# United States Department of Labor
# Employees' Compensation Appeals Board

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| **M.L., Appellant** | ) | |
| **and** | ) | **Docket No. 09-2330** |
| | ) | **Issued: August 20, 2010** |
| **U.S. POSTAL SERVICE, POST OFFICE, Detroit, MI, 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, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

### *JURISDICTION*

On September 21, 2009 appellant filed a timely appeal from the August 28, 2009 merit decision of the Office of Workers' Compensation Programs concerning the termination of her compensation. 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 disability compensation and medical benefits related to her accepted physical conditions effective February 14, 2009 and whether it met its burden of proof to terminate her wage-loss compensation related to her accepted psychiatric condition effective February 14, 2009.

### *FACTUAL HISTORY*

On September 27, 1990 the Office accepted that appellant, then a 29-year-old mark-up clerk, sustained bilateral carpal tunnel syndrome due to her repetitive work duties. Appellant stopped work on July 1, 1990. The Office subsequently accepted left thoracic outlet syndrome and depression. Appellant received compensation and medical benefits from the Office.

On January 12, 1993 Dr. John H. McCullough, an attending family practitioner, stated that recent electromyogram (EMG) testing ruled out a diagnosis of carpal tunnel syndrome. On February 25, 1997 Dr. Choon Soo Rim, a Board-certified psychiatrist and neurologist serving as an Office referral physician, stated that he did not find that appellant had carpal tunnel syndrome or thoracic outlet syndrome. He advised that her neurological examination was normal and that her pain complaints were related to her depression.

Appellant received medical treatment for her physical condition from Dr. Nancy Desantis, an osteopath and Board-certified physical medicine and rehabilitation physician. On April 20, 2005 Dr. Desantis diagnosed left thoracic outlet syndrome and recommended muscle strengthening exercises.

On July 26, 2006 the Office referred appellant to Dr. Jeffrey Middledorf, an osteopath and Board-certified physical medicine and rehabilitation physician, to evaluate whether appellant continued to have bilateral carpal tunnel syndrome and left thoracic outlet syndrome. On July 26, 2006 Dr. Middledorf noted that appellant reported pain in her left anterior supraclavicular region and numbness down into the fourth and fifth fingers of her left arm. He indicated that appellant's examination was completely normal and that he saw no evidence of thoracic outlet syndrome. Dr. Middledorf posited that appellant could return to her regular work as a mark-up clerk. In an August 16, 2006 supplemental report, Dr. Middledorf indicated that he did not formally evaluate the condition of carpal tunnel syndrome and therefore could not provide an opinion regarding whether appellant continued to have that condition.

In July 2007 the Office requested that Dr. Middledorf provide additional evaluation of appellant's physical condition. In a July 18, 2007 report, Dr. Middledorf stated that appellant reported that she had pain in her left anterior shoulder and between both shoulders, but that she did not have symptoms in her hands or wrists. On examination appellant complained of tenderness when palpating the supraclavicular area on the left, but that Adson's maneuver was normal showing no interruption of the radial pulse and that Wright's hyper-abduction maneuver was also normal. Dr. Middledorf reported that appellant's wrists had full active range of motion on flexion, extension, radial and ulnar deviation. Phalen's test, reverse Phalen's test and carpal tunnel compression test were negative bilaterally and Tinel's test of the median nerve over the volar surface of each wrist was negative. Dr. Middledorf stated that thumb opposition strength was normal and that sensation was intact in both upper extremities both distally and proximally. He noted that appellant had negative electrodiagnostic testing for carpal tunnel syndrome and that her clinical examination was negative for this condition. Dr. Middledorf found no evidence of carpal tunnel syndrome on either side.

With regard to the proximal left upper extremity, Dr. Middledorf was unable to find any clinical evidence of a thoracic outlet syndrome. He noted that appellant had an upper extremity arterial examination 15 years prior that showed moderate thoracic outlet vascular compression during the military maneuver and hyper abduction which caused diminished but not obliterated flows. Dr. Middledorf had no knowledge that this result had ever been repeated and noted, "Given the lack of pulsation change in the positions achieved today, I am unable to verify the presence of a vascular thoracic outlet syndrome and there is no clinical evidence of a neurogenic thoracic outlet syndrome." He found that appellant could return to her prior clerk work at the employing establishment without restrictions.

On February 27, 2008 Clifford F. Furgison, Ph.D., a clinical psychologist serving as an Office referral physician, stated that the results of appellant's personality assessment inventory testing were inconsistent when compared to the clinical population of individuals with a major depressive disorder. Borderline elevation was noted for depression that would be considered dysthymic but no other scale elevated within the pathological range. Dr. Furgison stated that there was no objective evidence to support the diagnosis of active major depression and diagnosed major depressive disorder in remission. He stated:

> "Based on this examination, I find no clinical evidence to suggest a disability relative to a major depressive disorder. It is my impression that she has been successfully managed psychiatrically resulting in this finding. She will require ongoing psychiatric support to maintain her stabilization. Assuming that she continues to remain stable, I see no reason that she would not be able to return to active employment in her date[-]of[-]injury position at this time without restriction. This is from a psychological standpoint, not medical."

In a May 18, 2008 report, Dr. Kai Anderson, an attending Board-certified psychiatrist, stated that appellant had been unable to work since 1990 due to her depressive symptoms which were secondary to chronic pain from thoracic outlet syndrome. During her treatment, appellant had experienced partial remission of her depressive symptoms with aggressive pharmacological management but continued to experience physical limitations which impaired her ability to clean her house, drive her children to activities, or lie down, sit or stand for sustained periods. Dr. Anderson stated that appellant was easily overwhelmed by additional stressors and was not currently in remission from a psychological standpoint. She had recently experienced an increase in her depressive symptoms, manifested by generalized anxiety, increased disruption of her sleep, depressed mood and feelings of hopelessness. Dr. Anderson concluded that appellant was not able to return to her prior occupation due to her depressive symptoms and chronic pain.

The Office found a conflict in medical opinion between Dr. Furgison and Dr. Anderson regarding whether appellant continued to have disability due to the accepted depression condition. In order to resolve the conflict, it referred her, pursuant to section 8123(a) of the Act, to Dr. Michael J. Freedman, a Board-certified psychiatrist, for an impartial medical examination and an opinion on the matter.

On November 24, 2008 Dr. Freedman stated that during his evaluation appellant appeared to be pleasant and cooperative and spoke in a normal tone of voice. Appellant's motor activity appeared to be basically normal and, for the most part, she sat in a relaxed manner during the evaluation. Dr. Freedman stated that on the formal mental status examination appellant performed in a manner consistent with the rest of the evaluation and well within normal limits, if not somewhat above average. Appellant advised that about once a week she had nightmares about bad things happening to her. Dr. Freedman noted that appellant's presentation would be consistent with an individual who had an underlying component of depression. Appellant's depression appeared to be related to her complaints of ongoing pain in her back and left shoulder and her presentation and history were consistent with a long-standing component of depression related to her physical complaints. Dr. Freedman noted that whether an individual would place appellant into a category of a dysthymic disorder, indicating a depression known for its chronicity as opposed to its severity, or into the category of a major depressive disorder was not the issue. If given the diagnosis of a major depressive disorder, one would have to consider the condition to be in at least partial remission. Dr. Freedman stated that appellant had two

children since her disability started in 1990 and that she appeared to function on a day-to-day basis, including driving a motor vehicle. He stated:

> "It is my understanding I was being asked to render an opinion, from a psychiatric standpoint only, as to whether or not [appellant] is capable of employment. The determination of ability versus disability is an issue that is separate from a diagnostic label and separate from whether or not somebody wants to or does not want to work within a particular job setting. It is related to an assessment of mental status and mental capacity. There was nothing during the time I spent with [appellant] that indicated her overall mental status was not intact. Her memory, recall, concentration and thought organization were all well within normal limits. It is on those factors which I base my conclusion that she has the mental capacity to be employed at any job for which she might otherwise be qualified.
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> "The records appear to indicate that [appellant's] depression became more severe after she had been evaluated by Dr. Furgison, who felt that she could return to work. I do not doubt that is the case. [Appellant] has been on disability for 18 years and has been receiving benefits during that period of time. She has been able to stay at home and be with her family during all of that time. I do not doubt that she would be less than pleased when informed that she should be returning to work."

In an April 23, 2008 letter, the Office advised appellant that it proposed to terminate her wage-loss compensation and medical benefits related to her accepted physical injuries and to terminate her wage-loss compensation related to her accepted psychiatric condition. It notified her that the termination of the accepted physical conditions was justified by the opinion of Dr. Middledorf and that the termination of the psychiatric condition was justified by the opinion of Dr. Freedman. The Office provided appellant 30 days to submit evidence and argument contesting the proposed action.

Appellant requested a hearing before an Office hearing representative. At the June 10, 2009 hearing, appellant's attorney indicated that he did not disagree with the Office's February 4, 2009 decision but wanted a clarification that appellant continued to be entitled to medical benefits for her depression.

In an August 28, 2009 decision, the Office hearing representative affirmed the February 4, 2009 decision, noting that appellant remained entitled to medical benefits for her depression.

## ***LEGAL PRECEDENT***

Under the Federal Employees' Compensation Act,[1] once the Office has accepted a claim it has the burden of justifying termination or modification of compensation benefits.[2] The Office may not terminate compensation without establishing that the disability ceased or that it was no

[1] 5 U.S.C. §§ 8101-8193.

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

longer related to the employment.[3] Its burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[4]

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."[5] 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.[6]

## ***ANALYSIS***

The Office accepted that appellant sustained bilateral carpal tunnel syndrome, left thoracic outlet syndrome and depression related to work-related physical conditions. The Board first finds that the Office properly terminated appellant's disability compensation and medical benefits related to her accepted physical conditions effective February 14, 2009.

The Office properly relied on the opinion of Dr. Middledorf, an osteopath and Board-certified physical medicine and rehabilitation physician, to find that appellant had no residuals of her accepted physical conditions after February 14, 2009.

In a July 18, 2007 report, Dr. Middledorf addressed examination of appellant and noted that Adson's maneuver was normal showing no interruption of the radial pulse and that Wright's hyper-abduction maneuver was also normal. He advised that Phalen's test, reverse Phalen's test and carpal tunnel compression test were negative bilaterally and Tinel's test of the median nerve over the volar surface of each wrist was negative. Dr. Middledorf stated that negative results on electrodiagnostic testing and clinical examination for carpal tunnel syndrome showed that appellant did not have this condition in either arm. With regard to the proximal left upper extremity, he was unable to find any clinical evidence of a thoracic outlet syndrome. Dr. Middledorf indicated that appellant had an upper extremity arterial examination 15 years prior that showed moderate thoracic outlet vascular compression, but that no test since that time had shown the same result. Dr. Middledorf found that appellant could return to her regular work with the employing establishment without restrictions.

The Board has carefully reviewed the opinion of Dr. Middledorf opinion and notes that it has reliability, probative value and convincing quality with respect to its conclusions regarding the relevant issue of the present case. Dr. Middledorf's opinion was based on a proper factual and medical history and accurately summarized the relevant medical evidence.[7] He provided medical rationale for his opinion by explaining that the findings upon diagnostic testing and

[3] *Id.*

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

[5] 5 U.S.C. § 8123(a).

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

[7] *See Melvina Jackson*, 38 ECAB 443, 449-50 (1987); *Naomi Lilly*, 10 ECAB 560, 573 (1957).

clinical examination showed that appellant no longer had bilateral carpal tunnel syndrome or left thoracic outlet testing. He described how the performance of specific tests showed that appellant did not have these conditions.

The Board further finds that the Office met its burden of proof to terminate appellant's wage-loss compensation related to her accepted psychiatric condition effective February 14, 2009.

The Office properly determined that there was a conflict in the medical opinion between Dr. Anderson, an attending Board-certified psychiatrist, and Dr. Furgison, a clinical psychologist acting as an Office referral physician, regarding whether appellant continued to have disability due to the accepted depression condition.[8] In order to resolve the conflict, the Office properly referred appellant, pursuant to section 8123(a) of the Act, to Dr. Freedman, a Board-certified psychiatrist, for an impartial medical examination and an opinion on the matter.[9]

On November 24, 2008 Dr. Freedman stated that during his evaluation appellant appeared to be pleasant and cooperative and she spoke in a normal tone of voice. He noted that on the formal mental status examination appellant performed in a manner consistent with the rest of the evaluation and well within normal limits, if not somewhat above average. Dr. Freedman posited that appellant's presentation would be consistent with an individual who had an underlying component of depression. Appellant's depression appeared to be related to her complaints of ongoing pain in her back and left shoulder and her presentation and history were consistent with a long-standing component of depression related to her physical complaints. Dr. Freedman indicated that appellant's condition could be characterized as a dysthymic disorder or a major depressive disorder in remission and posited that she could perform her regular work for the employing establishment.

The Board finds that the weight of the medical evidence is represented by the thorough, well-rationalized opinion of Dr. Freedman, the impartial medical specialist selected to resolve the conflict in the medical opinion regarding appellant's psychiatric disability.[10] The November 24, 2008 report of Dr. Freedman establishes that appellant had no disability due to her accepted depression condition after February 14, 2009.

Dr. Freedman's opinion was based on a proper factual and medical history and accurately summarized the relevant medical evidence.[11] It is sufficiently well rationalized to be given special weight regarding whether appellant continued to have disability due to her accepted depression condition. Dr. Freedman provided medical rationale for his opinion by explaining that, although appellant continued to have a work-related psychiatric condition, it was not severe

[8] The Office determined that both physicians indicated that appellant still required medical treatment for depression and later noted that it was not terminating appellant's medical benefits for such treatment.

[9] *See supra* note 5 and accompanying text.

[10] *See supra* note 6 and accompanying text. On February 27, 2008 Dr. Furgison, a clinical psychologist serving as an Office referral physician, diagnosed major depressive disorder in remission and indicated that appellant could perform her regular work for the employing establishment. In contrast, Dr. Kai Anderson found on May 18, 2008 that appellant was not able to return to her prior occupation due to her work-related depression.

[11] *See supra* note 7.

enough to prevent her from performing her regular work for the employing establishment. He stated that appellant had two children since her disability started in 1990 and that she appeared to function on a day-to-day basis, including driving a motor vehicle. Dr. Freedman further explained that appellant's memory, recall, concentration and thought organization were all well within normal limits.

## ***CONCLUSION***

The Board finds that the Office met its burden of proof to terminate appellant's wage-loss compensation and medical benefits related to her accepted physical conditions effective February 14, 2009 and met its burden of proof to terminate her wage-loss compensation related to her accepted psychiatric condition effective February 14, 2009.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the August 28, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 20, 2010
Washington, DC

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

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board