United States Department of Labor
Employees' Compensation Appeals Board

S.R., Appellant	)	
and	)	**Docket No. 09-990**
	)	**Issued: March 16, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Wilmington, DE, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On March 3, 2009 appellant filed a timely appeal from the May 22, 2008 merit decision of the Office of Workers' Compensation Programs terminating her medical benefits for reflex sympathetic dystrophy and left knee conditions. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether the Office met its burden of proof to terminate appellant's medical benefits for reflex sympathetic dystrophy and left knee conditions accepted in connection with her December 16, 1992 employment injury.

FACTUAL HISTORY

The Office accepted that on December 16, 1992 appellant, then a 26-year-old letter carrier, sustained a left knee sprain and internal derangement of the left knee when she twisted it while walking up a landing to deliver mail. On January 5, 1993 appellant underwent

arthroscopic left knee surgery which was authorized by the Office.[1] She worked in limited-duty jobs for the employing establishment and last worked on November 2, 1994. On September 6, 2000 the Office accepted reflex sympathetic dystrophy and paid appellant compensation for total wage loss retroactive to November 2, 1994.[2] On August 11, 2004 it also accepted that she sustained chronic pain disorder with psychological factors due to the December 16, 1992 injury.

On May 31, 2005 appellant came under the care of Dr. Nazim Ameer, a Board-certified anesthesiologist and specialist in pain medicine, who diagnosed appellant's condition as reflex sympathetic dystrophy, which he described as a kind of sympathetically mediated pain affecting the upper and lower extremities. Dr. Ameer prescribed medication and lumbar sympathetic blocks.

On April 10, 2006 an Office medical adviser recommended that appellant be sent for additional evaluation to an orthopedic surgeon, a neurologist and a psychiatrist. The Office subsequently referred appellant for second opinion examinations by Dr. Robert Smith, a Board-certified orthopedic surgeon, Dr. Ira Wexler, a Board-certified neurologist, and Dr. Fred Dittmer, a Board-certified psychiatrist.

On June 20, 2006 Dr. Smith described appellant's factual and medical history, including the findings on examination and diagnostic testing. He noted that appellant's January 1993 left knee surgery included excision of a thickened medial plica and that no evidence was found during the surgery of a meniscal or ligament tear. Dr. Smith advised that appellant complained of pain in both legs with some tingling sensation and noted that she claimed that she had restless leg syndrome. He stated that on physical examination appellant's lower extremities showed a normal appearance with no evidence of any change in skin color, mottling or cyanosis. Appellant did not exhibit any muscle or soft tissue atrophy in the lower extremities and that there was no joint stiffness in her knees, ankles or toes. Dr. Smith concluded that appellant had an essentially normal physical examination of the lower extremities with no residuals of the December 16, 1992 injury.[3] He noted that there was no sign of complications from the January 1993 surgery which included excision of a thickened medial plica. Dr. Smith stated that there was no medical necessity for sympathetic blocks or home care visits and that she did not have any work-related disability. He stated that any disability that appellant had would be due to a nonwork-related use of medications, including a high-grade narcotic. Dr. Smith completed a work capacity evaluation form dated June 20, 2006 indicating that appellant had no restrictions.

On July 25, 2006 Dr. Wexler reported that appellant had no overt cognitive impairment, no evidence of twitching or involuntary movement of the legs, no evidence of neurologic impairment and no findings suggestive of complex regional pain syndrome such as substantive

[1] The surgery included excision of a thickened medial plica. No evidence of meniscus tear, ligament injury or articular surface damage was found during the surgery.

[2] Reflex sympathetic dystrophy, also known as complex regional pain syndrome, is a progressive disease characterized by severe pain, swelling and changes in the skin.

[3] Dr. Smith also indicated that appellant did not exhibit any signs of reflex sympathetic dystrophy or restless leg syndrome. In a July 28, 2006 report, he stated that, at the time of his June 20, 2006 examination, appellant did not appear to have any clinical findings of reflex sympathetic dystrophy.

changes in skin surface. He noted that appellant walked to the examination room without limping or signs of gait disorder, but that when she was on the examining bench she appeared to have overt and profound weakness in the same muscles that she had used to walk. Dr. Wexler stated that the sensory examination of appellant's lower extremities was unreliable and stated that he could not ascribe appellant's current complaints in her feet and legs to the apparently mild injury to the left knee in December 1992. He stated that there was no objective impairment that would substantiate a need for ongoing addicting medication and home visits by a nurse. Dr. Wexler completed a work capacity evaluation form dated August 4, 2006 indicating that appellant could work eight hours per day with restrictions due to the left knee arthroscopy limiting her ability to carry weights or stand for prolonged periods.

On June 23, 2006 Dr. Dittmer diagnosed several disorders, including chronic intractable pain disorder, bipolar disorder and personality disorder. He opined that the claimant was totally disabled for any employment. Dr. Dittmer stated that appellant's severe mood swings "cannot easily be connected to work injuries." The Office later found a conflict in the medical evidence between Dr. Dittmer and Dr. Harry Doyle, an attending Board-certified psychiatrist, regarding appellant's psychological condition and referred appellant to Dr. Randy Rummler, a Board-certified psychiatrist, for an impartial medical examination. On February 6, 2007 Dr. Rummler determined that appellant's present emotional condition was not related to her December 16, 1992 left knee injury.

In a February 15, 2007 report, Dr. Ameer stated that appellant suffered from complex regional pain syndrome. He indicated that she was in remission and posited that the classic signs would not be seen due to ongoing treatment. There was no cure for this condition and appellant would need long-term treatment which was the standard of care for complex regional pain syndrome.

In a March 7, 2007 decision, the Office terminated appellant's compensation on the basis that she did not have any condition related to the December 16, 1992 employment injury. It relied on the reports of Dr. Smith, Dr. Wexler and Dr. Rummler. In a June 5, 2007 decision, an Office hearing representative reversed the termination, finding a conflict in the medical evidence between Dr. Smith and Dr. Wexler, on the one hand, and Dr. Ameer regarding whether appellant continued to have reflex sympathetic dystrophy.[4]

The Office referred appellant to Dr. Stephen Vanna, a Board-certified neurologist, for an impartial medical examination and opinion regarding whether he continued to have residuals of reflex sympathetic dystrophy. In a September 25, 2007 report, Dr. Vanna stated that he observed appellant walking with a limp towards the right side and lunging with her right leg. Cranial nerve examination revealed all functions to be intact and examination of motor systems revealed that she did not fully dorsiflex the right foot but was able to move it. Strength testing was

[4] The Office hearing representative also found that there was no conflict in the medical evidence regarding appellant's psychological condition. It was later determined that there was a conflict in the medical evidence between Dr. Doyle and Dr. Rummler regarding appellant's psychological condition and appellant was referred to Dr. Joseph Slap, a Board-certified psychiatrist, for an impartial medical examination. In October 1 and November 19, 2007 reports, Dr. Slap indicated that appellant continued to have a work-related chronic pain disorder. Appellant continued to receive Office compensation for his accepted emotional condition.

normal throughout and reflexes were 2+ in the arms and knees with diminished reflex in both ankles. Sensory examination showed normal pinprick, vibration and cold sense throughout. Appellant jumped when touched on the soles of the feet for sensory examination, but when testing for motor examination she tolerated fist pushing on both soles of the feet without any problem. Skin temperature was normal, there was no skin atrophy, dystrophy or change in hair distribution and toenails appeared normal. Dr. Vanna advised that his examination did not disclose any hallmark features of reflex sympathetic dystrophy or complex regional pain syndrome. Appellant did show some pitting edema in both lower extremities which might have been due to the fact that she tended to sit for long periods of time. Dr. Vanna diagnosed complex regional pain syndrome improved and also a functional overlay suggested by symptom magnification and anatomical protection and stated, "The above diagnostic impression would be related to her accident at work on December 16, 1992."

In a supplemental October 25, 2007 report, Dr. Vanna reviewed the February 15, 2007 report of Dr. Ameer. He stated that Dr. Ameer's report did not include any examination findings and simply attested to his opinion that appellant was previously diagnosed with chronic regional pain syndrome and still required treatment even though she now had no signs of it. Dr. Vanna stated:

> "I do not agree that the classic signs of reflex sympathetic dystrophy or chronic regional pain syndrome would not be seen due to ongoing treatment as stated by Dr. Ameer. There is no effective treatment for this condition and while some of the pain can be alleviated particularly in acute flare-ups, the chronicity of this particular condition does not respond to treatment of pain medicine and injection over long periods of time. At this time, I do not feel that she has any of the signs of chronic regional pain syndrome and as far as whether she had this condition or not, I have to go by the statement of accepted facts where the addendum states that she has reflex sympathetic dystrophy [in] both lower extremities due to work. That being said, I do not feel that she currently has this condition nor does she need treatment for it."

In a December 4, 2007 letter, the Office advised appellant that it proposed to terminate her compensation as she had no residuals of the December 16, 1992 employment injury and also informed her that it proposed to rescind its acceptance of her claim for reflex sympathetic dystrophy. It indicated that it was relying on the opinions of the impartial medical specialists, Dr. Vanna and Dr. Slap.[5]

Appellant, through her attorney, asserted that she continued to have residuals of her December 12, 1992 employment injury. In a December 6, 2007 report, Dr. Ameer diagnosed complex regional pain syndrome.

In a February 25, 2008 decision, the Office terminated appellant's medical benefits for the condition of reflex sympathetic dystrophy and found that the opinion of Dr. Vanna justified

[5] The Office indicated that there had been a conflict in the medical evidence between Dr. Smith and Dr. Wexler, on the one hand, and Dr. Ameer, regarding whether appellant had reflex sympathetic dystrophy and that this conflict necessitated the referral to Dr. Vanna.

this termination.[6] It terminated medical benefits for treatment of chronic pain disorder with psychological factors and determined that this termination was justified by the opinion of Dr. Slap, who served as an impartial medical specialist with respect to psychological matters. The Office also terminated medical benefits for appellant's left knee condition related to the December 16, 1992 work injury (left knee sprain and internal derangement of the left knee).

Appellant requested a review of the written record by an Office hearing representative.

In a May 25, 2008 decision, the Office hearing representative affirmed the Office's February 25, 2008 decision with respect to the termination of medical benefits for reflex sympathetic dystrophy, left knee sprain and internal derangement of the left knee. The hearing representative found, however, that the Office improperly terminated appellant's medical benefits with respect to the chronic pain disorder with psychological factors as Dr. Slap had found that appellant continued to have residuals of this condition.

LEGAL PRECEDENT

Under the Federal Employees' Compensation Act once the Office has accepted a claim it has the burden of justifying termination or modification of compensation benefits.[7] It may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[8] The Office's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[9]

Section 8123(a) of the Act provides in pertinent part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[10] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[11]

ANALYSIS

The Office accepted that on December 16, 1992 appellant sustained a left knee sprain with internal derangement after walking up a landing to deliver mail. On January 5, 1993 appellant underwent arthroscopic left knee surgery which was authorized by the Office. On

[6] The Office also suggested that it was rescinding its acceptance of appellant's claim for reflex sympathetic dystrophy, but it does not appear that the decision actually had the effect of rescinding this acceptance.

[7] *Charles E. Minniss*, 40 ECAB 708, 716 (1989); *Vivien L. Minor*, 37 ECAB 541, 546 (1986).

[8] *Id.*

[9] *See Del K. Rykert*, 40 ECAB 284, 295-96 (1988).

[10] 5 U.S.C. § 8123(a).

[11] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

September 6, 2000 the Office expanded appellant's claim to include reflex sympathetic dystrophy and paid her compensation for total wage loss retroactive to November 2, 1994. On August 11, 2004 it accepted that appellant sustained chronic pain disorder with psychological factors due to the December 16, 1992 injury.[12]

The Office based its termination of appellant's medical benefits related to reflex sympathetic dystrophy on the opinion of Dr. Vanna, a Board-certified neurologist who served as an impartial medical specialist. The Board notes that the Office properly determined that there was a conflict in the medical evidence regarding whether appellant continued to have reflex sympathetic dystrophy. The conflict existed between Dr. Wexler, a Board-certified neurologist, who served as an Office referral physician, and Dr. Ameer, an attending Board-certified anesthesiologist and specialist in pain medicine.[13] The Board properly referred appellant to Dr. Vanna for an impartial medical examination.

The Board finds that Dr. Vanna's October 1 and November 19, 2007 reports, which found that appellant no longer had any residuals of reflex sympathetic dystrophy, are entitled to the special weight accorded to rationalized opinions of impartial medical specialists.

Dr. Vanna provided an extensive discussion of appellant's medical history, including the reports of treating physicians, and of his own examination of appellant. He stated that cranial nerve examination revealed all functions to be intact,[14] strength testing was normal throughout and reflexes were 2+ in the arms and knees with diminished reflex in both ankles. Sensory examination showed normal pinprick, vibration and cold sense throughout. Dr. Vanna noted that appellant jumped when touched on the soles of the feet for sensory examination, but when testing for motor examination she tolerated fist pushing on both soles of the feet without any problem. Skin temperature was normal, there was no skin atrophy, dystrophy or change in hair distribution and toenails appeared normal.

Dr. Vanna concluded that appellant's reflex sympathetic dystrophy had resolved and also diagnosed the nonwork-related condition of functional overlay suggested by symptom magnification and anatomical protection. He provided medical rationale for this opinion by explaining that his examination did not disclose any hallmark features of reflex sympathetic dystrophy or complex regional pain syndrome.

On appeal counsel for appellant argued that Dr. Vanna's opinion was not based on a complete and accurate factual and medical history because he did not acknowledge that appellant ever had reflex sympathetic dystrophy. In an October 25, 2007 report, Dr. Vanna found that appellant had sustained reflex sympathetic dystrophy but that the condition was now resolved. Appellant's attorney also argued that Dr. Vanna did not provide adequate medical rationale for

[12] Appellant continues to receive compensation for this condition and this matter is not the subject of the present appeal.

[13] In a July 25, 2006 report, Dr. Wexler found that appellant did not have reflex sympathetic dystrophy or any related condition. In contrast, Dr. Ameer stated in several reports dated beginning in mid 2005 that appellant had reflex sympathetic dystrophy.

[14] Dr. Vanna noted that appellant did not fully dorsiflex the right foot but that she was able to move it.

his opinion because he did not consider that the symptoms of reflex sympathetic dystrophy can wax and wane. Dr. Vanna considered this circumstance by stating that he did not agree with Dr. Ameer that the classic signs of reflex sympathetic dystrophy or chronic regional pain syndrome would not be seen due to ongoing treatment. He noted, "There is no effective treatment for this condition and while some of the pain can be alleviated particularly in acute flare-ups, the chronicity of this particular condition does not respond to treatment of pain medicine and injection over long periods of time." Dr. Vanna further explained that appellant's recent medical history, as described in reports of attending physicians, did not contain any detailed description of physical findings representative of reflex sympathetic dystrophy. In addition to emphasizing that his examination did not show any signs of reflex sympathetic dystrophy, he suggested that appellant's current problems could be explained by the nonwork-related condition of functional overlay.[15]

The Board further finds that the Office also properly terminated medical benefits for appellant's left knee condition related to the December 16, 1992 employment injury -- left knee sprain and internal derangement of the left knee. To justify this termination, it correctly relied on the opinion of Dr. Smith, a Board-certified orthopedic surgeon who served as an Office referral physician. In a June 20, 2006 report, Dr. Smith stated that on physical examination appellant's lower extremities showed a normal appearance with no evidence of any change in skin color, mottling or cyanosis. He indicated that appellant did not exhibit any muscle or soft tissue atrophy in the lower extremities and that there was no joint stiffness in her knees, ankles or toes. Dr. Smith concluded that appellant did not have residuals of his December 16, 1992 work injury with respect to the orthopedic condition of her left knee. On appeal appellant's attorney argued that there was no rationalized medical opinion to support termination of medical benefits for appellant's left knee condition. However, Dr. Smith provided medical rationale for his opinion by explaining that appellant had an essentially normal physical examination of the lower extremities. He further explained that there was no sign of complications from the January 1993 surgery which included excision of a thickened medial plica.[16] The Board notes that the record does not contain any medical evidence showing that appellant continued to have residuals of the orthopedic conditions accepted due to the December 16, 1992 employment injury -- left knee sprain and internal derangement of the left knee.

For these reasons, the Office properly terminated appellant's medical benefits for reflex sympathetic dystrophy and left knee conditions accepted in connection with her December 16, 1992 employment injury.

CONCLUSION

The Board finds that the Office met its burden of proof to terminate appellant's medical benefits for reflex sympathetic dystrophy and left knee conditions accepted in connection with her December 16, 1992 employment injury.

[15] On appeal appellant's attorney also argued that Dr. Vanna did not adequately consider the reports of appellant's attending physicians. The Board notes that Dr. Vanna's reports contain an extensive discussion of the reports of appellant's attending physicians.

[16] Dr. Smith noted that no meniscus or ligament tear was found during the surgery.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' May 22, 2008 decision is affirmed.

Issued: March 16, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board