United States Department of Labor
Employees' Compensation Appeals Board

K.C., Appellant	)	
and	)	**Docket No. 20-1628**
	)	**Issued: September 1, 2021**
DEPARTMENT OF COMMERCE, NATIONAL OCEANIC & ATMOSPHERIC ADMINISTRATION, Silver Spring, MD, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 14, 2020 appellant filed a timely appeal from an April 15, 2020 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] Pursuant to the Federal

[1] Appellant submitted a timely request for oral argument before the Board. 20 C.F.R. § 501.5(b). Pursuant to the Board's *Rules of Procedure*, oral argument may be held in the discretion of the Board. 20 C.F.R. § 501.5(a). In support of appellant's oral argument request, he asserted that oral argument should be granted because the claims examiner did not review or consider any of the well-rationalized medical reports from his treating physicians and it would provide him with an opportunity to explain this evidence. The Board, in exercising its discretion, denies appellant's request for oral argument because the arguments on appeal can adequately be addressed in a decision based on a review of the case record. Oral argument in this appeal would further delay issuance of a Board decision and not serve a useful purpose. As such, the oral argument request is denied and this decision is based on the case record as submitted to the Board.

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]

ISSUES

The issues are: (1) whether OWCP has met its burden of proof to terminate appellant's wage-loss compensation and medical benefits, effective March 31, 2019, as he no longer had residuals or disability causally related to the accepted employment injury; and (2) whether appellant has met his burden of proof to establish continuing residuals or disability causally related to his accepted employment injuries on or after March 31, 2019.

FACTUAL HISTORY

On September 8, 2015 appellant, then a 49-year-old human resource specialist, filed an occupational disease claim (Form CA-2) alleging that factors of his federal employment including typing on a keyboard, lifting heavy manuals, filing documents, and using awkward telephone devices contributed to his bilateral carpal tunnel syndrome. He became aware of his condition and its relationship to his federal employment on March 2, 2015. OWCP assigned this claim OWCP File No. xxxxxx730.[4]

On January 27, 2016 OWCP accepted the claim for left and right carpal tunnel syndrome and later expanded acceptance of appellant's claim to include right cubital tunnel syndrome. It paid him wage-loss compensation benefits on the supplemental rolls from May 3, 2016 through August 18, 2018 and on the periodic rolls from August 19, 2018 through March 30, 2019.

[2] 5 U.S.C. § 8101 *et seq*.

[3] The Board notes that, following the April 15, 2020 decision, appellant submitted additional evidence to OWCP. However, the Boards *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] On April 19, 2004 while working as a letter carrier, appellant sustained a left wrist injury, which OWCP accepted for sprain of the left wrist under OWCP File No. xxxxxx580. OWCP granted him a schedule award for two percent permanent impairment of the left upper extremity. On February 3, 2011 appellant injured his right wrist, which OWCP accepted for right wrist sprain, right articular cartilage disorder, forearm, and right closed fracture triquetral (cuneiform) bone of the wrist under OWCP File No. xxxxxx363. OWCP granted him a schedule award for nine percent permanent impairment of the right upper extremity. It administratively combined OWCP File Nos. xxxxxx580, xxxxxx363, and xxxxxx730, with the latter serving as the master file.

An electromyogram and nerve conduction velocity study (EMG/NCV) performed on February 22, 2016 revealed mild bilateral carpal tunnel syndrome, mild right ulnar neuropathy, and findings suggestive of left cervical radiculopathy.[5]

On April 9, 2016 appellant was treated by Dr. Jonathan D. McCoy, a Board-certified family practitioner, who diagnosed C6 radiculopathy affecting the bilateral upper extremities. He noted that appellant experienced an exacerbation of his chronic bilateral carpal tunnel syndrome and C6 radiculopathy on March 2, 2015 due to repetitive work duties including lifting heavy binders overhead, filing work documents above and below his desk, increased telephone use, and a suboptimal ergonomic chair and desk. Dr. McCoy opined that the acceptance of appellant's claim should be expanded to include C6 radiculopathy as work related. He further advised that appellant was totally disabled from work.

Appellant was treated by Dr. Hugh O. House, a Board-certified orthopedist, who on May 3, 2016 performed a left endoscopic carpal tunnel release and diagnosed left carpal tunnel syndrome. In notes dated May 9 through June 14, 2016, Dr. House advised that appellant was status post carpal tunnel release on May 3, 2016 and was disabled from work.

In a May 23, 2016 report, Dr. Taisha Williams, an OWCP district medical adviser (DMA) and Board-certified physiatrist, reviewed Dr. McCoy's report and disagreed with his findings. She noted that cervical radiculopathy was the result of compression of the nerve as it comes off the spinal cord between two vertebrae and opined that it was improbable for carpal tunnel syndrome at the wrist to worsen cervical radiculopathy in the neck. Dr. Williams opined that, given the medical presentation, the claim should not be expanded to include the C6 radiculopathy. The DMA advised that C6 radiculopathy may have started while appellant was working as a letter carrier, which required lifting heavy objects and carrying a mailbag.

By decision dated May 26, 2016, OWCP denied expansion of the acceptance of appellant's claim to include the additional condition of C6 radiculopathy.

On September 29, 2016 Dr. Arnold T, Berman, a Board-certified orthopedic surgeon serving as a DMA for OWCP, reviewed the case record and noted abnormalities on an EMG of the cervical spine and abnormalities on an EMG demonstrating bilateral carpal tunnel syndrome and cubital tunnel syndrome at the elbow. He recommended that the acceptance of the claim be expanded to include right cubital tunnel syndrome ulnar nerve compression and authorized bilateral carpal tunnel syndrome surgery and ulnar nerve transposition and decompression.

[5] An EMG dated February 16, 2015 revealed electrophysiological evidence of mild C6 radiculopathy on the left, severe peripheral neuropathy with axonal degeneration affecting the ulnar sensory response, demyelinating neuropathy mildly affecting the median sensory response, mild latency delay affecting the right median sensory response, and possible mild neuropathy with axonal degeneration affecting the left median motor response and the right radial motor response. A magnetic resonance imaging (MRI) scan of the left wrist dated November 24, 2015 revealed subcortical bone marrow edema at the scapholunate joint with trace fluid within the joint space suggestive of partial scapholunate ligament tear, degeneration, partial tear of the ulnar insertion of the triangular fibrocartilage without a full-thickness tear, and soft tissue edema.

On October 4, 2016 Dr. House performed a right endoscopic carpal tunnel release, right ulnar nerve release of the elbow in situ, and right medial epicondyle fasciotomy. He diagnosed right carpal tunnel syndrome, right cubital tunnel syndrome, and right medial epicondylitis.

By decision dated December 15, 2016, OWCP accepted right cubital tunnel syndrome.

On February 6, 2017 Dr. House treated appellant in follow-up status post carpal tunnel release, cubital tunnel release, and medial epicondyle debridement on October 4, 2016. He noted improvement in symptoms, but persistent numbness and tingling. Dr. House diagnosed right lesion of the ulnar nerve, right carpal tunnel syndrome, and right medial epicondylitis.

To determine the status of appellant's accepted conditions and disability, OWCP referred him, along with a March 30, 2017 statement of accepted facts (SOAF) and a series of questions, to Dr. Kevin F. Hanley, a Board-certified orthopedic surgeon, for a second opinion evaluation.

Dr. House related, in an April 6, 2017 report, appellant's complaints of pain and swelling in the elbow. He diagnosed right lesion of the ulnar nerve, right carpal tunnel syndrome, and right medial epicondylitis. Dr. House opined that appellant would remain out of work due to long-term disability from cervical/lumbar issues.

In a May 1, 2017 medical report, Dr. Hanley described appellant's employment injury. He discussed appellant's medical history, reviewed diagnostic reports, and provided findings on physical examination. Dr. Hanley noted that appellant's history was significant for a mild stroke in February 2017 and an anterior cervical discectomy and fusion in 2015. He diagnosed surgically treated bilateral carpal tunnel syndrome and right ulnar neuritis; however, he noted that the record did not strongly support these diagnoses. Dr. Hanley advised that appellant made no progress after the hand surgeries and he noted an element of symptom magnification and exaggeration. He opined that there was insufficient evidence to confirm that he had bilateral carpal tunnel syndrome and ulnar neuritis on the right causally related to the employment activities. Dr. Hanley opined that these conditions had resolved and there was no evidence of underlying problems that were aggravated. He indicated that appellant did have upper extremity symptomology; however, he did not believe that it arose because of work exposure, rather it was of unclear cause and etiology. Findings on examination revealed that appellant walked with an assistive device, wore forearm splints bilaterally, was reluctant to demonstrate range of motion of the hands and wrists and appeared to be symptom magnifying, was unable to put his fingers into full extension or put palms flat, had full pronation and supination of both elbows, a well-healed scar over the right elbow, and intact reflexes. Dr. Hanley opined that appellant did not have work-related restrictions as a consequence of his accepted injuries of bilateral carpal tunnel syndrome and right ulnar cubital tunnel syndrome. In a work capacity evaluation (Form OWCP-5c) he noted that appellant could return to full-time modified-duty work.

On August 18, 2017 OWCP issued a notice proposing to terminate appellant's wage-loss compensation and medical benefits as he no longer had disability or residuals causally related to his accepted employment injury. It allowed him 30 days to respond to the proposal.

OWCP received additional evidence.

In reports dated August 30 and October 23, 2017, Dr. House related appellant's complaints of pain over the medial epicondyle, pain over the dorsal side of his right wrist, and numbness and

tingling into the right hand. He diagnosed radiculopathy, cervical region, lesion of the ulnar nerve, right upper limb, right carpal tunnel syndrome, other synovitis and tenosynovitis of the right hand, and medial epicondylitis of the right elbow. In a physician's certificate dated August 30, 2017, Dr. House indicated that appellant was totally disabled from August 30 through September 20, 2017.

On March 20, 2018 OWCP terminated appellant's wage-loss compensation and medical benefits effective the same day finding that the weight of the evidence was represented by Dr. Hanley.

Dr. House treated appellant in follow-up on February 5 and April 11, 2018 and diagnosed right medial epicondylitis of the right elbow. On February 5, 2018 he performed a cortisone injection into the right elbow joint/bursa with temporary relief in symptoms. In a physician's certificate dated April 11, 2018, Dr. House advised that appellant was off work from April 11 through June 11, 2018.

On March 26, 2018 appellant through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

By decision dated June 11, 2018, an OWCP hearing representative performed a preliminary review of the case and determined that OWCP's March 20, 2018 decision should be reversed. It advised that a conflict in medical opinion evidence existed between Dr. House, appellant's treating physician, and Dr. Hanley, OWCP's second opinion examiner, regarding his diagnosis and whether he had continuing disability from work as a result of the accepted employment injury.

Dr. House evaluated appellant on June 11 and September 24, 2018 for tingling and numbness in both hands. He noted tenderness over the medial epicondyle and diagnosed right medial epicondylitis of the right elbow, lesion of ulnar nerve, right and left upper limbs, and bilateral carpal tunnel syndrome. Dr. House recommended a medicated adhesive patch for medial epicondyle pain management.

On September 14, 2018 OWCP referred appellant to Dr. Mark A. Peterson, a Board-certified orthopedist, to resolve the conflict in medical opinion between Dr. House and Dr. Hanley. It prepared a SOAF dated September 18, 2018 noting in part that appellant's claim was accepted for right carpal tunnel syndrome, left carpal tunnel syndrome, and right cubital tunnel syndrome.

In a September 26, 2018 report, Dr. Peterson noted his review of the SOAF, as well as the medical evidence of record. On examination appellant presented in a wheel chair, he noted pain in the neck greater on the right side than left, limited range of motion of the shoulders bilaterally, he could lift his arms to 90 degrees, but would not extend his elbows fully, intact rotator cuff strength in the upper extremities, pain over the medialis condyle bilaterally, a surgical scar of the medial side of the right elbow, tenderness to palpation over the incision, positive Tinel's sign over the median and ulnar nerves bilaterally, no focal deficits, no obvious atrophy, and poor effort with strength in his hand. Dr. Peterson advised that "apparently" appellant developed carpal tunnel syndrome in both upper extremities and cubital tunnel syndrome in both extremities. Appellant reported cervical surgery in 2016 and lumbar surgery in 2017, however, the operative reports were not in the case record. Dr. Peterson noted that appellant had no relief with any of the surgeries and

reported persistent symptoms despite treatment. In responding to the question of whether the bilateral carpal tunnel syndrome and neuropathy of the ulnar nerve of the right upper extremity resolved, Dr. Peterson stated that he was in agreement with Dr. Hanley that the facts of the case were difficult to assess secondary to a confounding history and lack of improvement after surgery. He noted that appellant made no progress from the surgeries and he was concerned about symptom magnification. Dr. Peterson further questioned "the uncertainty and the evidence that [appellant's] carpal tunnel symptoms, bilaterally, and ulnar neuropathy of the right upper extremity are work related." He indicated that appellant had a prior stroke, which may be affecting his neurologic function. Dr. Peterson noted that appellant had cervical and lumbar complaints and underwent an anterior cervical discectomy and experienced no relief in symptoms. He opined that as these symptoms did not resolve he did "question the work-related causation of his problems," which appeared to be multi-factorial in origin.

In a November 19, 2018 report, Dr. House evaluated appellant for left wrist pain and tingling. He indicated that an NCV in 2016 revealed left cervical radiculopathy and carpal tunnel syndrome. Dr. House diagnosed left hand carpal tunnel syndrome and left-sided radiculopathy and recommended splinting, braces, and an updated NCV.

On December 3, 2018 OWCP request clarification from Dr. Peterson with regard to the accepted conditions and level of disability as a result of his work injury.

In an undated addendum report, Dr. Peterson indicated that the NCV suggest left and right carpal tunnel syndrome and cubital tunnel syndrome for which appellant underwent surgery in 2016. He indicated that although appellant continued to complain of similar symptoms it appeared that these symptoms were treated and resolved. Dr. Peterson advised that appellant's complaints of numbness and tingling in his hand relate to his neck and not to the carpal tunnel syndrome or cubital tunnel as they were treated surgically and "[r]esidual symptoms would have resolved by this time." He opined that appellant did not have any work-related injury.

On February 14, 2019 OWCP issued a notice proposing to terminate appellant's entitlement to wage-loss compensation and medical benefits based on Dr. Peterson's September 26, 2018 report and addendum. It afforded appellant 30 days to respond in writing if he disagreed with the proposed termination.

On February 21, 2019 appellant underwent an EMG/NCV, which revealed mild bilateral carpal tunnel syndrome with no electrophysiological evidence of additional neuropathic dysfunction.

In physician's certificates dated February 25 and March 4, 2019, Dr. House advised that appellant was disabled from work from November 19, 2018 through April 29, 2019.

Dr. Andrew Robinson, a Board-certified orthopedist, treated appellant on March 13, 2019 and opined that appellant was totally disabled from March 13 through April 12, 2019.

On April 2, 2019 OWCP terminated appellant's wage-loss compensation and medical benefits effective March 31, 2019 finding that the special weight of the evidence was represented by Dr. Peterson.

In an April 12, 2019 report Dr. Robinson noted evaluating appellant on March 13, 2019. Findings on examination revealed thenar atrophy on the right side, diminished sensibility to light touch in the median distribution and ulnar distribution, positive Hawkins impingement sign, tenderness to palpation between the thenar and hypothenar eminences, diminished power grip strength, and positive Tinel's and Phalen sign. Dr. Robinson noted that the electrodiagnostic studies were consistent with cumulative trauma disorder. He opined that it was reasonable to assume that repetitive and high-intensity tasks with both hands contributed to the development and worsening of his bilateral carpal tunnel syndrome and right cubital tunnel syndrome. Dr. Robinson reviewed Dr. Peterson's report of September 26, 2018 and disagreed with his assessment and opined that appellant exhibited objective signs and symptoms of recurrent carpal tunnel syndrome, which was supported by NCV studies. He concluded that the work-related conditions have not resolved as exhibited on the February 26, 2019 EMG.

On April 18, 2019 appellant through counsel, requested a telephonic oral hearing before a representative of OWCP's Branch of Hearings and Review. The hearing was held on August 14, 2019.

An EMG/NCV dated April 23, 2019 signed by Dr. Robinson revealed bilateral median nerve neuropathies at the wrist and abnormalities of the C5-6 nerve roots.

By decision dated September 27, 2019, an OWCP hearing representative affirmed the April 2, 2019 decision terminating appellant's wage-loss and medical benefits effective March 31, 2019 based on the reports of Dr. Peterson. However, it advised that another conflict in medical opinion evidence existed between Dr. Robinson, appellant's treating physician, and Dr. Peterson, OWCP's impartial medical examiner (IME), regarding whether appellant had continuing disability from work as a result of the accepted employment injury. It instructed OWCP to refer appellant's file and those files doubled with the instant claim to an IME to resolve the conflict of opinion with respect to the nature and extent of the work injury.

On February 12, 2020 OWCP referred appellant to Dr. John W. Aldridge, a Board-certified orthopedist, to resolve the conflict in medical opinion between Dr. Robinson and Dr. Peterson. It prepared a SOAF dated September 18, 2018 noting in part that appellant's claim was accepted for right carpal tunnel syndrome, left carpal tunnel syndrome, and right cubital tunnel syndrome. In an April 1, 2020 report, Dr. Aldridge noted his review of the SOAF, as well as the medical evidence of record. On examination he noted that appellant's fingers were numb upon light touch, he had full motion of the hands, some postsurgical swelling, full range of motion of the left wrist and elbow, and diminished grip strength on the left side. Dr. Aldridge opined that there did not appear to be a relationship between appellant's carpal tunnel syndrome and his work-related injury of March 2, 2015. He noted that the EMG/NCV reports preinjury and postinjury were basically the same showing mild carpal tunnel syndrome. Dr. Aldridge advised that the neuropathic changes from metabolic and systemic changes including diabetes would most likely be the cause of his median nerve complaints and pain in the upper extremities. He noted the findings on the February 2015 EMG/NCV, including severe peripheral neuropathy and demyelinating neuropathy, would indicate a nonwork-related condition. With regard to whether appellant's work-related conditions resolved, Dr. Aldridge opined that appellant did not have a medical work-related injury as it related to March 2, 2015 and that the carpal tunnel syndrome noted both pre and postinjury and postsurgical would not be related to the March 2, 2015 work-related injury. He opined that no further medical treatment was required.

By decision dated April 15, 2020, OWCP terminated appellant's wage-loss compensation and medical benefits effective March 31, 2019, finding that the special weight of the evidence was represented by Dr. Aldridge.

LEGAL PRECEDENT -- ISSUE 1

Once OWCP accepts a claim and pays compensation, it has the burden of proof to justify termination or modification of an employee's benefits.[6] After it has determined that, an employee has disability causally related to his or her federal employment, OWCP may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.[7] Its burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[8]

FECA provides that, if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[9] For a conflict to arise the opposing physicians' viewpoints must be of virtually equal weight and rationale.[10] Where OWCP has referred the case to an IME to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well-reasoned and based upon a proper factual background, must be given special weight.[11]

ANALYSIS -- ISSUE 1

The Board finds that OWCP failed to meet its burden of proof to terminate appellant's wage-loss compensation benefits and medical benefits.

OWCP accepted that appellant developed bilateral carpal tunnel syndrome and right cubital tunnel syndrome. It found that a conflict in medical opinion evidence existed between Dr. House, appellant's treating physician, and Dr. Hanley, OWCP's second opinion examiner, regarding whether his accepted conditions resolved and if he had continuing disability as a result of the accepted employment injury. OWCP referred appellant, together with a SOAF, to Dr. Peterson for an impartial medical examination. The SOAF provided to Dr. Peterson specifically noted that appellant's claim was accepted for right carpal tunnel syndrome, left carpal tunnel syndrome, and right cubital tunnel syndrome.

[6] *See D.G.*, Docket No. 19-1259 (issued January 29, 2020); *R.P.*, Docket No. 17-1133 (issued January 18, 2018); *S.F.*, 59 ECAB 642 (2008); *Kelly Y. Simpson*, 57 ECAB 197 (2005); *Paul L. Stewart*, 54 ECAB 824 (2003).

[7] *See D.G.*, *id.*; *R.P.*, *id.*; *Jason C. Armstrong*, 40 ECAB 907 (1989); *Charles E. Minnis*, 40 ECAB 708 (1989); *Vivien L. Minor*, 37 ECAB 541 (1986).

[8] *K.W.*, Docket No. 19-1224 (issued November 15, 2019); *see M.C.*, Docket No. 18-1374 (issued April 23, 2019); *Del K. Rykert*, 40 ECAB 284, 295-96 (1988).

[9] 5 U.S.C. § 8123(a); *see* 20 C.F.R. § 10.321; *Shirley L. Steib*, 46 ECAB 309, 317 (1994).

[10] *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

[11] *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

In a report dated September 26, 2018, Dr. Peterson, in addressing whether the accepted conditions of bilateral carpal tunnel syndrome and lesion of the ulnar nerve right upper limb resolved, questioned whether "his carpal tunnel symptoms bilaterally, and ulnar neuropathy of the right upper extremity are work related." He opined that appellant had a prior stroke that may be affecting his neurologic function. Dr. Peterson advised that despite treatment appellant experienced no relief in symptoms and had the same complaints reported prior to the surgeries. He concluded that appellant's symptoms had not resolved and again questioned "the work-related causation of his problems," which appeared to be multi-factorial in origin possibly related to symptom magnification. The Board notes that although Dr. Peterson submitted an addendum report in response to OWCP's request, he continued to opine that he did not think that appellant had any work-related injury.

It is OWCP's responsibility to provide a complete and proper frame of reference for a physician by preparing a SOAF. OWCP's procedures dictate that when an OWCP medical adviser, second opinion specialist, or IME renders a medical opinion based on a SOAF, which is incomplete or inaccurate or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.[12] As Dr. Peterson did not use the SOAF as the framework in forming his opinion, his opinion is of diminished probative value.[13] He questioned whether appellant's bilateral carpal tunnel symptoms and ulnar neuropathy of the right upper extremity were work related. As discussed, however, Dr. Peterson did not acknowledge that OWCP accepted the claim for left and right carpal tunnel syndrome and right cubital tunnel syndrome as work related. He failed to rely upon a complete and accurate SOAF, and thus his opinion is of diminished probative value and is not entitled to the special weight typically afforded to an IME.[14]

CONCLUSION

The Board finds that OWCP failed to meet its burden of proof to terminate appellant's wage-loss compensation benefits and medical benefits.[15]

[12] *Id.*; *see also N.W.*, Docket No. 16-1890 (issued June 5, 2017).

[13] *Id.*; *see also Y.D.*, Docket No. 17-0461 (issued July 11, 2017).

[14] *See S.T.*, Docket No. 18-1144 (issued August 9, 2019) (medical opinions based on an incomplete or inaccurate history are of limited probative value).

[15] In light of the Board's disposition of Issue 1, Issue 2 is rendered moot.

ORDER

IT IS HEREBY ORDERED THAT the April 15, 2020 decision of the Office of Workers' Compensation Programs is reversed.

Issued: September 1, 2021
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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