United States Department of Labor
Employees' Compensation Appeals Board

DEBORAH T. LYON, Appellant	)	
and	)	**Docket No. 05-116**
	)	**Issued: December 9, 2005**
U.S. DEPARTMENT OF THE TREASURY, BUREAU OF ALCOHOL, TOBACCO & FIREARMS, Washington, DC, Employer	)	

Appearances:
Capp P. Taylor, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
WILLIE T.C. THOMAS, Alternate Judge

JURISDICTION

On October 12, 2004 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit decision dated September 10, 2004, finding that she did not have residuals of her work-related conditions and that the diagnosed condition of reflex sympathy dystrophy was not due to her employment. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUES

The issues are: (1) whether the Office met its burden of proof to justify termination of appellant's benefits effective October 15, 1999; (2) whether appellant established that she had any continuing employment-related residuals after October 15, 1999; and (3) whether appellant met her burden of proof in establishing that she developed reflex sympathy dystrophy causally related to the accepted injury of October 31, 1985.

FACTUAL HISTORY

On November 12, 1985 appellant, then a 34-year-old management analyst, filed a traumatic injury claim alleging that on October 31, 1985 she tripped over loose carpeting and fell into an elevator and injured her back. On February 21, 1986 the Office accepted acute lumbosacral strain/sprain. Appellant stopped work on November 1, 1985 and did not return.

Appellant received treatment from Dr. David E. Couk, a Board-certified orthopedist, who noted her symptoms and history. A magnetic resonance imaging (MRI) scan dated February 8, 1986 revealed a bulging disc at L5-S1 level. Dr. Couk, in reports dated March 23 to April 27, 1990, diagnosed chronic lumbosacral strain, chronic myofascial pain syndrome, reflex sympathetic dystrophy secondary to the acute lumbosacral strain and spastic quadriplegia. Other reports dated July 19 and October 18, 1990, noted no appreciable change in appellant's condition and advised that she reached maximum medical improvement in October 1990. She was also treated by Dr. David A. Zohn, a Board-certified physiatrist, who in reports dated November 1 and 15, 1988, noted a history of injury in October 1985 and appellant's preexisting cerebral palsy, spastic type and advised that a thermography test revealed abnormalities consistent with reflex sympathetic dystrophy. Appellant sought additional treatment from Dr. Julio C. Gonzalez, a Board-certified orthopedist, who noted a history of her work-related injury and preexisting mild cerebral palsy and diagnosed chronic myofascial pain syndrome with radiculopathy and opined that these conditions were the result of the work-related injury of October 1985. He noted in reports dated December 28, 1988 to December 20, 1991 that appellant continued treatment for chronic back pain and reflex sympathetic dystrophy.

In developing the claim, the Office referred appellant to several second opinion physicians and to an Office medical adviser. This included referring her case record to Dr. Bruce M. Smoller, a Board-certified psychiatrist, who advised that he did not examine appellant but reviewed the entire case record and diagnosed myofascial syndrome, major depression and spastic dyplegia with deterioration. He noted that the depression was related to the fall in the elevator in October 1985 by virtue of aggravating her deteriorating spastic dyplegia. Dr. Smoller opined that appellant continued to experience physical deterioration but there was no indication of emotional residuals.[1]

Appellant was also seen by an Office referral physician, Dr. Ivan S. Logan, a Board-certified neurologist, who, in a February 23, 1990 report, diagnosed mild cerebral palsy and opined that her complaints were out of proportion to the October 1985 injury. He noted that appellant was psychiatrically disabled but had no organic disease. The Office found a medical conflict between Dr. Gonzalez, for appellant, who diagnosed chronic myofascial pain syndrome with radiculopathy and opined that these conditions were the result of the work-related injury of October 1985 and was totally disabled from work and Dr. Logan, for the Office, who determined that appellant had a psychiatric condition with no evidence of organic disease. To resolve the conflict, on December 4, 1991 she was referred to Dr. G.R. Mehryar, a Board-certified neurologist, who, in a report dated January 14, 1992, diagnosed reflex sympathetic dystrophy, causalgia and chronic radiculopathy. He opined that the lumbosacral injury caused the above

[1] The record is missing the first page of Dr. Smoller's report. The date of the report is unknown.

conditions and advised that appellant required an attendant to help her with her daily activities of life. On July 29, 1992 the Office medical adviser determined, after reviewing the second opinion reports, that she developed reflex sympathetic dystrophy, causalgia and autonomic nerve dystrophy which was causally related to the October 1985 work injury. Thereafter, the Office expanded appellant's claim to include depression resolved, causalgia and autonomic nerve dystrophy. On February 12, 1998 her file was forwarded to an Office medical adviser for a determination as to whether there was any objective findings to support a diagnoses of reflex sympathetic dystrophy. On February 18, 1998 the medical adviser noted that there were no objective findings to support a diagnosis of reflex sympathetic dystrophy and there was no relationship to the accepted lumbar sprain.

Appellant sought treatment from Dr. Feliz R. Mestas, a Board-certified family practitioner, who noted on December 7, 1998 that she had a history of cerebral palsy and unsteady gait. He noted that appellant sustained a work-related injury in October 1985 and was subsequently treated for reflex sympathetic dystrophy and depression. Dr. Mestas diagnosed chronic pain and reflex sympathetic dystrophy and advised that appellant was totally disabled.

On February 10, 1999 the Office referred appellant for a second opinion to Dr. Patrick A. Cullen, a Board-certified orthopedist. In a medical report dated March 23, 1999, he noted a history of her condition commencing with a work-related accident in 1985. Dr. Cullen's examination revealed severe cerebral palsy since birth with a typical pattern of spasticity in the upper and lower extremities, no sciatic abnormality and no muscle atrophy. He noted that appellant had good mobility as she was able to get on and off the examination table and walk in the office. Dr. Cullen advised that there was no objective evidence in the upper or lower extremities to suggest a diagnosis of reflex sympathetic dystrophy. He opined that the signs suggestive of reflex sympathetic dystrophy were absent, specifically noting that there were no contractures or joint abnormalities and skin coloration and sweat patterns were normal. Dr. Cullen diagnosed chronic sprain, minimal osteoarthritis of the spine and major psychiatric abnormalities and opined that appellant did not have orthopedic residuals as a result of the relatively minor injury in 1985.

In May 1999, the Office referred appellant for a second opinion to Dr. Frederick W. Schaerf, a Board-certified psychiatrist. In a medical report dated May 10, 1999, he noted that she reported being depressed initially after her injury but was treated successfully with medication. Dr. Schaerf's mental status examination revealed normal speech, no formal thought disorder, no suicidal or homicidal ideation, no hallucinations, delusions, obsessions, compulsions or phobias; he noted that appellant cognitively was alert and oriented without deficit. He diagnosed major depression, currently in remission and chronic pain disorder.

On July 23, 1999 the Office requested that Dr. Schaerf respond to follow-up questions addressing when appellant's psychiatric condition resolved. He submitted a July 23, 1999 supplemental report and noted that she had no current psychiatric symptoms and no residuals directly related to her 1985 work-related injury. Dr. Schaerf advised that appellant had many psychological factors contributing to her chronic pain disorder but they were not due to her work injury. He noted that her psychiatric condition resolved when he saw her on May 10, 1999 and noted that depression usually resolves in two to three months after treatment.

On August 16, 1999 the Office issued a notice of proposed termination of compensation on the grounds that Dr. Cullen and Dr. Schaerf's reports dated March 23, May 10 and July 23, 1999 established no residuals of the work-related employment injuries of acute lumbosacral strain/sprain and depression.

By decision dated October 15, 1999, the Office terminated appellant's compensation benefits effective the same day on the grounds that the weight of the medical evidence rested with the Office referral physicians, Dr. Cullen and Dr. Schaerf, who determined that she had no continuing orthopedic or psychiatric disability resulting from her accepted employment injuries.

Appellant requested a hearing before an Office hearing representative which was held on June 14, 2000. She submitted a June 27, 2000 report from Dr. Mestas, who noted a history of lumbar pain radiating into the hips. He noted that a thermograph was previously performed which confirmed a diagnosis of reflex sympathetic dystrophy and Dr. Mestas diagnosed severe back pain with L4-5 radiculopathy and reflex sympathetic dystrophy. Also submitted was a July 17, 2000 report from Dr. Gonzalez, who diagnosed third degree reflex sympathetic dystrophy which was a direct result of appellant's October 1985 work injury. He opined that her condition was progressively deteriorating and that she was totally disabled. Dr. Gonzalez advised that appellant's cerebral palsy did not contribute to her current condition.

In an October 2, 2000 decision, the hearing representative affirmed the October 15, 1999 decision with regard to the finding that appellant had no residuals of the accepted psychiatric condition but remanded the case for resolution of a conflict as to whether she developed reflex sympathy dystrophy as a result of her 1985 work injury. The hearing representative determined that a conflict of medical opinion had been established between Dr. Mestas and Dr. Gonzalez, appellant's treating physicians, who indicated that appellant developed reflex sympathy dystrophy as a result of her 1985 work injury and Dr. Cullen, an Office referral physician, who determined that she did not develop reflex sympathy dystrophy as a result of her 1985 work injury.

On January 12, 2001 the Office referred appellant to Dr. William J. Carracino, Jr., a Board-certified neurologist, to resolve the medical conflict. In a report dated February 8, 2001, he indicated that he reviewed the medical records and examined appellant. Dr. Carracino noted a history of appellant's work-related injury in October 1985 and her preexisting cerebral palsy. He noted examination findings of contractures about the knees and hips, normal range of motion of the upper extremities and cervical spine, brisk reflexes, shiny skin and swollen legs. Dr. Carracino opined that appellant had reflex sympathy dystrophy or a regional complex pain syndrome, of the right and left leg as a result of the work-related injury of 1985. Dr. Carracino advised that regional sympathetic dystrophy was difficult to diagnose because it is a clinical manifestation of an abnormal neuronal pathway linkage. He noted that appellant's condition was complicated by her spastic quadriparesis from cerebral palsy. Dr. Carracino advised that she did not need continuous attendant care. He opined that appellant was not totally disabled and could ambulate minimally and could return to a position tailored to her needs.

On August 14, 2001 the Office requested that Dr. Carracino return the original file to the Office.

On November 1, 2001 the Office requested clarification from Dr. Carracino regarding results of any diagnostic testing and an explanation of how the mechanism of injury resulted in the condition of reflex sympathetic dystrophy. In a supplemental report dated November 2, 2001, he advised that he did not perform any diagnostic tests but did perform a physical examination and referred to his findings in his original report. Dr. Carracino indicated that the statement of accepted facts noted that appellant tripped on a piece of loose carpeting and fell in an elevator. He advised that reflex sympathetic dystrophy can evolve from fairly trivial injuries such as appellant's and noted that she was predisposed to this condition because of her cerebral palsy. Dr. Carracino opined that the injury of 1985 was the incident that caused appellant's condition to begin.

In an undated and unsigned statement in the record, it was noted that the referee examination conducted by Dr. Carracino would be excluded from the record because "he failed to furnish a well-rationalized equivocal report." The note further provided that "he was given an opportunity to furnish a clarification report and failed to furnish the necessary evidence." In a December 20, 2001 letter, the Office notified appellant that Dr. Carracino failed to properly respond to the questions posed in their letter and to timely return the case record. The Office determined that a second referee examination was required to resolve the conflict of medical opinion.

On January 16, 2002 appellant was referred to Dr. Esham M. Kibria, a Board-certified neurologist, to resolve the medical conflict. In a medical report dated February 8, 2002, Dr. Kibria noted reviewing the medical record and examining appellant. He noted a history of her October 1985 work injury and her preexisting cerebral palsy. Dr. Kibria noted that as a child appellant underwent surgeries, including Achilles cords lengthening on the right and adductor tonotomy release of the left leg. He further noted that she was thrown forward in a motor vehicle accident on September 2, 1986 and thereafter had persistent buttock and leg pain. On examination Dr. Kibria noted a normal range of motion of the neck and shoulder, tenderness through the spine, no muscular spasm or atrophy, bilateral straight leg raises were 70 degrees without sciatic pain and limited range of motion of the lumbar spine. He found several physical findings which were not supportive of reflex sympathetic dystrophy, including a lack of skin and nail changes, no hair loss distally, warm and normal skin surface temperature, lack of ulcers, mottling and autonomic changes and a lack of a latency period prior to appellant experiencing symptoms of the condition. Dr. Kibria noted that appellant's right leg stiffness and flexor spasm may be due to her cerebral palsy. He advised that, although the thermograph test performed in 1988 was sensitive to symptoms of reflex sympathetic dystrophy, this test was nondiagnostic and would have been abnormal prior to appellant's injury because of her preexisting conditions. Dr. Kibria opined that the November 15, 1988 test revealed coolness of the plantar surface of the right foot in the heel and distal right leg; however, he advised that these abnormal findings could be attributed to appellant's prior surgeries. He diagnosed chronic myofascial pain syndrome which was not fully work related and opined that appellant's cerebral palsy and 1986 motor vehicle accident were relevant contributing factors in her initial injury and exacerbation of her symptoms. Dr. Kibria advised that appellant could work in a sedentary position with limitations on the use of her lower legs.

On February 14, 2003 the Office requested that Dr. Kibria provide a supplemental report. In a February 21, 2003 report, he diagnosed chronic myofascial pain syndrome and advised that

the diagnosis was 50 percent work related and the remainder was due to her preexisting conditions. Dr. Kibria indicated that he did not perform diagnostic testing. He opined that appellant did not have reflex sympathetic dystrophy and, therefore, determined that this was not related to the work injury of October 31, 1985.

In a June 11, 2003 decision, the Office denied appellant's claim, finding that the weight of the evidence was accorded to Dr. Kibria, who found that she did not have reflex sympathy dystrophy and there was no clear source of appellant's pain or evidence that her condition was causally related to the October 31, 1985 work injury.[2]

In a letter dated May 17, 2004, appellant requested reconsideration. She submitted several reports from Dr. William Ertag, a Board-certified internist, dated July 17, 2003 to April 23, 2004. He noted her history and diagnosed complex regional pain disturbance with vasomotor changes and hyperesthesia. Dr. Ertag noted that the vasomotor changes and increased tone could have been accentuated by appellant's underlying cerebral palsy. He diagnosed complex regional pain disturbance that resulted in chronic pain and total disability. Dr. Ertag noted that, prior to appellant's 1985 work injury, she was very active with minimal residuals from her cerebral palsy. His reports of January 9 and April 23, 2004 noted no appreciable change in appellant's condition and recommended studies for possible bilateral carpal tunnel syndrome. A report from Dr. Joseph Kandel, a Board-certified neurologist, dated August 27, 2003 indicated that there was no evidence of psychiatric illness, but noted that appellant did have reactive depression. He diagnosed reflex sympathetic dystrophy affecting the legs; however, Dr. Kandel opined that it was unclear whether the cerebral palsy predisposed appellant to this condition. Reports from David B. Rawlings, a psychologist, dated September 8 to 11, 2003, opined that appellant was more anxious than depressed. In a report dated March 17, 2004, Dr. Mestas diagnosed reflex sympathetic dystrophy due to the October 31, 1985 work injury and depression due to severe pain. He opined that, although appellant was born with cerebral palsy and was involved in a 1986 motor vehicle accident, he believed the 1985 work injury was the main cause of her conditions that were totally disabling. On April 27, 2004 Dr. Gonzalez submitted a statement which was duplicative of the statement submitted by Dr. Mestas on March 17, 2004.

In a decision dated September 10, 2004, the Office denied modification of the prior Office decision of June 11, 2003. The Office noted that the evidence was insufficient to establish that appellant developed reflex sympathy dystrophy as a result of her work-related injury of October 31, 1985 and the evidence did not support that she continued to have residuals of the work-related depression.

LEGAL PRECEDENT -- ISSUE 1

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation benefits.[3] After it has determined that an employee has disability

[2] The record contains an Office document dated August 13, 2002 that appears to be a draft of a decision; however, this does not appear to have been issued.

[3] *Gewin C. Hawkins*, 52 ECAB 242 (2001); *Alice J. Tysinger*, 51 ECAB 638 (2000).

causally related to his or her federal employment, the Office may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.[4]

ANALYSIS -- ISSUE 1

The Office accepted appellant's claim for acute lumbosacral strain/sprain, autonomic nerve dystrophy, depression and causalgia. In March 1999, the Office referred appellant to Dr. Cullen, an orthopedist, to determine whether she had residuals of her accepted orthopedic conditions. In his March 23, 1999 report, Dr. Cullen reviewed her history, noted findings and opined that appellant did not have residual orthopedic problems from her relatively minor injury in 1985.

Appellant submitted numerous reports from her treating physicians, Dr. Gonzalez and Dr. Mestas. Reports from Dr. Gonzalez dated September 7, 1995 to August 4, 1997 advised that she was under his care for injuries sustained at work and diagnosed progressive reflex sympathetic dystrophy of the lumbar spine and right lower extremity and recommended pain medication. However, the Board notes that he did not specifically address how any accepted condition continued as a result of the accepted October 1985 employment injury. Additionally, the Office never accepted that appellant sustained reflex sympathetic dystrophy as a result of her October 1985 work injury. Dr. Mesta's report dated December 7, 1998 did not specifically address how any continuing condition was causally related to the accepted October 1985 employment injury.

The Board finds that, under the circumstances of this case, the opinion of Dr. Cullen is sufficiently well rationalized and based upon a proper factual background such that it is the weight of the evidence and established that appellant's work-related orthopedic condition ceased and is sufficient to justify the Office's termination of benefits with regard to appellant's orthopedic conditions.

The Board further finds that the Office properly terminated benefits with regard to appellant's accepted psychiatric condition.

In May 1999, the Office referred appellant for a second opinion to Dr. Schaerf to determine if she had residuals of her accepted psychiatric condition. In his reports dated May 10 and July 23, 1999, Dr. Schaerf noted that mental status examination revealed normal no abnormalities. He diagnosed major depression, in remission and chronic pain disorder. Dr. Schaerf noted that appellant reported being depressed initially after the injury but was treated successfully with medication. In a supplemental report dated July 23, 1999, he noted that appellant had no current symptoms of a psychiatric condition and no residuals due to her October 1985 work injury. Dr. Schaerf noted that appellant had many psychological factors contributing to her chronic pain, but that these were not due to her work injury. He opined that appellant's psychiatric condition resolved when he saw her on May 10, 1999 and noted that depression usually resolves in two to three months after treatment.

[4] *Mary A. Lowe*, 52 ECAB 223 (2001).

The Board finds that, under the circumstances of this case, the opinion of Dr. Schaerf is sufficiently well-rationalized and based upon a proper factual background such that it establishes that appellant's work-related psychiatric condition ceased.

The Board finds that there was no reasoned medical evidence at the time of the Office's termination decision supporting that any continued disability was causally related to the accepted work injury. Dr. Cullen and Dr. Schaerf had full knowledge of the relevant facts and evaluated the course of appellant's condition. They are specialists in the appropriate fields. They clearly opined that she had no work-related reason for disability after October 15, 1999. Dr. Cullen and Dr. Schaerf are found to be probative and reliable. The Board finds that their opinions constitute the weight of the medical evidence and are sufficient to justify the Office's termination of benefits.

For these reasons, the Office met its burden of proof in terminating appellant's compensation benefits.

LEGAL PRECEDENT -- ISSUE 2

If the Office meets its burden of proof to terminate appellant's compensation benefits, the burden shifts to the employee to establish that she had continuing disability causally related to her accepted employment injury.[5] To establish a causal relationship between the condition, as well as any disability claimed and the employment injury, the employee must submit rationalized medical opinion evidence, based on a complete factual background, supporting such a causal relationship. Rationalized medical opinion evidence is medical evidence, which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant. The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.[6]

ANALYSIS -- ISSUE 2

The Board finds that appellant has not established that she has any continuing residuals of her acute lumbosacral strain/sprain, autonomic nerve dystrophy, depression and causalgia causally related to her accepted employment injuries on or after October 15, 1999. She submitted reports from Dr. Mestas dated June 27, 2000 and March 17, 2004 and Dr. Gonzalez dated July 17, 2000 and April 27, 2004, who opined that her conditions were a direct result of her work-related injury of October 1985. They further noted that appellant was asymptomatic prior to her work injury of October 31, 1985. However, the Board notes that neither Dr. Gonzalez nor Dr. Mestas specifically explained how any continuing condition or disability were causally related to the accepted October 1985 employment incident. Moreover, the Board

[5] *Manuel Gill*, 52 ECAB 282 (2001); *George Servetas*, 43 ECAB 424, 430 (1992).

[6] *See Connie Johns*, 44 ECAB 560 (1993); *James Mack*, 43 ECAB 321 (1991).

has held that an opinion that a condition is causally related to an employment injury because the employee was asymptomatic before the injury is insufficient without supporting rationale to support a causal relationship.[7] The Board finds that neither Dr. Gonzalez, nor Dr. Mestas provided a rationalized opinion specifically addressing how any continuing condition or disability were causally related to the accepted October 1985 employment injury.

Reports from Dr. Ertag from diagnosed complex regional pain disturbance which resulted in chronic pain and totally disability. He further noted that prior to appellant's work injury in 1985 she was asymptomatic and very active with minimal residual from her cerebral palsy. As noted above, an opinion that a condition is causally related to an employment injury because the employee was asymptomatic before the injury is insufficient without supporting rationale, to support a causal relationship.[8] Additionally, the Board notes that Dr. Ertag failed to specifically address how any continuing condition or disability was causally related to the accepted October 1985 employment incident. The Board has found that vague and unrationalized medical opinions on causal relationship have little probative value.[9] Regarding appellant's psychiatric condition, Dr. Ertag did not note findings consistent with depression, rather he advised that her affect improved and that she was without delusions, hallucinations or thought disturbances.

Reports from Dr. Kandel and Dr. Rawlings did not support continuing residuals of a psychiatric condition, rather they opined that there was no evidence of psychiatric illness and that appellant was more anxious than depressed.

None of the reports submitted by appellant after the termination of benefits included a rationalized opinion regarding the causal relationship between her current conditions and her accepted work-related injury of October 1985. Therefore, the Board finds that she has failed to meet her burden to establish that she had continuing disability causally related to her accepted employment conditions.

LEGAL PRECEDENT -- ISSUE 3

Section 8123(a), in pertinent part, provides: "If there is a 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."[10]

When the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in his original report. However, when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, the Office must submit the case record and a detailed statement of accepted facts to

[7] *Kimper Lee*, 45 ECAB 565 (1994).

[8] *Id*.

[9] *See Jimmie H. Duckett*, 52 ECAB 332 (2001).

[10] 5 U.S.C. § 8123(a).

a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[11]

ANALYSIS -- ISSUE 3

The Office referred appellant to Dr. Carracino, a Board-certified neurologist, to resolve the medical conflict regarding whether she developed reflex sympathetic dystrophy as a result of her work-related injury of October 1985. In his February 8, 2001 report, Dr. Carracino opined that this condition was employment related. The Office determined that Dr. Carracino's opinion required clarification and, on November 1, 2001 requested a supplemental report addressing whether testing was performed and how the mechanism of injury resulted in reflex sympathetic dystrophy.

In a supplemental report dated November 2, 2001, Dr. Carracino advised that he did not perform any diagnostic tests but did perform a physician examination of appellant and referred to his findings in his original report. He indicated that reflex sympathetic dystrophy can evolve from fairly trivial injuries like the injury appellant sustained when she tripped on a piece of loose carpeting and fell and opined that the injury of 1985 was the incident which caused her condition to begin.[12]

As noted above, Board precedent provides that when the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in his original report. Only when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, should the Office refer the claimant to a second impartial specialist.[13]

The Office found that Dr. Carracino failed to properly respond to the questions posed in their letter and to timely return the case record. The Office did not explain why it found his reports, when read as a whole, to be deficient; rather the evidence suggests that Dr. Carracino responded to the only clarification request of record and specifically addressed the questions posed to him and provided an unequivocal and reasoned opinion that appellant developed reflex sympathetic dystrophy as a result of her work-related injury of October 1985. Dr. Carracino specifically responded that he performed no diagnostic testing but based his opinion on his examination. He advised that reflex sympathetic dystrophy can evolve from fairly trivial injuries

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[11] *Talmadge Miller*, 47 ECAB 673 (1996); *Harold Travis*, 30 ECAB 1071, 1078 (1979); *see also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.0810(11)(c)(1)-(2) (April 1993).

[12] Dr. Carracino's report is consistent with the report of a prior impartial examiner, Dr. Mehryar, who, in 1992 indicated that appellant's employment injury caused her reflex sympathy dystrophy. The record is unclear as to why the Office did not accept that diagnosis at that time.

[13] *See id.*

like the injury appellant sustained when she tripped on a piece of loose carpeting and fell and opined that the injury of 1985 was what caused her condition to begin.

However, the Office referred appellant to another impartial medical specialist, Dr. Kibria, to resolve the conflict, without providing any reasoning with regard to why Dr. Carracino's reports did not resolve the medical conflict.[14] The Board finds that the Office erred by referring her to a second impartial medical specialist to resolve a conflict which appears to have been properly resolved by Dr. Carracino. As he properly responded to the Office's questions and there is no evidence that Dr. Carracino failed to provide an adequate and clear response, the Office improperly referred appellant for a second impartial medical examination. Consequently, Dr. Kibria's report cannot be considered to be the report of an impartial specialist as there was no outstanding conflict in the medical evidence regarding reflex sympathy dystrophy when the matter was referred to him.

This case will be remanded to the Office to take further action consistent with the findings of Dr. Carracino.

CONCLUSION

The Board finds that the Office met its burden of proof to terminate appellant's compensation benefits effective October 15, 1999. The Board further finds that she failed to establish that she had any continuing disability after October 15, 1999 due to her accepted condition. Finally, the Board finds that the case is not in posture for a decision with respect to appellant's claim that the diagnosed condition of reflex sympathy dystrophy was causally related to the October 31, 1985.

[14] Office procedures note that a referral to a second impartial specialist "should be undertaken with care; a premature or inappropriate second impartial examination would defeat the intent of 5 U.S.C. § 8123(a) and could lead to the suspicion that [the Office] is 'doctor shopping.'" Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.11(c)(2) (April 1993).

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated September 10, 2004 is affirmed in part and remanded in part.

Issued: December 9, 2005
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Willie T.C. Thomas, Alternate Judge
Employees' Compensation Appeals Board