



Respondent argues the ALJ disregarded uncontrovered evidence,<sup>4</sup> consisting of the EMG testing recommended by the neutral examining physician, Dr. Bruce Toby, that revealed claimant did not have BCTS. Respondent contends claimant's symptoms were caused, not by BCTS, but instead by an overuse-type condition, and the keyboard use required by claimant's work was not the prevailing factor causing her alleged injuries. Respondent insists claimant could not develop CTS unless her wrists were used in a flexed position relative to her keyboard, which was not proven. Respondent requests the Board reverse the Award.

Claimant argues the preponderance of the evidence established she had BCTS, and she questions the credibility of Dr. Chris Fevurly's opinion that her repetitive job duties could not be the prevailing factor in causing her alleged BCTS. Claimant asserts, although Dr. Toby found no evidence of BCTS, his opinions are outweighed by the other medical evidence. Claimant maintains the ALJ correctly found Dr. Ketchum's opinions were the most persuasive, but contends future medical compensation should be left open. With the exception of future medical, claimant requests the Board affirm the Award.

The issues are:

1. Did claimant sustain personal injury by repetitive trauma, arising out of and in the course her of employment, including whether claimant proved the "prevailing factor" requirement?
2. Did the ALJ disregard the results of diagnostic testing, in violation of K.S.A. 44-508(e)?
3. Did the ALJ disregard the opinions of the neutral examining physician?
4. What is the nature and extent of claimant's disability?
5. Is claimant entitled to future medical treatment?

#### **FINDINGS OF FACT**

Claimant is age 39, and in October 2006, she began working for respondent as a program specialist in the unemployment division call center of the Kansas Department of Labor. Claimant was required to process and review unemployment claims by taking incoming calls and inputting information obtained from unemployment claimants into a database via the use of a keyboard.

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<sup>4</sup> See *Demars v. Rickel Manufacturing Corporation*, 223 Kan. 374, 573 P.2d 1036 (1978). (Uncontroverted evidence that is not improbable or unreasonable cannot be disregarded unless it is shown to be untrustworthy, and is ordinarily regarded as conclusive).

Claimant performed her duties at a work station, using a headset, a computer with two monitors and a keyboard. Claimant's work hours were 8:00 a.m. to 4:30 p.m., Monday through Friday. She spent seven to seven and a half hours every working day using the keyboard to input data. Claimant testified she handled a lot of calls and frequently used her hands inputting data with the keyboard.

In approximately November 2012, claimant noticed numbness, tingling and aching in her hands and wrists, the right worse than the left. Claimant testified her pain and numbness would start in mid-morning on working days, worsen as the day progressed, and by the end of the business day, she could not perform her duties. According to claimant, her keyboard use seemed to bring about her symptoms. According to claimant, between November 2012 and June 10, 2014, her symptoms worsened as she continued to perform her job.

Claimant talked to her supervisor about her hand and wrist difficulties in November 2012. Claimant informed her supervisor her pain was caused by the high call volume and a lot of keying. One of claimant's supervisors suggested claimant make a claim for workers compensation.

Claimant's saw Dr. Michael J. Murphy, her primary care physician, on January 7, 2014. The doctor documented claimant's burning and tingling symptoms in her fingers, and noted claimant did a lot of computer work. Dr. Murphy prescribed wrist splints or braces, and ordered an EMG.

Claimant saw Jonson Huang, M.D., a board certified neurologist, on January 20, 2014. Dr. Huang conducted an EMG of claimant's upper extremities that revealed she had mild BCTS, right greater than left. Dr. Huang testified CTS can be caused by a variety of factors, but the most common cause is repetitive use of the hands. Keyboard data entry could be a significant factor causing CTS, depending on the position of the wrists relative to the hands, and the location of the keyboard. If the wrists were held in a relatively neutral position, such injuries were less likely, and if the wrists were flexed, such injuries were more likely. Dr. Huang expressed no formal opinions regarding causation, prevailing factor and need for treatment.

Claimant was referred to Dr. Mark Baraban, a hand surgeon, who opined claimant had symptoms consistent with bilateral carpal tunnel neuropathy.<sup>5</sup> The doctor performed a left endoscopic carpal tunnel release on June 10, 2014. According to claimant, the surgery reduced her left wrist pain and numbness, although the left wrist pain did eventually return.<sup>6</sup> Claimant's right-sided symptoms remain the same, and other than medication and splinting, she has received no treatment for her right-sided symptoms.

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<sup>5</sup> P.H. Trans., Cl. Ex. 3.

<sup>6</sup> R.H. Trans. at 17-20, 22-23, and 30-31.

Dr. Chris Fevurly examined claimant at respondent's request on July 23, 2014. Dr. Fevurly is board certified in internal, preventive and occupational medicine, but is neither a surgeon nor a neurologist. He took a history and reviewed medical records. The patient's history included the following:

Ms. Acosta is 39-years-old and is right-handed, works in the call center at the Kansas Department of Labor on a full-time basis (40 hours per week), over the last seven and a half years. She does data entry on unemployment insurance claims and does repetitive keyboarding at least 90% of her time in the job duties and does not really do anything else in these duties. The job demand has varied throughout the years but is very significant in that she works 2 hours straight before getting a 15 minute break and then another 2 hours until lunch.<sup>7</sup>

Dr. Fevurly found claimant's initial EMG showed mild median nerve entrapment at the wrists consistent with BCTS, but the doctor opined claimant's current pain was caused by "overuse phenomena." According to Dr. Fevurly, claimant's overuse phenomena occurred when small muscles in her upper extremities performed repetitive tasks over a period of time, causing the muscles and tendons to become fatigued or slightly inflamed, resulting in myofascial pain, a "musculotendinous disorder."<sup>8</sup> The doctor distinguished CTS as a "neurological disorder."<sup>9</sup> Dr. Fevurly testified CTS is not caused by keyboarding, but keyboarding is associated with overuse phenomena.

Dr. Fevurly found claimant's second EMG, conducted on January 28, 2015, was normal. He also testified there is no objective measure to provide a permanent impairment rating based on the Fourth Edition of the *AMA Guides*. For treatment of claimant's non-work related injuries, Dr. Fevurly recommended claimant see a physical therapist to teach claimant exercises, stretches and to help gain control over her myofascial pain.

At the request of claimant's counsel, Dr. Edward Prostic, a board certified orthopedic surgeon, evaluated claimant on August 26, 2014. He took a history, performed a physical examination and reviewed medical records. Claimant reported to the doctor she was injured by repetitive keying for respondent. Dr. Prostic concluded:

From repetitious keying during the course of her employment with the Employment Security Division of the State of Kansas, Flor Martinez-Acosta developed bilateral peripheral nerve entrapment. She has been partially relieved by the endoscopic surgery at the left carpal canal. Presently, her symptoms appear to be greater from the pronator tunnel than from the carpal canal. This is worsened by the pronated position<sup>10</sup> required for keying. Eventually, she may require decompression of the median nerves at the proximal forearms as well as at the right wrist. If possible, her

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<sup>7</sup> Fevurly Depo., Ex. 2 at 1.

<sup>8</sup> *Id.* at 29.

<sup>9</sup> *Id.*

<sup>10</sup> Generally, the pronator position is when the hand and arm are in a "downward" position.

claim should be settled with open medical benefits. Permanent partial impairment is currently rated at 15% of each upper extremity, for combined impairment of 17% of the body as a whole on a functional basis. The repetitive minor trauma while working for the State of Kansas is the prevailing factor in causing the injury, the medical condition, the need for medical treatment, and the resulting disability or impairment.<sup>11</sup>

Pursuant to the ALJ's order, Dr. Bruce Toby, who specializes in hand and upper extremity microsurgery, conducted a neutral medical evaluation on December 10, 2014. Dr. Toby took a history from claimant, which refers to the keyboard activity and transcription work required by her job. Although Drs. Huang, Baraban, Fevurly and Prostic, found claimant's initial EMG showed BCTS, Dr. Toby opined that test was "essentially normal,"<sup>12</sup> although he later refers to the EMG being "almost normal."<sup>13</sup> Dr. Toby recommended repeat EMG testing.

Following the repeat EMG, Dr. Toby authored a March 3, 2015, supplemental report to the ALJ, in which the doctor opined claimant's testing was completely normal; showed no evidence of entrapment median neuropathy or carpal tunnel syndrome in either wrist; showed no evidence of cervical radiculopathy in either upper extremity; and revealed no evidence of cubital tunnel syndrome or other abnormal neuromuscular processes. In Dr. Toby's opinion, claimant's pain is an overuse or fatigue-type pain, and she has no permanent functional impairment.

Dr. Toby found tenderness over the proximal left forearm, and positive Tinel's bilaterally. He recommended a repeat EMG. In Dr. Toby's opinion, "her pain is more due to an overuse and might be more of a fatigue problem."<sup>14</sup>

Dr. Lynn D. Ketchum, board certified in plastic surgery and hand surgery, evaluated claimant at her counsel's request on November 12, 2015. The doctor reviewed medical records, took a history and performed a physical examination.

Claimant told Dr. Ketchum her symptoms came on as she performed her keyboard work, and denied any problems with her hands and arms before her employment with respondent. Regarding the EMG ordered by Dr. Toby, and conducted by another physician on January 28, 2015, Dr. Ketchum questioned the validity of that test vis-a-vis the *AMA Guides*. According to Dr. Ketchum, the *AMA Guides* recommend the EMG be performed at the end of a work day when the flexor tenosynovium is the most swollen and symptomatic. The doctor found the same flaw applied to Dr. Huang's EMG. According to Dr. Ketchum, claimant did not work on January 28, 2015.

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<sup>11</sup> Prostic Depo., Cl. Ex. 2 at 2

<sup>12</sup> Dr. Toby's December 10, 2014 report at 2.

<sup>13</sup> *Id.* at 1.

<sup>14</sup> *Id.*

Dr. Ketchum diagnosed mild BCTS, and recommended a repeat EMG after six months.

Dr. Ketchum testified that based on Table 16, Page 57 of the *AMA Guides*, claimant sustained a 10 percent permanent impairment of function to each upper extremity, which translates to 6 percent of the whole body for each extremity. Combining the upper extremity ratings results in a total functional impairment of 12 percent to the whole person. Dr. Ketchum testified the prevailing factor for claimant's 12 percent whole body impairment is the repetitive work she did for respondent.

Dr. Ketchum recommended Pyridoxine, an over the counter vitamin B6, 100 milligrams three times a day, and using splints at work. Dr. Ketchum testified he would have to see the next EMG to determine if claimant is a candidate for right carpal tunnel release surgery. Dr. Ketchum testified Dr. Baraban's preoperative and post-operative diagnosis was left carpal tunnel neuropathy that resulted from the swelling of claimant's flexor tenosynovium and the thickening of the synovium, caused by claimant's repetitive keyboarding activity.

Dr. Ketchum did not recommend additional surgery on claimant's left upper extremity, but on the right side he opined future treatment would be determined by the EMG he recommended in a six-month follow-up. Dr. Ketchum recommended the EMG only if claimant does not show improvement. As stated above, his only other recommendation was for claimant to take Pyridoxine.

Dr. Prostic examined claimant a second time on May 18, 2015. The doctor reviewed records from Dr. Toby and the second EMG. Dr. Prostic testified claimant's symptoms were about the same for each examination. Dr. Prostic's second examination showed evidence of entrapment of the median nerve at the pronator tunnel, located in the proximal forearm. Claimant had significant loss of grip strength bilaterally. Dr. Prostic compared the two EMGs: the first showed motor conduction within normal limits bilaterally, normal needle examination, and abnormal sensory conduction findings consistent with CTS. For the period of time between the two EMGs, claimant underwent surgery on the left wrist, but no treatment on the right other than splints and medication. Claimant's second EMG revealed no evidence of carpal tunnel syndrome.

Dr. Prostic's diagnosis from his second examination was different on the right because claimant had median nerve compression at the right pronator tunnel, which he did not examine in his first visit.

Dr. Prostic rated each extremity at 15 percent, which combines to 17 percent impairment to the whole body. Dr. Prostic relied on the *AMA Guides*, page Table 16, Page 57, and the combined values chart on page 300.

Dr. Prostic testified the prevailing factor for claimant's bilateral carpal tunnel syndrome, her medical treatment and permanent impairment was the repetitiousness of keying required by her employment. Dr. Prostic testified the prevailing factor for claimant's need for medical treatment was her repetitive trauma working for respondent. The doctor also testified the prevailing factor for claimant's permanent impairment was the repetitive keying while working for respondent.

Dr. Prostic testified it is more probable than not claimant will not need additional medical treatment on her left side. If claimant continues keying six and a half hours a day, Dr. Prostic testified she will most likely require an additional surgery on the right. If claimant's physical examination indicates pronator tunnel syndrome, and she continues to have irritability of the nerve at the wrist, surgery would be appropriate.

Claimant's condition has improved since her surgery because her left hand no longer has numbness, but her achiness returned. Claimant's right hand has both numbness and achiness. Claimant currently has pain in the wrists and up toward the elbows and toward the hands.

#### **PRINCIPLES OF LAW, ANALYSIS AND CONCLUSIONS**

The relevant legal principles are set forth in the Award, and are hereby adopted by the Board and incorporated into this Order as though specifically set forth. The Board finds:

1. Claimant sustained personal injury by repetitive trauma, arising out of and in the course of her employment, and her repetitive trauma was the prevailing factor causing her injuries, medical condition, need for treatment and impairment and disability.

Claimant's testimony clearly establishes she felt her data entry duties required repetitive use of her keyboard and caused her injuries. Her description of the nature of her job is unrefuted and the record reveals no other likely cause for her upper extremity injuries. Essentially, all the medical experts concluded claimant sustained injuries to her upper extremities caused by the repetitive hand and arm use required by the substantial majority of her job. There is some dispute among the witnesses as to the precise name to apply to claimant's injuries: BCTS, an overuse or fatigue problem, pronator tunnel syndrome or overuse phenomena. No credible medical expert opined claimant's bilateral repetitive use injuries were caused by anything other than the almost constant use of her hands and arms to input data using the keyboard. K.S.A. 44-508(f)(1) defines an injury as a lesion or change in the physical structure of the body, causing damage or harm thereto. There is no requirement that a particular diagnosis is identified.<sup>15</sup> Further, the nature of claimant's repetitive injuries was demonstrated by both diagnostic and clinical tests, thus satisfying the definition of "repetitive trauma" contained in K.S.A. 44-508(e).

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<sup>15</sup> See *Armstrong v. City of Wichita*, 21 Kan. App. 2d 750 (1995), rev. denied, 259 Kan. 927 (1996).

The dilemma for the fact finder in this claim is the conflicting medical opinions. Medical evidence is not essential to the establishment of the existence, nature and extent of an injured worker's disability.<sup>16</sup> Furthermore, the finder of fact is free to consider all the evidence and whether an accident arises out of and in the course of the worker's employment depends upon the facts peculiar to the particular case.<sup>17</sup>

However, with full knowledge of the results of the second EMG, both Dr. Ketchum and Dr. Prostic found claimant sustained injuries, the prevailing cause of which was the repetitive upper extremity use required by her work. Dr. Huang pointed out that repetitive use as the most common cause of CTS.

Respondent contends claimant cannot have BCTS because there is no showing her hands and arms were in a particular posture relative to her keyboard. However, both Drs. Prostic and Ketchum were made aware of claimant's job duties at their depositions, by a verbatim reading of claimant's regular hearing testimony to both physicians. As noted previously, undisputed evidence is normally regarded as conclusive. Respondent did not prove such evidence was unreasonable or untrustworthy.

Although Drs. Fevurly and Toby disagree with Drs. Ketchum, Prostic and Huang, the Board finds the preponderance of the credible evidence supports the ALJ's findings regarding compensability.

2. As is readily apparent from the Award, the judge considered all evidence in the record, and so has the Appeals Board. Specifically, the ALJ did not disregard Dr. Toby's opinions, or any other evidence.

3. Similarly, the Board finds the ALJ did not disregard the results of diagnostic testing, specifically the second EMG. There is no evidence the ALJ disregarded any evidence. On the contrary, the Award makes it clear the entire record was reviewed and considered by the ALJ, and so has the Appeals Board.

4. The Board likewise finds no error in the ALJ's award of PPD based on a finding of 12 percent permanent impairment of function. The evidence produced by claimant via her sworn testimony and the opinions of Drs. Ketchum, Prostic and Huang establish by a preponderance of the credible evidence that claimant sustained a 12 percent permanent function to the body as a whole, and that her repetitive trauma was the prevailing factor in causing her disability.

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<sup>16</sup> *Chinn v. Gay & Taylor, Inc.*, 219 Kan.196, 547 P. 2d 751 (1976).

<sup>17</sup> *Springston v. IML Freight, Inc.*, 10 Kan. App. 2d 501, 704 P. 2d 394, *rev. denied* 238 Kan. 878 (1985).

5. When claimant reached maximum medical improvement (MMI), a rebuttable presumption arose that respondent’s obligation to provide claimant with further treatment ended. Once the presumption arose, the burden of proof shifted to clamant to prove, by medical evidence, it is more likely than not future treatment will be required. The opinions of Drs. Fevurly and Toby establish that future treatment will not be necessary, and the opinions of Drs. Prostic and Ketchum on this issue are speculative. The Board finds that claimant did not overcome the presumption and agrees with the ALJ that future medical should denied.

**AWARD**

**WHEREFORE**, the Board finds the Award of Administrative Law Judge Rebecca A. Sanders dated March 18, 2016, is affirmed in all respects.

**IT IS SO ORDERED.**

Dated this \_\_\_\_\_ day of October, 2016.

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BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

c: George H. Pearson III, Attorney for Claimant  
georgepearsonlaw@sbcglobal.net  
dfloyd.georgepearsonlaw@yahoo.com

Nathan D. Burghart, Attorney for Respondent and its Insurance Carrier  
nate@burghartlaw.com  
stacey@burghartlaw.com

Honorable Rebecca A. Sanders, Administrative Law Judge