United States Department of Labor
Employees' Compensation Appeals Board

T.K., Appellant	)	
and	)	**Docket No. 15-1081**
	)	**Issued: September 4, 2015**
DEPARTMENT OF HOMELAND SECURITY, New York City, NY, Employer	)	

Appearances:
Thomas R. Uliase, 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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 16, 2015 appellant, through counsel, filed a timely appeal from a February 17, 2015 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 has met his burden of proof to establish the diagnosed conditions of right cubital tunnel syndrome, right elbow tendinopathy, right carpal tunnel syndrome, and right knee tendinitis are causally related to his accepted December 10, 2012 injury.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On December 11, 2012 appellant, then a 36-year-old special agent, filed a traumatic injury claim (Form CA-1) alleging that on December 10, 2012 he injured his right knee as a result of landing on an uneven surface after jumping over a fence in pursuit of a suspect.

In a report dated January 2, 2013, Dr. Robert Marx, a Board-certified internist, diagnosed appellant with right knee anterior contusion with patellar tendinitis and right elbow flexor-pronator mass tendinopathy. He stated, "On December 10th, [appellant] was chasing a suspect and jumped a fence, which is 12 to 15 feet. He initially hung from his right arm and aggravated his right elbow. [Appellant] then landed on his right knee."

On February 20, 2013 Dr. Milan Sheth, a Board-certified radiologist, examined the results of a magnetic resonance imaging (MRI) scan of appellant's right knee. She diagnosed him with mild distal patellar tendinosis, with no meniscal tear. Dr. Sheth also examined the results of an MRI scan of appellant's right elbow, and stated an impression of mild thickening at the insertion of the lateral ulnar collateral ligament. She stated that this could represent a mild sprain or mild partial tear at its insertion.

In a report dated February 26, 2013, Dr. Nicholas Avallone, a Board-certified orthopedist, diagnosed appellant with elbow sprain, knee sprain, and cubital tunnel syndrome.

On April 3, 2013 OWCP accepted appellant's claim for right knee sprain, right elbow sprain, and a right knee contusion. It noted that, while Dr. Avallone had indicated a diagnosis of cubital tunnel syndrome, he did not provide an opinion as to whether this condition was caused by the event of December 10, 2012. OWCP further noted that, while Dr. Marx had diagnosed appellant with right elbow tendinopathy and patellar tendinitis, these conditions, too, were not supported by an opinion on causal relationship. It afforded appellant 30 days to submit medical evidence related to these conditions if he wanted to claim them as work related.

In a report dated May 14, 2013, Dr. Avallone noted that appellant continued to have symptoms of cubital tunnel syndrome and recommended electromyography (EMG).

In a diagnostic report dated June 27, 2013, Dr. Wei Ma, a Board-certified neurologist, noted that the EMG study demonstrated evidence of moderate bilateral median neuropathy affecting both motor and sensory nerves, worse on the right, and localized to carpal tunnel on the left.

On July 9, 2013 appellant requested authorization for right ulnar nerve transposition and right carpal tunnel surgery.

On August 30, 2013 OWCP denied appellant's request to expand his claim to include right cubital tunnel syndrome, carpal tunnel syndrome, right elbow tendinopathy, and right patellar tendinitis. It stated that he had not submitted sufficient evidence to establish a causal relationship between these conditions and the traumatic event of December 10, 2012.

In a letter dated September 12, 2013, Dr. Avallone stated, "I first saw [appellant] for injuries sustained during a work accident in January 2013. [Appellant] had sustained the work

accident in December 2012. He had been complaining about hand numbness and weakness since the accident. We found over that time and decided over the course of the next [three] visits, that [appellant] had significant cubital tunnel syndrome, as well as carpal tunnel syndrome. These complaints about numbness into the hand and weakness only came about as per his history after the accident at work. [Appellant] states that he did not have these problems prior to the work-related accident. It does appear then that one would surmise that this is an injury from the work-related incident and that this would normally be covered under workers' compensation."

On September 30, 2013 appellant requested reconsideration of OWCP's August 30, 2013 decision. He explained that he now had a right hand with two digits that curled into his palm, and numbness from his right elbow into his hand.

In a report dated July 9, 2013, received by OWCP on November 11, 2013, Dr. Avallone diagnosed appellant with cubital tunnel syndrome and carpal tunnel syndrome. He noted that, while EMG did not show cubital tunnel syndrome, by examination this diagnosis was obvious.

By decision dated December 11, 2013, OWCP reviewed the merits of appellant's claim and denied modification of its decision dated August 30, 2013. It found that he had not submitted a sufficiently rationalized explanation of how the traumatic event of December 10, 2012 could have caused his right cubital tunnel syndrome, right carpal tunnel syndrome, right elbow tendinopathy, and right patellar tendinitis.

On May 6, 2014 Dr. Avallone stated that appellant had been suffering from cubital tunnel syndrome for almost two years. He noted that, while he had planned to perform a carpal tunnel release and ulnar nerve transposition, these procedures had not been authorized, and as such they had not been performed. Dr. Avallone stated, "[Appellant] has severe cubital tunnel syndrome that is progressing. He already has signs of severe nerve damage. Had we initially done this surgery when we first wanted to, the outcome would have been much better.... We will forego a carpal tunnel release at this time as he thinks this is unrelated to his injury, and just proceed with ulnar nerve transposition of the elbow."

By letter dated May 16, 2014, Dr. Avallone stated that "[Appellant] has been seen by me for cubital tunnel syndrome for the past many months. This is the primary problem stemming from his original injury.... It is imperative that he receive an ulnar nerve transposition surgery to alleviate the pain and severe weakness he has developed since his initial injury."

OWCP authorized right ulnar nerve surgery on May 28, 2014.

On June 30, 2014 appellant, through counsel, requested reconsideration of OWCP's December 11, 2013 decision. It noted that OWCP had authorized right elbow surgery and requested that OWCP accept his right elbow condition.

In an operative report dated June 24, 2014, Dr. Avallone described performing a right elbow ulnar nerve anterior transposition and release. There were no noted complications.

By decision dated July 30, 2014, OWCP reviewed the merits of appellant's claim and denied modification of its decision dated December 11, 2013. It noted that he had not yet

submitted a rationalized medical opinion on causal relationship and that the EMG of June 27, 2013 stated that he had neuropathy of both the left and right elbows.

On July 30, 2013 OWCP authorized therapeutic exercises, an occupational therapy evaluation, and manual therapy.

On September 18, 2014 appellant, through counsel, appealed OWCP's July 30, 2014 decision to the Board. However, this appeal was later withdrawn.

By letter dated September 24, 2014, Dr. Avallone stated, "[T]he injury to the right elbow on December 10, 2012 is the only incident that was related to me as causing damage to the right upper extremity. The ulnar nerve is susceptible to injury in these cases and EMG results are known to show damage to this nerve when it is present only 70 percent of the time. Thus, 30 percent of the time an injury to the ulnar nerve is missed by EMG testing.... I base the causality of this ulnar nerve issue on the fact that [appellant] related to me that he did not have a problem prior to the work injury in December 2012.... It is within a degree of medical certainty that an elbow injury in the manner in which this occurred can cause cubital tunnel syndrome and require surgical intervention."

On November 25, 2014 appellant, through counsel, requested reconsideration of OWCP's July 30, 2014 decision.

In a report dated December 16, 2014, Dr. Avallone stated that appellant continued to struggle with cubital tunnel syndrome. He noted that he had no improvement in sensation and continued to complain of numbness in the ulnar nerve distribution of the hand.

By decision dated February 17, 2015, OWCP reviewed the merits of appellant's claim and denied modification of its July 30, 2014 decision. It noted that he had still not submitted a rationalized opinion from a physician on the issue of causal relationship regarding the conditions of right cubital tunnel syndrome, right carpal tunnel syndrome, right elbow tendinopathy, and right knee tendinitis.

LEGAL PRECEDENT

An employee seeking benefits under FECA[2] 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 filed within the applicable time limitation; that an injury was sustained while in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury.[3] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated on a traumatic injury or an occupational disease.[4]

[2] *Id*.

[3] *C.S.*, Docket No. 08-1585 (issued March 3, 2009); *Bonnie A. Contreras*, 57 ECAB 364, 366 (2006).

[4] *S.P.*, 59 ECAB 184, 188 (2007); *Joe D. Cameron*, 41 ECAB 153, 157 (1989).

The claimant has the burden of establishing by the weight of reliable, probative and substantial evidence that the condition for which compensation is sought is causally related to a specific employment incident or to specific conditions of employment.[5] An award of compensation may not be based on appellant's belief of causal relationship. Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish a causal relationship.[6]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[7] Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is a causal relationship between the employee's diagnosed condition and compensable employment factors.[8] 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.[9]

ANALYSIS

The Board finds that the medical evidence submitted by appellant does not establish that the incident of December 10, 2012 caused or aggravated his diagnosed right cubital tunnel syndrome, right carpal tunnel syndrome, right elbow tendinopathy, or right knee patellar tendinitis. OWCP has accepted that he sustained the conditions of right elbow strain, right knee sprain, and contusion. It has not accepted other diagnosed conditions related to appellant's right elbow, wrist, and knee.

Regarding these other conditions, appellant submitted a number of reports from Dr. Avallone. In a letter dated September 12, 2013, Dr. Avallone stated that appellant had been complaining about hand numbness and weakness since the December 2012 employment incident. He found that appellant had significant cubital tunnel syndrome, as well as carpal tunnel syndrome. Regarding causal relationship, Dr. Avallone explained that the complaints of numbness in the hand and weakness only came about after the accident at work. He reported that appellant did not have these problems prior to the work-related accident. Dr. Avallone reasoned that appellant's injury was from the work-related incident and that it would normally be covered under workers' compensation.

[5] *Roma A. Mortenson-Kindschi*, 57 ECAB 418, 428 n.37 (2006); *Katherine J. Friday*, 47 ECAB 591, 594 (1996).

[6] *P.K.*, Docket No. 08-2551 (issued June 2, 2009); *Dennis M. Mascarenas*, 49 ECAB 215, 218 (1997).

[7] *Y.J.*, Docket No. 08-1167 (issued October 7, 2008); *A.D.*, 58 ECAB 149, 155-56 (2006); *D'Wayne Avila*, 57 ECAB 642, 649 (2006).

[8] *J.J.*, Docket No. 09-27 (issued February 10, 2009); *Michael S. Mina*, 57 ECAB 379, 384 (2006).

[9] *I.J.*, 59 ECAB 408, 415 (2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

On May 16, 2014 Dr. Avallone explained that appellant's cubital tunnel syndrome was his primary problem stemming from his original injury. He opined that it was imperative that appellant receive an ulnar nerve transposition surgery to alleviate the pain and weakness he had developed since the injury. OWCP authorized the right ulnar nerve transposition surgery on May 28, 2014. The fact that surgery was authorized is not a decision to accept causal connection. In *James F. Aue*,[10] the Board held that the mere fact that OWCP authorized and paid for medical treatment did not establish that the condition for which the employee received treatment was employment related.[11]

By letter dated September 24, 2014, Dr. Avallone stated:

> "[T]he injury to the right elbow on December 10, 2012 is the only incident that was related to me as causing damage to the right upper extremity. The ulnar nerve is susceptible to injury in these cases and EMG results are known to show damage to this nerve when it is present only 70 percent of the time. Thus, 30 percent of the time an injury to the ulnar nerve is missed by EMG testing.... I base the causality of this ulnar nerve issue on the fact that the patient related to me that he did not have a problem prior to the work injury in December 2012.... It is within a degree of medical certainty that an elbow injury in the manner in which this occurred can cause cubital tunnel syndrome and require surgical intervention."

Dr. Avallone's statements on causal relationship do not contain a medically sound explanation of how the December 10, 2012 traumatic incident could have caused or aggravated appellant's right cubital tunnel syndrome or right elbow tendinopathy. He did not explain how the incident resulted in the diagnosed conditions. Furthermore, Dr. Avallone's opinion is based solely on appellant's statements that the condition arose only after the December 10, 2012 traumatic incident. The Board has found insufficient a causal relationship statement that appellant had no symptoms prior to the injury and symptoms after the injury.[12]

While Dr. Avallone also diagnosed carpal tunnel syndrome, he offered no medical explanation regarding the cause of this condition. He did note in his May 16, 2014 report that appellant did not believe that this condition was caused by the accepted injury.

Dr. Avallone's letters of September 12, 2013 and September 24, 2014 are not sufficient to establish a causal relationship between the event of December 10, 2012 and appellant's diagnosed conditions of cubital tunnel syndrome, carpal tunnel syndrome, and right elbow tendinopathy. While other medical reports were submitted to the record, which offered diagnoses, there are no other reports of record containing an opinion regarding causal relationship.

[10] 25 ECAB 151 (1974).

[11] *See also M.R.*, Docket No. 11-2084 (issued July 23, 2012).

[12] *Supra* note 9.

Dr. Marx diagnosed right elbow tendinopathy in his January 2, 2013 report and noted appellant's history of injury, but offered no opinion regarding the cause of the diagnosed condition. Similarly, Dr. Sheth, in a February 20, 2013 report, related that an MRI scan of appellant's right elbow showed thickening at the insertion of the lateral ulnar collateral ligament, but offered no opinion regarding the cause of this condition. Likewise Dr. Marx reviewed a June 27, 2013 EMG study and noted evidence of moderate bilateral median neuropathy affecting both motor and sensory nerves, worse on right, and localized to the carpal tunnel on the left, but offered no opinion regarding the cause of these diagnosed conditions.

Regarding appellant's right knee condition, the Board notes that while Dr. Avallone appears to be appellant's primary treating physician of record, his treatment concerned only appellant's right upper extremity conditions, rather than his right knee condition. While Dr. Marx and Dr. Sheth did note a diagnosis of right knee patellar tendinitis, they offered no opinion regarding the cause of this condition.

As appellant has not submitted any rationalized medical evidence to support his allegation that he sustained right cubital tunnel syndrome, carpal tunnel syndrome, right elbow tendinopathy, or right knee patellar tendinitis causally related to a December 10, 2012 employment incident, he has not met his burden of proof to establish a claim for these conditions.

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 the diagnosed conditions of right cubital tunnel syndrome, right carpal tunnel syndrome, right elbow tendinopathy, and right knee tendinitis are causally related to his accepted December 10, 2012 injury.

ORDER

IT IS HEREBY ORDERED THAT the February 17, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 4, 2015
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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