United States Department of Labor
Employees' Compensation Appeals Board

S.C., Appellant	)	
and	)	**Docket No. 10-1968**
	)	**Issued: June 10, 2011**
DEPARTMENT OF THE ARMY, U.S. ARMY AVIATION & MISSILE COMMAND, Redstone Arsenal, AL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On July 27, 2010 appellant timely appealed a June 22, 2010 merit decision of the Office of Workers' Compensation Programs terminating her compensation benefits. Pursuant to the Federal Employees' Compensation Act[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this claim.

ISSUE

The issue is whether the Office met its burden of proof to terminate appellant's medical and wage-loss compensation benefits effective November 22, 2009 on the grounds that she no longer had any residuals or disability causally related to her accepted employment-related injuries.

On appeal counsel for appellant contends that the Office's determination is contrary to fact and law.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On November 26, 1999 appellant, then a 52-year-old contract specialist, filed an occupational disease claim alleging that pain to her bilateral wrists, arms, shoulders and neck was due to typing, writing and the use of new computers, which required use of a mouse. She first realized her condition was caused or aggravated by her employment on November 20, 1997. Appellant stopped work on November 26, 1999 and did not return. The Office accepted the condition of bilateral reflex sympathetic dystrophy (RSD) of the arms and paid wage-loss benefits.

In a June 18, 2009 report, Dr. Weston Welker, a Board-certified family practitioner, noted that appellant had chronic pain syndrome with a combination of fibromyalgia and RSD for many years. On examination, appellant was unable to raise her arms above horizontal, secondary to shoulder pain. Multiple trigger points on her upper and lower back and her medial legs were noted with no motor or neurologic deficits. Dr. Welker provided an assessment of chronic pain syndrome with concomitant fibromyalgia and RSD, depression and frozen shoulders bilaterally. He opined that appellant was totally disabled.

To determine whether appellant continued to have residuals of her November 29, 1997 work injury and whether she was capable of working, the Office referred her together with the case record, a statement of accepted facts and a list of questions to Dr. Eston G. Norwood, III, a Board-certified neurologist, for a second opinion evaluation. In an August 6, 2009 report, Dr. Norwood reviewed the history of injury, medical records and statement of accepted facts. He reported normal examination findings. Dr. Norwood could not confirm the presence of RSD or complex regional pain syndrome (CRPS) type I as there were no objective clinical findings and her pain sensitivity and skin appeared normal. He explained that RSD and CRPS were poorly understood disorders which lacked protypical signs and symptoms or definite diagnostic findings. Dr. Norwood stated that generally one of the accepted criteria was the exclusion of other diagnoses. Because appellant had been diagnosed with fibromyalgia syndrome, he stated that this could account for much of her clinical syndrome. Dr. Norwood opined that, since there was no evidence of a work-related injury or other neurologic deficit not typical for her age, it was medically probable that the work-related injury had resolved. He stated that subjective complaints outweighed objective findings and there was no evidence of neurological deficit that was not typical for appellant's age. Dr. Norwood advised that she could return to her date-of-injury position, but noted that she might need restricted duty due to pain. He stated that pain was a subjective complaint and prophylactic reasons for the work restriction were not recognized. Dr. Norwood reiterated that he found no evidence of other conditions or residuals related to the accepted condition. A work capacity evaluation worksheet was completed.

By notice dated September 10, 2009, the Office proposed to terminate appellant's wage loss and medical benefits, finding that the weight of the medical evidence established that the accepted medical condition of bilateral RSD had ceased. It accorded determinative weight to the opinion of Dr. Norwood, the second opinion specialist.

In response to the proposed termination of benefits, appellant submitted a September 21, 2009 statement contending that Dr. Norwood's second opinion examination was incomplete. In an October 19, 2009 report, Dr. K. Dean Willis, a Board-certified pain management specialist,

advised that appellant had CRPS type I; bilateral upper extremity (right greater than left) status post injury; opioid dependence related to chronic pain; fibromyalgia related to chronic sleep disorder related to chronic pain; lumbar spondylosis with grade 1 spondylolisthesis of L5 on S1; and right median compression syndrome. He opined that the CRPS to both upper extremities was work related and was not medically resolved as it still resulted in significant physical limitations. Dr. Willis stated that appellant reached maximum medical improvement some time ago and that the functional capacity evaluation of October 13, 2009 served as appellant's current permanent physical limitations. The October 13, 2009 functional capacity evaluation indicated that appellant was capable of working eight hours a day at the sedentary work level with restrictions.

Emergency room records of visits of February 20 and 25, March 3 and April 12, 2009 were also submitted. Dr. Ric Koler, an osteopath and Board-certified family practitioner, saw appellant on February 20, March 3 and April 12, 2009. Dr. Russell Simpson, Board-certified in emergency medicine, treated appellant on February 25, 2009. Appellant was seen for complaints of pain in multiple sites, chest pain -- suspected cardiac, shoulder pain and complete arm pain. Diagnosis provided included: acute chest pain; chronic pain syndrome; chronic rib and shoulder pain and chronic regional pain syndrome. The musculoskeletal system was noted to be positive for pain and/or myalgias and the other systems were negative.

By decision dated November 2, 2009, the Office terminated appellant's wage-loss compensation and medical benefits for her accepted bilateral RSD condition effective November 22, 2009.

On November 11, 2009 appellant disagreed with the Office's decision and requested an oral hearing, which was held telephonically on March 22, 2010. She testified about her injury, symptoms and medical treatment provided. Appellant stated that her RSD was moving to different parts of her body and that she was being treated for RSD in the foot. She stated that, although the functional capacity evaluation stated that she could work eight hours sedentary, she was unable to do so because of the medications she was taking and because her pain prevented her from wearing suitable clothes for work. Appellant asserted that she could only tolerate working two hours at a time. Counsel argued that Dr. Norwood's report did not contain very convincing rationale and was somewhat inconsistent. He also noted that, while Dr. Norwood was authorized to perform additional tests, he chose not to do so. Furthermore, Dr. Norwood used no tools to measure appellant's movements.

Additional evidence included statements from appellant dated November 12, 2009 and January 4, 2010. In her November 12, 2009 statement, appellant stated that Dr. Norwood's examination was no more than 10 minutes and his only testing involved using a large old safety pin taken from his lab coat pocket for pin prick testing. She alleged that he refused to do any other testing and was very unprofessional.

In a November 19, 2009 report, Dr. Norwood stated that he performed a thorough neurologic physical examination and there was no need for further testing. He stated that he manually tested appellant's strength, tested her reflexes with a reflex hammer, noted her pulses by palpation and tested sensation by pinprick testing and light touch. Although appellant reported numbness, he stated there was no objective evidence of sensory loss.

In a March 17, 2010 report, Dr. George C. Morgan, Jr., a Board-certified neurologist, stated that appellant has a diagnosis of RSD and was being followed for allodynia, probable thoracic outlet syndrome (TOS) bilaterally and small fiber neuropathy. He advised that Dr. Willis treated appellant's RSD for several years and she was now being followed by Dr. David McLain, a Board-certified internist and rheumatologist. In a March 8, 2010 progress note, Dr. McLain listed appellant's diagnoses as fibromyalgia, scoliosis, osteoarthritis and lumbar degenerative disc disease.

Laboratory results from 2005 and 2009 noted positive musculoskeletal symptoms with pain and a negative review of other systems.[2] In a December 3, 2009 letter, the director of health information management of the hospital where appellant sought emergency care noted that the correct diagnosis for billing purposes should be RSD of the upper limb.

By decision dated June 22, 2010, an Office hearing representative affirmed the November 2, 2009 decision terminating compensation benefits. The hearing representative found, however, that after the termination a conflict of medical opinion evidence arose between Dr. Morgan and Dr. Norwood as to whether appellant still had RSD.

LEGAL PRECEDENT

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation benefits.[3] It may not terminate compensation without establishing that disability ceased or that it was no longer related to the employment.[4] The Office's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[5]

The right to medical benefits for an accepted condition is not limited to the period of entitlement to compensation for disability.[6] To terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition, which requires further medical treatment.[7]

ANALYSIS

The Office accepted appellant's claim for bilateral RSD. It terminated her compensation benefits effective November 22, 2009 on the grounds that the accepted work-related condition

[2] Appellant was seen by Dr. Koler on April 12, 2009 and Dr. Wayne Jones, a Board-certified family practitioner, on October 25, 2009.

[3] *Jorge E. Sotomayor*, 52 ECAB 105, 106 (2000).

[4] *Mary A. Lowe*, 52 ECAB 223, 224 (2001).

[5] *See Del K. Rykert*, 40 ECAB 284 (1988).

[6] *T.P.*, 58 ECAB 524 (2007).

[7] *I.J.*, 59 ECAB 408 (2008); *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

had resolved without residuals. The Office accorded determinative weight to the opinion of Dr. Norwood, the second opinion specialist.

The Board finds that the Office met its burden of proof in terminating appellant's wage-loss and medical benefits based on the August 6, 2009 report of Dr. Norwood who reviewed appellant's medical history, examined her and found no objective evidence of ongoing residuals or disability due to the accepted bilateral RSD condition. Dr. Norwood reviewed the statement of accepted facts and the medical record. He reported normal examination findings and found no objective evidence of the RSD condition or any evidence of other conditions or residuals related to the accepted condition. Dr. Norwood explained that RSD was a poorly understood disorder and that one of the accepted criteria was the exclusion of other diagnosis. As appellant was also diagnosed with fibromyalgia syndrome, he stated that this could account for her clinical syndrome. Dr. Norwood indicated that appellant could return to her date-of-injury position with restrictions due to pain that was prophylactic in nature.[8] He noted that he found no evidence of other conditions or residuals related to the accepted condition.

Dr. Welker opined that appellant had chronic pain syndrome from a combination of fibromyalgia and RSD and was totally disabled. However, he offered no objective findings consistent with a diagnosis or RSD. While Dr. Welker noted that appellant was not able to raise her arms above the horizontal secondary to shoulder pain, the Board generally has held that pain is not a specific diagnosis such as to support basis for payment of compensation.[9] He did not provide any further explanation of appellant's condition. Dr. Welker's diagnosis of chronic pain syndrome is not sufficient to meet appellant's burden of proof.

Dr. Willis opined that appellant suffered with work-related CRPS, type I, bilateral upper extremity (right greater than left) and that it was not medically resolved as it still resulted in significant physical limitations. However, the Office had not accepted the condition of CRPS.[10] Additionally, Dr. Willis failed to provide a rationalized opinion addressing how this condition was employment related. This lack of rationale greatly reduces the probative value of his opinion to the extent the condition affects appellant's bilateral upper extremities.[11]

The emergency room records from Drs. Koler and Simpson do not support that appellant had any continuing employment-related residuals or disability of her work injury. The physicians noted appellant's symptoms, diagnosis and treatment but they did not relate

[8] *Carlos A Marrero*, 50 ECAB 117 (1998); *Mary A. Geary*, 43 ECAB 300 (1991) (fear or possibility of further injury is not compensable).

[9] *Robert Broome*, 55 ECAB 339 (2004); *Thomas A. Faber*, 50 ECAB 566 (1999); *Samuel Senkow*, 50 ECAB 370 (1999).

[10] *See T.M.*, Docket No. 08-975 (issued February 6, 2009) (for conditions not accepted or approved by the Office as being due to an employment injury, the claimant bears the burden of proof to establish that the condition is causally related to the employment injury through the submission of rationalized medical evidence); *see also Jaja K. Asaramo*, 55 ECAB 200 (2004).

[11] *Deborah L. Beatty*, 54 ECAB 340 (2003).

appellant's diagnosed conditions to her employment.[12] While the director of health information management of the hospital stated that appellant's emergency room visits stemmed from RSD of the upper limb, the director's opinion is not probative on the medical issue of causal relationship and appears to relate to billing issues.[13]

The weight of the medical opinion is determined by the opportunity for and thoroughness of examination, the accuracy and completeness of physician's knowledge of the facts of the case, the medical history provided, the care of analysis manifested and the medical rationale expressed in support of stated conclusions.[14] Dr. Norwood discussed the history of injury and explained that there were no objective findings to support that appellant had any continuing employment-related residuals or disability. While appellant and her attorney contended that Dr. Norwood did not perform sufficient testing or examination, Dr. Norwood indicated that a thorough neurologic examination was performed and there was no need for further testing. He further stated there was no objective evidence of sensory loss despite appellant's reports of numbness. The Board finds that Dr. Norwood's opinion is sufficiently detailed, well rationalized and based upon a complete and accurate history and therefore represents the weight of the medical evidence at the time the Office terminated benefits. There is no opinion from appellant's attending physicians contemporaneous with the termination of benefits, which either opposes Dr. Norwood's opinion regarding RSD or supported that appellant had continuing residuals of her accepted condition. Accordingly, the Office met its burden of proof to terminate compensation.[15]

Counsel contends on appeal that the Office's decision is contrary to fact and law. However, for the reasons noted herein, the Office met its burden of proof to terminate compensation.

CONCLUSION

The Board finds that the Office properly terminated appellant's wage loss and medical benefits effective November 22, 2009.

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

[13] *See Gloria J. McPherson*, 51 ECAB 441 (2000) (lay individuals are not competent to render a medical opinion). *See* 5 U.S.C. § 8101(2).

[14] *See K.W.*, 59 ECAB 271 (2007); *Ann C. Leanza*, 48 ECAB 115 (1996).

[15] The Board notes that the issue of whether appellant had any continuing employment-related residuals or disability after November 22, 2009 is not in posture for decision as it is currently under development by the Office.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated June 22, 2010 is affirmed.

Issued: June 10, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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