United States Department of Labor
Employees' Compensation Appeals Board

J.H., Appellant	)	
and	)	**Docket No. 18-1637**
	)	**Issued: January 29, 2020**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION, Montrose, NY, 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:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 29, 2018 appellant, through counsel, filed a timely appeal from a June 21, 2018 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 his burden of proof to establish additional conditions causally related to his March 4 or June 2, 2015 employment injuries.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts of the case as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On June 3, 2015 appellant, then a 38-year-old procurement analyst, filed a traumatic injury claim (Form CA-1) alleging that on June 2, 2015 he sustained injury to his wrists, ankles, right hand, and left shin when he slipped and fell going down wet steps at work while in the performance of duty.[4]

The findings of a March 26, 2015 magnetic resonance imaging (MRI) scan of appellant's right wrist contained an impression of a tear of the right triangular fibrocartilage complex (TFCC). A June 3, 2015 report of bilateral wrist x-rays indicated an impression of no fracture, dislocation, or osteopenia, and a June 30, 2015 MRI scan of the left wrist included an impression of left TFCC tear.[5]

In a report dated July 22, 2015, Dr. Debra Parisi, an attending Board-certified orthopedic surgeon, noted that appellant reported that, when he fell on June 2, 2015, he tried to catch himself with his hands. She diagnosed left wrist osteoarthritis as shown by MRI scan as well as left TFCC tear and left ulnar nerve syndrome.

In a statement dated July 28, 2015, appellant indicated that, when he fell on June 2, 2015, his hands struck the concrete sidewalk at the base of the stairs.

By decision dated August 6, 2015, OWCP accepted appellant's claim for bilateral wrist and ankle sprains. It also determined that the reports of his attending physicians were insufficient to accept either a TFCC tear or left ulnar nerve syndrome as being causally related to the March 4 or June 2, 2015 employment injuries.

In a report dated September 2, 2015, Dr. Parisi diagnosed left TFCC tear and preexisting left ulnar syndrome. She attributed the left TFCC tear to the June 2, 2015 employment injury and recommended an electromyogram (EMG) to rule out cubital tunnel syndrome. On September 16, 2015 Dr. Parisi diagnosed left TFCC tear and left wrist osteoarthritis. She advised that appellant developed cubital tunnel symptoms and that he had been asymptomatic prior to his June 2, 2015

[3] Docket No. 16-1740 (issued September 26, 2017).

[4] Under a separate case file (OWCP File No. xxxxxx065), OWCP had previously accepted that on March 4, 2015 appellant sustained a right wrist sprain due to a fall at work. The case file for the March 4, 2015 employment injury has been administratively combined with the case file for the present claim as a subsidiary file.

[5] The case record contains a form for authorization for examination and/or treatment (Form CA-16) executed by the employing establishment on June 4, 2015.

fall. Dr. Parisi opined that the left TFCC tear was related to his fall on June 2, 2015. She indicated that appellant might also have hit his left elbow when he fell and noted that the swelling due to such a fall could have caused left ulnar nerve syndrome/cubital tunnel syndrome.

By decision dated October 14, 2015, OWCP advised appellant that his claim had been accepted for the additional condition of "other specified sprain of left wrist, initial encounter."

By separate decision dated October 14, 2015, OWCP determined that appellant's claim was denied for the conditions of left wrist osteoarthritis, cubital tunnel syndrome, and ulnar nerve syndrome. It found that Dr. Parisi had not provided sufficient medical rationale in her reports to establish that these conditions were causally related to the March 4 or June 2, 2015 employment injuries.

On October 22, 2015 appellant, through counsel, requested a telephonic hearing with a representative of OWCP's Branch of Hearings and Review.

Prior to the hearing, appellant submitted additional medical reports to OWCP. A December 18, 2015 EMG/nerve conduction velocity (NCV) study of his upper extremities contained an impression of bilateral cubital tunnel syndrome. In a report dated February 3, 2016, Dr. Parisi discussed the December 18, 2015 EMG/NCV results and diagnosed cubital tunnel syndrome referable to the June 2, 2015 employment injury.

In April 2016 OWCP referred appellant to Dr. Louis D. Nunez, a Board-certified orthopedic surgeon, for a second opinion medical examination and evaluation of his work-related medical conditions. In an April 22, 2016 report, Dr. Nunez provided a history of the March 4 and June 2, 2015 employment injuries and discussed the March 26 and June 30, 2015 MRI scan reports as well as the December 18, 2015 EMG/NCV report. He opined that appellant's bilateral TFCC tears were directly related to the June 2, 2015 employment injury.[6]

In a May 20, 2016 report, Dr. Parisi indicated that appellant had symptoms causally related to work injuries and that he was totally disabled on account of such injuries. She repeated her diagnosis of left TFCC tear and left ulnar syndrome.

At the hearing held on May 25, 2016, appellant testified that he had no injuries to his hands or elbows prior to March 4, 2015. He indicated that his left elbow hit the ground when he fell on June 2, 2015 and that he later developed swelling and tingling in his left elbow.

By decision dated July 1, 2016, OWCP's hearing representative affirmed the October 14, 2015 decision, finding that appellant's claim was properly denied for the conditions of left wrist osteoarthritis, cubital tunnel syndrome, and ulnar nerve syndrome. He found that the reports of Dr. Parisi lacked adequate medical rationale. The hearing representative noted, "It is

[6] Dr. Nunez noted, "The claimant had reduced ranges of motion and positive ulnar grind test. This, combined with the MRI scan evidence of a torn [TFCC], is indicative of the fact that the conditions are causally related to the employment injury of June 2, 2015."

recommended that [OWCP] expand the merged claims to include bilateral TFCC tear[s] as diagnosed by Dr. Nunez, the second opinion medical examiner."

By decision dated June 20, 2017, OWCP advised appellant that, as a result of the referral to Dr. Nunez, his claim had been accepted for the additional condition of bilateral TFCC tears.

Appellant appealed OWCP's July 1, 2016 decision to the Board and, by decision dated September 26, 2017,[7] the Board affirmed the July 1, 2016 decision. The Board found that appellant had not submitted medical evidence containing medical rationale sufficient to establish additional conditions causally related to his March 4 or June 2, 2015 employment injuries.

On March 22, 2018 appellant, through counsel, requested reconsideration of OWCP's denial of his claim for additional conditions causally related to his March 4 and June 2, 2015 employment injuries. Counsel asserted that an attached March 8, 2018 report from Dr. Neil Allen, an attending Board-certified internist, established appellant's claim for additional work-related conditions.

In his March 8, 2018 report, Dr. Allen indicated that he had reviewed appellant's medical records in order to establish whether causal relationship existed between his left elbow and wrist injuries and the acute work-related trauma he sustained on June 2, 2015. He noted that appellant had been diagnosed by his treating physicians with bilateral TFCC tears and bilateral ulnar nerve syndrome "secondary to a fall onto outstretched arms and extended wrists (a fall onto the hands)." Regarding appellant's past medical history, Dr. Allen indicated, "Unremarkable for history of bilateral elbow and left wrist injury. Prior work-related injury of the right wrist." He posited that appellant's diagnosed bilateral TFCC tears were work related, noting that such injuries often occur when an individual falls on outstretched hands. Dr. Allen concluded that the accepted conditions should be upgraded to include cubital tunnel syndrome and ulnar nerve syndrome of both elbows, noting that appellant denied symptoms in his elbows prior to June 2, 2015.

Dr. Allen further indicated that, when appellant's upper limbs were exposed to the impact of the fall on June 2, 2015, his body's inflammatory response was activated and blood/fluid rushed to the site of injury and caused edema. He noted that the swelling in appellant's upper limbs, specifically the elbows, resulted in the compression of the ulnar nerves within the cubital tunnels. Dr. Allen indicated that typical subjective complaints of those suffering from an ulnar neuropathy included weakness in grasping objects and numbness and/or pain along the ulnar aspect of the forearm, hand, and the fourth and fifth digits. He noted that appellant's work-related bilateral ulnar nerve syndrome and bilateral cubital tunnel syndrome conditions had been confirmed by EMG testing. Dr. Allen concluded, "[Appellant's] injuries directly resulted from the fall he suffered on June 2, 2015. These conditions, noted above, are both reasonable and expected based upon the mechanism described by the patient and documented within the [Board] decision dated September 26, 2017."

[7] *See supra* note 3.

By decision dated June 21, 2018, OWCP denied appellant's claim for additional conditions causally related to his March 4 and June 2, 2015 employment injuries.[8]

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish 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 timely filed within the applicable time limitation period of FECA,[9] that an injury was sustained in the performance of duty as alleged, and that any disability or medical condition for which compensation is claimed is causally related to the employment injury.[10] These are the essential elements of each and every compensation claim, regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[11]

The medical evidence required to establish a 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.[12] The absence of a physical examination by a physician may affect the weight given to a medical report, but does not necessarily render it incompetent as medical evidence.[13] In cases where the sole issue is one of causal relationship, a physical examination is unnecessary as it would be of no consequence and would only result in additional delay and cost.[14]

[8] OWCP indicated that Dr. Allen's March 8, 2018 report established that appellant sustained bilateral TFCC tears on June 2, 2015 and noted that the Board's September 26, 2017 decision should be vacated in part to effectuate acceptance of these conditions. Its comments in this regard were unnecessary in that appellant's claim had already been accepted for bilateral TFCC tears. Moreover, OWCP failed to present legal authority for its assertion that it could vacate a Board decision, in part or in full.

[9] *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

[10] *J.M.*, Docket No. 17-0284 (issued February 7, 2018); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[11] *K.M.*, Docket No. 15-1660 (issued September 16, 2016); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

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

[13] *See W.C.*, Docket No. 18-1386 (issued January 22, 2019); *M.M.*, Docket No. 17-0438 (issued March 13, 2018); *C.B.*, Docket No. 17-0726 (issued July 3, 2017); *Melvina Jackson*, 38 ECAB 443, 447-52 (1987).

[14] *See Sherry Shreiber*, Docket No. 04-1966 (issued January 24, 2005) (the Board held that the fact that an OWCP-selected second opinion physician had not physically examined the claimant was of no consequence as the diagnosis had already been established, and thus the only question was causal relationship).

ANALYSIS

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

Preliminarily, the Board notes that it is unnecessary to consider the evidence it already considered in connection with rendering the September 26, 2017 decision denying appellant's claim for additional conditions causally related to his March 4 or June 2, 2015 work injuries.[15]

In an April 22, 2016 report, Dr. Nunez, a second opinion physician, opined that appellant's bilateral TFCC tears were directly related to the June 2, 2015 work employment injury. By decision dated June 20, 2017, OWCP advised appellant that, as a result of the referral to Dr. Nunez, his claim had been accepted for the additional condition of bilateral TFCC tears.

After the Board issued its September 26, 2017 decision, appellant submitted a March 8, 2018 report of Dr. Allen. In his March 8, 2018 report, Dr. Allen opined that the accepted conditions should be expanded to include the additional conditions of cubital tunnel syndrome and ulnar nerve syndrome of both elbows, noting that appellant denied symptoms in his elbows prior to the accepted June 2, 2015 employment injury. He indicated that, when appellant's upper limbs were exposed to the impact of the fall at work on June 2, 2015, his body's inflammatory response was activated and blood/fluid rushed to the site of injury and caused edema. Dr. Allen explained that the swelling in appellant's upper limbs, specifically the elbows, resulted in the compression of the ulnar nerves within the cubital tunnels. He documented that appellant's bilateral ulnar nerve syndrome and bilateral cubital tunnel syndrome conditions had been confirmed by EMG testing. Dr. Allen concluded that the additional conditions not yet accepted as employment related were a direct consequence of appellant's accepted employment injuries.

The Board finds that the March 8, 2018 report of Dr. Allen is sufficient to require further development of the medical evidence to see that justice is done.[16] Dr. Allen is a Board-certified physician who is qualified in his field of medicine to render rationalized opinions on the issue of causal relationship and he provided a comprehensive and convincing review of the medical record and case history. It is further found that he provided a comprehensive and convincing pathophysiological explanation as to how the mechanism of the accepted employment injuries were sufficient to cause the additional conditions of cubital tunnel syndrome and ulnar nerve syndrome of both elbows. The Board has long held that it is unnecessary that the evidence of record in a case be so conclusive as to suggest causal connection beyond all possible doubt. Rather, the evidence required is only that necessary to convince the adjudicator that the conclusion drawn is rational, sound, and logical.[17] Following review of Dr. Allen's March 8, 2018 report, it is found

[15] OWCP had accepted that on March 4, 2015 appellant sustained a right wrist sprain and that on June 2, 2015 he sustained bilateral wrist sprains, bilateral ankle sprains, and "other specified sprain of left wrist, initial encounter." It denied that the following conditions were related to his March 4 or June 2, 2015 work injuries: left wrist osteoarthritis, cubital tunnel syndrome, and ulnar nerve syndrome.

[16] *D.S.*, Docket No. 17-1359 (issued May 3, 2019); *X.V.*, Docket No. 18-1360 (issued April 12, 2019); *C.M.*, Docket No. 17-1977 (issued January 29, 2019); *William J. Cantrell*, 34 ECAB 1223 (1983).

[17] *W.M.*, Docket No. 17-1244 (issued November 7, 2017); *E.M.*, Docket No. 11-1106 (issued December 28, 2011); *Kenneth J. Deerman*, 34 ECAB 641, 645 (1983) and cases cited therein).

that his medical opinion is well rationalized and logical and is therefore sufficient to require further development of appellant's claim.

It is well established that proceedings under FECA are not adversarial in nature and, while appellant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[18] OWCP has an obligation to see that justice is done.[19]

On remand OWCP shall refer appellant to an appropriate specialist, along with the case record and a statement of accepted facts. Its referral physician shall provide a well-rationalized opinion as to whether appellant's diagnosed conditions of cubital tunnel syndrome and ulnar nerve syndrome of both elbows are causally related to the accepted March 4 or June 2, 2015 employment injuries. If the physician opines that the diagnosed conditions are not causally related to the employment injuries, he or she must explain with rationale how or why their opinion differs from that of Dr. Allen. After such further development of the case record as OWCP deems necessary, it shall issue a *de novo* decision.[20]

CONCLUSION

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

[18] *See id. See also A.P.*, Docket No. 17-0813 (issued January 3, 2018); *Jimmy A. Hammons*, 51 ECAB 219, 223 (1999).

[19] *See B.C.*, Docket No. 15-1853 (issued January 19, 2016).

[20] The case record contains a form for authorization for examination and/or treatment (Form CA-16) executed by the employing establishment on June 4, 2015. The Board notes that where an employing establishment properly executes a Form CA-16 which authorizes medical treatment as a result of an employee's claim for a work-related injury, the Form CA-16 creates a contractual obligation, which does not involve the employee directly, to pay for the cost of the examination or treatment regardless of the action taken on the claim. *See Tracy P. Spillane*, 54 ECAB 608 (2003). The period for which treatment is authorized by a Form CA-16 is limited to 60 days from the date of issuance, unless terminated earlier by OWCP. *See* 20 C.F.R. § 10.300(c). The record is silent as to whether OWCP paid for the cost of appellant's examination or treatment for the period noted on the form.

ORDER

IT IS HEREBY ORDERED THAT the June 21, 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: January 29, 2020
Washington, DC

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

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

Alec J. Koromilas, Alternate Judge, dissenting:

The majority opinion finds that, although the medical report of Dr. Neil Allen, an attending Board-certified internist, was insufficient to meet appellant's burden of proof to establish their claim, it was sufficient to require the Office of Workers' Compensation Programs (OWCP) to further develop the medical evidence. I disagree.

As a standard proposition, the Board has long held that the weight of medical opinion is determined by the opportunity for thoroughness of examination, the accuracy, and completeness of the physician's knowledge of the facts of the case, the medical history provided, the care of analysis manifested, and the medical rationale expressed in support of stated conclusions.[1]

The Federal (FECA) Procedural Manual also sets out parameters for the weighing of medical evidence.[2] It describes a comprehensive report as one which reflects that all testing and analysis necessary to support the physician's final conclusions were performed. OWCP's procedures provide that, in general, greater probative value is given to a medical opinion based on

[1] *R.C.*, Docket No. 14-1964 (issued January 22, 2015); *Anna C. Leanza*, 48 ECAB 115 (1996).

[2] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.810.6(a)(4) (September 2010).

an actual examination. An opinion based on a cursory or incomplete examination will have less value compared to an opinion based on a more complete evaluation.[3]

The case at bar raises a novel constellation of facts where appellant's physician is providing a causal opinion without examining appellant. While arguably considered a treating physician, Dr. Allen never saw in person nor physically examined appellant. He premised his opinion solely on what he characterized as medical records that he had reviewed. Dr. Allen did not, however, identify the records provided for his review nor describe the reports on which he relied.

It is an important distinction that the medical report of Dr. Allen in this case is being used to remand the case for further development.[4] The majority finds that, although his opinion contains insufficient medical rationale to establish the claim, it is sufficient to remand for OWCP to further develop the claim. This is effectuated by the 30-year-old Board-created standard, which provides that "when there is sufficient evidence to establish that the incident occurred, as alleged, but the medical evidence was insufficiently developed to establish the component of fact of injury, evidence submitted by appellant, which contains a history of injury, an absence of any other noted trauma, and an opinion that the condition found was consistent with the original injury is sufficient, given the absence of any opposing medical evidence, to require further development of the record."[5] It could be characterized as a reduced subjective standard, which effectively shifts the burden of proof to OWCP. This case was previously denied by OWCP based on in-person physical examination(s), which were found to be insufficient under the same reduced standard.

Especially in this posture, I believe certain basic medical examination parameters must be met. Dr. Allen espoused an opinion on causal relationship without the benefit of direct physical examination or observations and based his findings on the second-hand opinion(s) of what we believe to be other physicians. This is the type of injury that lends itself to physical examination for the purposes of diagnosis and causation, where the physician is able to palpate the patient, question and receive a first-hand account of the injury and compare same. This remains critical even when the only issue is causation. I do not agree that words of causation in the ordinary course alone can be separated from an examination of appellant by appellant's physician.

Of course, there are occasions where a physical examination cannot be conducted, such as when appellant is deceased. In that situation, record reviews are required and the weight of medical reports in the first instance are weighed using the above-mentioned criteria. But those circumstances are rare and that is inapplicable in the present case.

One could argue that this type of situation is similar to the use by OWCP of a district medical adviser (DMA). The Board has found that the unique status of the DMA, which allows for an advisory medical opinion without a physical examination, can be of sufficient probative

[3] *Id*.

[4] *R.H.*, Docket No. 17-1966 (issued March 6, 2018); *John J. Carlone*, 41 ECAB 354 (1989).

[5] *Id*.

value in certain circumstances.[6] I believe that there is an important distinction between a DMA as described in *Jackson* and a treating physician such as Dr. Allen in this case. A treating physician and DMA do not share the same status. DMAs have a much more defined and narrow purpose. They are generally charged with the computations of schedule awards, the medical necessity of requested surgeries, and other such issues that do not require an in-person examination. As well, they operate under parameters that ensure appropriate review of the evidence, as they have the benefit of the complete OWCP record, as well as a statement of accepted facts created by OWCP, which they must follow for the purposes of history, knowledge, and analysis. In Dr. Allen's situation, there are no such safeguards.

If Dr. Allen had physically examined appellant, noted an in-person history, reviewed the entire record, and made his own conclusions, I would be inclined to perhaps be satisfied with his knowledge and understanding of the matter and agree with the majority that his opinion would be sufficient to remand for OWCP to pay for a second opinion physician to further develop the medical evidence. However, the majority finding in my view, without the benefit of in-person physical examination, effectively shifts the burden of proof to OWCP to disprove the claim based on a medical report that is of questionable probative value, leading to what I fear will be the advent of mail order medicine.

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

[6] *Melvina Jackson*, 38 ECAB 443 (1987) (regarding the importance, when assessing medical evidence, of such factors as a physician's knowledge of the facts and medical history, and the care of analysis manifested and the medical rationale expressed in support of the physician's opinion).