United States Department of Labor
Employees' Compensation Appeals Board

T.T., Appellant	)	
and	)	**Docket No. 19-0544**
	)	**Issued: August 14, 2020**
DEPARTMENT OF HEALTH & HUMAN SERVICES, FEDERAL OCCUPATIONAL HEALTH, Atlanta, GA, Employer	)	

Appearances:
Daniel M. Goodkin, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On January 2, 2019 appellant, through counsel, filed a timely appeal from a September 13, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the

[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.

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.[3]

ISSUE

The issue is whether appellant has met her burden of proof to establish that the acceptance of her claim should be expanded to include additional conditions of the right upper extremity.

FACTUAL HISTORY

On September 10, 2014 appellant, then a 40-year-old physician, filed an occupational disease claim (Form CA-2) alleging that she sustained an aggravation of preexisting right cubital and carpal tunnel syndromes due to factors of her federal employment, including typing on a laptop computer, using a mouse, and flipping pages. She noted that she first became aware of her claimed condition on July 9, 2014 and realized its relation to her federal employment on July 23, 2014.[4] OWCP initially accepted appellant's claim for right ulnar nerve neuropathy, and later expanded the acceptance of the claim to include an aggravation of right shoulder rotator cuff tendinosis/bursitis, right ulnar nerve lesion, and polyneuropathy of the right arm. Appellant stopped work on February 17, 2015.[5] OWCP paid her wage-loss compensation on the supplemental rolls from February 17 through April 4, 2015 and on the periodic rolls beginning April 5, 2015.

In a report dated January 27, 2015, Dr. Gary Lourie, Board-certified in orthopedic and hand surgery, noted that appellant complained of numbness in her right ring and small fingers which she reported was secondary to probable overuse of the right upper extremity. Appellant indicated that she sustained a recurrence of cubital tunnel syndrome which occurred in April 2014 with an increase in her work duties, including increased typing. She also reported developing right thumb metacarpophalangeal (MCP) joint synovitis, probably secondary to overuse. On examination of the right upper extremity, Dr. Lourie observed decreased sensation at the posterior branch of the medial antebrachial cutaneous nerve, increased discomfort with Tinel's sign and the flexor carpi ulnaris (FCU) muscle, positive Brooks test distal to the medial epicondyle, and resisted flexion of the flexor digitorum superficialis (FDS) at the ring finger with the aponeurotic arch causing the

[2] 5 U.S.C. § 8101 *et seq.*

[3] The Board notes that, following the September 13, 2018 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

[4] The case record contains a report showing that, on June 9, 2009, she underwent right carpal tunnel release and right ulnar nerve transposition at the elbow. In an accompanying statement dated September 10, 2014, appellant advised that she had sustained a traumatic amputation of her left hand below the elbow in 1981 and that the conditions of right cubital and carpal tunnel syndromes had been surgically corrected in 2009.

[5] Appellant returned to work on April 21 and 22, 2015, but an OWCP record of a telephone call from an employing establishment official indicates that an ergonomic workstation was not available for her. She did not return to work thereafter.

majority of her discomfort. He diagnosed probable recurrence of cubital tunnel syndrome secondary to increased demands, and hypertrophy of the two heads of the FCU and FDS at the ring finger (aponeurotic arch). Dr. Lourie recommended revision surgery of the right upper extremity.

On February 16, 2015 Dr. Lourie performed OWCP-authorized right cubital tunnel syndrome surgery with complex revision, re-identification of ulnar nerve, application of a Neuragen nerve wrap, and anterior subcutaneous transposition.

OWCP subsequently referred appellant for a second opinion examination to Dr. Eric Furie, a Board-certified orthopedic surgeon. It requested that he provide an opinion regarding whether appellant continued to have residuals of her accepted employment conditions. In a March 8, 2016 report, Dr. Furie noted that, on physical examination, appellant exhibited full strength of the right shoulder with internal and external rotation, pain with resisted abduction, and crepitus with range of motion. Appellant had decreased sensation on the ulnar side of the right ring finger and small finger, as well as hypermobility of the right hand joints. Dr. Furie indicated that appellant's accepted employment conditions were still active. He further noted that appellant's potential for full-time reemployment was significantly limited by ophthalmic issues causing significant vision limitation.

On May 2, 2016 appellant underwent OWCP-authorized arthroscopic limited debridement of the labrum, rotator cuff repair, and subacromial decompression of the right shoulder.

In a letter dated February 13, 2017, appellant asserted that she had right thumb injuries, including overuse capsulitis/synovitis of the MCP joint and arthritis, and right wrist injuries, including two full tears, partial tear, and capsule rupture, which she felt should be accepted under the present claim. She indicated that she extensively used her right thumb at work to manipulate a trackball computer mouse.

Appellant subsequently submitted a January 20, 2017 report from Dr. Lourie who indicated that appellant complained of right thumb MCP joint symptoms which were either secondary to overuse on the right side or secondary to inflammatory conditions. On examination of the right hand, Dr. Lourie observed tenderness to touch. He noted that an x-ray of the right wrist showed widening greater than three millimeters at the scapholunate interface, but no true dorsal intercalated segment instability. Dr. Lourie diagnosed right thumb MCP joint synovitis.

A February 7, 2017 magnetic resonance imaging (MRI) scan of the right wrist contained an impression of full-thickness tear involving the dorsal and membranous portions of the scapholunate ligament at the scaphoid attachment with mild widening of the scapholunate interval, high-grade partial tear involving the ulnar collateral ligament of the thumb MCP joint along with joint effusion and synovitis, medial capsular tear at the level of the ulnar styloid with tearing of the ulnocarpal ligament and contrast extravasation medial to the distal ulna, and soft tissue ganglia anterior to the ulnar styloid and radioscaphoid joint.

On February 9, 2017 Dr. Lourie noted that the right scapholunate ligament tear seen on the February 7, 2017 MRI scan could be due to inflammatory arthropathy. In a February 17, 2017 note, he indicated that appellant had undifferentiated inflammatory erosive arthritis and he opined

that the right scapholunate ligament changes were inflammatory in nature, rather than post traumatic.

In a February 27, 2017 letter, Dr. Lourie indicated that he had treated appellant since January 2015 for her accepted condition of right ulnar neuropathy, as well as for ongoing right thumb and lateral wrist pain. He noted that her recovery from surgery was protracted and her ulnar nerve remained symptomatic with intermittent parasthesias and numbness. Dr. Lourie indicated that appellant fell in November 2016 and that she had an MRI scan on February 17, 2017 which showed a full-thickness scapholunate tear, high-grade partial tear of the MCP ulnar collateral ligament (with limited displacement, joint effusion, and synovitis), and a medial capsular tear at the level of the ulnar styloid with tearing of the ulnocarpal ligament. He advised that he was unable to completely characterize these injuries as acute versus chronic due to an overriding intervening diagnosis which bore significantly on the disease process and treatment options. Dr. Laurie opined that the tears were the result of an underlying rheumatological/inflammatory condition of undifferentiated erosive inflammatory arthritis, which was strongly suggestive as a "significant contributing factor into her extensive history of ligament, tendon, and nerve problems resulting from overuse and repetitive use, including the current accepted conditions." He noted that, although appellant's fall might have worsened her symptoms, he did not "opine the fall as causative." Dr. Lourie, on behalf of appellant, requested that her right wrist ligament tears, synovitis, and capsular tear be added to the accepted employment-related conditions of the present claim given their presentation at the same time as her other overuse/repetitive strain injuries deemed as due to office work, and due to their ongoing symptomatic presentation.

On April 11, 2017 Dr. Lourie reiterated his request for additional conditions to be added to appellant's accepted employment-related conditions, noting that an underlying autoimmune inflammatory condition had been discovered which increased her susceptibility to repetitive strain injuries and hindered orthopedic recovery. He noted that, given the several active symptomatic tears in her right wrist and thumb, any significant wrist or thumb activity might further exacerbate her condition.

On May 11, 2017 OWCP referred appellant and the case record (including a statement of accepted facts (SOAF)) for a second opinion examination to Dr. Raju Vanapalli, a Board-certified orthopedic surgeon. It requested that Dr. Vanapalli evaluate whether her accepted employment conditions had resolved and to provide an opinion on her ability to work.

In a June 6, 2017 report, Dr. Vanapalli discussed appellant's factual and medical history and reported physical examination findings, noting that she did not exhibit residual symptoms of her June 9, 2009 carpal tunnel release. On examination of the right shoulder, he noted hypermobility and pain over the posterior aspect. Dr. Vanapalli indicated that appellant's right ulnar neuropathy had resolved with no residual wasting or weakness of the muscles, as had her right rotator cuff tendinosis. He noted that the May 2, 2016 right shoulder surgery was successful with no residual weakness or signs of impingement present, except for subjective complaints of pain. Dr. Vanapalli indicated that, solely with respect to her resolved employment conditions, appellant could return to her date-of-injury job. He further noted that, as she had severely impaired vision and used special lenses to drive, she would be limited from operating a motor vehicle at work. In an attached June 6, 2017 work capacity evaluation form (Form OWCP-5), Dr. Vanapalli listed various work restrictions, including lifting, pushing, and pulling no more than 10 pounds.

In a June 23, 2017 letter, Dr. Lourie reiterated that appellant had compensable right arm overuse injuries of her right shoulder and elbow which had been surgically corrected, as well as additional wrist and thumb conditions, which were pending acceptance by OWCP and likely required surgical correction. He noted that her case was complicated by an underlying autoimmune inflammatory disorder affecting the integrity of her joints, tendons, and ligaments, which greatly increased her susceptibility to repetitive strain injuries. Dr. Lourie recommended use of a prosthetic left hand.

In a July 7, 2017 letter, Dr. Lourie expressed his disagreement with the findings of Dr. Vanapalli's June 6, 2017 report. He indicated that Dr. Vanapalli had inappropriately found that appellant's right arm was at maximum medical improvement (MMI) because she still had active injuries to her right wrist and thumb which were significantly limiting given she only had one hand. Dr. Lourie further indicated that Dr. Vanapalli inappropriately suggested that appellant could return to a position requiring heavy typing, mouse usage, and paper flipping because these duties might worsen her right wrist and thumb injuries. He noted that Dr. Vanapalli's report did not address many of appellant's current indicated difficulties, including loss of grip strength, difficulty driving, difficulty lifting away from the body, and pain in the right wrist and thumb.

In a July 24, 2017 letter, Dr. Timothy S. Maughon, a Board-certified orthopedic surgeon, noted that he had reviewed Dr. Vanapalli's June 6, 2017 report, as well as the recent reports of Dr. Lourie. He indicated that, as an amputee for over 35 years, appellant had engaged in extensive overuse of her entire right arm, which complicated her case due to increased susceptibility to repetitive strain injuries in the context of chronic inflammation. Dr. Maughon maintained that MMI could not be declared, as appellant had active, untreated conditions of her right wrist and thumb, including some which were newly discovered. He noted agreement with Dr. Lourie that the tears of appellant's right wrist and thumb were overuse-related in the setting of chronic inflammation due to the extensive hand/wrist movements necessary for typing and using a mouse, which were her primary duties as a physician. Dr. Maughon concurred with Dr. Lourie that appellant's right hand and wrist conditions should be added to the accepted employment-related conditions of the claim.

OWCP requested that Dr. Vanapalli provide a supplemental report. It provided an updated SOAF listing all the accepted employment conditions and requested that he indicate whether the accepted employment conditions inadvertently not mentioned on the prior SOAF (right ulnar nerve lesion and polyneuropathy of the right arm) had resolved. OWCP also requested that Dr. Vanapalli clarify whether the conditions of MCP joint synovitis of the right thumb and a scapholunate ligament tear of the right wrist were "caused or aggravated by the claimed work event or approved work injuries."

In a supplemental report dated August 11, 2017, Dr. Vanapalli indicated that appellant's right ulnar neuropathy and ulnar lesion had resolved as his June 2017 clinical examination did not reveal signs of these conditions. As to the MCP joint synovitis of her right thumb and scapholunate ligament tear of her right wrist, Dr. Vanapalli expressed his belief that these conditions were due to an underlying rheumatologic/inflammatory condition of undifferentiated erosive inflammatory arthritis diagnosed by Dr. Lourie in February 2017.

OWCP then referred appellant's case to Dr. Nathan Hammel, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA).[6] It provided the DMA with a SOAF and requested that he render an opinion regarding whether the medical evidence of record indicated that the tears of appellant's right thumb and wrist were causally related to an accepted employment factor/condition. It also requested that Dr. Hammel opine as to whether a proposed prosthetic left hand to assist in relief of the right upper extremity was necessitated by an accepted employment condition.

In a September 11, 2017 report, Dr. Hammel advised that, based on the medical evidence of record, the tears of appellant's right thumb and wrist were causally related to the accepted conditions. However, he went on to indicate that she had undifferentiated inflammatory polyarthritis, and noted that there was no injury mechanism in the SOAF that could be responsible for the ligament tears evidenced in the medical evidence. Dr. Hammel also noted that the proposed prosthetic for the left hand to assist in relief of the right upper extremity was medically necessary.

On February 1, 2018 OWCP requested clarification from Dr. Hammel as to whether the tears of the right thumb and wrist were causally related to appellant's accepted employment injury, and whether proposed surgery for repair of both the right thumb and wrist were medically necessary and causally related to appellant's accepted conditions. It noted that it was unclear from his report whether he agreed or disagreed that tears of the right thumb and wrist were related to accepted employment conditions in this claim.

In a February 5, 2018 report, Dr. Hammel responded noting that there was no clear causal link between the work injury mechanism in the SOAF and the claimed additional conditions. He indicated that there was no evidence that the tears were related to appellant's employment.

In a February 8, 2018 report, Dr. John Mowbray, Board-certified in orthopedic and hand surgery, diagnosed traumatic amputation below the left elbow, right ulnar neuropathy, and injury of tendon of right rotator cuff.

By decision dated May 10, 2018, OWCP denied expansion of the acceptance of appellant's claim to include tears of the right thumb and right wrist, as well as surgery for repair of both conditions. It found that the medical evidence of record failed to establish that these conditions were related to her accepted employment factors/conditions.

On July 3, 2018 appellant, through counsel, requested reconsideration of the May 10, 2018 decision.

Appellant submitted a May 7, 2018 report from Dr. Zachary Fausel, a Board-certified internist, who examined appellant for right radial dorsal hand pain. Dr. Fausel noted that appellant reported that the pain flared up after she suffered a nonwork-related fall onto her outstretched right hand on November 24, 2016. He advised that a right wrist MRI scan from February 2017 demonstrated a partial triangular fibrocartilage complex tear and a partial scapholunate tear. A

[6] On August 2, 2017 OWCP requested that Dr. Lourie provide a narrative medical report explaining whether appellant had a condition, other than those already accepted, which was caused or aggravated by employment factors. It afforded Dr. Lourie 30 days to respond, but he did not do so within the afforded period.

right wrist MRI scan from August 2017 demonstrated healing of the triangular fibrocartilage complex tear, but showed a continued tear of the scapholunate ligament. Dr. Fausel indicated that appellant underwent surgery in October 2017 with Dr. Lourie, including arthroscopy of the right wrist with synovectomy and debridement of the scapholunate ligament. He noted that during surgery, Dr. Lourie reported that appellant had an intact scapholunate ligament without evidence of tear.[7] On examination of the right hand, wrist, and fingers, Dr. Fausel noted tenderness to palpation over the right scapholunate interval and a mildly positive Finkelstein test. He diagnosed right wrist pain with mixed etiology, likely related to scapholunate instability (radiocarpal joint) and carpometacarpal (CMC) arthritis.

Appellant also submitted a November 9, 2017 report from Dr. Maughon who noted that she complained of right knee pain after completing a half iron man course. In an August 15, 2018 report, Dr. Maughon advised that appellant had returned for evaluation of her right shoulder.[8]

By decision dated September 13, 2018, OWCP denied modification of its May 10, 2018 decision.

LEGAL PRECEDENT

When 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.[9]

The medical evidence required to establish causal relationship between a claimed specific condition and/or period of disability and an employment injury is rationalized medical opinion evidence. The opinion of the physician must be based on a complete factual and medical background of the claimant, 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.[10]

The Board has held that when the medical evidence supports an aggravation or acceleration of an underlying condition precipitated by working conditions or injuries, such disability is compensable.[11] However, the normal progression of untreated disease cannot be stated to constitute "aggravation" of a condition merely because the performance of normal work duties reveals the underlying condition.[12]

[7] The case record does not contain a copy of the surgery report.

[8] Appellant also submitted an August 17, 2018 ultrasound test of her right shoulder.

[9] *J.R.*, Docket No. 20-0292 (issued June 26, 2020); *W.L.*, Docket No. 17-1965 (issued September 12, 2018); *V.B.*, Docket No. 12-0599 (issued October 2, 2012); *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004).

[10] *See E.J.*, Docket No. 09-1481 (issued February 19, 2010).

[11] *C.H.*, Docket No. 17-0488 (issued September 12, 2017).

[12] *Id.*

Section 8123(a) of FECA provides, in pertinent part: "If there is 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."[13] In situations where 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 upon a proper factual background, must be given special weight.[14]

ANALYSIS

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

Following a review of the medical evidence of record the Board finds that there is an unresolved conflict in the medical opinion evidence between appellant's treating physicians, Drs. Lourie and Maughon, and the second opinion examiner and DMA, Drs. Vanapalli and Hammel respectively, regarding whether appellant's additional diagnosed right upper extremity conditions, including MCP joint synovitis of the right thumb, ulnar collateral ligament tear, CMC arthritis, and scapholunate ligament tears of the right wrist, were causally related to employment factors/conditions.

Drs. Lourie and Maughon opined that appellant sustained additional employment-related right upper extremity conditions. In a February 27, 2017 report, Dr. Lourie indicated that appellant underwent a February 17, 2017 MRI scan which showed a full-thickness scapholunate tear, high-grade partial tear of the MCP ulnar collateral ligament (with limited displacement, joint effusion, and synovitis), and a medial capsular tear at the level of the ulnar styloid with tearing of the ulnocarpal ligament. He opined that, although appellant's underlying rheumatological/ inflammatory condition (undifferentiated erosive inflammatory arthritis) contributed to the observed medical conditions, her "overuse and repetitive use" at work were a "significant contributing factor" to these conditions as well. Dr. Lourie requested that appellant's right wrist ligament tears, synovitis, and capsular tear be added to the accepted employment-related conditions of the present claim given their presentation at the same time as her other overuse/repetitive strain injuries deemed as due to office work, and given their ongoing symptomatic presentation. On April 11, 2017 he reiterated his request for additional right upper extremity conditions (including right wrist and thumb ligament tears) to be added to her accepted employment-related conditions, noting that an underlying autoimmune inflammatory condition had been discovered which increased her susceptibility to repetitive strain injuries.

In a July 24, 2017 letter, Dr. Maughon indicated that, as an amputee for over 35 years, appellant had extensive overuse of her entire right arm, which complicated her case due to increased susceptibility to repetitive strain injuries in the context of chronic inflammation. He noted agreement with Dr. Lourie that the tears of appellant's right wrist and thumb were overuse related in the setting of chronic inflammation due to the extensive hand/wrist movements necessary

[13] 5 U.S.C. § 8123(a).

[14] *D.M.*, Docket No. 18-0746 (issued November 26, 2018); *R.H.*, 59 ECAB 382 (2008); *James P. Roberts*, 31 ECAB 1010 (1980).

for typing and using a mouse, which were her primary duties as a physician. Dr. Maughon concurred with Dr. Lourie that appellant's right hand and wrist conditions should be added to the accepted employment-related conditions of the claim.

In contrast to these reports, Dr. Vanapalli, an OWCP referral physician, indicated in an August 11, 2017 report that appellant's MCP joint synovitis of the right thumb and scapholunate ligament tear of the right wrist were the results of an underlying rheumatologic/inflammatory condition of undifferentiated erosive inflammatory arthritis diagnosed by Dr. Lourie in February 2017. In a February 5, 2018 report, Dr. Hammel, serving as a DMA, opined that there was no clear causal link between the work injury mechanism in the SOAF and the claimed additional right upper extremity conditions. He indicated that there was no evidence that the observed ligament tears were related to appellant's employment.

For these reasons, the issue of whether appellant's claim should be expanded to include additional conditions of the right upper extremity causally related to the accepted factors of federal employment is unresolved at this time. Under section 8123(a) of FECA, OWCP must resolve this conflict by referring appellant, together with the medical record and an updated SOAF, to an impartial medical specialist.[15] After this and such other development as OWCP deems necessary, OWCP shall issue a *de novo* decision on appellant's expansion claim.

CONCLUSION

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

[15] *See D.P.*, Docket No. 10-0121 (issued July 23, 2010).

ORDER

IT IS HEREBY ORDERED THAT the September 13, 2018 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: August 14, 2020
Washington, DC

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

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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