United States Department of Labor
Employees' Compensation Appeals Board

C.M., Appellant **and** **DEPARTMENT OF LABOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, Dallas, TX, Employer**	)))))))))	**Docket No. 15-1250** **Issued: October 7, 2015**

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 29, 2015 appellant filed a timely appeal from a November 7, 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.[2]

[1] 5 U.S.C. § 8101 *et seq*.

[2] Under the Board's *Rules of Procedure*, an appeal must be filed within 180 days from the date of issuance of an OWCP decision. An appeal is considered filed upon receipt by the Clerk of the Appellate Boards. *See* 20 C.F.R. § 501.3(e)-(f). One hundred and eighty days from November 7, 2014, the date of OWCP's last decision, was May 6, 2015. Since using May 7, 2015, the date the appeal was received by the Clerk of the Appellate Boards would result in the loss of appeal rights, the date of the postmark is considered the date of filing. The date of the U.S. Postal Service postmark is April 29, 2015, rendering the appeal timely filed. *See* 20 C.F.R. § 501.3(f)(1).

ISSUE

The issue is whether appellant established a bilateral elbow condition consequential to accepted bilateral upper extremity conditions.

FACTUAL HISTORY

OWCP accepted that on or before February 2, 2012 appellant, then a 55-year-old claims examiner, sustained bilateral carpal tunnel syndrome, calcifying tendinitis of both shoulders, and a neck sprain due to repetitive upper extremity motions in the performance of duty.[3]

Appellant was followed by Dr. Marvin Van Hal, a Board-certified orthopedic surgeon, beginning on December 28, 2011. He obtained imaging studies demonstrating cervical degenerative disc disease, bilateral acromial impingement, a right supraspinatus tendon tear, and a left subscapularis tendon tear.[4] January 25, 2012 electromyography (EMG) and nerve conduction velocity (NCV) studies showed bilateral carpal tunnel syndrome and right C5 radiculopathy, with no abnormality of the ulnar nerves. Dr. Van Hal diagnosed bilateral carpal tunnel syndrome, bilateral shoulder impingement, a right rotator cuff tear, a cervical spine syndrome, and C5 radiculopathy. He attributed these conditions to repetitive upper extremity motions and overuse in her duties as a claims examiner.

Beginning in November 2012, Dr. Van Hal related appellant's symptoms of bilateral elbow pain. In reports from November 8, 2012 to March 7, 2013, he observed that cervical spine motion and shoulder range of motion produced radicular pain and numbness into both elbows and the right hand. In a May 2, 2013 report, Dr. Van Hal noted that appellant needed a right elbow splint due to possible ulnar neuropathy. He prescribed an extension night splint, authorized by OWCP.

On June 6, 2013 Dr. Van Hal diagnosed right ulnar neuritis and right carpal tunnel syndrome. He noted that appellant's symptoms improved as of a June 20, 2013 examination, but that she had objective signs of bilateral cubital tunnel syndrome, greater on the right, with paresthesias extending into both hands. On July 30, 2013 Dr. Van Hal related that appellant's right elbow pain and paresthesias extended to the shoulder and hand.

In November 7 and 11, 2013 reports, Dr. Van Hal noted continued bilateral shoulder, elbow and wrist symptoms, and cervical spine complaints. EMG and NCV studies showed bilateral carpal tunnel syndrome. On examination of the right elbow, Dr. Van Hal found full extension, 130 degrees flexion, symptoms into the middle finger, positive Tinel's and Phalen's

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[3] OWCP initially denied the claim by July 18, 2012 decision finding that causal relationship was not established. Following a review of the written record, an OWCP hearing representative reversed the July 18, 2012 decision on October 10, 2012.

[4] December 28, 2011 x-rays of appellant's cervical spine showed degenerative disc disease from C4 to C7. March 1, 2012 x-rays of the right shoulder showed significant impingement with type II to III acromion. A January 25, 2012 magnetic resonance imaging (MRI) scan of the cervical spine showed stenosis and spondylosis at multiple levels. A June 16, 2012 MRI scan of the right shoulder showed a type II acromion, supraspinatus and infraspinatus tendinopathy with a tiny full thickness tear of the anterior supraspinatus tendon, and a partial subscapularis tear. A March 20, 2013 MRI scan of the left shoulder showed a type II to III acromion, mild rotator cuff tendinopathy, and a partial subscapularis tendon tear.

signs on the right, as well as an equivocally positive Phalen's on the left. He opined that appellant had reached maximum medical improvement. In a January 21, 2014 report, Dr. Van Hal opined that appellant's right elbow condition was related to the accepted bilateral wrist and shoulder conditions.

On March 11, 2014 OWCP obtained a second opinion from Dr. Sofia M. Weigel, a Board-certified physiatrist.[5] Dr. Weigel noted appellant's account of aching bilateral elbow pain with shooting pain upon movement. She observed normal sensation in the hands and fingers.

In a May 27, 2014 report, Dr. Van Hal explained appellant had progressive bilateral elbow symptoms, worse on the right, with radiation into the right hand. He opined that appellant's presentation was indicative of "an ulnar neuritis, cubital tunnel type of issue as well as elbow sprain/strain." Dr. Van Hal reported that appellant required additional treatment for her right elbow.

On June 18, 2014 appellant requested that OWCP expand her claim to include a bilateral elbow condition, consequential to the accepted bilateral shoulder and wrist conditions. In a June 19, 2014 letter, it advised appellant of the additional evidence needed to establish her claim, including her physician's opinion explaining how and why the claimed bilateral elbow condition was related to the accepted conditions.

In response, appellant provided a July 3, 2014 report from Dr. Van Hal, noting that her condition had worsened, in part because she was still performing regular duty with repetitive upper extremity motion. He noted positive signs over the cubital tunnels bilaterally. Dr. Van Hal diagnosed bilateral ulnar neuritis at the elbows, with developing adhesive capsulitis of both shoulders. He explained in a September 18, 2014 report that appellant's bilateral ulnar neuritis was related both to the accepted bilateral shoulder and wrist conditions, as well as working with her elbows flexed. Dr. Van Hal recommended additional electrodiagnostic tests.

In a September 25, 2014 letter, appellant noted that she continued to perform the same repetitive motion tasks that caused the accepted cervical spine and upper extremity conditions. She asserted that Dr. Van Hal's September 18, 2014 report was supportive of causal relationship.

In an October 14, 2014 report, an OWCP medical adviser reviewed the medical record and a statement of accepted facts. He opined that the medical record did not support a diagnosis of ulnar neuritis, as the January 25, 2012 EMG study did not show any ulnar nerve abnormalities, and Dr. Weigel had found normal sensation in all fingers.

By decision dated November 7, 2014, OWCP denied appellant's claim for a bilateral elbow condition, finding that the medical evidence was insufficient to establish causal relationship.

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[5] OWCP obtained Dr. Weigel's opinion pursuant to appellant's December 17, 2013 claim for a schedule award. On April 30, 2014 it issued appellant a schedule award for five percent impairment of the right arm and three percent impairment of the left arm, based on the accepted bilateral shoulder and wrist conditions. The schedule award claim is not before the Board on the present appeal.

LEGAL PRECEDENT

The Board has held that if a member weakened by an employment injury contributes to a later injury, the subsequent injury will be compensable as a consequential injury, if the further medical complication flows from the compensable injury, so long as it is clear that the real operative factor is the progression of the compensable injury.[6]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[7] The opinion of the physician must be based on a complete factual and medical background of the employee, 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 employee.[8]

ANALYSIS

OWCP accepted that appellant sustained bilateral carpal tunnel syndrome, calcifying tendinitis of both shoulders, and a cervical spine sprain. On June 18, 2014 appellant claimed a consequential bilateral elbow condition.

In support of her claim, appellant provided reports from Dr. Van Hal, a Board-certified orthopedic surgeon, who treated appellant for the accepted conditions beginning in December 2011. He obtained January 25, 2012 electrodiagnostic studies demonstrating no ulnar nerve abnormalities. Dr. Van Hal first noted appellant's symptoms of bilateral elbow pain in November 2012, attributing them to cervical radiculitis or referred shoulder pain. After appellant exhibited definitively positive Tinel's and Phalen's signs at the right elbow, Dr. Van Hal diagnosed right ulnar neuritis on June 6, 2013, and bilateral cubital tunnel syndrome on June 20, 2013.

Dr. Van Hal characterized appellant's condition as "an ulnar neuritis, cubital tunnel type of issue as well as elbow sprain/strain, attributable to the effects of the accepted bilateral wrist, and shoulder pathologies, and aggravated by working with her elbows flexed. However, he did not explain how and why altered mechanics precipitated by the accepted bilateral carpal tunnel syndrome, shoulder tendinitis, and cervical spine sprain would cause or contribute to ulnar neuritis or cubital tunnel syndrome. Dr. Van Hal generally supported causal relationship, but did not set forth the medical reasoning leading to his conclusion. In the absence of such rationale, his opinion is insufficient to establish causal relationship.[9]

Additionally, OWCP obtained a second opinion from Dr. Weigel, a Board-certified physiatrist, who noted normal sensation in the hands and fingers. An OWCP medical adviser explained that these findings, coupled with a negative EMG, demonstrated that appellant had no

[6] *S.M.,* 58 ECAB 166 (2006); *Raymond A. Nester,* 50 ECAB 173, 175 (1998).

[7] *I.R.,* Docket No. 09-1229 (issued February 24, 2010); *D.I.,* 59 ECAB 158 (2007).

[8] *I.J.,* 59 ECAB 408 (2008); *Victor J. Woodhams,* 41 ECAB 465 (2005).

[9] *Deborah L. Beatty*, 54 ECAB 340 (2003).

objective ulnar nerve impairment. These opinions cast further doubt on Dr. Van Hal's diagnoses.

OWCP advised appellant by a June 19, 2014 letter of the necessity of submitting her physician's opinion explaining how and why the claimed bilateral elbow condition was related to the accepted conditions. However, appellant did not submit such evidence. Therefore, OWCP's November 7, 2014 decision denying appellant's claim was appropriate under the facts and circumstances of this case.

On appeal, appellant asserts that Dr. Van Hal's opinion supports that she sustained bilateral cubital tunnel syndrome consequential to the accepted conditions. She contends that OWCP ignored Dr. Van Hal's reports. As noted above, Dr. Van Hal's opinion was insufficiently rationalized to establish causal relationship.

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 established a bilateral elbow condition consequential to her accepted bilateral upper extremity conditions.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 7, 2014 is affirmed.

Issued: October 7, 2015
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board