

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of CYNTHIA WILBURN and U.S. POSTAL SERVICE,
POST OFFICE, Philadelphia, PA

*Docket No. 03-1226; Submitted on the Record;
Issued January 26, 2004*

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether appellant met her burden of proof to establish that she had any disability on or after June 14, 1999 causally related to her employment injury.

This case was previously on appeal before the Board.¹ In an April 22, 2002 decision, the Board noted that appellant had filed a timely traumatic injury claim which was accepted for left ankle and foot sprain. The Board found that the opinion of the impartial medical specialist, Dr. I. Howard Levin, a Board-certified neurologist, was properly accorded the special weight of the medical evidence and affirmed the Office's June 14, 1999 decision terminating appellant's compensation on the grounds that her injury-related disability had ceased.² The law and facts as set forth in this decision are herein incorporated by reference.

Subsequent to the Board's April 22, 2002 decision, appellant's representative requested reconsideration by letter dated June 7, 2002. In support of his request, he repeated his earlier arguments that Dr. Levin's report showed that appellant developed a consequential somatoform condition resulting in a "perception of impairment" that was a consequence of the work injury. Additionally, he provided a February 8, 2002 report from Dr. Clancy D. McKenzie, a Board-certified psychiatrist.

In his February 8, 2002 report, Dr. McKenzie stated that he was concerned about the severe depression and suicidal potential in appellant. He indicated that appellant was treated for work injuries in 1995, "until a workers' compensation doctor saw her for what she reports to be five minutes and according to her wrote that there is no disability and furthermore it is not

¹ Docket No. 01-1424 (issued April 22, 2002).

² Dr. Levin was selected to resolve a conflict between appellant's physician, Dr. Robert Knobler, a Board-certified neurologist, who opined that appellant was totally disabled from performing her regular duties, and the second opinion physician, Dr. Steven J. Valentino, an osteopath, who indicated the objective findings were normal and that the effects of her work injury had ceased, and that she had no evidence of any ongoing disability.

related to the work injury.” Dr. McKenzie noted that appellant continued to be “inflicted by pain” and inability to function resulting in a major depression that was chronic and permanently debilitating.

By decision dated August 22, 2002, the Office denied modification of the prior decision. By letter dated January 10, 2003, appellant’s representative again requested reconsideration. In support of his request, he provided a January 10, 2003 report from Dr. Knobler.

In his January 10, 2003 report, Dr. Knobler advised that appellant continued to suffer from chronic pain disorder and reflex sympathetic disorder. He disagreed with the conclusions reached by Dr. Levin, opining that Dr. Levin did not recognize the well-established fact, heavily supported in the medical literature, that “a simple ankle sprain” could give rise to reflex sympathetic disorder. Dr. Knobler explained that reflex sympathetic disorder could remain present for years, and even spread to other portions of the body. He also disagreed with the history reported by Dr. Levin and his examination findings that no abnormalities were noted. He noted that a magnetic resonance imaging (MRI) scan of September 25, 2000 revealed “very mild muscle atrophy predominantly involving the distal musculature of the left calf,” which he opined was nonspecific and might represent chronic disuse or findings of Stage III reflex sympathetic disorder. He advised that atrophy from disuse was not a likely prospect since appellant had been using her left leg throughout and hurt her left brachial plexus leaning on a cane on the left side while walking on the left leg and noted that none of these latter details appeared in the report of Dr. Levin, who indicated that persistent abnormalities of the left foot/ankle included that the temperature of the left foot was consistently cooler to touch and there was swelling noted by comparing the markings her stockings left on her ankles and that there was less mobility of the toes on the affected left foot. He indicated that pain on the left foot fluctuated between 7-8/10 most of the time, but could be even more severe, “yet Dr. Levin reported no abnormalities could be detected on his examination.”

In addition to the leg difficulties, Dr. Knobler indicated that appellant developed a neurogenic bladder secondary to the reflex sympathetic disorder, with urinary urgency and frequency. He noted that appellant had also developed frontal, left-sided headaches, a problem consistent with thoracic outlet syndrome, which resulted from cane use traumatizing the left brachial plexus. Dr. Knobler noted that Dr. Levin did not report that he examined the area of the brachial plexus but suggested “thoracic outlet syndrome from her cane was absurd.” Dr. Knobler further disagreed with Dr. Levin in that he found several objective features of reflex sympathetic disorder such as increased vein markings on the left foot, decreased temperature of the toes on the left side, decreased movement of the left toes, shininess of the skin on the left, allodynia (irritation of her skin by her knee high stockings), deeper coloring and puffiness of the left foot, more prominent hair follicles on the left foot and that appellant’s nails had vertical ridging and were brittle. Dr. Knobler explained that another manifestation of the thoracic outlet syndrome affecting the left upper extremity and neck from cane use was the development of chest pain on the left. He opined that, within a reasonable degree of medical certainty, there continued to be highly credible evidence for ongoing disability due to the chronic pain disorder, complex regional pain syndrome and reflex sympathetic dystrophy, which were initiated by the work. Dr. Knobler repeated his opinion that Dr. Levin was wrong in his opinion that reflex sympathetic disorder could not come from a simple ankle sprain, noting that he did not

acknowledge the persistent complaints and impairment associated with appellant's reflex sympathetic disorder as detailed above, including the bladder dysfunction and depression. He concluded that there was a lack of objective evidence to show that she was still suffering from reflex sympathetic disorder.

By decision dated April 11, 2003, the Office again denied modification of the June 14, 1999 decision on the grounds that the evidence submitted was insufficient.

The Board finds that appellant has failed to meet her burden of proof in establishing any continuing disability on or after June 14, 1999.

As the Office met its burden of proof to terminate appellant's compensation, the burden shifted to appellant to establish that she had further disability or medical residuals causally related to her accepted employment injury.³ To establish a causal relationship between the condition, as well as any disability claimed, and the employment injury, the employee must submit rationalized medical opinion evidence, based on a complete factual background, supporting such a causal relationship. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant. The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.⁴

Following the April 22, 2002 decision of the Board, appellant submitted additional medical evidence including a report from Dr. Knobler, dated January 6, 2003. In his report, he essentially repeated his previous findings and indicated that he disagreed with Dr. Levin's report. He reiterated his opinion that an ankle sprain could result in reflex sympathetic disorder and that appellant had developed a neurogenic bladder secondary to reflex sympathetic disorder, and frontal to left-sided headaches consistent with thoracic outlet syndrome, which he opined developed from appellant's cane use and were related to the employment injury. He also alleged that Dr. Levin did not put any of these details in his report. The Board has held that, where the attending physician was on one side of the conflict in the medical opinion which was resolved by the impartial specialist, additional reports of the attending physician are insufficient to overcome the weight of the impartial medical specialist or to create a new conflict in the medical opinion unless the additional reports contain new, relevant information.⁵ In this case, Dr. Knobler's report dated January 6, 2003 did not contain new, relevant information or a well-rationalized medical opinion based on new information.⁶ Although he indicated that he disagreed with

³ *George Servetas*, 43 ECAB 424, 430 (1992).

⁴ *James Mack*, 43 ECAB 321 (1991).

⁵ *See Dorothy Sidwell*, 41 ECAB 857, 874 (1990).

⁶ His previous report were comprised of unsigned treatment notes dated July 20 and October 28, 1999 and

Dr. Levin's opinion, and alleged that he did not include details, these allegations are incorrect as the report of Dr. Levin was deemed to be well rationalized and addressed the areas noted by Dr. Knobler. The report of Dr. Knobler was therefore insufficient to create a new conflict.

Appellant also submitted a February 8, 2002 report in which Dr. McKenzie, a psychiatrist, stated that he was concerned about the severe depression and suicidal potential in appellant. However, the only conditions accepted by the Office were sprain of the left foot and ankle and Dr. McKenzie's report contained no specific diagnosis, no rationalized opinion on continuing disability or an opinion causally relating appellant's depression to her accepted foot/ankle employment injury. His report is therefore insufficient to meet appellant's burden.⁷

Consequently, appellant has not established that her condition on and after June 14, 1999 was causally related to her employment injury.

The April 11, 2003 and August 22, 2002 decisions of the Office of Workers' Compensation Programs are hereby affirmed.

Dated, Washington, DC
January 26, 2004

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member

April 27, 2000 wherein he indicated that he was treating appellant on February 12, 1998 for a work-related injury to her left foot and ankle, sustained on March 2, 1995. In his previous reports, he stated that this led to reflex sympathetic disorder and that appellant had persistent pain, swelling and atrophy as manifestations of the injury that persisted and that appellant was totally disabled from performing her regular duties in her former or any related-type job as a direct result of the injury, due to her level of pain, her inability to stand, walk or sit for prolonged periods of time. Dr. Knobler also stated that appellant could only perform in a light-duty capacity and that her restrictions were permanent in nature.

⁷ Gary J. Watling, 52 ECAB 278 (2001).