

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of BARBARA A. WILBURN and NATIONAL ARCHIVES & RECORDS
ADMINISTRATION, FEDERAL RECORDS CENTER, Dayton, OH

*Docket No. 99-1209; Submitted on the Record;
Issued May 14, 2001*

DECISION and ORDER

Before DAVID S. GERSON, A. PETER KANJORSKI,
PRISCILLA ANNE SCHWAB

The issues are: (1) whether residuals of appellant's employment-related bilateral carpal tunnel syndrome (CTS) have ceased; and (2) whether appellant developed reflex sympathetic dystrophy (RSD) as a result of her accepted employment injury.

On September 23, 1993 appellant, then a 43-year-old archive aide, filed an occupational illness claim asserting that she developed bilateral CTS as a result of her federal employment. The Office of Workers' Compensation Programs accepted her claim for bilateral CTS and authorized surgical releases. She received compensation benefits.

On March 27, 1996 appellant's attending orthopedic surgeon, Dr. Ronald E. Hodges, diagnosed RSD and indicated that this condition was due to appellant's employment injury and totally disabled her for work. The Office advised Dr. Hodges that it had accepted appellant's claim for bilateral CTS, not RSD, and asked him to submit an opinion that appellant had RSD as a result of the accepted CTS. Dr. Hodges submitted several additional form reports, but on these forms he diagnosed CTS.

The Office referred appellant, together with medical records and a statement of accepted facts, to Dr. Arthur L. Hughes, a Board-certified neurologist, for a second opinion. In a report dated June 26, 1996, Dr. Hughes diagnosed bilateral hand pain and numbness. He discussed appellant's condition:

“[Appellant] developed complaints of bilateral hand pain and night paresthesias in 1993 and was suspected of having bilateral carpal tunnel syndrome by Dr. Hodges, but her examination at the time disclosed negative Tinel's signs, positive Phalen's signs, and her motor and sensory latencies were normal. Despite the negative findings, a left carpal tunnel release was carried out in March 1994 and a right carpal tunnel release in August 1994, without improvement. In March 1995 Dr. Hodges found no evidence of reflex sympathetic dystrophy and repeat electromyographic studies in May 1995 remained normal. Nonetheless, a bone scan in May 1995 raise[d] the question of reflex sympathetic dystrophy on the right, though the flow study was not consistent with reflex sympathetic

dystrophy, and [appellant] underwent a stellate ganglion block with some success, but a subsequent block was not helpful. On her functional capacity evaluation she not only failed to satisfy the validity criteria for hand tests but failed to satisfy validity criteria for other types of tests, even though those parts of the body were not involved. While in physical therapy, she claimed on two occasions that she did not feel she could improve.

“On my examination today, she demonstrated nonorganic weakness of the fingers. It was unclear to me whether this was due to conversion reaction or to malingering.

“Though the patient has insulin-dependent diabetes mellitus, I do not believe that this is playing a role in the production of any symptoms related to her hands. I have completed the appropriate forms.

“At this point, in view of the absence of any organic abnormalities and my strong suspicion that malingering may be a major factor, I find no reason why she cannot return to her former employment. I should make note at this point that the initial diagnosis of carpal tunnel syndrome was quite uncertain and there was no convincing evidence at any time that she had reflex sympathetic dystrophy, and she most certainly has no evidence of reflex sympathetic dystrophy at the present time.”

The Office sent a copy of Dr. Hughes’ report to Dr. Hodges and requested comment. Dr. Hodges responded with a form report indicating that appellant’s carpal tunnel syndrome totally disabled her for work.

The Office determined that a conflict in medical opinion existed between appellant’s attending physician, Dr. Hodges, and the second-opinion physician, Dr. Hughes. To resolve the conflict, the Office referred appellant, together with the medical record and a statement of accepted facts, to Dr. Joel Vandersluis, a Board-certified neurologist.

In a report dated February 19, 1997, Dr. Vandersluis related appellant’s history, complaints and medical treatment. After describing his findings on general and neurological examination, he reported his assessment:

“46-year-old woman with a three-year history of hand pain and dysfunction. Initial diagnosis of bilateral median mononeuropathy was supported only by limited findings on the examination without electrophysiologic evidence. The latter does not absolutely rule out carpal tunnel as the small unmyelinated nerve fibers which may be affected without EMG [electromyogram] change. As well, I note that the initial EMG did not include palmar stimulations which are said to be more sensitive for carpal tunnel syndrome. Still, the operative findings were minimal.

“Despite surgical release, she continued to complain of pain, and more significantly dysfunction. Bone scan was reported as demonstrating periarticular enhancement. This is not the pattern of reflex sympathetic dystrophy in which diffuse enhancement should be observed. Furthermore, in the absence of chronic pain, definite skin changes secondary to alterations in sympathetic innervation, a

clinical or laboratory diagnosis of reflex sympathetic dystrophy can not be supported. Thus, I would conclude that there is no evidence at this time for reflex sympathetic dystrophy.

“Examination today was without definite evidence of either neurologic or articular dysfunction. As her complaints at this time [are] that of hand dysfunction and I can find no definitive evidence of dysfunction or its cause, I recommend a return to work.”

On January 20, 1998 the Office issued a notice of proposed termination of compensation. In a decision dated March 5, 1998, the Office finalized the termination on the grounds that the weight of the medical evidence demonstrated that residuals and disability resulting from the accepted CTS and surgery had ceased and that RSD had not developed as a result of the accepted condition.

Appellant requested a hearing, which was held on October 29, 1998. She submitted a July 30, 1998 report from Dr. Peter S. Barre, a Board-certified orthopedic surgeon. Dr. Barre related appellant’s history and his findings on physical examination. He reported his impression and recommendations:

“Status post bilateral carpal tunnel syndrome. She has 0 pounds of strength with grip and 0 pounds of key pinch when we tested her today. I think she has some residuals from her sympathetic dystrophy that she had in the past.

“There is no surgical treatment that should be done for her and I told her husband that I do n[o]t think any type of surgical intervention would help her hand. Repeat electrodiagnostic studies to look for any muscular abnormality could be done, as it has been three years, according to the patient, since an electrodiagnostic study was performed. I told her I have nothing else to offer her and there is no surgical treatment. I think she just has to learn to live with her impaired function.”

In a decision dated December 17, 1998, the hearing representative affirmed the Office’s March 5, 1998 decision. The hearing representative found that the opinion of the impartial medical specialist, Dr. Vandersluis, represented the weight of the medical evidence and established that appellant did not have RSD or residuals of the accepted work injury.

The Board finds that the weight of the medical opinion evidence establishes that residuals of appellant’s employment-related bilateral CTS have ceased and that she did not develop RSD as a result of her accepted employment injury.

Once the Office accepts a claim it has the burden of proof to justify termination or modification of compensation benefits.¹ 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

¹ *Harold S. McGough*, 36 ECAB 332 (1984).

employment.² Because the Office accepted appellant's claim for bilateral CTS, it has the burden of proof to justify the termination of appellant's compensation.

A conflict in medical opinion arose between appellant's attending physician, Dr. Hodges, and the second-opinion physician, Dr. Hughes. Dr. Hodges reported that appellant was totally disabled by RSD. When the Office advised that RSD was not an accepted condition, he reported that appellant was totally disabled by CTS. Dr. Hughes reported that, given the absence of organic abnormalities and a strong suspicion that malingering might be a major factor, there was no reason appellant could not return to her former employment. He noted that there was no convincing evidence at any time that appellant had RSD and that she most certainly had no evidence of RSD currently.

Section 8123(a) of the Federal Employees' Compensation Act provides in 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."³

To resolve the conflict between Dr. Hodges and Dr. Hughes, the Office referred appellant to Dr. Vandersluis, a Board-certified neurologist. Dr. Vandersluis concluded that there was no evidence of RSD. He explained that a prior bone scan was reported as demonstrating periarticular enhancement. This was not the pattern of RSD, in which diffuse enhancement should be observed. Further, he explained that a clinical or laboratory diagnosis of RSD could not be supported absent chronic pain and definite skin changes secondary to alterations in sympathetic innervation. Dr. Vandersluis recommended that appellant return to work because her examination was without definite evidence of either neurologic or articular dysfunction.

When 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.⁴

The Board finds that the opinion of Dr. Vandersluis is entitled to special weight. With the medical record and a statement of accepted facts in hand, Dr. Vandersluis based his opinion on a proper factual and medical background. He found no evidence of neurologic or articular dysfunction and provided sound medical reasoning to support his opinion. The Board finds that the opinion of Dr. Vandersluis is sufficient to meet the Office's burden of proof to justify the termination of benefits for the accepted condition of bilateral CTS.

The opinion of Dr. Vandersluis finding no evidence of RSD is also sufficient to establish that appellant did not develop RSD as a result of her accepted employment injury. Because the

² *Vivien L. Minor*, 37 ECAB 541 (1986); *David Lee Dawley*, 30 ECAB 530 (1979); *Anna M. Blaine*, 26 ECAB 351 (1975).

³ 5 U.S.C. § 8123(a).

⁴ *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

Office did not accept RSD as an employment-related condition, appellant has the burden of proof to establish a causal connection between this condition and her employment.⁵

Dr. Barre stated that he thought appellant had some residuals from the RSD that she had in the past. He offered no medical reasoning, however, to support any neurological dysfunction, and he did not address the opinion offered by the impartial medical specialist.⁶ Further, Dr. Barre simply assumed the existence of RSD from the reports of Dr. Hodges.⁷ His opinion on RSD residuals is unexplained and uncertain;⁸ thus, it has diminished probative value and is insufficient to create a second conflict in medical opinion.⁹

The December 17, 1998 decision of the Office of Workers' Compensation Programs is affirmed.

Dated, Washington, DC
May 14, 2001

David S. Gerson
Member

A. Peter Kanjorski
Alternate Member

Priscilla Anne Schwab
Alternate Member

⁵ *John R. Knox*, 42 ECAB 193 (1990) (consequential injuries). See generally *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989); *John A. Ceresoli, Sr.*, 40 ECAB 305 (1988) (claimant's burden of proof).

⁶ The Board has held that medical conclusions unsupported by rationale are of little probative value. *Ceferino L. Gonzales*, 32 ECAB 1591 (1981); *George Randolph Taylor*, 6 ECAB 968 (1954).

⁷ Medical conclusions based on inaccurate or incomplete histories are also of little probative value. See *James A. Wyrick*, 31 ECAB 1805 (1980) (physician's report was entitled to little probative value because the history was both inaccurate and incomplete). See generally *Melvina Jackson*, 38 ECAB 443, 450 (1987) (addressing factors that bear on the probative value of medical opinions).

⁸ It is not necessary that the evidence be so conclusive as to suggest causal connection beyond all possible doubt in the mind of a medical scientist. The evidence required is only that necessary to convince the adjudicator that the conclusion drawn is rational, sound and logical. *Kenneth J. Deerman*, 34 ECAB 641, 645 (1983) and cases cited therein at note 1.

⁹ See *Dorothy Sidwell*, 41 ECAB 857 (1990); *Helga Risor (Windell A. Risor)*, 41 ECAB 939 (1990).