



## **FACTUAL HISTORY**

On May 17, 2006 appellant, then a 32-year-old security screener, filed a traumatic injury claim alleging that she sustained an injury in the performance of duty when she tripped and fell while carrying bins on May 11, 2006. The Office accepted the claim for neck sprain, contusion of the chest wall, lateral epicondylitis of the left elbow and lumbar and thoracic back sprains. Appellant was placed on the periodic rolls.

Appellant was treated by Dr. Leo E. Batash, a physiatrist. On September 18 and October 30, 2006 Dr. Batash stated that appellant continued to experience pain in her back, neck, left elbow, as well as headaches, two to three times per week. Examination revealed numbness and tingling in the upper limbs and restricted range of motion. Dr. Batash opined that appellant was unable to work due to her accepted May 11, 2006 injury.

The Office referred appellant to Dr. Edward Weiland, a Board-certified neurologist, for a second opinion examination. In a report dated October 31, 2006, Dr. Weiland noted that appellant had subjective complaints of periodic headaches and impaired memory, difficulty grasping, episodic numbness bilaterally, pain and limited range of motion. Based on objective findings, however, he opined that appellant's accepted conditions had fully resolved. A detailed neurologic examination revealed that cognitive functions were intact without evidence of aphasia or apraxia. The fundoscopic evaluation failed to reveal any evidence of raised intracranial pressure. The pupils were briskly reactive at seven to three millimeters (mm). The cornea reflex was intact bilaterally. The extraocular movements were full, without evidence of nystagmus. Facial sensation and the muscles of facial expression were within normal limits. There was full range of motion of the neck and both shoulders, as well as the lower torso. The straight leg raising maneuver was unlimited at 90 degrees, and there was no sciatic notch tenderness. The foraminal compression test and Kemp maneuver were negative and Lhermitte sign was absent. Dr. Weiland identified no focal atrophic changes or other atypical motor movements. He observed that appellant was able to remove her clothing with minimal difficulty. The segmental motor examination involving the lower extremities and right upper extremity revealed 5/5 power resistance throughout. No atypical motor movements or signs of active tissue inflammation were noted in the axial structures. Dr. Weiland did not identify any reproducible dermatomal peripheral nerve distribution sensory loss. Deep tendon reflexes are 2+ and symmetric throughout with plantar flexor responses bilaterally. Gait and coordination skills are within normal limits.

Dr. Weiland diagnosed: history of closed head trauma and subjective headache disorder; cervical strain/sprain, resolved; thoracic strain/sprain, resolved; lumbosacral strain/sprain, resolved and physical examination findings consistent with symptom magnification. He stated:

“I find no evidence of a primary neurologic disability at the present time as relates to any injury reportedly occurring on May 11, 2006. There is no finding of any neurologic permanency or residual based upon the physical examination findings noted today.”

Dr. Weiland opined that maximum medical improvement had been reached and she was able to return to gainful employment without restrictions.

The Office found a conflict in medical opinion between Dr. Batash and Dr. Weiland. It referred appellant, together with a statement of accepted facts and the medical record, to Dr. William B. Head, Jr., a Board-certified neurologist, to resolve the conflict as to whether she had any residuals or disability causally related to her employment injury.<sup>1</sup> In a report dated August 14, 2008, Dr. Head reviewed the entire medical record and statement of accepted facts. He reported results of testing with the Jamar dynamometer, as well as sensory, motor and range of motion testing, all of which fell within the normal range. Dr. Head found no objective sign of a neurological impairment or of reflex sympathetic dystrophy, *i.e.* regional pain syndrome) in the left upper extremity. He found no objective sign of any cognitive impairment. There was no evidence of aphasia, appellant was able to process thoughts quickly, her immediate recall was intact and her overall memory was within the normal range.

Dr. Head's physical examination revealed no areas of increased tenderness, swelling or deformity. Carotid pulsations were present and equal. There were no arthritic changes noted in the finger joints. Circumferential measurements of the upper and lower extremities were within the boundaries of physiological variation. There was no evidence of muscular atrophy. On range of motion testing of the cervical spine, appellant was able to flex from 0 to 50 degrees, extend from 0 to 60 degrees, flex laterally from 0 to 45 degrees, bilaterally and rotate from 16 to 80 degrees, bilaterally. Appellant was able to flex the lumbar spine from 30 to 60 degrees and extend the lumbar spine from 7.5 to 25 degrees. Dr. Head stated that these findings were subjective in nature, and that his indirect observation revealed a more complete range of motion. There was no paraspinal muscle spasm in the cervical, thoracic or lumbosacral region. Straight leg raising testing was negative bilaterally, on both direct and indirect testing. Appellant could walk on her heels and toes and could perform tandem walking with ease. She arose easily from a chair, without assistance. There were demonstrable reflexes in both upper and lower extremities. There was no clonus and no Babinskis noted. Tinel's and Phalen's testing was negative bilaterally. Dr. Head concluded that appellant was attempting to simulate pathology on Jamar grip testing, on range of motion testing of her neck and back, on calculations testing, on general motor testing and on general sensory testing. He found no objective sign of reflex sympathetic dystrophy in the left upper extremity, and no objective sign of any neurological impairment. Dr. Head diagnosed symptom-magnification syndrome and opined that appellant's accepted conditions had fully resolved.

On September 12, 2008 the Office proposed to terminate appellant's compensation and medical benefits. It determined that, based on Dr. Head's August 14, 2008 report, appellant's injury-related disability had ceased and the accepted conditions had resolved. Appellant was afforded 30 days within which to submit any additional evidence.

Appellant submitted a September 17, 2008 disability slip from Dr. Batash, which provided a diagnosis of cervical and lumbar sprains and left epicondylitis. She also submitted progress notes from Dr. Batash dated September 24 and October 1, 2008. In a September 19,

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<sup>1</sup> The Board notes that the Office initially referred appellant to Dr. Peter Dzenis, a Board-certified orthopedic surgeon, for a referee medical examination scheduled for March 28, 2007. Due to Dr. Dzenis' inability to complete an examination of appellant or to reschedule an appointment, the Office scheduled a new referee examination with Dr. Head.

2008 statement, appellant asserted that she continued to experience residuals from the accepted injury and that Dr. Head's examination was "torture."

By decision dated October 15, 2008, the Office finalized the termination of appellant's compensation benefits effective October 14, 2008. It found that the weight of the evidence rested with the opinion of Dr. Head, the impartial medical examiner.

On October 31, 2008 appellant requested reconsideration. On November 5, 2008 she modified her request to a request for an oral hearing. In support of her request, appellant submitted progress notes from Dr. Batash dated February 11 through 23, 2009. On November 5, 2008 Dr. Batash stated that appellant had memory loss and insomnia due to constant neck and buttock pain. On November 26, 2008 he diagnosed left elbow epicondylitis; cervical and lumbar sprain; and contusion of the abdominal wall. Dr. Batash opined that appellant was disabled from May 11, 2006 through December 7, 2008 and that she could return to work with no restrictions on December 8, 2008. In a February 23, 2009 disability slip, he stated that appellant should refrain from any work-related activity. The record also contains physical therapy notes dated May 30, 2006 through November 28, 2007.

On February 4, 2009 appellant filed a CA-2a form alleging that she sustained a recurrence of disability on December 10, 2008 after returning to work. She stated that the employing establishment's injury compensation specialist told her that she had to leave immediately because she was complaining of her head and hand injury. Appellant submitted a February 23, 2009 work slip in which Dr. Batash restricted her from any work-related activity.<sup>2</sup>

Appellant submitted a February 23, 2009 report from Dr. Igor Cohen, a treating physician. She advised him that she continued to experience headaches, neck and mid and lower back pain and left elbow pain as a result of a May 11, 2006 work-related injury. Dr. Cohen stated that no medical records were available for his review. Examination revealed moderately severe tenderness with hypertonicity and multiple trigger points in the cervical, thoracic and lumbosacral paraspinal muscles bilaterally on palpation. There was diffuse tenderness in the elbow. In the cervical spine, range of motion (ROM) was restricted and accompanied by pain, Jackson compression test was positive bilaterally and the cervical distraction test was positive bilaterally. In both the thoracic and lumbar spine, ROM was restricted and accompanied by pain, straight leg raise test was positive bilaterally and the Kemp's standing test was positive bilaterally. Appellant refused active or passive ROM testing of the left elbow secondary to pain. A neurological examination revealed intact cognitive function. Muscle bulk and tone were normal in the major muscle groups of all four extremities. All muscles tested were within normal limits; however, appellant refused testing of the left upper extremity due to pain. All sensory dermatomes were normal to light touch and pinprick, except for hypoesthesia in the left C5 through T1 dermatomes and bilateral L4, L5 and S1 dermatomes. Dr. Cohen indicated that his findings were consistent with postconcussion syndrome, post-traumatic headache, cervicobrachial syndrome, thoracic spine pain, lower back syndrome, cervical and lumbar nerve

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<sup>2</sup> On March 11, 2009 the Office informed appellant that no action would be taken on her recurrence claim pending the outcome of her request for an oral hearing.

root injuries, cervical, thoracic and lumbar myofascitis and left elbow derangement with lateral and medial epicondylitis. He stated:

“The patient’s present condition is directly related to the accident described in this report. The mechanism of injury is entirely consistent with the clinical presentation. Therefore, the accident of May 11, 2006 is the direct producing cause of [appellant’s] injuries and pathologies.”

Dr. Cohen recommended physical therapy three times a week for four to six weeks, with the appropriate therapeutic modalities and therapeutic exercises and an addendum of nerve block, laser therapy and chiropractic adjustments; a series of cervical and lumbosacral paraspinal trigger point injections as a valuable addendum to her pain management three times a week for four weeks; an updated MRI scan of the cervical and lumbar spine for better evaluation of possible herniated nucleus pulposus; an MRI scan of the left elbow for better evaluation of structural abnormalities causing persistent pain; EMG and nerve conduction study of the upper and lower extremities for better evaluation of radicular component and to pinpoint cervical and lumbar nerve root injuries; neurometer testing of the upper and lower extremities for better evaluation of sensory deficit and electrocardiogram as a screening test for gym clearance; computerized muscle testing and range of motion testing of the cervical, thoracic and lumbar spine and left elbow for better evaluation of functional loss. He opined that appellant sustained a total disability as a result of her work-related injuries and recommended that she avoid heavy lifting, bending, prolonged sitting, walking or standing and pushing or pulling of heavy objects that might aggravate her symptoms of pain.

On March 2, 2009 appellant filed a traumatic injury claim alleging that she experienced headaches and pain in her left hand and back. She stated that a number of incidents added to her injury, including carrying and cutting badges from a load of old uniforms and teaching trainees the “full body pat down.”

At the March 16, 2009 hearing, appellant testified that she reinjured herself upon her return to work on December 8, 2008. She alleged that Dr. Head performed only a cursory five-minute examination, and that he took a sharp object and slashed it across her face.

Appellant submitted a March 11, 2009 report from Dr. Mehran Manouel, a Board-certified orthopedic surgeon. Physical examination of the cervical and lumbar spine revealed pain on palpation. Straight leg raise examination bilaterally was negative. Range of motion of both hips was within normal limits. Neurovascular examination was within normal limits. Dr. Manouel diagnosed cervical and lumbar sprain with MRI scan evidence of disc bulge. He opined that appellant’s current symptoms and MRI scan findings were directly related to her May 11, 2006 work injury and that she was totally disabled as a result of the injury. On March 23, 2009 Dr. Manouel noted appellant’s report of worsening neck and back pain. Appellant stated that she tried unsuccessfully to return to work on December 8, 2008. Physical examination of the cervical and lumbar spine revealed pain to palpation and limitation of range of motion. Straight leg raise bilaterally was negative. Range of motion of both hips was within normal limits. Neurovascular examination was normal. X-rays of the lumbar spine, cervical spine and pelvis were unremarkable. Dr. Manouel reiterated his assessment that appellant was

totally disabled due to cervical and lumbar spine sprain and opined that her condition was directly related to her May 11, 2006 work injury.

Appellant submitted a March 24, 2009 report from Dr. Fedel Rodriguez, a treating physician. On examination, Dr. Rodriguez found tenderness along the lumbar paraspinal muscles and over the cervical paraspinal muscles and trapezius bilaterally. Appellant was able to move her neck minimally. She had tenderness with very minimal palpation on the left elbow, but refused ROM testing. Muscle strength was normal. Dr. Rodriguez diagnosed “work-related injuries with cervicobrachial syndrome, lower back syndrome and possible left elbow derangement. He stated that the mechanism of injury was entirely consistent with the clinical presentation. Dr. Rodriguez also opined that appellant’s condition was directly related to the May 11, 2006 accident and that she was totally disabled. In a follow-up report dated April 2, 2009, he related appellant’s report that she sustained a work-related injury on December 10, 2008 when she was training some new employees. Appellant allegedly bent down and heard a crack in her low back. Later, she injured her left hand while carrying some bags with both hands and subsequently cutting something using scissors. Examination revealed tenderness of the lumbar paraspinal muscles and reduced flexion of the lumbar spine. Straight leg raise test was positive in bilateral lower extremities. Dr. Rodriguez found it difficult to perform a complete neurological examination, as appellant displayed a lot of protective behavior and did not make much of an effort. Motor strength examination revealed “give away” strength of the psoas, quadriceps and extensor hallucis longus. Grip strength was weak and sensation was impaired. MRI scans of the lumbar spine showed mild right convex lumbar scoliosis with some loss of lumbar lordosis and posterior disc bulges at L4-5 and L5-S1. An MRI scan of the cervical spine showed typical scoliosis and posterior disc bulges at C2-3 through C6-7. Dr. Rodriguez stated that appellant had experienced “an apparent reexacerbation of her lower back syndrome with lumbar disc bulges, possible lumbar radiculopathy and left hand uncertain of diagnosis.” He stated that appellant was totally disabled and opined that the December 10, 2008 accident was the direct producing cause of her injuries and pathologies.

The record contains an April 13, 2009 report from Dr. Patrick De Rosa, a treating physician, who noted that appellant sustained a work-related injury to her head, neck, lower back, midback, left elbow and left hand. Three days after returning to work on December 8, 2008, appellant injured her neck, lower back, left elbow and left hand, rendering herself disabled. Examination revealed tenderness in the cervical spine. Rotation to left and right was to 50 degrees, flexion was to 30 degrees, extension was to 10 degrees and lateral bending was to 20 degrees. Sensation was intact to the right hand and slightly decreased to left upper extremity, arm and forearm, and she had difficulty elevating her left upper extremity more than 30 degrees actively. Appellant was able to move up to 170 degrees passively. The reflexes were +1 to the left upper extremity and +2 to the right upper extremity. There was paraspinal and midline muscle tenderness. Straight leg raising was positive to 70 degrees bilaterally. Pursuant to March 26, 2009 MRI scans of the cervical and lumbar spine, Dr. De Rosa diagnosed bulging discs at C2-3 through C6-7 and at L4-5 and L5-S1.<sup>3</sup> He also diagnosed lateral epicondylitis of the left elbow.

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<sup>3</sup> The record contains reports of the March 26, 2009 MRI scans of the cervical and lumbar spine.

By decision dated May 12, 2009, an Office hearing representative affirmed the October 15, 2008 decision terminating appellant's compensation and medical benefits.

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

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation.<sup>4</sup> After it has been determined that an employee has disability causally related to her employment, the Office may not terminate compensation without establishing that the disability had ceased or that it was no longer related to the employment.<sup>5</sup> The Office's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.<sup>6</sup>

The right to medical benefits for an accepted condition is not limited to the period of entitlement to compensation for disability.<sup>7</sup> 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.<sup>8</sup>

In situations where there are 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 on a proper factual background, must be given special weight.<sup>9</sup>

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

The Board finds that the Office properly terminated appellant's compensation and medical benefits effective October 14, 2008.

The Office determined that a conflict in the medical opinion evidence arose between appellant's attending physician, Dr. Batash, who opined that she was disabled due to her accepted May 11, 2006 injury, and the Office referral physician, Dr. Weiland, who opined that the accepted injury had resolved and that she could work full duty without restrictions. In order to resolve the conflict, it referred appellant to Dr. Head for an impartial medical examination.

In his August 14, 2008 referee report, Dr. Head reviewed the entire medical record and statement of accepted facts. He provided detailed examination findings, which revealed no objective sign of a neurological impairment, reflex sympathetic dystrophy (RSD) or cognitive impairment. On range of motion testing, appellant's ability to flex, extend and rotate was

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<sup>4</sup> A.W., 59 ECAB \_\_\_ (Docket No. 08-306, issued July 1, 2008).

<sup>5</sup> J.M., 58 ECAB 478 (2007).

<sup>6</sup> See *Del K. Rykert*, 40 ECAB 284 (1988).

<sup>7</sup> T.P., 58 ECAB 524 (2007).

<sup>8</sup> I.J., 59 ECAB \_\_\_ (Docket No. 07-2362, issued March 11, 2008); *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

<sup>9</sup> *Gloria J. Godfrey*, 52 ECAB 486 (2001).

subjectively limited. Dr. Head stated, however, that his indirect observation revealed a more complete range of motion. He found no paraspinal muscle spasm in the cervical, thoracic or lumbosacral region. Straight leg raising testing was negative bilaterally, on both direct and indirect testing. Dr. Head diagnosed symptom-magnification syndrome and opined that appellant's accepted conditions had fully resolved. The Board finds that his August 14, 2008 medical report is comprehensive, well rationalized and based on an accurate factual and medical history. Therefore, it is entitled to the special weight of the medical opinion evidence afforded an impartial medical specialist.

Dr. Batash's September 17, 2008 disability slip and September 24 and October 1, 2008 progress notes do not contain an opinion regarding the cause of appellant's diagnosed conditions. Therefore, they are of diminished probative value<sup>10</sup> and are insufficient to overcome the weight of medical evidence afforded the opinion of the impartial medical examiner, or to create a new conflict. Appellant's September 19, 2008 statement that she continued to experience residuals from the accepted injury, and that Dr. Head's examination was "torture," does not constitute probative medical evidence. Neither the fact that the condition became apparent during a period of employment, nor the belief that the condition was caused or aggravated by employment factors or incidents, is sufficient to establish causal relationship.<sup>11</sup>

The Board finds that the weight of medical evidence rests with the well-rationalized report of the impartial medical examiner. The Board further finds that the Office met its burden of proof to terminate appellant's compensation and medical benefits effective October 14, 2008.

On appeal, appellant contends that the medical evidence establishes that she has residuals of the accepted injury. For reasons stated, the Board finds this argument to be without merit.

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

As the Office met its burden of proof to terminate appellant's wage-loss compensation on October 14, 2008, the burden shifted to her to establish that she had any continuing disability causally related to her accepted injury.<sup>12</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>13</sup> Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.<sup>14</sup> Rationalized medical evidence is medical evidence which includes a physician's

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<sup>10</sup> Medical evidence which does not offer an opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship. *A.D.*, 58 ECAB 149 (2006); *Michael E. Smith*, 50 ECAB 313 (1999).

<sup>11</sup> *See Joe T. Williams*, 44 ECAB 518, 521 (1993).

<sup>12</sup> *See I.R.*, 61 ECAB \_\_\_\_ (Docket No. 09-1229, issued February 24, 2010); *see also Joseph A. Brown, Jr.*, 55 ECAB 542 (2004).

<sup>13</sup> *Jennifer Atkerson*, 55 ECAB 317 (2004).

<sup>14</sup> *Id.*

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>15</sup>

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

The Board finds that appellant submitted insufficient medical evidence to establish that she continued to be disabled after October 14, 2008 due to the accepted May 11, 2006 injury.

Appellant submitted progress notes and reports from Dr. Batash for the period November 26, 2008 through February 23, 2009 and physical therapy notes dated May 30, 2006 through November 28, 2007. As they do not contain an opinion regarding the cause of appellant's diagnosed conditions, they are of limited probative value.<sup>16</sup>

Dr. Cohen's February 23, 2009 report lacks sufficient probative value to establish continuing residuals. He provided examination findings and diagnosed postconcussion syndrome, posttraumatic headache, cervicobrachial syndrome, thoracic spine pain, lower back syndrome, cervical and lumbar nerve root injuries, cervical, thoracic and lumbar myofascitis and left elbow derangement with lateral and medial epicondylitis. Dr. Cohen opined that appellant's "injuries and pathologies" were directly related to the May 11, 2006 injury and stated that "the mechanism of injury [was] entirely consistent with the clinical presentation." However, he did not provide any explanation for his opinion. Medical conclusions unsupported by rationale are of limited probative value.<sup>17</sup> Dr. Cohen's report was not based on a complete factual and medical background. As he had no medical records available for review, he was unable to address Dr. Head's opinion that appellant's accepted conditions had resolved by the date of his August 14, 2008 examination, or to explain why or how she had symptoms relating to her accepted injury that were not present previously.<sup>18</sup> Dr. Cohen's report was based solely on his examination of appellant, which, admittedly, was incomplete due to her unwillingness to permit range of motion testing of her elbow. For all of these reasons, his report is insufficient to establish that appellant had had any continuing employment-related disability or condition after October 14, 2008 due to her accepted injury.

On March 11 and 23, 2009 Dr. Manouel diagnosed cervical and lumbar sprain with MRI scan evidence of disc bulge and opined that appellant's condition was directly related to her

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<sup>15</sup> *Leslie C. Moore*, 52 ECAB 132 (2000); *Victor J. Woodhams*, 41 ECAB 345 (1989).

<sup>16</sup> Medical evidence which does not offer an opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship. *A.D.*, 58 ECAB 149 (2006); *Michael E. Smith*, 50 ECAB 313 (1999).

<sup>17</sup> *Willa M. Frazier*, 55 ECAB 379 (2004).

<sup>18</sup> The Board notes that the only conditions accepted by the Office were neck sprain; contusion of the chest wall; lateral epicondylitis of the left elbow; and lumbar and thoracic back sprains.

May 11, 2006 work injury. As he did not provide any explanation for his opinion, it is of limited probative value.

On March 24, 2009 Dr. Rodriguez diagnosed “work-related injuries with cervicobrachial syndrome, lower back syndrome, and possible left elbow derangement.” He opined that appellant’s condition was directly related to the May 11, 2006 accident and that she was totally disabled. On April 2, 2009 Dr. Rodriguez opined that appellant had experienced “an apparent reexacerbation of her lower back syndrome” in a December 10, 2008 work accident, which was the direct producing cause of her injuries and pathologies. These reports are devoid of any explanation supporting his conflicting opinions. Therefore, they are of diminished probative value.

Dr. De Rosa’s April 13, 2009 report does not support appellant’s claim that she continued to experience residuals of the May 11, 2006 injury. Rather, he stated that appellant sustained a work-related injury to her head, neck, lower back, midback, left elbow and left hand three days after returning to work on December 8, 2008. Dr. De Rosa provided examination findings and diagnosed bulging C2-3 through C6-7, bulging L4-5 and L5-S1, and lateral epicondylitis of the left elbow. However, he provided no opinion on the relevant issue, namely whether appellant had continuing residuals of the May 11, 2006 injury. Other medical evidence of record, including reports of MRI scans and x-rays, which does not contain an opinion on causal relationship, is also of limited probative value and insufficient to establish appellant’s claim.

Appellant’s own statements undermine her claim that her current condition is due to the May 11, 2006 employment injury. In a March 2, 2009 traumatic injury claim, she alleged that she exacerbated her accepted injury by carrying and cutting badges from a load of old uniforms, and teaching trainees the “full body pat down.” At the March 16, 2009 hearing, appellant testified that she reinjured herself upon her return to work on December 8, 2008. These incidents would constitute a new injury, which is more appropriately addressed under another claim.

The Board finds that appellant did not submit sufficient rationalized medical opinion evidence to establish ongoing residuals or disability after October 14, 2008 due to her accepted May 11, 2006 injury.

### **CONCLUSION**

The Board finds that the Office met its burden of proof to terminate appellant’s compensation benefits effective October 14, 2008. Appellant failed to establish that she had any disability or condition after October 14, 2008 causally related to her accepted injury.

**ORDER**

**IT IS HEREBY ORDERED THAT** the May 12, 2009 and October 15, 2008 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: June 28, 2010  
Washington, DC

David S. Gerson, Judge  
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge  
Employees' Compensation Appeals Board

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