United States Department of Labor
Employees' Compensation Appeals Board

K.K., Appellant	)	
and	)	**Docket No. 17-1061**
	)	**Issued: July 25, 2018**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION, East Orange, NJ, Employer	)	

Appearances:
James D. Muirhead, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 18, 2017 appellant, through counsel, filed a timely appeal from a November 22, 2016 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 the claim.[3]

[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.*

[3] The record provided to the Board includes evidence received after OWCP issued its November 22, 2016 decision. The Board's jurisdiction is limited to the evidence that was before OWCP at the time of its final decision. Therefore, the Board is precluded from reviewing this additional evidence for the first time on appeal. 20 C.F.R. § 501.2(c)(1).

ISSUE

The issue is whether appellant has met her burden of proof to establish a recurrence of total disability commencing December 3, 2014, causally related to her accepted December 12, 2011 employment injury.

FACTUAL HISTORY

This case was previously before the Board.[4] The facts and circumstances as set forth in the prior decision are incorporated herein by reference. The relevant facts are as follows.

On December 15, 2011 appellant, then a 47-year-old medical clerk, filed a traumatic injury claim (Form CA-1) alleging that she injured her left thumb, wrist, and shoulder while in the performance of duty on December 12, 2011 when her chair slipped from underneath her. OWCP accepted that she sustained a left thumb sprain.

Appellant continued to work in a full-time, full-duty capacity until December 3, 2014 when she stopped work. She filed a notice of recurrence (Form CA-2a) on December 4, 2014 alleging an increase in pain of her left thumb, wrist, and shoulder due to unaccepted conditions of carpal tunnel syndrome, cubital tunnel syndrome, and left carpometacarapal (CMC) joint arthritis.

By decision dated March 13, 2015, OWCP denied appellant's recurrence claim as she had not established total disability due to the accepted injury. It also found that she had not established that any additional conditions were causally related to the accepted injury.

Appellant appealed to the Board on April 8, 2015. By decision dated August 19, 2015, the Board affirmed OWCP's March 13, 2015 denial of the recurrence claim. The Board also found that the evidence of record was insufficient to support the expansion of the acceptance of appellant's claim to include additional conditions.

In a May 6, 2015 attending physician's report (Form CA-20), Dr. Susan Scott, an orthopedic hand surgeon, noted that appellant had sustained a fall in the workplace with hand trauma on December 12, 2011 and had no history or evidence of concurrent or preexisting disease. She opined that appellant's left thumb basal joint arthritis and left carpal tunnel were caused or aggravated by her employment activity, which was described as "job traumatic arthritis and neuropathy." Dr. Scott indicated that appellant was disabled until August 18, 2015 due to pain and weakness and would need future surgeries.

On May 19, 2015 appellant underwent left carpal tunnel release, left cubital tunnel release, left thumb trapeziectomy and left first CMC arthroplasty, which Dr. Scott performed. On July 7, 2015 she underwent a removal of K wire. These surgeries were not approved by OWCP.

Appellant, through counsel, requested reconsideration on August 26, 2015.

[4] Docket No. 15-1037 (issued August 19, 2015).

A May 9, 2012 x-ray report indicated mild degenerative change in the first CMC joint and a slight narrowing of the third and fourth metacarpophalangeal joints. No radiopaque foreign body was identified.

In a March 13, 2014 report, Dr. Nigel Shenoy, Board-certified in neuromuscular medicine, physical medicine, and rehabilitation, related that appellant received a CMC injection. He provided a diagnosis of left thumb pain due to first CMC arthritis.

In a March 31, 2013 report, Dr. Wesley San, a specialist in physical medicine and rehabilitation, treated appellant's left first CMC with an injection. He noted that appellant's thumb pain had worsened as the prior injection wore off. Dr. San opined that appellant's left thumb pain was due to CMC arthritis. In a March 31, 2013 report, Dr. San treated appellant with a left first CMC injection. He opined that her left thumb pain was due to CMC arthritis. Dr. San also opined that appellant's right thumb pain was likely due to "OA." In an August 2, 2013 report, Dr. Rana Rand, a specialist in physical medicine and rehabilitation, opined that appellant's left first CMC pain was secondary to first CMC arthritis.

In a partial September 3, 2013 report, Dr. Gwen Lacerda, a specialist in physical medicine and rehabilitation, provided an assessment of left first CMC pain secondary to first CMC arthritis. The first page of the report was not included.

An October 8, 2014 electromyography (EMG) study revealed mild left carpal tunnel syndrome and incidental finding of left Martin Gruber anastomosis with concomitant left thenar eminence pain status post steroid injections in the past.

In the May 19, 2015 preoperative note, Dr. Edward Deisole, a Board-certified internist, indicated that appellant had a fall at work injuring her left thumb. Since then, she had left thumb pain, left wrist/hand pain, and now, numbness radiating from her elbow. Dr. Deisole diagnosed left carpal tunnel, left cubital tunnel, and left thumb CMC arthritis and noted that she would be undergoing a left carpal tunnel release.

As noted, on May 19, 2015, appellant underwent left carpal tunnel release and left thumb basal joint arthroplasty. On July 7, 2015 the hardware was removed.

In a July 17, 2015 letter, Dr. David P. Taormina, an orthopedic surgeon, noted that appellant's history of injury began in 2011 when she fell off a chair and landed on her hand. He indicated that she had hyperextended her left thumb which led to her primary injury. Given this mechanism of injury, Dr. Taormina noted that appellant was at risk for post-traumatic arthritis. He opined that it was likely that this was the cause of her development of thumb/CMC post-traumatic arthritis and ultimate surgery.

In a two-month postoperative status report of July 22, 2015, Dr. Taormina removed appellant's sutures and indicated that she was to begin occupational therapy. The July 22, 2015 postoperative x-ray report noted postoperative changes as well as scattered degenerative changes involving the interphalangeal articulations, with no evidence of cortical destruction.

In a July 22, 2015 report, Dr. Daniel Kao, an internist, and Dr. Marguerite Diab, a physiatrist, evaluated appellant for hand therapy and splinting. Dr. Kao noted that appellant's pain

and numbness had improved since her left cubital tunnel release, left thumb trapeziectomy, first CMC interpositional arthroplasty and carpal tunnel release, and Kirschner wire removal. In a July 22, 2015 addendum, Dr. Diab noted the history of the work injury as reported by appellant. Appellant indicated that her left upper extremity symptoms began in 2011 after a fall at work and that she was diagnosed with left cubital tunnel syndrome, carpal tunnel syndrome, and left thumb CMC arthritis.

By decision dated November 24, 2015, OWCP denied modification of its March 13, 2014 denial of appellant's claim for recurrence.[5] It found that there was no sufficiently well-rationalized medical opinion as to whether the December 12, 2011 work injury caused, contributed, or aggravated any hand, thumb, or wrist condition or which established that she had a return of disability or increased disability as a result of a consequential condition.

On January 16, 2016 appellant, through counsel, requested reconsideration. He asserted that the medical record was sufficient to support causal relationship as it documented a serious injury to appellant's left hand and shoulder and noted the history of the injury.

Duplicative treatment notes, physical therapy records, x-ray reports, EMG and MRI scan reports between the period February 22, 2012 through December 4, 2014, which the Board had previously addressed in its August 19, 2015 decision, were received.

A June 11, 2011 progress note and a December 13, 2011 note from a nurse practitioner, documented appellant's left wrist, hand, and shoulder symptoms.

By decision dated March 28, 2016, OWCP denied modification of its November 24, 2015 decision. It found that the evidence of record was insufficient to support her claimed recurrence.

On July 12, 2016 appellant, through counsel, requested reconsideration. Counsel requested that OWCP approve the case for traumatic osteoarthritis of the CMC joint of the left thumb, post-traumatic left carpal tunnel syndrome, chronic post-traumatic medial epicondylitis of the left elbow, post-traumatic cubital tunnel syndrome for the left elbow, post-traumatic tendinitis of the left wrist and the surgeries that have occurred, which included ulnar nerve release at the cubital tunnel of the left elbow, left carpal tunnel release at the wrist, left thumb arthroplasty and removal of the wire fixation from the thumb arthroplasty.

In a May 2, 2016 report, Dr. David Weiss, an osteopath, noted his review of the medical records and set forth examination findings. He diagnosed post-traumatic osteoarthritis of the CMC joint of the left thumb, post-traumatic left carpal tunnel syndrome, chronic post-traumatic medial epicondylitis to the left elbow, post-traumatic cubital tunnel syndrome to the left elbow, and chronic post-traumatic extensor tendinitis to the left wrist. Dr. Weiss indicated that appellant sustained significant musculoskeletal trauma to her left elbow and left wrist and hand secondary to a post-traumatic hyperextension injury to the left wrist and hand and a direct impact injury to the medial aspect of the left elbow. He opined that her orthopedic injuries and necessity for multiple surgical procedures were directly attributable to the traumatic work-related

[5] As noted, the Board previously affirmed OWCP's March 13, 2015 decision on August 19, 2015 in Docket No. 15-1037.

hyperextension injury to the left wrist and hand which caused her post-traumatic osteoarthritis of the CMC joint, the left wrist strain and sprain, and the post-traumatic carpal tunnel syndrome. In terms of the left elbow, the medial contusion resulted in a chronic medial epicondylitis and a documented left ulnar nerve neuropathy for which she eventual underwent surgeries to the left wrist and hand with a CMC joint arthroplasty, an open left carpal tunnel syndrome release and a left ulnar nerve release of May 19, 2015.

By decision dated November 22, 2016, OWCP denied modification of its March 28, 2016 decision. It found that the evidence did not provide sufficient medical rationale to support the December 3, 2014 claimed recurrence.

LEGAL PRECEDENT

FECA pays compensation for the disability of an employee resulting from personal injury sustained while in the performance of duty.[6] Disability means the incapacity, because of an employment injury, to earn the wages the employee was receiving at the time of injury. It may be partial or total.[7]

A recurrence of disability is defined as the inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition which had resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness.[8] The Board has held that whether a particular injury causes an employee to be disabled from work is a medical question that must be resolved by competent and probative medical evidence.[9] The weight of medical opinion is determined on the report of a physician, who provides a complete and accurate factual and medical history, explains how the claimed disability is related to the employee's work, and supports that conclusion with sound medical reasoning.[10] Where no such rationale is present, medical evidence is of diminished probative value.[11]

In order to establish that a claimant's alleged recurrence of the condition was caused by the accepted injury, medical evidence of bridging symptoms between his or her present condition and the accepted injury must support the physician's conclusion of causal relationship.[12]

[6] 5 U.S.C. § 8102(a).

[7] 20 C.F.R. § 10.5(f).

[8] *Id.* at § 10.5(x). *See S.F.*, 59 ECAB 525 (2008); *Albert C. Brown*, 52 ECAB 152 (2000); *Terry R. Hedman*, 38 ECAB 222 (1986).

[9] *See R.C.*, 59 ECAB 546 (2008); *Carol A. Lyles*, 57 ECAB 265 (2005); *Donald E. Ewals*, 51 ECAB 428 (2000).

[10] *Sandra D. Pruitt*, 57 ECAB 126 (2005).

[11] *Michael Stockert*, 39 ECAB 1186, 1187-88 (1988*); see Ronald C. Hand*, 49 ECAB 113 (1957).

[12] *Mary A. Ceglia*, 55 ECAB 626 (2004).

For conditions not accepted by OWCP as being employment related, it is the employee's burden to provide rationalized medical evidence sufficient to establish causal relationship, not OWCP's burden to disprove such relationship.[13]

ANALYSIS

The Board finds that appellant has not established a recurrence of disability commencing December 3, 2014 causally related to her accepted December 12, 2011 employment injury.

OWCP accepted that appellant sustained a left thumb sprain on December 12, 2011. Appellant worked in a full-time, full-duty capacity until December 3, 2014, when she stopped work. She filed a recurrence claim alleging an increase of pain due to unaccepted conditions of carpal tunnel syndrome, cubital tunnel syndrome, and left CMC arthritis. On August 19, 2015 the Board affirmed OWCP's denial of the recurrence claim and the denial of the expansion of the claim to include additional conditions. Findings made in prior Board decisions are *res judicata* absent any further review by OWCP under section 8128 of FECA.[14] The Board will, therefore, not review the evidence addressed in the prior appeals.

The evidence of record does not establish that appellant had a spontaneous return of disability due to her accepted left thumb strain of December 12, 2011.[15] There is also no medical evidence to support that the accepted thumb sprain was still active when appellant stopped work on December 4, 2014.

A May 9, 2012 x-ray report indicated that appellant had continuing left thumb pain with mild degenerative change in first CMC joint. Appellant received CMC injections for her left thumb pain as well as bilateral knee viscosupplementation. Several physicians including Drs. Lacerda, San, and Shenoy, opined that appellant's left first CMC pain was due to first CMC arthritis. However, none of these physicians addressed causal relationship to her accepted employment injury. Medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[16] Furthermore, pain is a description of a symptom rather than a clear diagnosis of a medical condition.[17] Thus, these reports are insufficient to establish that the December 12, 2011 work incident caused, contributed to, or aggravated any left thumb condition.

Dr. Scott opined, in her May 6, 2015 Form CA-20 report, that appellant's left thumb basal joint arthritis and left carpal tunnel were caused or aggravated by her employment activity, which was described as "job traumatic arthritis and neuropathy." She also indicated that appellant was

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

[14] *See B.R.*, Docket No. 17-0294 (issued May 11, 2018).

[15] *Supra* note 8.

[16] *Jaja K. Asaramo, supra* note 13.

[17] *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *Robert Broome*, 55 ECAB 339 (2004) (the Board has consistently held that pain is a symptom rather than a compensable medical diagnosis).

disabled until August 18, 2015 due to pain and weakness and would need future surgeries. However, Dr. Scott provided no medical rationale to support her opinion on causal relationship. The Board has found that medical conclusions unsupported by rationale are of little probative value.[18] Thus, Dr. Scott's opinion is insufficient to establish appellant's claim.

In the May 19, 2015 preoperative note, Dr. Deisole indicated that appellant injured her left thumb during a work fall. Since then, she had left thumb, wrist, and hand pain, and now, numbness radiating from her elbow. While he noted the work injury and provided diagnoses of left carpal tunnel, left cubital tunnel, and left thumb CMC arthritis, Dr. Deisole failed to provide an opinion on causal relationship.[19] He failed to offer an explanation as to why appellant's left thumb pain would persist and how or why the additional diagnoses were causally related to the work injury. Thus, Dr. Deisole's report is insufficient to establish appellant's claim,

In his July 17, 2015 letter, Dr. Taormina, noted that the hyperextension of appellant's left thumb led to her primary injury and put her at risk for post-traumatic arthritis. He opined that it was likely that this was the cause of her development of thumb/CMC post-traumatic arthritis and ultimate surgery. Dr. Taormina's opinion, however, is of diminished probative value as it is conclusory and equivocal in character.[20] While he noted hyperextension of appellant's left thumb during the accepted employment injury, he did not explain how physiologically hyperextension would have in fact caused or contributed to her diagnosed conditions.[21] Thus, Dr. Taormina's report is insufficient to establish appellant's claim.

Similarly, in his May 2, 2016 report, Dr. Weiss noted the history of the work injury. He diagnosed post-traumatic osteoarthritis of the CMC joint of the left thumb, post-traumatic left carpal tunnel syndrome, chronic post-traumatic medial epicondylitis to the left elbow, post-traumatic cubital tunnel syndrome to the left elbow, and chronic post-traumatic extensor tendinitis to the left wrist which he opined were directly attributable to the work injury. Dr. Weiss indicated that appellant sustained significant musculoskeletal trauma to her left elbow and left wrist and hand secondary to a post-traumatic hyperextension injury to the left wrist and hand and had a direct impact injury to the medial aspect of the left elbow. He indicated that appellant's conditions were directly attributable to the hyperextension injury to the left wrist and hand which caused her post-traumatic osteoarthritis of the carpometacarpal joint, the left wrist strain and sprain, and the post-traumatic carpal tunnel syndrome. Dr. Weiss also indicated that the medial contusion of the left elbow resulted in a chronic medial epicondylitis and a document left ulnar nerve neuropathy. However, he provided no medical rationale to support his opinion on causal relationship. Without explaining how physiologically appellant's work injury caused or contributed to her diagnosed post-traumatic osteoarthritis of the CMC joint of the left thumb, post-traumatic left carpal tunnel syndrome, chronic post-traumatic medial epicondylitis to the left elbow, post-traumatic cubital

[18] *M.P.*, Docket No. 14-1289 (issued September 26, 2014).

[19] *Jaja K. Asaramo, supra* note 13.

[20] *D.D.*, 57 ECAB 734 (2006).

[21] *See D.P.*, Docket No. 16-1358 (issued December 19, 2016).

tunnel syndrome to the left elbow, and chronic post-traumatic extensor tendinitis to the left wrist, Dr. Weiss' opinion is of limited probative value.[22]

In a July 22, 2015 report, Dr. Diab reported the history of the work injury as reported by appellant. She also noted that appellant indicated that she was diagnosed with left cubital tunnel syndrome, carpal tunnel syndrome, and left thumb CMC arthritis. This report is of diminished probative value as there is no discussion of objective findings, or a physician's explanation and opinion on the cause of the conditions.[23]

The remainder of the medical evidence is also of limited probative value. The record contains reports from occupational therapists and physical therapists which document appellant's left wrist, hand, and shoulder symptoms. However, the Board has held that treatment notes signed by such providers are not considered probative medical evidence as those providers are not considered physicians under FECA.[24]

Appellant's honest belief that accepted December 12, 2011 employment incident caused her recurrence of disability as of December 3, 2014 as well as her additional conditions, however sincerely held, does not constitute medical evidence sufficient to establish causal relationship.[25]

Appellant has not submitted a sufficiently reasoned medical opinion explaining why her recurrence of disability beginning December 3, 2014 was caused or aggravated by the December 12, 2011 employment injury.

On appeal counsel asserts that the medical evidence of record established that her left wrist, hand, and shoulder symptoms immediately began after her fall at work and became progressively worse. However, as discussed above, none of the medical evidence supports her claim for recurrence.

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.

[22] *See D.P.*, Docket No. 16-1358 (issued December 19, 2016).

[23] *A.D.*, 58 ECAB 149 (2006) (medical evidence which does not offer any opinion regarding the cause of an employee s condition is of limited probative value on the issue of causal relationship).

[24] *See David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006) (lay individuals such as physician assistants, nurses, and physical therapists are not competent to render a medical opinion under FECA); *see also J.J.*, Docket No. 15-0727 (issued July 16, 2015) (reports from appellant's occupational therapist have no probative medical value. Occupational therapists are not considered physicians as defined under FECA). *See* 5 U.S.C. § 8101(2) (this subsection defines a physician as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law).

[25] *H.H.*, Docket No. 16-0897 (issued September 21, 2016).

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish a recurrence of disability as of December 3, 2014, causally related to her December 12, 2011 employment injury.

ORDER

IT IS HEREBY ORDERED THAT the November 22, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 25, 2018
Washington, DC

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

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

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