United States Department of Labor
Employees' Compensation Appeals Board

W.L., Appellant	)	
	)	**Docket No. 17-1965**
and	)	**Issued: September 12, 2018**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATATION MEDICAL CENTER, West Palm Beach, FL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On September 21, 2017 appellant, through counsel, filed a timely appeal from a July 27, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). 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] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met her burden of proof to expand the acceptance of her claim to include additional medical conditions causally related to her accepted April 22, 2014 employment injury.

FACTUAL HISTORY

On April 22, 2014 appellant, then a 44-year-old nurse, filed a traumatic injury claim (Form CA-1) alleging that on that date she sustained right neck, shoulder, and arm injuries while in the performance of duty. She claimed that she was cleaning up a patient when she slipped on spilled coffee. Appellant caught herself with her right arm on the footboard of the patient's bed, which pulled her right neck, shoulder, and arm backwards. She stopped work on the date of injury.[3]

OWCP, by development letter dated June 11, 2014, noted that appellant's claim initially appeared to be a minor injury that resulted in minimal or no lost time from work. It had approved a limited amount of medical expenses without considering the merits of her claim. OWCP reopened appellant's claim because appellant had not returned to work in a full-time capacity. It reviewed the claim and accepted the claim for right elbow sprain and pectoral sprain.

OWCP subsequently expanded the accepted conditions to include right acute cubital tunnel syndrome. It authorized right ulnar release at the elbow to treat this accepted condition, which was performed on August 4, 2014.

In an October 22, 2014 medical report, Dr. Robert R. Reppy, an attending general practitioner, noted appellant's history of injury, discussed findings on physical examination, and reviewed diagnostic test results. He provided an impression of cervical disc herniation with radiculopathy at the C3-4 level, cervical stenosis, a partial tear of the right common extensor tendon, torn right radial collateral ligament, neuropathy of the right medial nerve, and status post right ulnar nerve release. Dr. Reppy requested that the acceptance of appellant's claim be expanded to include the diagnosed conditions. He opined that, based on his examination and review of the records and within a reasonable degree of medical certainty, the April 22, 2014 employment injuries were the direct and proximate cause of the diagnoses and conditions.

On January 23, 2015 OWCP referred appellant, together with a statement of accepted facts (SOAF), the medical record, and a list of questions, to Dr. David B. Lotman, a Board-certified orthopedic surgeon, for a second opinion. In a March 17, 2015 report, Dr. Lotman reviewed the SOAF and medical records. He noted appellant's medical history and cervical, right hand and fingers, and right shoulder complaints. Dr. Lotman examined her and provided a clinical impression of herniated nucleus pulposus (HNP) at C3 that was very tiny based on a cervical magnetic resonance imaging (MRI) scan. He also provided a clinical impression of cervical spondylosis, bilateral carpal tunnel syndrome, status post tennis elbow surgery with residual incongruity of the common extensor origin, and degenerative arthritis of the right elbow with left elbow effusion. Dr. Lotman opined that the diagnosed conditions were not causally related to the

[3] The record indicates that appellant resigned from the employing establishment on January 6, 2015.

mechanism of injury. He provided an additional clinical impression of ulnar neuritis and opined that the condition was causally related to the mechanism of injury.

In response to the questions posed by OWCP, Dr. Lotman indicated that he did not believe additional testing would help to verify the sources of appellant's symptomatology. He related that her right elbow and pectoral sprains had resolved. Dr. Lotman further related that the acute right cubital tunnel syndrome had resolved, but that it had required surgery. He noted that appellant had residual ulnar irritation based on electrophysiological studies. Appellant's subjective complaints were consistent with objective physical findings. Dr. Lotman believed that appellant had scarification from her prior surgery which may have compromised as the ulnar nerve dove into the proximal forearm between the two heads of the flexor ulnaris. He maintained that this was compounded by her underlying degenerative arthritis of the elbow joint and elbow joint effusion. Dr. Lotman advised that appellant had active limitations due to her work injury as indicated in an accompanying work capacity evaluation (Form OWCP-5c). He determined that she was unable to perform the date-of-injury position as described in the SOAF, but she was fit to work in a fairly sedentary capacity that always required the use of her left arm, eight hours per day. Dr. Lotman indicated that appellant's right upper extremity was quite dysfunctional at that point. He stated that there was no point in prescribing a functional capacity evaluation at that juncture. Dr. Lotman questioned the treatment appellant received, noting, among other things, that appellant always had medial elbow pain since the date of injury and he was not sure why the radial side of the elbow was considered. He concluded that she had not reached maximum medical improvement (MMI). Dr. Lotman maintained that clarification was necessary to determine why she had bilateral carpal tunnel syndrome and whether surgery was indicated. He recommended referral to a neurologist.

On May 20, 2015 OWCP referred appellant to Dr. Melvin Grossman, a Board-certified neurologist, for a second opinion. In a June 8, 2015 report, Dr. Grossman noted appellant's history of injury and medical treatment. He discussed physical examination findings and provided an impression that the examination essentially suggested right medial epicondylitis, and ulnar symptomatology primarily motor, but there may be some sensory suggestions although the bulk of what was seen was motor in the presentation. In response to the questions posed by OWCP, Dr. Grossman related that appellant's carpal tunnel syndrome may have been an incidental finding. He maintained that it was an occupational condition based on the type of work she performed as a nurse rather than a condition related to the April 22, 2014 employment injury. Dr. Grossman advised that surgery was not necessary. He determined that appellant had not reached MMI and recommended that she continue treatment of her right upper extremity.

By letter dated July 23, 2015, OWCP informed appellant that it had received Dr. Reppy's request to expand the acceptance of her claim. It informed her that, while the physician attributed her cervical conditions to the accepted conditions, his report was insufficient to establish causal relationship. OWCP noted the opinions of Drs. Grossman and Lotman who found that appellant had no cervical or back problems related to the April 22, 2014 work injury. It afforded appellant 30 days to provide additional medical evidence. Appellant did not submit the requested information within the time allotted.

In a September 10, 2015 decision, OWCP denied appellant's request to expand the acceptance of her claim. It noted that it had not received any additional medical evidence in response to its July 23, 2015 development letter.

By letter dated September 16, 2015, appellant, through counsel, requested a telephone hearing with an OWCP hearing representative. A hearing was held on April 19, 2016.

An undated report and reports dated December 14, 2015, January 27, and March 9, 2016 from Dr. Kyle J. Moyles, a Board-certified orthopedic surgeon, and Dr. Jonathan C. Levy, an orthopedic surgeon, discussed physical examination findings and diagnostic test results, diagnosed appellant as having right cubital tunnel syndrome, right elbow osteoarthritis with ulnar neuritis following ulnar nerve decompression. The physicians addressed her medical treatment, which included authorized right elbow arthroscopy with extensive debridement and removal of loose bodies and subcutaneous ulnar nerve neuroplasty with transposition that was performed on March 17, 2016 by Dr. Levy. They also addressed appellant's work restrictions.

In a July 6, 2016 decision, an OWCP hearing representative set aside the September 10, 2015 decision and remanded the case for OWCP to, among other things, obtain a supplemental report from Dr. Lotman requesting that he review Dr. Grossman's report and provide a rationalized medical opinion as to whether appellant's cervical, right elbow, and right hand conditions were causally related to the April 22, 2014 employment injury.

On July 14, 2016 OWCP requested that Dr. Lotman review Dr. Grossman's June 8, 2015 report and provide whether appellant's diagnosed conditions were causally related to the April 22, 2014 employment injury.

In a supplemental report dated July 15, 2016, Dr. Lotman related that, as indicated in his prior report, the diagnosis of cervical disc herniation was predicated solely on an MRI scan report. He noted that appellant's physical examination in this regard revealed negative objective findings. However, Dr. Lotman indicated that he did not review the MRI scan. He related that regardless, based on appellant's mechanism of injury, he did not believe that any cervical pathology was causally related to the injury in question. Dr. Lotman explained that this was particularly obvious as the degenerative changes described in the MRI scan report took years to occur and they would have been inconsistent with the time frame between appellant's injury and the cervical MRI scan. He again referenced his original report and opined that the tear of the radial collateral ligament and the median nerve neuropathy were not causally related to the accepted work injury. Dr. Lotman did not believe appellant's carpal tunnel symptoms were causally related to accepted injury. He believed that the valgus stress to the elbow as described to him by her was consistent with traction to the ulnar nerve and possible neurapraxia of the ulnar nerve resulting in or requiring the need for ulnar nerve release. The valgus stress was exactly the opposite of what would be necessary to result in a tear of the radial collateral ligament. Dr. Lotman maintained that appellant's only causally related injury was to the ulnar nerve. He further maintained that her other conditions, which included right elbow degenerative arthritis, surgery performed for tennis elbow (lateral epicondylitis), right shoulder strain, bilateral carpal tunnel syndrome, cervical spondylosis (arthritis), and HNP at C3 were not causally related to the April 22, 2014 employment injury.

In a September 15, 2016 decision, OWCP again denied appellant's request to expand the acceptance of her claim to include additional conditions. It found that Dr. Lotman's July 15, 2016 report constituted the weight of the medical opinion evidence and established that appellant did not have any additional medical conditions causally related to the April 22, 2014 employment injury.

By letter dated September 20, 2016, appellant, through counsel, requested a telephone hearing with an OWCP hearing representative. A hearing was held on May 17, 2017.

In a decision dated July 27, 2017, an OWCP hearing representative affirmed the September 15, 2016 decision. He found that the weight of the medical opinion evidence rested with Dr. Lotman's July 15, 2016 opinion.

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.[4] 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.[5] Causal relationship is a medical issue and the medical evidence required to establish causal relationship is rationalized medical evidence.[6] 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.[7] 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.[8]

The general rule respecting consequential injuries is that, when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause, which is attributable to the employee's own intentional conduct.[9] The subsequent injury is compensable if it is the direct and natural result of a compensable primary injury.[10] With respect to consequential injuries, the Board has stated that, where an injury is sustained as a consequence of an impairment residual to an employment injury, the new or second injury, even though nonemployment related, is deemed, because of the chain of causation to arise out of and in the course of employment and is compensable.[11]

[4] *Jaja K. Asaramo*, 55 ECAB 200 (2004).

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

[6] *D.E.*, 58 ECAB 448 (2007); *Mary J. Summers*, 55 ECAB 730 (2004).

[7] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (2005).

[8] *V.W.*, 58 ECAB 428 (2007); *Ernest St. Pierre*, 51 ECAB 623 (2000).

[9] *Albert F. Ranieri*, 55 ECAB 598 (2004).

[10] *S.M.*, 58 ECAB 166 (2006); *Debra L. Dillworth*, 57 ECAB 516 (2006); *Carlos A. Marrero*, 50 ECAB 117 (1998); A. *Larson, The Law of Workers' Compensation* § 10.01 (2005).

[11] *L.S.*, Docket No. 08-1270 (issued July 2, 2009); *Kathy A. Kelley*, 55 ECAB 206 (2004).

ANALYSIS

The Board finds that this case is not in posture for decision.

OWCP accepted that on April 22, 2014 appellant sustained employment-related right elbow sprain, pectoral sprain, and right acute cubital tunnel syndrome and authorized an August 4, 2014 right ulnar release at the elbow. Appellant later claimed that she sustained additional cervical and right upper extremity conditions on April 22, 2014. OWCP, in its decisions dated September 15, 2016 and July 27, 2017, denied appellant's claim to expand the acceptance of her claim. It found that the weight of medical opinion rested with Dr. Lotman, an OWCP referral physician.

The Board notes initially that appellant bears the burden of proof to establish that any additionally-diagnosed conditions were causally related to or a consequence of her accepted injury.[12] In support of her request, appellant submitted an October 22, 2014 report from Dr. Reppy. Dr. Reppy diagnosed additional conditions of cervical disc herniation with radiculopathy at the C3-4 level, cervical stenosis, a partial tear of the right common extensor tendon, torn right radial collateral ligament, and neuropathy of the right medial nerve. He concluded that appellant's April 22, 2014 employment injury was the direct and proximate cause of these conditions. Dr. Reppy noted that his opinion was supported by his examination and review of diagnostic test results. While Dr. Reppy provided an opinion on causal relationship, he did not sufficiently explain why examination findings and diagnostic testing led him to conclude that the April 22, 2014 employment injuries caused or contributed to the diagnosed conditions. Medical reports without adequate rationale on causal relationship are of diminished probative value and are insufficient to meet an employee's burden of proof.[13] Thus, the Board finds that Dr. Reppy's report is insufficient to meet appellant's burden of proof.

Similarly, the reports from Drs. Moyles and Levy diagnosed right elbow osteoarthritis with ulnar neuritis, in addition to the accepted diagnosis of right cubital tunnel syndrome, but failed to provide a history of injury[14] or offer a specific opinion as to whether the accepted employment injury caused or aggravated the additional diagnosed conditions.[15]

When Dr. Lotman initially examined appellant on March 17, 2015, he provided her history and reviewed medical records and SOAF. Dr. Lotman diagnosed HNP at C3 that was very tiny based on a cervical MRI scan, cervical spondylosis, bilateral carpal tunnel syndrome, status post tennis elbow surgery with residual incongruity of the common extensor origin, and degenerative

[12] *Supra* note 4.

[13] *Ceferino L. Gonzales*, 32 ECAB 1591 (1981). The opinion of a physician supporting causal relationship must rest on a complete factual and medical background supported by affirmative evidence, address the specific factual and medical evidence of record and provide medical rationale explaining the relationship between the diagnosed condition and the established incident or factor of employment. *See Lee R. Haywood*, 48 ECAB 145 (1996).

[14] *Frank Luis Rembisz*, 52 ECAB 147 (2000) (medical opinions based on an incomplete history have little probative value).

[15] *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *J.F.*, Docket No. 09-1061 (issued November 17, 2009); *A.D.*, 58 ECAB 149 (2006) (medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

arthritis of the right elbow with left elbow effusion. He opined that the diagnosed conditions were not causally related to the mechanism of injury. Dr. Lotman further opined that the accepted April 22, 2014 employment-related right elbow and pectoral sprains and acute right cubital tunnel syndrome condition, which required surgery, had resolved. He opined, however, that appellant had right ulnar neuritis causally related to the accepted mechanism of injury. Dr. Lotman noted that she had residual ulnar irritation based on her electrophysiological studies. He believed that appellant's subjective complaints were consistent with her objective physical findings. Dr. Lotman also believed that she had scarification from her prior surgery for her right cubital tunnel syndrome may have been compromised as the ulnar nerve dove into the proximal forearm between the two heads of the flexor ulnaris. He related that this fact was compounded by appellant's underlying degenerative arthritis of the elbow joint and elbow joint effusion. Dr. Lotman also recommended a referral to a neurologist to determine why appellant had bilateral carpal tunnel syndrome.

Based on Dr. Lotman's opinions, OWCP referred appellant to Dr. Grossman, a Board-certified neurologist, for a second opinion. In his June 8, 2015 report, Dr. Grossman opined that appellant's carpal tunnel syndrome was not causally related to the April 22, 2014 employment injuries. Instead, he found that the condition was related to appellant's nurse work duties. The medical evidence of record therefore does not substantiate that appellant's carpal tunnel syndrome was causally related to the accepted April 22, 2014 employment injury.[16]

On July 15, 2016 Dr. Lotman reviewed Dr. Grossman's June 8, 2015 report and reiterated his prior opinion that appellant's cervical disc herniation, right elbow degenerative arthritis, tennis elbow (lateral epicondylitis) surgery, right shoulder strain, bilateral carpal tunnel syndrome, cervical spondylosis (arthritis), HNP at C3, and tear of the radial collateral ligament were not causally related to the April 22, 2014 employment injuries. He again opined, however, that the only causally related injury was to the ulnar nerve. Dr. Lotman noted that the valgus stress to the elbow as appellant described to him was consistent with traction to the ulnar nerve and possible neurapraxia of the ulnar nerve which resulted in or required ulnar nerve release. The Board notes that, while OWCP authorized appellant's August 4, 2014 right elbow ulnar release to treat her accepted right acute cubital tunnel syndrome, it has not accepted appellant's claim for the subsequently diagnosed ulnar nerve condition.[17] Dr. Lotman opined in his March 17, 2015 report that appellant had an additional condition of ulnar neuritis that was causally related to the mechanism of injury and to her right shoulder strain, due to chronic favoring of the right upper extremity. He further explained that appellant had scarification from her prior surgery for her right cubital tunnel syndrome which may have compromised the ulnar nerve as it dove into the proximal forearm between the two heads of the flexor ulnaris. Dr. Lotman's reports therefore suggest that appellant may have secondary ulnar nerve condition which developed as a consequence of her accepted right cubital tunnel syndrome. The Board finds that, once OWCP undertook development of the evidence by referring appellant to a second opinion physician, it had an obligation to obtain

[16] *Supra* note 7.

[17] *G.A.*, Docket No. 09-2153 (issued June 10, 2010); *Jaja K. Asaramo*, 55 ECAB 200 (2004); *Alice J. Tysinger*, 51 ECAB 638 (2000).

a sufficiently reasoned report as to whether appellant had a consequential condition causally related to the April 22, 2014 employment injuries.[18]

The Board will, therefore, set aside the July 27, 2017 decision and remand the case for OWCP to obtain a supplemental report from Dr. Lotman clarifying whether appellant had a consequential condition causally related to the accepted April 22, 2014 work injuries. After this and any further development deemed necessary, it shall issue a *de novo* decision on appellant's consequential injury claim.

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the July 27, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: September 12, 2018
Washington, DC

Patricia H. Fitzgerald, Deputy 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

[18] *See R.O.*, Docket No. 16-1516 (issued August 28, 2017); *see also Phillip L. Barnes*, 55 ECAB 426 (2004); *Virginia Richard (Lionel F. Richard)*, 53 ECAB 430 (2002); *Dorothy L. Sidwell*, 36 ECAB 699, 707 (1985); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).