



On appeal, appellant's attorney asserts that the statement of accepted facts was deficient because it did not describe her job duties and that the opinion of the impartial referee physician is not entitled to special weight. Counsel contends that the medical evidence is sufficient to establish that appellant has residuals of the employment injury and consequential conditions.

### **FACTUAL HISTORY**

On May 30, 2003 the Office accepted that appellant, then a 43-year-old mail processor, sustained tendinitis, tenosynovitis and a ganglion of the left wrist.<sup>2</sup> Appellant began modified duty. On December 5, 2005 Dr. Victor R. Frankel, a Board-certified orthopedic surgeon, performed ganglion cyst excision of the left wrist. Appellant was placed on the periodic rolls. She returned to modified duty on February 10, 2006.

In a February 2, 2007 report, Dr. Robert M. Dalsey, Board-certified in orthopedic and hand surgery, noted appellant's complaint of left upper extremity pain. On physical examination, appellant had complaints and physical findings to suggest and recommended further studies. February 15, 2007 left hand and wrist x-rays were reported as normal. A bone scan that day noted slight increased uptake in the radial aspect of the proximal left wrist with no additional findings. In a March 5, 2007 report, Dr. Dalsey reviewed the diagnostic results and advised that they did not suggest CRPS. He diagnosed possible recurrent de Quervain's tendinitis, possible CRPS and failed ganglion cyst excision. A March 10, 2007 magnetic resonance imaging scan of the left upper extremity demonstrated de Quervain's tenosynovitis, a ganglion cyst and effusion of the distal radial ulnar joint with a possible partial tear of the triangular fibrocartilage. In a March 23, 2007 report, Dr. Morris E. Antebi, Board-certified in anesthesiology and pain medicine, noted appellant's complaint of constant sharp and shooting pain in her left hand and wrist that radiated up her left forearm. Dr. Dalsey submitted additional reports, reiterating the possibility of CRPS or fibromyalgia.

On April 10, 2007 appellant filed a recurrence of disability claim and stopped work on April 16, 2007. On April 17, 2007 Dr. Dalsey performed resection of a ganglion cyst of the left wrist with radial nerve exploration and neurolysis and resection of a small end-branch of the radial nerve and first dorsal compartment release. On April 20, 2007 he noted that appellant was doing well following surgery. Dr. Dalsey advised that her radiating arm pain was unrelated to her tendinitis and ganglion cyst and needed separate evaluation and treatment. Appellant's proximal aches and pains could also be related to separate cervical disease or a primary shoulder problem.

On May 11, 2007 the Office placed appellant on the periodic rolls in receipt of compensation for total disability.

On June 19, 2007 the Office referred appellant to Dr. Edward Spellman, a Board-certified neurologist, for a second opinion evaluation. In a July 19, 2007 report, Dr. Spellman noted his review of the statement of accepted facts and medical record and her complaints of left upper extremity pain, decreased sensation and tingling. He provided findings on physical examination

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<sup>2</sup> The accepted conditions have also been identified as enthesopathy of left wrist and carpus, left radial styloid tenosynovitis and left ganglion of joint.

including decreased range of motion of the left shoulder and wrist with complaints of pain and tenderness over the entire left upper extremity. Dr. Spellman diagnosed left arm, hand and wrist pain and numbness and advised that there was no objective neurologic injury and no objective sign of cervical radiculopathy, brachial plexopathy, peripheral nerve entrapment or RSD, noting that appellant's complaints could be related to orthopedic problems or from failed ganglion cyst surgeries. He opined that she needed no further physical therapy and recommended referral to an orthopedic specialist and pain control and management. Dr. Spellman stated that, because of her pain complaints, appellant could not perform the full duties of a mail processor and, at the most, could perform sedentary work with little use of the left arm. He concluded that her continued disability was related to her employment injury.

Dr. Dalsey submitted reports addressing appellant's continued complaints of diffuse pain from the hand into the shoulder. He additionally diagnosed mild adhesive capsulitis of the shoulder and advised that she was restricted in the use of the left arm. On August 2, 2007 Dr. Dalsey advised that Tinel's test was negative with no hypersensitivity and no signs of recurrent ganglion or recurrent tendinitis, with a great deal of possible psychological overlay to her pain. He recommended counseling for chronic pain management to rule out possibly varying CRPS.<sup>3</sup>

In an August 6, 2007 work capacity evaluation, Dr. Spellman advised that appellant could not return to her usual job due to severe, constant left arm and wrist pain but could work three to four hours a day with restrictions to her left upper extremity including a five-pound weight restriction.

In August 2007, the Office referred appellant to Dr. Zohar Stark, Board-certified in orthopedic surgery, for a second opinion evaluation.

In a September 18, 2007 report, Dr. Stark noted the history of injury, a review of the medical records and appellant's complaint of pain in her left upper extremity from her shoulder to the tip of her finger. On physical examination, there was left upper extremity tenderness on palpation over every point of the extremity. Dr. Stark noted that appellant would not perform any motion with her left shoulder and would not let him perform passive motion, complaining that it was too painful. Appellant held her left elbow in a fully extended position and would not flex, pronate or supinate the forearm but elbow examination revealed no local tenderness. Examination of her left wrist revealed a well-healed scar over the dorso-lateral aspect with tenderness to palpation over every point of her wrist and hand. Dr. Stark stated that appellant would not actively move or let him passively move her wrist and advised that there appeared to be a reduced sensation to pinprick to all dermatomes of the left upper extremity with equal deep tendon reflexes bilaterally. Tinel's test was negative for entrapment of the median or ulnar nerves at the wrists and at the ulnar nerves at the elbows. Dr. Stark noted that appellant was not cooperative in assessing motion of the left upper extremity. After examining her and reviewing the medical records, he found no objective findings of the accepted conditions. Dr. Stark advised that the accepted conditions had resolved and that no further medical treatment was necessary. He stated that she was malingering and could return to her regular duties as a mail processor. In

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<sup>3</sup> Dr. Dalsey referred appellant for diagnostic studies. A September 21, 2007 three-phase bone scan of both wrists was reported as normal.

an attached work capacity evaluation, Dr. Stark advised that maximum medical improvement had been reached and that appellant was fully capable of performing her regular job.

In a September 28, 2007 report, Dr. Donald B. Barone, an osteopath, noted that motor examination demonstrated limited motor activity in the left fingers, wrist and hand. He advised that the weakness appeared to be more pain related and that it was difficult to assess whether there was a true muscle weakness. Dr. Barone suspected that appellant had CRPS/RSD and possibly sensory radial neuropathy in the left forearm and hand and possible brachial plexopathy underlying peripheral neuropathy and cervical radiculopathy. Diagnostic testing of October 16, 2007 demonstrated very mild left carpal tunnel syndrome.<sup>4</sup>

On October 19, 2007 appellant began therapy with Nicholas J. Mazzagatti, Ph.D., a licensed clinical psychologist, who noted the history of injury, medical treatment and her complaint that she could not function as she did prior to the injury. Dr. Mazzagatti diagnosed generalized anxiety disorder, pain disorder associated with both psychological factors and a general medical condition that were employment related. In reports dated October 8 and November 26, 2007, Dr. Dalsey advised that it was his clinical impression that appellant did not have a CRPS and that there could be a component of symptom magnification as noted by the occupational therapist during testing and the variable evaluations in his office. He recommended evaluation by another hand surgeon.

The Office found that a conflict in medical opinion between Dr. Dalsey and Dr. Stark regarding whether appellant continued to have residuals and disability due to her accepted conditions. On January 3, 2008 it referred her to Dr. Roy B. Friedenthal, a Board-certified orthopedic surgeon, for an impartial medical evaluation.

Dr. Russell Ferstandig, a Board-certified psychiatrist, treated appellant on January 21, 2008 and noted that she appeared to be nearly catatonic and noted worsening symptomatology since 2003. He found no gross evidence of psychosis, diagnosed major depressive disorder secondary to injuries of the left upper extremity and provided medication therapy.

In a February 6, 2008 report, Dr. Friedenthal noted that appellant presented with a flat affect and was very slow to respond both physically and verbally but understood his questions and instructions. He reviewed the medical treatment records and statements of accepted facts. Dr. Friedenthal listed the employment injury and appellant's work history and noted her complaint of constant pain in the left arm extending from the fingertips to the shoulder with a constant cold, numb and tingling feeling involving the entire arm and hand. Appellant reported that she did not use her left arm for any activities and had substituted her right arm for virtually all activities. She moved the left shoulder slowly, complaining of pain down the entire arm into the wrist, hand and fingers and that she appeared to be in severe distress. Dr. Friedenthal found no crepitus on shoulder motion or evidence of impingement. Rotator cuff testing showed intact function with give-way weakness in all planes and no measured upper arm atrophy with both upper arms measuring 12½ inches in circumference. Full range of elbow motion was achieved

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<sup>4</sup> In reports dated August 3 and 31, September 28, October 26 and November 23, 2007, Alice Jones, a pain management nurse practitioner, advised that appellant was seen for left wrist pain. She provided physical examination findings, noting that there were no signs consistent with CRPS and diagnosed neuropathic pain.

slowly with no evidence of crepitus, joint effusion, soft tissue swelling or induration and pain on all motions on the left. There was no measured forearm atrophy with forearm girth equaling 10 inches bilaterally. The wrists showed no deformity with a well-healed transverse dorsal scar on the left wrist. There was no soft tissue swelling, warmth, erythema, crepitus, joint effusion or soft tissue induration. Active range of motion of the wrist was severely limited and passive full range of motion was gently achieved without crepitus. Tendon functions were intact with strength actively limited in all planes. Finkelstein testing was not performed on the left because of complaints of pain. There was no evidence of de Quervain's syndrome and no effusion in the first dorsal compartment. No ganglion cyst was palpable in any area and radial and ulnar deviations and small joint motions were intact without crepitus.

Dr. Friedenthal stated that appellant actively moved the left hand extremely slowly, reporting diffuse pain in the entire arm and found no evidence of tendon sheath stenosis into the hand, no thenar or intrinsic muscle atrophy, no inflammatory changes into the fingers and no dystrophic changes of the hands, with equal temperature, equal hair distribution, normal sweat distribution and no skin changes. Circulation was intact with equal capillary filling. Dr. Friedenthal noted that testing was difficult because of complaint of pain on the left but that Adson's test was negative. Neurologic evaluation revealed complaints of decreased sensation and paresthesias throughout the entire left upper extremity without dermatomal pattern. Motor testing was characterized by give-way weakness in all muscle groups without evidence of a myotomal pattern of deficit. Deep tendon reflexes were full and symmetric. Tinel's sign was diffusely positive over the left upper extremity without physiologic pattern, including over the radial and median nerve distribution and at the medial and lateral aspects of the elbow and through the entire upper arm and forearm with paresthesias all going into the same distribution of four fingers on the dorsum of the left hand.

Dr. Friedenthal diagnosed status post resection of ganglion cyst of the left wrist; status post resection recurrent ganglion cyst, exploration and neural lysis radial nerve and release of first dorsal compartment left wrist; early degenerative disc disease of the cervical spine and early degenerative disease of the left shoulder. He noted that the left wrist ganglion cyst and de Quervain's syndrome of the left thumb were accepted in this case and that, while both conditions appeared sporadically without relationship to specific injury, both had at times been considered related to repetitive stress injuries and thus a causal relationship could exist. Dr. Friedenthal found that, on an orthopedic basis, appellant could perform her regular duties, noting that examination showed inconsistent and paradoxical findings with no objective impairment, all positive findings being of a subjective nature only. He noted the absence of any muscle atrophy, which, he opined, was inconsistent with the severe disuse described. There were virtually no dystrophic changes evident on examination and no evidence of joint synovitis or tenosynovitis at the time of his examination. Dr. Friedenthal advised that the ganglion cyst and de Quervain's syndrome had been appropriately treated with clinical resolution. The finding of very mild left carpal tunnel syndrome was not consistent with appellant's subjective complaints or objective findings, with no evidence of injury to the carpal canal. Dr. Friedenthal stated that her mild condition was most likely of a degenerative basis and was not of clinical importance and was not a basis for disability. He advised that appellant had fully recovered from the accepted conditions without residual impairment, noting that secondary gain and/or psychological issues were active on the basis of the inconsistent and paradoxical findings with

clear symptom magnification. Dr. Friedenthal concluded that nonorthopedic causes of her complaints and reported disability were beyond the scope of his examination.

On February 15, 2008 the Office proposed to terminate appellant's compensation benefits on the grounds that the medical weight of opinion was represented by Dr. Friedenthal and established that she no longer had residuals or disability due to the accepted conditions.

In a February 4, 2008 report, Dr. Dalsey advised that on physical examination appellant had no specific area of hypersensitivity and that, although she reported intermittent tingling, it was diffuse and not clearly dermatomal. He stated that the electromyogram (EMG) finding of very mild carpal tunnel syndrome was not characteristic of her current complaints, concluding that there were no signs of recurrent ganglion, no signs of ongoing de Quervain's tendinitis and that it was unclear whether she had some type of associated CRPS. In a February 25, 2008 report, Dr. Ferstandig noted that appellant was markedly improved with medication but was still very depressed. He advised that her pain was more suggestive of a neuropathic disease rather than RSD and diagnosed post-traumatic stress disorder; major depression, single episode; and likely neuropathic pain of medial and radial etiology.

In a decision dated March 17, 2008, the Office terminated appellant's compensation benefits.

On March 24, 2008 appellant, through her attorney, requested a hearing. In a December 20, 2007 report, Dr. Antebi reiterated his previous findings and conclusions. In a February 11, 2008 report, Dr. Ferstandig noted appellant's continued treatment. On March 17, 2008 he advised that she demonstrated an "absolutely remarkably positive" response to medication and was doing very well overall. Dr. Ferstandig reiterated his diagnoses. In an April 16, 2008 report, Dr. Barone opined that he still suspected that appellant had CRPS/RSD, stating that no evidence of any other etiology had emerged. In reports dated March 10 to May 19, 2008, Dr. Dalsey provided physical examination findings, recommended updated EMG studies and an evaluation by another hand surgeon. He advised that appellant could work eight hours daily with strict left upper extremity restrictions.<sup>5</sup>

At the hearing, held on July 15, 2008, appellant testified that her duties were modified following the December 2005 surgery. She described pain, numbness and tingling of the left upper extremity. Counsel contended that the Office should have developed the psychological component of her condition and that Dr. Friedenthal's report was not sufficient to carry the weight of the medical evidence. In an August 11, 2008 report, Dr. Dalsey provided findings on physical examination, noting negative Finkelstein's and Tinel's testing. He advised that the ganglion cyst excision with radial nerve neurolysis and first dorsal compartment release did not appear to be currently causing any clinical symptoms, noting that appellant had been diagnosed with an atypical CRPS. Dr. Dalsey stated that there had been a suspicion of median nerve irritation but that appellant's clinical complaints did not correlate with this.

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<sup>5</sup> Appellant also submitted evidence previously of record and additional treatment notes from Ms. Jones dated January 18, February 15 and March 14, 2008.

By decision dated September 23, 2008, an Office hearing representative found that Dr. Friedenthal and Dr. Dalsey agreed that the EMG findings of carpal tunnel syndrome were minimal and that there was no probative medical evidence to establish that appellant had CRPS or RSD causally related to the accepted employment injury. She found that Dr. Friedenthal's opinion was properly accorded the weight of medical opinion and affirmed the March 17, 2008 decision.

On April 2, 2009 appellant requested reconsideration and submitted additional evidence.<sup>6</sup> A functional capacity evaluation (FCE) dated September 12, 2007 was reported as invalid due to submaximal effort and noted that she exhibited overt symptom exaggeration and inappropriate illness behavior.

In a February 9, 2009 report, Dr. Dalsey noted that appellant was right hand dominant and reviewed his care and treatment beginning on February 2, 2007. Postoperatively appellant continued to have pain and problems with her left wrist and persistent shoulder pain. Dr. Barone and Dr. Antebi believed there was a CRPS and she was also seen by a counselor. Dr. Dalsey opined that appellant reported limitations in the functional use of her left arm and that her physical examination revealed limitations. It was unclear whether secondary gain was at issue or a psychological component to her residual complaints and functional limitations; regardless, she remained limited in the use of her left upper extremity and had permanent residuals, which precluded her from work. Appellant's condition had been stable and unchanged for more than a year, her limitations were permanent and further improvement was not anticipated. Further, surgery was not indicated on her left upper extremity and she would continue medical management of chronic pain problems. Dr. Dalsey concluded that her history and medical records supported a diagnosis of left upper extremity problems that had been attributed to her job requirements as a postal employee. Despite revision surgery, permanent persistent pain and functional limitations in the left upper extremity continued to prevent appellant from returning to her previous employment. On April 30, 2009 Dr. Dalsey reviewed Dr. Friedenthal's report and agreed with his conclusion that the etiology of appellant's residual subjective complaints and functional impairment was unclear. He disagreed with Dr. Friedenthal's assessment that she had fully recovered from the accepted conditions without residuals. Dr. Dalsey agreed with Dr. Friedenthal that her residual problems were not due to recurrent de Quervain's tendinitis or a dorsal ganglion cyst but that problems including myofascial syndrome and/or atypical CRPS and psychological issues could be associated with musculoskeletal injury and subsequent surgery. He reiterated that appellant was permanently limited from performing the essential duties of her occupation.

In a merit decision dated June 18, 2009, the Office denied modification of the prior decisions.

### **LEGAL PRECEDENT -- ISSUE 1**

Once the Office accepts a claim and pays compensation, it has the burden of justifying modification or termination of an employee's benefits. It may not terminate compensation

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<sup>6</sup> Appellant initially filed an appeal with the Board in Docket No. 09-712. By letter dated April 2, 2009, counsel withdrew the appeal. By order dated June 26, 2009, the Board dismissed the appeal.

without establishing that the disability ceased or that it was no longer related to the employment.<sup>7</sup> The Office's burden of proof in terminating compensation includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.<sup>8</sup>

Section 8123(a) of the Federal Employees' Compensation Act<sup>9</sup> provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary of Labor shall appoint a third physician who shall make an examination.<sup>10</sup> When 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 on a proper factual background, must be given special weight.<sup>11</sup>

### **ANALYSIS -- ISSUE 1**

The Board finds that the Office met its burden of proof to terminate appellant's compensation benefits on March 17, 2008. The accepted conditions in this case are tendinitis, tenosynovitis and ganglion of the left wrist. The Office determined that a conflict in medical evidence had been created between the opinions of appellant's treating physician, Dr. Dalsey, and Dr. Stark, an Office referral physician, regarding the extent of appellant's work-related injuries and continuing disability. It then properly referred her to Dr. Friedenthal, Board-certified in orthopedic surgery, for an impartial evaluation.

In a February 6, 2008 report, Dr. Friedenthal noted the history of injury, his review of the medical records and appellant's complaint of constant left upper extremity pain extending from the shoulder to the fingertips. He advised that physical examination demonstrated inconsistent and paradoxical findings that were of a subjective nature and that she had no objective findings. Dr. Friedenthal noted that the absence of muscle atrophy which he opined was inconsistent with the severe disuse described, stating that there were virtually no dystrophic changes evident on examination and no evidence of joint synovitis or tenosynovitis. He advised that the EMG findings of very mild carpal tunnel syndrome were not consistent with appellant's subjective complaints or objective findings, noting no evidence of injury to the carpal canal. Dr. Friedenthal opined that the mild condition was most likely of a degenerative basis and was not of clinical importance or a basis for disability, finding that secondary gain and/or psychological issues were active on the basis of the inconsistent and paradoxical findings and clear symptom magnification and concluding that appellant had fully recovered from the accepted conditions without residual impairment to afford any disability.

The Board finds that, as Dr. Friedenthal provided a comprehensive, well-rationalized opinion in which he clearly advised that any residuals of appellant's accepted conditions had

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<sup>7</sup> *Jaja K. Asaramo*, 55 ECAB 200 (2004).

<sup>8</sup> *Id.*

<sup>9</sup> 5 U.S.C. §§ 8101-8193.

<sup>10</sup> *Id.* at § 8123(a); see *Geraldine Foster*, 54 ECAB 435 (2003).

<sup>11</sup> *Manuel Gill*, 52 ECAB 282 (2001).

resolved, his opinion is entitled to the special weight accorded an impartial examiner and constitutes the weight of the medical evidence.<sup>12</sup>

The Board further finds that the medical evidence appellant subsequently submitted is insufficient to overcome the weight accorded Dr. Friedenthal as an impartial medical specialist regarding whether she had residuals of her accepted conditions. In his February and March 2008 reports, Dr. Ferstandig noted that she had improved with medication but was still very depressed, advised that her pain was more suggestive of a neuropathic type rather than RSD and reiterated his diagnoses. In an April 16, 2008 report, Dr. Barone advised that he suspected that appellant had CRPS/RSD because no evidence of an etiology had emerged. Neither physician provided an opinion regarding the accepted conditions in this case, whether they had resolved or whether she could work. Their reports are therefore insufficient to overcome the weight of Dr. Friedenthal's report.

In a February 4, 2008 report, Dr. Dalsey advised that appellant had no specific area of hypersensitivity on physical examination and that, although she reported intermittent tingling, it was diffuse and not clearly dermatomal. He stated that the EMG finding of very mild carpal tunnel syndrome was not characteristic of her current complaints, concluding that there were no signs of recurrent ganglion, no signs of ongoing de Quervain's tendinitis and that it was unclear whether she had some type of associated CRPS. In reports dated from March 10 to August 11, 2008, Dr. Dalsey noted that appellant had been diagnosed with atypical CRPS and advised that she could work eight hours a day with restrictions to her left upper extremity, further stating that, although there had been a suspicion of median nerve irritation, her clinical symptoms did not correlate. Reports from a physician who was on one side of a medical conflict that an impartial specialist resolved, are generally insufficient to overcome the weight accorded to the report of the impartial medical examiner or to create a new conflict.<sup>13</sup> Dr. Dalsey had been on one side of the conflict resolved by Dr. Friedenthal. His reports are not supportive that appellant continued to be disabled from the accepted left upper extremity conditions.

The Board therefore concludes that Dr. Friedenthal's opinion is entitled to the special weight accorded an impartial medical examiner<sup>14</sup> and the additional reports from Drs. Dalsey, Ferstandig and Barone are insufficient to overcome the weight accorded him as an impartial medical specialist regarding whether appellant had residuals of her accepted left upper extremity conditions. The Office therefore properly terminated appellant's compensation benefits on March 17, 2008.<sup>15</sup>

### **LEGAL PRECEDENT -- ISSUE 2**

As the Office met its burden of proof to terminate appellant's compensation benefits on March 17, 2008, the burden shifted to her to establish that she had any continuing disability

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<sup>12</sup> See *Sharyn D. Bannick*, 54 ECAB 537 (2003).

<sup>13</sup> *I.J.*, 59 ECAB \_\_\_\_ (Docket No. 07-2362, issued March 11, 2008).

<sup>14</sup> See *Sharyn D. Bannick*, *supra* note 12.

<sup>15</sup> *Manuel Gill*, *supra* note 11.

causally related to her accepted right upper extremity injury.<sup>16</sup> To establish a causal relationship between the condition, as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence, based on a complete factual and medical background, supporting such a causal relationship.<sup>17</sup> Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.<sup>18</sup> Rationalized medical evidence is medical evidence which includes a physician's rationalized medical 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.<sup>19</sup>

### **ANALYSIS -- ISSUE 2**

The Board finds that appellant submitted insufficient medical evidence with her April 29, 2009 reconsideration request to establish that she continued to be disabled after March 17, 2008 due to the accepted left upper extremity conditions. With appellant's reconsideration request, she submitted a September 12, 2002 FCE. This, however, was reported as invalid due to submaximal effort and therefore does not constitute probative medical evidence. Dr. Dalsey provided treatment notes dated from September 22, 2008 to April 20, 2009. In a February 9, 2009 report, he advised that it was unclear whether there were secondary gain issues and a psychological component to her residual complaints and functional limitations but that regardless, she remained limited in the use of her left upper extremity and had permanent disabilities which precluded her from returning to her previous employment. On April 30, 2009 Dr. Dalsey stated that he agreed with Dr. Friedenthal's conclusion that the etiology of appellant's residual subjective complaints and functional impairment was unclear. The Board thus finds his opinion regarding her continued disability equivocal.<sup>20</sup> As stated above, it is appellant's burden to establish that she continued to be disabled due to the employment injury after March 17, 2008. Under the Act, the term "disability" means the incapacity, because of an employment injury, to earn the wages that the employee was receiving at the time of injury.<sup>21</sup> Whether a particular injury causes an employee to be disabled for employment and the duration of that disability are medical issues which must be proved by a preponderance of the reliable, probative and

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<sup>16</sup> See *Joseph A. Brown, Jr.*, 55 ECAB 542 (2004).

<sup>17</sup> *Jennifer Atkerson*, 55 ECAB 317 (2004).

<sup>18</sup> *Id.*

<sup>19</sup> *Leslie C. Moore*, 52 ECAB 132 (2000); *Victor J. Woodhams*, 41 ECAB 345 (1989).

<sup>20</sup> *D.D.*, 57 ECAB 734 (2006) (medical opinions that are speculative or equivocal in character are of diminished probative value).

<sup>21</sup> See 20 C.F.R. § 10.5(f); *Cheryl L. Decavitch*, 50 ECAB 397 (1999).

substantial medical evidence<sup>22</sup> and medical opinions that are speculative or equivocal in character are of diminished probative value.<sup>23</sup>

The Board finds that the medical evidence is insufficient to establish that appellant continues to have work-related disability due to the accepted left upper extremity conditions.

### **LEGAL PRECEDENT -- ISSUE 3**

The general rule respecting consequential injuries is that, when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause, which is attributable to the employee's own intentional conduct. The subsequent injury is compensable if it is the direct and natural result of a compensable primary injury. With respect to consequential injuries, the Board has stated that, where an injury is sustained as a consequence of an impairment residual to an employment injury, the new or second injury, even though nonemployment related, is deemed, because of the chain of causation to arise out of and in the course of employment and is compensable.<sup>24</sup>

A claimant bears the burden of proof to establish a claim for a consequential injury. As part of this burden, he or she must present rationalized medical opinion evidence, based on a complete factual and medical background, showing causal relationship. Rationalized medical evidence is evidence which relates a work incident or factors of employment to a claimant's condition, with stated reasons of a physician. The opinion must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship of the diagnosed condition and the specific employment factors or employment injury.<sup>25</sup>

In discussing the range of compensable consequences, once the primary injury is causally connected with the employment, Larson notes that, when the question is whether compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury, the rules that come into play are essentially based upon the concepts of direct and natural results and of claimant's own conduct as an independent intervening cause. The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.<sup>26</sup>

To establish her claim that she sustained an emotional condition in the performance of duty, appellant must submit the following: (1) medical evidence establishing that she has an emotional or stress-related disorder; (2) factual evidence identifying employment factors or incidents alleged to have caused or contributed to her condition; and (3) rationalized medical

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<sup>22</sup> *Fereidoon Kharabi*, 52 ECAB 291 (2001).

<sup>23</sup> *D.D.*, *supra* note 20.

<sup>24</sup> *S.S.*, 59 ECAB \_\_\_\_ (Docket No. 07-579, issued January 14, 2008).

<sup>25</sup> *Charles W. Downey*, 54 ECAB 421 (2003).

<sup>26</sup> Larson, *The Law of Workers' Compensation* § 1300; *see Downey supra* note 25.

opinion evidence establishing that the identified compensable employment factors are causally related to her stress-related condition.<sup>27</sup> If a claimant does implicate a factor of employment, the Office should then determine whether the evidence of record substantiates that factor.<sup>28</sup> When the matter asserted is a compensable factor of employment and the evidence of record establishes the truth of the matter asserted, the Office must base its decision on an analysis of the medical evidence.<sup>29</sup>

Workers' compensation law does not apply to each and every injury or illness that is somehow related to an employee's employment. In the case of *Lillian Cutler*,<sup>30</sup> the Board explained that there are distinctions as to the type of employment situations giving rise to a compensable emotional condition arising under the Act.<sup>31</sup> There are situations where an injury or illness has some connection with the employment but nevertheless does not come within coverage under the Act.<sup>32</sup> When an employee experiences emotional stress in carrying out his or her employment duties and the medical evidence establishes that the disability resulted from an emotional reaction to such situation, the disability is generally regarded as due to an injury arising out of and in the course of employment. This is true when the employee's disability results from his or her emotional reaction to a special assignment or other requirement imposed by the employing establishment or by the nature of the work.<sup>33</sup> Allegations alone by a claimant are insufficient to establish a factual basis for an emotional condition claim.<sup>34</sup>

### **ANALYSIS -- ISSUE 3**

The Board finds that appellant did not establish that she sustained a consequential CRPS/RSD condition. While Dr. Dalsey, an attending orthopedist, first reported in February 2007 that she had physical findings suggestive of CRPS, in reports in October and November 2007, he advised that it was his clinical impression that she did not have CRPS and there could be a component of symptom magnification. In January 2008, however, he again raised the possibility that appellant could have CRPS and concluded that there seemed to be a psychological overlay which could explain why she did not have a typical presentation of CRPS. In a February 4, 2008 report, Dr. Dalsey advised that it was unclear whether she had some type of CRPS. Finally, in an April 30, 2009 report, he advised that he agreed with Dr. Friedenthal's conclusion that the etiology of appellant's subjective complaints and functional impairment was unclear but also stated that her problems could be caused by an atypical CRPS. Dr. Dalsey's

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<sup>27</sup> *Leslie C. Moore*, 52 ECAB 132 (2000).

<sup>28</sup> *Dennis J. Balogh*, 52 ECAB 232 (2001).

<sup>29</sup> *Id.*

<sup>30</sup> 28 ECAB 125 (1976).

<sup>31</sup> *See supra* note 9.

<sup>32</sup> *See Robert W. Johns*, 51 ECAB 137 (1999).

<sup>33</sup> *Lillian Cutler*, *supra* note 30.

<sup>34</sup> *J.F.*, 59 ECAB \_\_\_\_ (Docket No. 07-308, issued January 25, 2008).

opinion regarding the CRPS diagnosis and its cause is equivocal at best<sup>35</sup> and is therefore insufficient to establish that appellant sustained a consequential CRPS condition.

The Board also finds Dr. Barone's reports insufficient to meet appellant's burden. In reports dated September 28, 2007 to April 16, 2008, Dr. Barone advised that he suspected that she had CRPS/RSD and recommended an EMG study that demonstrated very mild left carpal tunnel syndrome. He, however, did not discuss the EMG findings in relationship to a diagnosis of CRPS and did not provide any affirmative evidence to support his conclusion.<sup>36</sup> While Dr. Antebi and Dr. Ferstandig diagnosed neuropathic pain, neither physician provided an explanation regarding the cause of the condition.<sup>37</sup> While Dr. Mazzagatti, an attending psychologist, diagnosed a pain disorder associated with both psychological factors and a general medical condition and advised that this was employment related, he too failed to provide a rationalized explanation as he did not discuss the nature of the diagnosed condition or soundly explain to a reasonable degree of medical certainty how the accepted conditions or other employment activities caused or aggravated the pain condition.<sup>38</sup>

In a July 19, 2007 report, Dr. Spellman, an Office referral neurologist, found that there was no objective evidence of neurological disease or RSD. In a September 18, 2007 report, Dr. Stark, an Office referral orthopedic surgeon, advised that appellant was malingering and could return to her usual work as a mail processor. Dr. Friedenthal, who was selected to perform an impartial evaluation for the Office, did not diagnose CRPS or RSD in his February 6, 2008 report, advising that secondary gain and/or psychological issues were active and were the basis of inconsistent and paradoxical physical findings with clear symptom magnification present. The Board therefore concludes that appellant has not discharged her burden of proof to establish that CRPS was caused by her employment-related left upper extremity conditions.<sup>39</sup>

Regarding the claimed consequential depression, beginning in October 2007, Dr. Mazzagatti diagnosed depression, advising that it was employment related and Dr. Ferstandig, an attending psychiatrist, diagnosed major depressive disorder secondary to injuries of the left upper extremity. Neither, however, explained with sufficient rationale how the claimed emotional condition was caused by the accepted left upper extremity conditions that have since resolved or how the condition was caused by other employment factors. A claimant bears the burden of proof to establish a claim for a consequential injury. As part of this burden, he or she must present rationalized medical opinion evidence.<sup>40</sup> Appellant did not do so in this case.

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<sup>35</sup> *D.D.*, *supra* note 20.

<sup>36</sup> *See A.D.*, 58 ECAB 149 (2006).

<sup>37</sup> *Willie M. Miller*, 53 ECAB 697 (2002) (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).

<sup>38</sup> *J.M.*, 58 ECAB 303 (2007).

<sup>39</sup> *See generally, K.E.*, 60 ECAB \_\_\_\_ (Docket No. 08-1461, issued December 17, 2008).

<sup>40</sup> *Charles W. Downey*, *supra* note 25.

**CONCLUSION**

The Board finds that the Office met its burden of proof to terminate appellant's compensation benefits on March 17, 2008 on the grounds that she had no residuals of an accepted left wrist conditions and that she did not establish that she had any continuing employment-related disability or condition after that date due to her accepted condition. The Board further finds that she did not meet her burden of proof to establish that she had a CRPS/RSD condition or depression as a consequence of the accepted condition.<sup>41</sup>

**ORDER**

**IT IS HEREBY ORDERED THAT** the June 18, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 10, 2010  
Washington, DC

Colleen Duffy Kiko, Judge  
Employees' Compensation Appeals Board

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

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

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<sup>41</sup> The Board notes that, subsequent to the filing of this appeal with the Board, appellant, through his attorney, requested reconsideration of the July 18, 2009 decision. It is well established that the Board and the Office may not have concurrent jurisdiction over the same case. *D.S.*, 58 ECAB 392 (2007).