United States Department of Labor
Employees' Compensation Appeals Board

T.T., Appellant	)	
	)	**Docket No. 17-1084**
and	)	**Issued: April 2, 2018**
	)	
DEPARTMENT OF AGRICULTURE, FOOD SAFETY & INSPECTION SERVICE, Kinston, NC, Employer	)	

Appearances:
Appellant, pro se
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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 24, 2017 appellant filed a timely appeal from a December 2, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] Appellant timely requested oral argument before the Board. By order dated December 19, 2017, the Board exercised its discretion pursuant, to 20 C.F.R. § 501.5(a), and denied the request, finding that the issues could properly be adjudicated based on the evidence of record. *Order Denying Request for Oral Argument*, Docket No. 17-1084 (issued December 19, 2017).

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has established that he sustained renal failure and post-traumatic stress disorder (PTSD) consequential to his accepted bilateral upper extremity conditions.

FACTUAL HISTORY

On May 15, 2012 appellant, then a 30-year-old food inspector, filed an occupational disease claim (Form CA-2) alleging that performance of repetitive upper extremity movements while inspecting poultry, resulted in bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, and a right trigger thumb. He stopped work on May 14, 2012. OWCP initially accepted appellant's claim for bilateral carpal tunnel syndrome. Appellant received wage-loss compensation on the supplemental rolls commencing May 15, 2012 and on the periodic rolls commencing July 1, 2012.

On June 12, 2012 Dr. Semaan El-Khoury, an attending internist, prescribed nonsteroidal anti-inflammatories (NSAIDs) to treat the accepted carpal tunnel syndrome.

Dr. Lawrence N. Larabee, Jr., an attending Board-certified orthopedic surgeon, diagnosed bilateral carpal tunnel syndrome on June 29, 2012.[3] He returned appellant to light duty. On September 11, 2012 report, Dr. Larabee diagnosed tendinitis of the right thumb and administered a steroid injection. He recommended on October 2, 2012 that appellant take nonprescription NSAIDs and wear prescribed splints.

On October 15, 2012 appellant returned to work for two hours a day. OWCP paid appellant wage-loss compensation benefits. Dr. Larabee held appellant off work from December 5, 2012 onward pending a right carpal tunnel release. OWCP paid appellant compensation for temporary total disability commencing December 16, 2012. On December 17, 2012 it expanded acceptance of the claim to include bilateral cubital tunnel syndrome, and right trigger finger.

On January 31, 2013 Dr. Larabee performed an authorized right carpal tunnel release. On April 18, 2013 he performed an authorized left carpal tunnel release and authorized left ulnar nerve transposition. Appellant remained off work. Dr. Larabee released appellant to full, unrestricted duty as of July 24, 2013.

By decision dated August 19, 2013, OWCP issued appellant a schedule award for three percent permanent impairment of each upper extremity. Following additional development, by decision dated February 2, 2015, it found that the medical evidence of record established that appellant had 14 percent permanent impairment of the right upper extremity and 17 percent permanent impairment of the left upper extremity.

[3] An August 8, 2012 electromyography (EMG) study demonstrated bilateral carpal tunnel syndrome. A November 29, 2012 EMG and nerve conduction velocity study showed bilateral carpal tunnel syndrome, right greater than left.

In a November 27, 2013 report, Dr. Larabee found that appellant's right hand clawing had worsened. He diagnosed advancing right cubital tunnel syndrome and ulnar nerve mononeuropathy. Dr. Larabee held appellant from work. OWCP paid appellant compensation for total disability on the periodic rolls.

On May 22, 2014 Dr. Larabee performed an authorized right carpal tunnel release, right ulnar nerve artery repair, and right ulnar nerve release at the wrist.

In a July 29, 2014 report, Dr. Larabee diagnosed chronic ulnar clawing of the right hand. He noted that appellant was on kidney dialysis and was "very sick and in the hospital." He prescribed Percocet for hand pain.

In August 19 and 20, 2014 reports, Dr. Larabee found appellant permanently and totally disabled from all work due to severe clawing of the right hand. He submitted periodic progress reports.

On April 19, 2015 appellant filed an occupational disease claim (Form CA-2) alleging that, on or before June 27, 2014, he sustained renal failure and PTSD consequential to the accepted bilateral upper extremity conditions.

In an April 30, 2015 development letter, OWCP notified appellant of the additional evidence needed to establish his claim, including a detailed narrative report from his attending physician explaining how and why the accepted bilateral upper extremity conditions or their treatment would cause renal failure and PTSD. It afforded appellant 30 days to submit such evidence.[4]

In response, appellant submitted an October 4, 2015 letter in which he asserted that the medications he took for the accepted bilateral carpal tunnel syndrome worsened his kidney condition. He provided medical literature from internet websites on analgesic nephropathy. There was no evidence submitted relative to the PTSD claim.

On July 16, 2015 Dr. Larabee performed an authorized right anterior ulnar nerve transposition at the elbow. In a September 30, 2015 report, he opined that appellant had attained maximum medical improvement. Dr. Larabee found that appellant remained permanently and totally disabled for work.

By decision dated November 3, 2015, OWCP denied appellant's claim for consequential PTSD and renal failure as the medical evidence of record did not contain sufficient medical rationale to establish causal relationship of the conditions of renal failure and PTSD.

[4] By decision dated April 30, 2015, OWCP denied appellant's claims for travel reimbursement on intermittent dates from November 29, 2012 to March 17, 2015. By decision dated May 6, 2015, it denied appellant's claim for attendant services as the evidence of record did not establish that such services were necessary under 5 U.S.C. § 8111(a). On May 12, 2015 appellant requested reconsideration of OWCP's May 6, 2015 decision. By decision dated June 8, 2015, OWCP denied modification as additional evidence did not establish that attendant services were necessary under 5 U.S.C. § 8111(a).

On October 24, 2016 appellant requested reconsideration. He submitted additional evidence which he contended established his claim.

In a February 4, 2015 report, Dr. Graham V. Bynum, Jr., an attending Board-certified internist specializing in nephrology, noted that appellant had been diagnosed with human immunodeficiency virus (HIV) prior to beginning dialysis in June 2014. He had been recently weaned off dialysis.

In an October 5, 2015 report, Dr. Bynum diagnosed end stage renal disease (ESRD) and recommended a kidney transplant. He noted in a December 21, 2015 letter that appellant should avoid NSAID drugs as they could "cause his chronic kidney disease to worsen more quickly."[5]

In an October 23, 2016 report, Dr. Bynum explained that the etiology of appellant's "end-stage renal disease is biopsy proven HIV nephropathy." The biopsy also demonstrated interstitial nephritis superimposed on glomerular changes characteristic of chronic renal disease. Dr. Bynum opined that appellant's longstanding use of NSAIDs "more likely than not accelerated the progression of his underlying chronic kidney disease and, in addition to that, probably created NSAID-related interstitial nephritis which, again, would accelerate his underlying chronic kidney disease."

In an October 31, 2016 letter, OWCP requested that Dr. Bynum submit a rationalized medical report differentiating between chronic kidney disease resulting from NSAID exposure and HIV nephropathy. Dr. Bynum responded by November 18, 2016 letter. He noted that appellant's "renal biopsy findings were consistent with HIV nephropathy" with a significant interstitial inflammatory infiltrate. Dr. Bynum noted that appellant had taken prescription and over-the-counter NSAIDs to treat carpal tunnel syndrome. He opined that it was more likely than not that appellant's "heavy use of NSAIDs would accelerate progression to ESRD." Dr. Bynum explained that NSAIDs were one cause of interstitial nephritis, but that other causes could not be ruled out in appellant's case. He noted that he did not treat appellant during his use of NSAID medication, and had not reviewed appellant's treatment records. Dr. Bynum emphasized, however, that "based on medical literature relating to NSAID use in the setting of CKD [chronic kidney disease] and from [his] clinical experience it was more likely than not" that appellant's NSAID use accelerated his chronic kidney disease.

By decision dated December 2, 2016, OWCP denied modification as the medical evidence of record was insufficient to establish causal relationship. It found that Dr. Bynum's reports were insufficiently rationalized to establish causal relationship between appellant's ESRD and NSAID use related to the accepted upper extremity conditions. OWCP also found that Dr. Bynum's opinion was diminished by his incomplete knowledge of the case, as he did not review medical records from the two-year period that appellant had taken NSAID medication.

[5] In a September 6, 2016 report, Dr. Harrison G. Tuttle, an attending Board-certified orthopedic surgeon, noted appellant's complaints of increased right hand pain and weakness. He noted that appellant was on dialysis for chronic renal failure. Dr. Tuttle commented that the cause of appellant's renal failure was not clear, but could be related to his HIV infection.

LEGAL PRECEDENT

A claimant bears the burden of proof to establish a claim for a consequential injury. As part of this burden, he or she must present rationalized medical opinion evidence, based on a complete factual and medical background, showing causal relationship. The opinion must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship of the diagnosed condition and the specific employment factors or employment injury.[6]

In discussing the range of compensable consequences, once the primary injury is causally connected with the employment, Larson notes that, when the question is whether compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury, the rules that come into play are essentially based upon the concepts of direct and natural results and of the claimant's own conduct as an independent intervening cause. The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.[7]

To establish causal relationship between the condition as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence based on a complete medical and factual background supporting causal relationship.[8] Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence. A medical report is of limited probative value on a given medical question if it is unsupported by medical rationale.[9] Medical rationale includes a physician's detailed opinion on the issue of whether there is causal relationship between the claimant's diagnosed condition and the implicated employment activity. The opinion of the physician must be based on a complete factual and medical background of the claim, 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 specific employment activity or factors identified by the claimant.[10] 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 causal relationship.[11]

[6] *See Charles W. Downey*, 54 ECAB 421 (2003).

[7] Larson, *The Law of Workers' Compensation* § 1300; *P.J.*, Docket No. 17-0570 (issued October 26, 2017); *K.S.*, Docket No. 16-0404 (issued April 11, 2016).

[8] *M.W.*, 57 ECAB 710 (2006); *John D. Jackson*, 55 ECAB 465 (2004).

[9] *T.F.*, 58 ECAB 128 (2006).

[10] *A.D.*, 58 ECAB 149 (2006).

[11] *A.C.*, Docket No. 08-1453 (issued November 18, 2008).

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish that he sustained renal failure and PTSD consequential to his accepted bilateral upper extremity conditions.

As appellant did not submit any medical evidence addressing PTSD, he has failed to meet his burden of proof with regard to this condition.[12]

Appellant submitted several medical reports which address his kidney disease. Dr. Bynum, an attending Board-certified internist specializing in nephrology, opined in an October 23, 2016 report that appellant's ESRD was due to "biopsy proven HIV nephropathy" superimposed on chronic renal disease. He explained that appellant's longstanding NSAID use for treatment of the accepted bilateral carpal tunnel syndrome "more likely than not" accelerated underlying chronic kidney disease and "probably created NSAID-related interstitial nephritis." The Board finds that the probative value of Dr. Bynum's opinion is diminished by its equivocal nature.[13] It lacks the definite, unambiguous quality of the evidence needed to meet appellant's burden of proof in establishing causal relationship.[14]

In response to OWCP's October 31, 2016 request for clarification, Dr. Bynum provided a November 18, 2016 report in which he noted that he had not treated appellant during the time he took NSAID medication and, as such, did not have access to those treatment records. The Board has held that medical opinions not based on a complete medical and factual history are of diminished probative value.[15] As Dr. Bynum did not review the treatment records, serology reports, prescription records, laboratory tests, and other relevant material related to appellant's NSAID use, his opinion is insufficient to meet appellant's burden of proof in establishing causal relationship.

OWCP notified appellant by April 30, 2015 letter of the additional evidence needed to establish his claim for consequential injury, including his physician's well-reasoned opinion that supported a pathophysiologic connection between NSAID use and the development of kidney disease and PTSD. As appellant did not submit such evidence, he did not meet his burden of proof.

On appeal appellant contends that OWCP unreasonably delayed adjudicating his claims and required unnecessary referral examinations. The Board notes that there is no evidence of record that OWCP erred or abused its discretion in processing appellant's claims.

[12] *Supra* note 6.

[13] *Ricky S. Storms*, 52 ECAB 349 (2001).

[14] *Id.*

[15] *See Douglas M. McQuaid*, 52 ECAB 382 (2001) (medical reports must be based on a complete and accurate factual and medical background and medical opinions based on an incomplete or inaccurate history are of little probative value).

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 that he sustained renal failure and PTSD consequential to his accepted bilateral upper extremity conditions.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated December 2, 2016 is affirmed.

Issued: April 2, 2018
Washington, DC

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

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

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