United States Department of Labor
Employees' Compensation Appeals Board

I.H., Appellant	)	
and	)	**Docket No. 15-1798**
	)	**Issued: March 17, 2016**
DEPARTMENT OF THE AIR FORCE, MAINTENANCE WORKING CAPITAL FUND, RANDOLPH AIR FORCE BASE, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 31, 2015 appellant filed a timely appeal from an August 14, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether OWCP met its burden of proof to terminate appellant's wage-loss compensation and medical benefits effective August 23, 2015.

FACTUAL HISTORY

On February 9, 2001 appellant, then a 54-year-old air craft electrician, filed an occupational disease claim (Form CA-2) alleging that his right hand conditions caused him to

[1] 5 U.S.C. § 8101 *et seq.*

overuse his left hand in performing his duties.[2] He stopped work on April 26, 2001. Initial medical reports diagnosed left hand and wrist tendinitis. February 21, 2001 left hand x-rays showed osteoarthritis of the interphalangeal joint of the thumb and index finger. Electrodiagnostic testing of the same date was consistent with moderate focal median neuropathy around the left wrist with motor and sensory involvement, but no evidence of radiculopathy.

OWCP accepted the claim for left hand tendinitis and left carpal tunnel syndrome. Appellant received compensation benefits and was placed on the periodic compensation rolls. As part of receiving compensation under the periodic rolls, he is required to send to OWCP medical reports verifying his continuing disabled status.

In a December 17, 2013 report, Dr. Raju M. Vanapalli, a Board-certified orthopedic surgeon and treating physician, noted appellant's history of injury and treatment. He determined that appellant's chief complaint was pain in the left elbow and along the left forearm into the fingers.

Examination of the elbows bilaterally revealed no fixed flexion deformity, but negative 10 degrees short of full extension to 130 degrees of flexion was present. Dr. Vanapalli found that the pain was radiating from the left elbow to the wrist and fingers. He found for the left wrist, that there was slight swelling on both sides, with mild crepitus. Dr. Vanapalli determined that appellant had forward flexion and dorsiflexion to 40 degrees and ulnar and radial deviation to 10 degrees. He examined the fingers of the left hand and found that the left thumb tip could be brought to the base of all the other fingers. Dr. Vanapalli further determined that, for the rest of the digits, appellant could bend and barely touch the palm from neural extension. He determined that sensations and circulation of the left hand were satisfactory, but there was paresthesia typically over the carpal tunnel distribution on both sides, but this had been released and improved since the surgeries, according to appellant. Dr. Vanapalli advised that appellant had a documented history of polyneuropathy related to diabetes mellitus. He recommended continued exercises, no yard work, and to return in approximately one year for a regular checkup.

On March 20, 2014 OWCP referred appellant for a second opinion to Dr. Alexander N. Doman, a Board-certified orthopedic surgeon, to determine whether appellant continued to have any work-related residuals and or restrictions. In a May 13, 2014 report, Dr. Doman, noted appellant's history of injury and treatment and provided results on examination. His findings included a well-healed surgical scar over the right and left wrist overlying the carpal tunnel. Dr. Doman also found full range of motion of the left and right wrist. He determined that appellant had a well-healed fusion of the interphalangeal joint of the opposite right thumb and his pulses were normal. Dr. Doman also indicated that appellant had decreased sensation to light touch in all the fingers of both hands as well as the feet. He diagnosed left carpal tunnel syndrome and indicated that it had resolved. Dr. Doman explained that there was no evidence of ongoing tendinitis of the left hand and wrist. He advised that the nonspecific decreased feeling in appellant's fingers in the left hand was present in all four extremities and he attributed it to

[2] The record indicates that appellant later had filed several claims including claims that OWCP accepted for aggravation of right thumb degenerative joint disease, status post fusion, as well as right hand carpal tunnel syndrome, status post release. Appellant received compensation benefits. These other claims are not before the Board on the present appeal.

appellant's nonwork-related medical condition of diabetes mellitus. It was Dr. Doman's firm and definite opinion that appellant's left hand condition was not due to the work injury of February 2, 2001. He explained that the present condition was related to a progressive neuropathy from diabetes and not to the accepted left carpal tunnel syndrome. Dr. Doman explained that the median nerve testing objectively showed no other incident of any further carpal tunnel syndrome. He opined that appellant was able to return to gainful employment. Dr. Doman further advised that the hand condition was not work related and reiterated that appellant's left carpal tunnel syndrome had resolved.

In an August 4, 2014 report, Dr. Vanapalli noted seeing appellant after Dr. Doman's examination. He advised that he had reviewed the second opinion physician's report. Dr.Vanapalli explained that he had been an orthopedic surgeon for 45 years, and a hand surgery fellow for 35 years, and had examined and treated many individuals with such conditions. He opined that he "strongly" disagreed with Dr. Doman's second opinion report. Dr. Vanapalli advised that the symptoms and signs of carpal tunnel syndrome predated the onset of diabetes mellitus. He indicated that diabetes mellitus resulted in permanent aggravation of carpal tunnel syndrome and would not cure the work-related carpal tunnel syndrome. Dr. Vanapalli advised that, after many years of treating carpal tunnel syndrome as a hand surgeon, "it is my firm and definite opinion that there is no confirmatory test to prove that the work-related carpal tunnel syndrome was resolved, while the claimant continued to experience and suffer with the same subjective complaints and revealed the same objective findings."

On December 2, 2014 OWCP referred appellant along with a statement of accepted facts, and the medical record to Dr. Norman L. Donati, a Board-certified orthopedic surgeon, for an impartial medical evaluation to resolve the conflict in opinion between Drs. Vanapalli and Doman on the nature and extent of any ongoing residuals of the work injury and appellant's resulting ability to work.

In a report dated December 15, 2014, Dr. Donati noted appellant's history of injury and treatment and provided findings on examination. His findings included full left elbow flexion and extension with no swelling. Appellant described pain on full flexion and extension posterior and anterior elbow, but there was no instability and no crepitus. The left forearm was diffusely tender in every area and no matter where Dr. Donati touched appellant described significant pain. Dr. Donati noted that appellant had skin color and texture changes which appellant advised that he had since Vietnam. He found no swelling, redness, or warmth of the left forearm.

Regarding the left wrist, Dr. Donati found full range of motion with pain on all movement and even more pain on extremes of flexion and extension, and diffuse wrist tenderness more dorsal than volar, with no effusion and no instability.

For the left hand, appellant had diffuse tenderness of all areas of his hand no matter where he touched and slightly more across the A-l pulleys. Dr. Donati explained that there was no swelling of his left hand passively and noted that he could move his metacarpophalangeal (MP) and proximal interphalangeal (PIP) joints completely and with full motion, although appellant described pain on doing this. Appellant's distal interphalangeal (DIP) joints had slight loss of motion, with the left index finger displaying enlargement of the joint, and the third finger had a slight mallet deformity. He found that the first carpometacarpal (CMC) joint had near normal range of motion with pain and slight crepitus, but there was no instability with a normal

IP joint of the thumb. The pulses were intact and the two-point discrimination testing revealed seven to eight millimeters at all fingers, but was inconsistent. Appellant had definite sensation to sharp pressure and a negative Tinel's sign at the median nerve.

Dr. Donati noted that when the median nerve was tapped appellant described pain shooting up his left forearm in a nonspecific way and not into his fingers. He also advised that appellant had the exact same sensation when he tapped over his ulnar nerve at the wrist. Dr. Donati indicated that appellant had a tender ulnar nerve at the elbow, but a negative percussion sign. He advised that manual muscle testing of appellant's arm revealed an extremely poor effort and the testing was not accurate. Appellant also would not give a good effort to pinch and grip and adduction abduction of the fingers, but he was able to do all of this. Dr. Donati found "absolutely no evidence of any intrinsic wasting of his left hand." He diagnosed chronic left upper extremity pain with no evidence of carpal tunnel syndrome or residuals of carpal tunnel syndrome.

Dr. Donati found that appellant's symptoms were inconsistent with carpal tunnel syndrome, but were consistent with nonspecific musculoskeletal complaints. He noted signs of arthritis and advised that appellant's symptoms were not consistent with any form of carpal tunnel syndrome. Dr. Donati advised that appellant was diabetic and had a known peripheral neuropathy and thus many of his symptoms could be related to that, but that he could not provide a specific diagnosis." There was no evidence of any specific carpal tunnel of the left upper extremity and all symptoms and physical findings were consistent with nonspecific musculoskeletal pain which was possibly related to peripheral neuropathy. Dr. Donati also indicated that recent diagnostic testing showed no evidence of carpal tunnel. He opined that appellant could return to work with full use of his left hand, and if appellant was unable to work, it had nothing to do with the carpal tunnel syndrome and it was purely due to some other type of musculoskeletal or neurological problem that he was unable to diagnose. In a December 16, 2014 work capacity report, Dr. Donati noted appellant's history and advised that the accepted left hand carpal tunnel syndrome had resolved.

In a January 9, 2015 report, Dr. Vanapalli provided examination findings and diagnosed bilateral carpal tunnel syndrome, with residual symptoms as well as objective findings, diabetic peripheral neuropathy, migraine headaches, tennis elbow on the left, and severe degenerative arthritis of the fingers. He opined that the work-related conditions continued, were worsening and disabling, and opined that appellant was not capable of returning to any type of gainful employment.

On June 11, 2015 OWCP issued a notice of proposed termination of compensation. It proposed to terminate appellant's wage-loss compensation and medical benefits on the basis that the weight of the medical evidence, as demonstrated by the opinion of Dr. Donati, established that appellant no longer had disability or residuals of the work injury. Appellant was given 30 days to submit additional evidence or argument.

OWCP also received February 26 and March 26 and 31, 2015 hospital notes and laboratory reports, to include reports from Dr. Awharitefe Urhuago, a family practitioner, who advised that appellant came to him with chest pain and advised that it was a possible syncopal episode. It also received a March 26 and April 9, 2015 report from Dr. Talley F. Culclasure, a Board-certified internist and a May 7, 2015 report from Dr. Olena Klindukhova, a Board-

certified internist. They were related to appellant's hospitalization of February 26, 2015 for a possible syncopal episode. OWCP also received copies of previously submitted medical evidence.

In June 29, 2015 reports, Dr. Vanapalli again diagnosed bilateral carpal tunnel syndrome, status post release with residual symptoms as well as objective findings, diabetic neuropathy, tennis elbow on the left, resolved, and triggering of the left middle finger, resolved, degenerative arthritis of the finger joints still present, but range of movements improved since earlier examinations. He advised that appellant continued to experience disability due to his hands because of the persistent signs and symptoms of bilateral carpal tunnel syndrome.

In a July 9, 2015 report, Dr. Udaya G. Moti, an internist, advised that appellant had multiple medical problems which included severe arthritis of the spine and a history of depression. He noted that appellant also had diabetes and high blood pressure and was on very strong medications. Dr. Moti opined that appellant was not employable for the rest of his lifetime in any occupation.

In an August 14, 2015 decision, OWCP terminated appellant's wage-loss compensation and medical benefits effective August 23, 2015. It found that the weight of medical evidence rested with Dr. Donati and supported that appellant no longer had any disability from work stemming from the accepted work-related conditions.

LEGAL PRECEDENT

Once OWCP accepts a claim and pays compensation, it bears the burden to justify modification or termination of benefits.[3] Having determined that an employee has a disability causally related to his or her federal employment, OWCP may not terminate compensation without establishing either that the disability has ceased or that it is no longer related to the employment.[4]

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."[5] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of

[3] *Curtis Hall*, 45 ECAB 316 (1994).

[4] *Jason C. Armstrong*, 40 ECAB 907 (1989).

[5] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207, 210 (1993).

such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[6]

ANALYSIS

In the instant case, OWCP accepted that appellant sustained left hand tendinitis and left carpal tunnel syndrome. It developed the claim and determined that a conflict of medical opinion existed between Dr. Doman, the second opinion physician, who found that appellant had no work-related residuals and could perform his usual job, and Dr. Vanapalli, the treating physician, who disagreed with Dr. Doman and indicated that the accepted conditions had not resolved. Therefore, OWCP properly referred appellant to Dr. Donati, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the conflict, pursuant to 5 U.S.C. § 8123(a).

In his December 15, 2014 report, Dr. Donati noted appellant's history and findings on examination, such as full range of motion in the left wrist with no effusion and no instability. There was no swelling of appellant's left hand passively and he could move his joints completely and with full motion. The pulses were intact, but two-point discrimination testing was inconsistent. Dr. Donati found "absolutely no evidence of any intrinsic wasting of [appellant's] left hand." He diagnosed chronic left upper extremity pain with no diagnostic evidence of carpal tunnel syndrome or residuals carpal tunnel syndrome.

Dr. Donati determined that appellant's symptoms were not consistent with carpal tunnel syndrome, but were consistent with nonspecific musculoskeletal complaints. He also found signs of arthritis, and advised that appellant's symptoms of discomfort were not consistent with any form of carpal tunnel syndrome. Dr. Donati opined that all symptoms and physical findings were consistent with nonspecific musculoskeletal pain which was possibly related to peripheral neuropathy. He opined that appellant could return to work with full use of his left hand. Dr. Donati pointed out that if appellant was unable to work, it had nothing to do with the carpal tunnel syndrome and it was purely due to some other type of musculoskeletal or neurological problem that he was unable to diagnose. In a December 16, 2014 work capacity report, he advised that the accepted conditions had resolved and that appellant had reached maximum medical improvement.

The Board finds that Dr. Donati's opinion is entitled to the special weight of the medical evidence as an impartial medical examiner. Dr. Donati's report is sufficiently well rationalized and based upon a proper factual background and thorough examination. OWCP properly relied upon his reports in finding that appellant no longer had any employment-related residuals and was no longer disabled from work due to the accepted employment injuries. Dr. Donati did not attribute any current left hand or arm conditions to appellant's employment.

Prior to finalizing the termination, OWCP received January 9 and June 29, 2015 reports from Dr. Vanapalli, who argued that appellant had objective findings of bilateral carpal tunnel syndrome. Dr. Vanapalli explained that appellant continued to experience disability due to his hands because of the persistent signs and symptoms of bilateral carpal tunnel syndrome.

[6] *See Roger Dingess*, 47 ECAB 123, 126 (1995); *Juanita H. Christoph*, 40 ECAB 354, 360 (1988); *Nathaniel Milton*, 37 ECAB 712, 723-24 (1986).

However, the Board notes that as Dr. Vanapalli had been on one side of the conflict in the medical opinion that the impartial specialist resolved, the treating physician's report was insufficient to overcome the special weight accorded the impartial specialist or to create a new medical conflict.[7] Other medical reports submitted by appellant did not address the accepted conditions.

For these reasons, OWCP properly terminated appellant's wage-loss compensation and medical benefits effective August 23, 2015. Accordingly, the Board shall affirm OWCP's August 14, 2015 termination decision.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that OWCP properly terminated appellant's wage-loss compensation and medical benefits effective August 23, 2015, as he was no longer disabled from work as a result of his work-related injury.

ORDER

IT IS HEREBY ORDERED THAT the August 14, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 17, 2016
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[7] *Alice J. Tysinger*, 51 ECAB 638 (2000); *Barbara J. Warren*, 51 ECAB 413 (2000).