

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

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In the Matter of VERONICA A. McCANN and U.S. POSTAL SERVICE,  
POST OFFICE, Jersey City, NJ

*Docket No. 98-1721; Submitted on the Record;  
Issued February 18, 2000*

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DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON,  
WILLIE T.C. THOMAS

The issue is whether appellant had any disability on or after February 4, 1996, causally related to her October 18, 1988 accepted contusion of her right toes and right lower extremity reflex sympathetic dystrophy.

On December 18, 1988 appellant, then a 54-year-old mailhandler,<sup>1</sup> had a skid roll over her right foot and toes. The Office of Workers' Compensation Programs accepted that she sustained contusions of her right toes and right foot reflex sympathetic dystrophy (RSD). Concurrent disability not due to injury was noted to include depression and osteoporosis of the right foot. Appellant stopped work and did not return.

By report dated January 20, 1989, appellant's treating physician, Dr. E.A. Tolentino, a Board-certified orthopedic surgeon, diagnosed contusion of the right foot, noted that x-rays revealed increased osteoporosis of all bones probably secondary to disuse and the sympathetic dystrophy and indicated that appellant was totally disabled.

However, on April 18, 1989 Dr. Salvatore R. Lenzo, a Board-certified orthopedic surgeon, noted appellant's complaints as burning pain within her right foot exacerbated by walking and a feeling of numbness and coldness within her right foot. He opined that appellant was not totally disabled and that she could work in a sedentary position. In an attached OWCP-5 work restriction evaluation, Dr. Lenzo indicated that appellant could work 8 hours per day sedentary duty with a 2-hour restriction on intermittent walking and standing and a 10-pound lifting limit.

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<sup>1</sup> Illegible nonfatal summary reports appellant's date of birth as September 12, 1943, however, the medical reports of record report her age as much younger.

On October 1, 1990 Dr. Paul A. Foddai, a Board-certified orthopedic surgeon, opined, based upon a functional capacity evaluation, that appellant could attempt to return to work for two to four hours per day at a job that allowed her to sit and use her upper extremities.

On May 31, 1990 the employing establishment offered appellant a flexible limited-duty job in accordance with her physician's restrictions. By letter dated August 20, 1990, appellant accepted this job offer, however, she predicated the acceptance on being provided transportation and salary for a 40-hour week because she had been a regular and not flexible worker. She, however, did not return to work.

On November 15, 1990 Dr. Foddai opined that appellant could sit intermittently for four hours per day. On May 28, 1991 Dr. Foddai opined that appellant's condition had worsened.

By report dated April 25, 1994, Dr. Arthur E. Taubman, a Board-certified orthopedic surgeon, opined that, after five years and unsuccessful treatments, appellant had reached maximal orthopedic benefit and opined that no further treatment was necessary at that time.

On September 20, 1995 appellant was referred to Dr. Charles E. Granatir, a Board-certified orthopedic surgeon, for a second opinion as to appellant's continuing disability and ability to work. By report dated October 16, 1995, Dr. Granatir reviewed appellant's records, noted a history of depression, examined her and found no atrophy of the right calf and slight atrophy on the left related to a recent left ankle fracture, noted full range of right ankle and foot motion without any swelling, no trophic skin changes, no anhidrosis or right foot sweating and full subtalar range of motion without pain or restrictions. Dr. Granatir found no instability about the ankle or foot and independent dorsiflexion, eversion and inversion, but he noted that appellant had no motion in response to command. He noted glove and stocking sensory loss from the ankle distally which did not correspond to any dermatome whatsoever. Dr. Granatir noted that x-rays demonstrated completely normal bony anatomy without bony atrophy or evidence of RSD. Dr. Granatir opined that appellant had extreme amplification of complaints with minimal objective evidence of disuse or dystrophy about the right lower extremity. He also diagnosed rule out over amplification of symptoms, rule out hysteria, rule out malingering. Dr. Granatir opined that orthopedic disability was not demonstrated upon examination, although he indicated that there might be a psychiatric basis to appellant's complaints. He noted that appellant's prolonged disability did not relate to RSD and that no objective permanent restrictions were noted about the right foot related to the injury of October 18, 1988. Dr. Granatir also noted that appellant's right foot injury could not be blamed as the cause of her subsequent orbital fracture, left ankle fracture or lumbosacral complaints and that a full work capacity was recommended at that time in reference to the right foot findings and disability, without any further orthopedic evaluation or treatment necessary. On an accompanying work restriction evaluation Dr. Granatir indicated that appellant could work for eight hours per day without any orthopedic restrictions. A psychiatric disorder was noted as a nonwork-related condition which could limit appellant. He also noted that appellant had reached maximum medical improvement.

On December 22, 1995 the Office issued a notice of proposed termination of compensation, finding that appellant had not submitted a report supporting disability since May 28, 1991, that Dr. Taubman's May 25, 1994 report stated that appellant could perform

modified work – specifically desk work and had reached maximum orthopedic benefit with no further treatment necessary and that, therefore, appellant was referred to Dr. Granatir for a second opinion to clarify the extent of appellant’s disability and need for further treatment. The Office noted that Dr. Granatir reviewed the statement of accepted facts and the pertinent case record, thoroughly examined appellant, found that there was no objective evidence of permanent disability or need for orthopedic restrictions, noted that there was normal bony anatomy without bony dystrophy or evidence of RSD and noted that appellant’s other injuries were not related to her right foot injury. He opined that appellant could work eight hours a day without restrictions and that no further orthopedic treatment or evaluation was necessary. The Office found that Dr. Granatir’s report constituted the weight of the medical evidence because it was complete, well rationalized and based upon a correct factual background as presented in the statement of accepted facts and because there was no other current medical opinions of record which disputed his findings and conclusions.

Appellant was given 30 days within which to submit other medical evidence or argument against the proposed termination of compensation. She did not respond within the allotted time period.

On January 22, 1996 the Office terminated appellant’s compensation and entitlement to medical care effective February 3, 1996 finding that she had no continuing disability as a result of the October 18, 1988 injury.

On October 15, 1996 the Office received a September 23, 1996 prescription from Dr. Iqbal H. Jafri, a physiatrist Board-certified in physical medicine and rehabilitation, which stated: “The above named patient was initially seen by me on April 5, 1996. Right foot as a result of trauma sustained on October 18, 1988 and her pain is getting progressively worse, she has developed [RSD] of right foot, today she comes for [follow-up] visit still reports severe pain in her foot. Patient has not worked since then secondary to the right foot pain.”

By letter dated December 11, 1996, appellant, through her representative, requested reconsideration.

On December 16, 1996 the Office received a September 23, 1996 narrative report from Dr. Jafri, which indicated that appellant said she hurt her foot when a heavy package fell on the foot, that appellant described a throbbing pain sensation and temperature changes in the right foot and that she had difficulty in ambulation secondary to pain and weakness in the right foot. He noted that appellant reported that because of pain she was unable to go back to work and that she had decreased sensation on the dorsum of the right foot and in the plantar aspect, with limited range of right ankle motion, mainly in dorsiflexion, an antalgic gait and used a cane. Dr. Jafri diagnosed complex regional pain syndrome Type I. Also submitted on December 16, 1996 was an April 8, 1996 report from Dr. Jafri, which stated the same as his later reports.

Additionally on December 16, 1996 Dr. Jafri reported in an undated report that appellant reported that she injured herself by a “heavy package over the foot,” that she complained of weakness in the right foot, that she had difficult ambulation secondary to foot pain, that because of the weakness she had fallen numerous times and sustained other injuries and that she was seen on September 23, 1996 and was diagnosed as having complex regional pain syndrome, Type I,

secondary to trauma to the right foot. Upon physical examination Dr. Jafri noted that appellant was depressed, that she had a color change in her right foot, limited range of motion in the ankle, weakness on dorsiflexion and that she was unable to dorsiflex her ankle. He noted limited plantar flexion and diminished sensation throughout the foot. Dr. Jafri diagnosed chronic pain and weakness of the right foot and an ambulation dysfunction and opined that appellant was disabled secondary to pain and weakness of the right foot.

By decision dated March 5, 1997, the Office denied modification of the January 22, 1996 decision finding that the evidence submitted in support of the request was insufficient to warrant modification. The Office found that Dr. Jafri's reports were of diminished probative value as he was not a specialist in orthopedics, as he did not provide a compensable diagnosis and as he provided no medical rationale, basing his opinion only on appellant's subjective complaints of pain and weakness.

By letter dated November 14, 1997, appellant, through her representative, again requested reconsideration. In support she submitted further reports from Dr. Jafri.

By report dated December 26, 1996, Dr. Jafri repeated the contents of his December 16 and September 23, 1996 reports.

By report dated January 20, 1997, Dr. Jafri noted that appellant's right foot showed some color changes and was cold to the touch distally. He also noted diminished sensations in the right foot. Dr. Jafri diagnosed right foot drop, RSD affecting the right foot and chronic pain right foot.

By report dated February 7, 1997, an electromyogram (EMG) and nerve conduction studies were reported as being normal, with no evidence of peripheral nerve lesion in the right lower limb and no evidence of common peroneal nerve palsy on the right side.

By report dated February 21, 1997, Dr. Jafri reported that EMG studies and nerve conduction studies on February 7, 1997 were normal and that appellant still reported pain in the right foot and he recommended a home exercise program.

By report dated April 23, 1997, Dr. Jafri noted that appellant reported constant pain status post RSD, that she had weak ankle dorsiflexion and toe extensors, skin discoloration on the right side of the dorsum of the foot and the distal part of the leg.

By report dated July 29, 1997, Dr. Jafri reported that appellant injured her right foot after a heavy object fell on her foot, that she had difficulty in ambulation secondary to right foot weakness and that she was using a right ankle orthosis and a cane for ambulation. Dr. Jafri noted that examination revealed right foot drop, color changes and weakness of the ankle and was unable to dorsiflex the ankle. He diagnosed "trauma to the right foot with resultant RSD, weakness of the right foot, difficulty in ambulation and lower back pain."

Also submitted were duplicates of previously submitted and considered reports.

By decision dated February 13, 1998, the Office denied modification of the March 5, 1997 decision finding that the evidence submitted in support was insufficient to warrant modification. The Office noted that Dr. Jafri's reports were cumulative in nature and that the EMG and nerve conduction results were reported as normal. It found that, since the only new objective evidence supported the absence of disability, a disability was not present. The Office noted that the absence of objective evidence of disability is more compatible with the absence of objective disability than with its presence, citing *Anna Chrun*, 33 ECAB 829 (1982).

The Board finds that appellant has failed to establish that she had any disability after February 4, 1996, causally related to her October 18, 1988 accepted contusion of her right toes and right lower extremity RSD.

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation benefits.<sup>2</sup> After it has determined that an employee has disability 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.<sup>3</sup>

However, after the Office has met its burden to modify or terminate compensation, clearly warranted on the basis of the medical evidence of record, appellant bears the burden of proof for reinstating compensation benefits. In order to prevail, appellant must establish by the weight of the reliable, probative and substantial evidence that she had an employment-related disability which continued after termination of compensation benefits.<sup>4</sup>

In the instant case, the Office met its burden of proof to terminate compensation based upon the well-rationalized report of Dr. Granatir. The last medical evidence of record prior to the termination which supported any continuing disability was Dr. Foddai's May 28, 1991 brief and unrationalized statement to the effect that appellant's "condition had worsened." As this report was unrationalized and contained no report of objective evidence of disability, it was of diminished probative value. Subsequent to this report, Dr. Taubman opined that appellant had reached maximum medical improvement and that no further treatment was necessary. Thereafter Dr. Granatir, in a thorough and well-rationalized report, discussing the objective evidence upon examination and based on a complete and accurate factual and medical history, concluded that orthopedic disability was not demonstrated upon examination, that appellant's continuing problems and subsequent injuries did not related to an accepted condition and that appellant could return to work eight hours per day without any restrictions.

As this report was thorough and well rationalized and was based upon an accurate factual and medical background, it was entitled to great probative value. As no other contrary probative

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<sup>2</sup> *Harold S. McGough*, 36 ECAB 332 (1984); see Federal (FECA) Procedure Manual, Chapter 2.812.3 (March 1987).

<sup>3</sup> *Vivien L. Minor*, 37 ECAB 541 (1986); *David Lee Dawley*, 30 ECAB 530 (1979); *Anna M. Blaine*, 26 ECAB 351 (1975).

<sup>4</sup> *Talmdge Miller*, 47 ECAB 673 (1996).

medical evidence was present in the record, the Office properly determined that Dr. Granatir's report constituted the weight of the medical opinion evidence and terminated appellant's compensation on that basis.

Thereafter, the burden of proof to establish continuing disability shifted to appellant. Appellant submitted in support of her request for reconsideration April 8, September 23 and December 16, 1996 reports from Dr. Jafri, which contained inaccurate histories of injury about a heavy box falling on appellant's right foot and reported symptoms on the basis of appellant's subjective complaints of pain, weakness and decreased sensation. No clinical measurements of this weakness were reported. Dr. Jafri's examinations did not reveal and objectively disabling conditions, just discoloration and coldness, which were not explained as to how they disabled appellant and he reported loss of ankle range of motion, without explaining how ankle motion was related to a right foot and toes injury. He stated that appellant developed RSD injury, but he did not support this diagnosis on the basis of neurological studies or radiographic studies. Further, Dr. Jafri diagnosed not an objective compensable diagnosis, but a pain based diagnosis of chronic pain and weakness and ambulation dysfunction, secondary to the pain and weakness. The Board notes that it has frequently explained that statements about an appellant's pain, not corroborated by objective findings of disability being demonstrated, or a diagnosis of "pain" or "chronic pain syndrome," do not constitute a basis for payment of compensation.<sup>5</sup> Due to these deficiencies, Dr. Jafri's reports are of diminished probative value and are insufficient to establish appellant's claim of continuing disability.

Following a second request for reconsideration appellant submitted further reports by Dr. Jafri diagnosing chronic pain, right foot drop and right foot RSD. However, no objective evidence of RSD or right foot drop was presented and no explanation as to how right foot drop was related to right foot and toes contusions in 1988 was presented. Dr. Jafri's further reports merely restated what he had reported in earlier reports, offering no new diagnoses supported by objective evidence of disability. These reports were largely cumulative, their contents had been previously considered and they were, therefore, of diminished probative value in establishing appellant's claim.<sup>6</sup> Further, nerve conduction studies done on February 7, 1997 demonstrated no evidence of peripheral nerve lesions or common peroneal nerve palsy on the right and were reported as being normal. This evidence, therefore, does not support continuing injury-related right lower extremity disability. As no further new probative and well-rationalized medical evidence was submitted supporting continuing disability due to appellant's 1988 injuries, appellant has failed to meet her burden of proof to establish her claim.

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<sup>5</sup> See *John L. Clark*, 32 ECAB 1618 (1981); *Huie Lee Goad*, 1 ECAB 180 (1948).

<sup>6</sup> See, e.g., *Roseanne S. Allexenberg*, 47 ECAB 498 (1996); *James A. England*, 47 ECAB 115 (1995).

Accordingly, the decision of the Office of Workers' Compensation Programs dated February 13, 1998 is hereby affirmed.

Dated, Washington, D.C.  
February 18, 2000

George E. Rivers  
Member

David S. Gerson  
Member

Willie T.C. Thomas  
Alternate Member