravation of cervical degeneration and the period of said disability. OWCP determined that Dr. Hogan no longer participated in performing impartial medical examinations. Accordingly, on June 10, 2009 it referred appellant to Dr. Andrew Gelman, a Board-certified orthopedic surgeon, to resolve the conflict.

In a July 1, 2009 report, Dr. Gelman noted that appellant's comorbidities have probably contributed to his presentation, and that he believed his presentation is more significant to his numerous medical issues and comorbidities as opposed to any actual cervical spine and peripheral entrapment. He noted that he would be interested in an independent objective electrodiagnostic result.

By letter dated December 10, 2009, OWCP asked for clarification from Dr. Gelman. It asked Dr. Gelman if the diagnosis of bilateral carpal tunnel syndrome was established and if so, to explain how the findings establish the diagnosis and whether this resulted in disability. OWCP also noted that it accepted aggravation of cervical disc degeneration as work related, and asked him to determine if this aggravation was temporary or permanent. Finally, it asked Dr. Gelman to address work restrictions on or after March 12, 2002.

In a December 23, 2009 supplemental report, Dr. Gelman indicated that median nerve entrapment, *i.e.*, bilateral carpal tunnel syndrome has not been established as clinical findings have been equivocal, and electrodiagnostic testing in 2002 and 2009 did not confirm median nerve entrapment through carpal tunnel. He reported that, with regard to the diagnosis of cervical disc degeneration or spondylosis, the condition in and of itself is a progressive condition which typically will have good and bad days, and that as it is a permanent progressive situation, one will need to be advised with regards to addressing symptoms should they flare. Dr. Gelman noted that whether work or ordinary activities of daily living create the need for medical attention is an unknown issue and the subjective presentation for which individuals typically present is not predictable. He noted that appellant's cervical disc degeneration situation is permanent and will typically further deteriorate over time. With regard to restrictions in the March 2002 time frame, Dr. Gelman advised appellant of some work style accommodations, that sedentary to light-duty work would be acceptable, and that at no time did it appear that appellant was totally disabled. He noted that he appeared to have capacity of working in at least a sedentary to light capacity and that at no time was he totally disabled.

In a March 5, 2010 decision, OWCP denied appellant's claim. It determined that the accepted employment-related condition of aggravation of cervical disc degeneration was temporary and had since ceased. OWCP again denied compensation for the period March 12, 2002 through a January 24, 2008 due to the fact that he received an increase in his service-connected disability award as a result of his civilian employment and failed to make an election between VA and FECA benefits.

Appellant, through counsel, requested an oral hearing before an OWCP hearing representative. At the hearing held on June 25, 2010, appellant's counsel argued that Dr. Gelman's examination did show evidence of carpal tunnel syndrome. He also argued that Dr. Gelman should be disqualified since he was partners with Dr. Mesa and also because his report was not sufficiently well reasoned, noting that he did not have Dr. Fried's records and did not perform a new EMG. Counsel also asked for new referee medical examination, arguing that Dr. Gelman had two chances and should be disqualified.

In an October 22, 2010 decision, an OWCP hearing representative remanded the case for further development of the medical evidence, specifically noting that an updated EMG study must be conducted and reviewed. She noted that since Dr. Gelman had previously examined appellant and rendered several opinions that have not resolved the outstanding issues in this case, OWCP should properly identify a new referee evaluator for an examination and opinion in this case.

In a January 29, 2009 report, Dr. Fried noted that he performed a detailed review of the January 15, 2009 EMG/NCV study, and diagnosed neuropathy; radial neuropathy right (radial

tunnel) and radial neuropathy left (radial tunnel); brachial plexopathy/cervical radiculopathy right; with radicular symptoms; carpal tunnel medial neuropathy; and disc space narrowing at C5-6 and C6-7. In a July 25, 2011 report, Dr. Fried noted that there were positive Tinel's and compression testing of the radial nerve in both elbows radiating approximately in the radial nerve distribution. He opined that appellant needed further treatment.

On March 6, 2012 OWCP referred appellant to Dr. Jerry L. Case, a Board-certified orthopedic surgeon, for an impartial medical examination. In an April 4, 2012 report, Dr. Case diagnosed: cervical spondylosis C4 to C7, preexisting; history of chronic lumbar strain, preexisting; multiple reports of brachial plexopathy on several EMG reports; and carpal tunnel syndrome, bilateral, mild. He explained that the June 3, 2011 EMG revealed borderline right median nerve sensory component compromise and an EMG conducted on January 29, 2009 reported bilateral carpal tunnel neuropathy although other EMGs did not report carpal tunnel findings. Dr. Case noted that carpal tunnel syndrome which is relatively mild may or may not show up on EMG studies, but it is primarily a clinical diagnosis. He also indicated that appellant's complaints of burning and numbness in the entire arm were likely related to his chronic cervical problem that was preexisting. Dr. Case determined that the numbness in the median nerve distribution appears to show positive signs on a physical examination of some diminished sensation and a positive Tinel's and positive Phalen's sign bilaterally as well as two EMG studies which suggested carpal tunnel syndrome findings. He noted that, if you accepted appellant's history that his numbers in his hands has continued since 1995, then it could be related to continuous keyboarding activity which appeared to be permanent in nature since it has persisted to the present time. Dr. Case noted that it was a somewhat confusing case because of the somewhat widespread symptoms and preexisting cervical spondylosis and the findings of brachial plexopathy in the upper extremities on multiple EMG studies, which would be unrelated to his work activities.

By letter dated May 8, 2012, OWCP asked Dr. Case to clarify whether the aggravation of appellant's preexisting cervical condition continued to be present, whether appellant's carpal tunnel syndrome is related to the original work injury of April 12, 1995, and to explain what he meant when he stated that carpal tunnel syndrome which is relatively mild may or may not show up on EMG studies, but is primarily a clinical diagnosis.

In a May 10, 2012 response, Dr. Case responded that he did not make a diagnosis of aggravation of preexisting cervical condition. He reiterated that he did opine that, if one accepted appellant's history that the numbness continued since 1995, that it could be related to the continuous keyboarding activity, and that therefore the carpal tunnel syndrome would be related to the employment injury of April 12, 1995. Dr. Case also noted that the carpal tunnel syndrome was relatively mild and may not show upon all EMG studies, but it is primarily a clinical diagnosis. However, he noted that clinical diagnosis is more important in finding sensory loss in the median nerve distribution as well as positive provocative tests such as positive Tinel's and Phalen's signs at the wrist.

In a September 21, 2012 letter, OWCP informed appellant that Dr. Case's reports were speculative and nonresponsive to the issues presented, as he was unable or unwilling to give direct answers to questions posed, and that therefore a new referee examination was being arranged. The record contains screen shots indicating that in choosing a new impartial medical

examiner, OWCP bypassed Drs. Gelman and Case as appellant had already seen these doctors. Screen shots also indicate that OWCP contacted Dr. Peter F. Townsend, a Board-certified orthopedic surgeon, but that he failed to return calls several times. Dr. Steven M. Dellose, a Board-certified orthopedic surgeon, was bypassed because he treats knee and hips only, and Dr. Paul C. Kupcha, a Board-certified orthopedic surgeon, was bypassed because he only treats feet. Dr. Elliott H. Leitman, a Board-certified orthopedic surgeon, was bypassed because he moved to another practice.

In a November 2, 2012 letter responding to appellant's congressman, OWCP noted that as appellant's case dates back 17 years and as FECA regulations mandate that an impartial medical examination be done by a physician who has not been previously involved in this, the scheduler encountered difficulty finding an appropriate examiner. The record also contains reports of telephone calls with regard to scheduling the impartial medical examination.

On November 5, 2012 OWCP referred appellant to Dr. Karl Rosenfeld, a Board-certified orthopedic surgeon, for a new impartial medical examination. In a December 5, 2012 report, Dr. Rosenfeld reviewed the medical evidence and the results of his examination, and determined that appellant was presently disabled due to his symptoms, save for light duty such as he has performed in the past. He noted no limitation other than repetitive use of his hands or lifting more than a few pounds with each hand. Regarding causation, Dr. Rosenfeld agreed with most of the doctors that there was no evidence for carpal tunnel syndrome both by examination, history, and most importantly the studies. He noted that even Dr. Fried's initial electrical studies fail to show significant carpal tunnel symptoms, and that a subsequent study showed mild left-sided carpal tunnel complaints, but not right. Dr. Rosenfeld also agreed that the other radial findings, brachial plexus findings, *etc.*, are out of proportion to his examination. He concluded that, with reasonable medical certainty, he did not find that the burning in appellant's arms related to carpal tunnel syndrome. Dr. Rosenfeld also indicated that it was questionable that his cervical abnormality is the cause either, noting that he moved his neck fully, had good strength except for grip (which he believed to be subjective), and that the slight atrophy in his right hand compared to his left (thenar) could be due to the nondominant side presentation.

Lastly, Dr. Rosenfeld noted that appellant has diabetes and hypothyroidism, which are both well-known causes of neuropathy. He opined that the amount of discomfort that appellant has in face of minimal objective findings and even tests would suggest that his neuropathy is related to his underlying hypothyroidism and diabetes rather than the repetitive nature of his former job. Dr. Rosenfeld concluded that, with reasonable medical certainty, he did not believe that appellant has carpal tunnel issues, at least clinically. He also noted that it was questionable that his cervical disc disease has become aggravated by his work efforts. Dr. Rosenfeld further opined that appellant's medical problems, his hypothyroidism and diabetes, should be recognized as the most likely cause of appellant's pain, which is a nonanatomic fashion for a carpal tunnel syndrome, which is described as "burning," and people with cervical radiculopathy usually do not complain of burning with mechanical factors from one's neck.

In a September 19, 2013 decision, OWCP denied appellant's claim as the medical evidence did not establish that the claimed medical condition was related to the accepted work-related event.

Appellant, through counsel, requested an oral hearing before an OWCP hearing representative. At the hearing held on June 11, 2014, appellant was not present, but his counsel argued that Dr. Case found that there was bilateral carpal tunnel syndrome and acknowledged that it was related to appellant's work, that the case should have been resolved at that point, but OWCP went doctor shopping and referred appellant to Dr. Rosenfeld, an act which counsel alleged was an abuse of process. He also argues that Dr. Rosenfeld's opinion is deficient in that he does not rationally explain why he found no carpal tunnel syndrome. Counsel encouraged reversal of OWCP's decision and payment of benefits.

In a decision dated August 26, 2014, the hearing representative affirmed the September 19, 2013 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of establishing the essential elements of his or her claim, including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was timely filed within the applicable time limitation period, that an injury was sustained in the performance of duty as alleged, and that any disabilities and/or specific conditions for which compensation is claimed are causally related to the employment injury.[2] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[3]

Whether an employee actually sustained an injury in the performance of duty begins with an analysis of whether fact of injury has been established.[4] To establish fact of injury in an occupational disease claim, an employee must submit: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[5]

Causal relationship is a medical issue and the evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is evidence which includes a physician's 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, 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.[6]

[2] *Elaine Pendleton*, 40 ECAB 1143 (1989).

[3] *Victor J. Woodhams*, 41 ECAB 345 (1989).

[4] *See S.P.*, 59 ECAB 184, 188 (2007).

[5] *See Roy L. Humphrey*¸ 57 ECAB 238, 241 (2005); *see also P.W.*, Docket No. 10-2402 (issued August 5, 2011).

[6] *I.J.*, 59 ECAB 408 (2008); *supra* note 3.

If there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[7] When there exist 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 on a proper factual background, must be given special weight.[8]

OWCP has specific procedures for the selection of the impartial medical specialist designed to provide adequate safeguards against any possible appearance that the selected physician's opinion was biased or prejudiced. The procedures contemplate that the impartial medical specialist will be selected on a strict rotating basis in order to negate any appearance that preferential treatment exists between a particular physician and OWCP.[9] The Medical Management Application (MMA), which replaced the Physician Directory System (PDS), allows users to access a data base of Board-certified specialist physicians and is used to schedule referee examinations. If an appointment cannot be scheduled in a timely manner, or cannot be scheduled for some other reason such as a conflict or the physician is of the wrong specialty, the scheduler will update the application with an appropriate bypass code. Upon the entering of a bypass code, the MMA will select the next physician in the rotation.[10]

ANALYSIS

The Board finds that appellant has not established bilateral carpal tunnel syndrome causally related to factors of his employment.

Dr. Fried, appellant's treating physician, opined that appellant had ongoing evidence of bilateral upper extremity injuries with repetitive strain injury and a resultant neuropathy due to his military service. He indicated that appellant's repetitive activities at the employing establishment, including answering telephones, filing, computer work, and keying, exacerbated and further aggravated his condition. Dr. Fried noted that appellant had multiple objective findings correlating his clinical complaints. He opined that appellant was unable to perform his regular work activities.

Dr. Salem, the second opinion physician, opined that appellant had been incorrectly diagnosed with carpal tunnel syndrome, and was capable of performing his usual job.

To resolve the conflict between the opinions of Dr. Fried and Dr. Salem, OWCP referred appellant to Dr. Hogan for a referee opinion. Dr. Hogan, in a March 19, 2004 report, found that appellant had no evidence of carpal tunnel syndrome.

[7] *Regina T. Pellecchia*, 53 ECAB 155 (2001).

[8] *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

[9] *Raymond J. Brown*, 52 ECAB 192 (2001).

[10] *See* FECA Procedure Manual, Part 3 -- Medical, *OWCP Directed Medical Examinations*, Chapter 3.500.5 (July 2011, December 2012, and May 2013).

OWCP took no action on appellant's claim until December 5, 2006, when it referred appellant to Dr. Mesa for a new second opinion, which Dr. Mesa completed on February 7, 2007. Based on Dr. Mesa's opinion, in an October 31, 2008 decision, OWCP denied appellant's claim for bilateral carpal tunnel syndrome.

However, the Board finds that the hearing representative, in a decision dated February 3, 2009, correctly remanded the case and instructed OWCP to exclude the opinion of Dr. Mesa because OWCP should have given Dr. Hogan an opportunity or clarify his report.[11] The Board finds that this action on the part of OWCP, *i.e.*, the exclusion of Dr. Mesa's report, was proper under the Board's holding in *Joseph R. Alsing*,[12] where the Board found that OWCP properly excluded the medical report of a second impartial medical examiner which was obtained prior to any attempt to have the original impartial medical examiner clarify his opinion.[13]

On remand, OWCP determined that Dr. Hogan no longer performed impartial medical examinations, and referred appellant to Dr. Gelman for a new impartial medical examination. Dr. Gelman, in a July 1, 2009 report, opined that appellant's presentation was more consistent with other medical issues and comorbidities than with cervical spine and peripheral nerve entrapment. OWCP asked for a clarification from Dr. Gelman, and in a December 23, 2009 update, Dr. Gelman opined that bilateral carpal tunnel syndrome was not established.

The case again lay dormant until March 6, 2012 when OWCP referred appellant to Dr. Case for a new impartial medical examination. In an April 4, 2012 report, Dr. Case found multiple reports of brachial plexopathy on several EMG reports and mild bilateral carpal tunnel syndrome. He noted that, if one accepted appellant's history that numbness in his hands had continued since 1995, then it could be related to continuous keyboarding activity. Dr. Case noted that it was a confusing case because of appellant's numerous symptoms and his preexisting cervical spondylosis and findings of branchial plexopathy in the upper extremities on multiple EMG studies. OWCP properly asked Dr. Case to clarify his medical opinion.[14] However, in his May 10, 2012 response, Dr. Case reiterated the exact statements and conclusions set forth in his initial report. He also reiterated that carpal tunnel syndrome which is mild may not show on EMG studies but would be a clinical diagnosis. Accordingly, Dr. Case did not provide clarifying responses to OWCP's questions. He had been asked whether an aggravation of the claimant's preexisting cervical condition continued and, whether appellant's diagnosed carpal tunnel syndrome was related to appellant's work. Dr. Case had also been asked to provide an

[11] *See Harold Travis*, 30 ECAB 1071, 1078 (1979) (whether the Board held that in a situation where OWCP secures an opinion from an impartial medical examiner for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, OWCP has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion).

[12] 39 ECAB 1012 (1988).

[13] *See Terrance R. Stath*, 45 ECAB 412 (1994) (where the Board distinguished situations where medical reports were excluded because OWCP might have influenced the opinion of an impartial medical specialist from circumstances in which the medical report obtained was defective for other procedural reasons). *See also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.12 (September 2010).

[14] *See supra* note 11.

explanation of whether carpal tunnel syndrome was a primarily clinical diagnosis. Contrary to appellant's counsel's assertion on appeal, OWCP attempted to obtain clarification from Dr. Case. Dr. Case's additional opinion did not clarify the issues.

Therefore, OWCP properly referred appellant to Dr. Rosenfeld for a new impartial medical opinion.[15] Dr. Rosenfeld reviewed the medical evidence and the results of his examination and determined that appellant was not disabled at the time of examination. He agreed with most of the other doctors of record that there was no evidence of carpal tunnel syndrome in the examination, history, or, most importantly, the studies. Dr. Rosenfeld noted that radial findings and brachial plexus findings were out of portion to his examination. He opined that the burning in appellant's arms was unrelated to carpal tunnel syndrome. Dr. Rosenfeld also found that appellant did not have carpal tunnel. Based on the report of Dr. Rosenfeld, OWCP denied appellant's claim. The denial was affirmed by a hearing representative. The Board finds that the special weight of medical opinion is represented by the report of Dr. Rosenfeld, the most recent impartial medical examiner.

Despite multiple impartial medical examiner reports, the Board does not find that OWCP engaged in impermissible doctor shopping, as alleged. OWCP's procedures state that OWCP should request a supplemental report from the referee physician to clarify inadequacies in the initial report. Only if the referee physician does not respond or does not provide a sufficient response after being asked, should OWCP request a new referee examination.[16] Drs. Hogan, Case, and Gelman were unable or unwilling to clarify their opinions. OWCP improperly referred appellant to Dr. Mesa for a second opinion but excluded his report.[17]

The Board rejects the argument that Dr. Rosenfeld was improperly chosen outside of the required process. OWCP used the MMA which replaced the PDS and allows users to access a data base of Board-certified specialist physicians and is used to schedule referee examinations.[18] The record contains screen shots showing that prior to referring appellant to Dr. Rosenfeld, Drs. Gelman and Case had been bypassed because appellant had been seen by those doctors. The record demonstrates that Dr. Townsend failed to return OWCP's calls, and Drs. Dellose and Kupcha were bypassed because they had exclusive specialties not appropriate for the present case. Dr. Leitman was bypassed because he had moved. OWCP properly entered the codes and continued it search until it appointed Dr. Rosenfeld. Accordingly, appellant's arguments are without merit.

[15] *See James P. Roberts*, 31 ECAB 1010 (1980) (where the Board found that OWCP properly referred claimant to a second impartial medical examiner where the first impartial medical examiner was twice requested to clarify his report and failed to do so).

[16] *E.M.*, Docket No. 13-1876 (issued March 26, 2014); *see also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.11.e (September 2010).

[17] *See supra* note 13.

[18] *See supra* note 10.

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 has not met his burden of proof to establish that he developed carpal tunnel syndrome causally related to factors of his federal employment.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 26, 2014 is affirmed.

Issued: October 5, 2015
Washington, DC

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

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

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