United States Department of Labor
Employees' Compensation Appeals Board

D.N., Appellant	)	
and	)	**Docket No. 09-651**
	)	**Issued: April 20, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Los Angeles, CA, Employer	)	

Appearances:
Sally F. LaMacchia, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On January 8, 2009 appellant, through counsel, filed a timely appeal from a June 26, 2008 decision of the Office of Workers' Compensation Programs denying her claim for wage-loss compensation and an October 10, 2008 decision denying her request for reconsideration. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this appeal.

ISSUES

The issues are: (1) whether appellant met her burden of proof to establish that she was disabled commencing October 31, 2006 causally related to her federal employment; and (2) whether the Office properly denied her request for further merit review under 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On March 29, 1984 appellant, then a 39-year-old distribution clerk, injured the middle finger of her right hand while cleaning a machine at work. The Office accepted her claim for: a

chip fracture of the right middle finger; causalgia; reflex sympathetic dystrophy (RSD) of the right arm; trigger finger of the middle finger of the left hand; trigger thumb and symptoms involving the her head and neck. Appellant stopped work on March 30, 1984. She returned to light-duty work in July 1984 and worked intermittently until June 26, 1987. Appellant stopped work and received wage-loss compensation.

The Office developed the claim and found a conflict in medical opinion between Dr. Peng Thim Fan, an attending rheumatologist, and Dr. Robert H. Roth, a referral Board-certified orthopedic surgeon, necessitating referral to an impartial medical specialist. Based on the report of Dr. William G. Kiblinger, a Board-certified orthopedic surgeon, the Office terminated appellant's compensation for her accepted conditions in an October 29, 2002 decision. The termination was affirmed by an Office hearing representative in a decision dated September 11, 2003.[1]

As part of appellant's treatment, the Office authorized the implantation of a spinal cord stimulator. It subsequently authorized the surgical removal of the stimulator on May 23, 2006 due to malfunction and authorized surgery for a C5 through T1 laminectomy. The Office paid compensation for total disability from October 23, 2003 through October 30, 2006 due to the malfunctioning of appellant's spinal cord stimulator and recovery from the laminectomy surgery.

Appellant claimed wage-loss compensation beginning November 1, 2006 for a left shoulder and other conditions that she contends were a result or consequence of the March 29, 1984 work injury. She also attributed her left shoulder condition to injury sustained during the May 23 and September 18, 2006 surgeries.

In a September 18, 2006 report, Dr. Hyun Bae, a Board-certified orthopedic surgeon, stated that appellant was seen in follow-up after a planned epidural decompression for hematoma. He explained that no hematoma was found, only scar tissue from the previous implant. Dr. Bae advised that no further surgical management was needed but requested authorization for a computerized tomography (CT) scan to check on the laminectomy. He found that appellant could not return to work but could resume her previous status. In a September 25, 2006 report, Dr. Bae noted that appellant complained of a very stiff shoulder. He found a positive impingement sign and rotator cuff weakness. Dr. Bae opined that there was an underlying rotator cuff tear. He stated, "maybe we accentuated this during the surgical procedure itself when we had to tape her shoulders down." Dr. Bae recommended a left shoulder magnetic resonance imaging (MRI) scan and physical therapy. On October 30, 2006 he advised that the cervical CT scan was normal as far as the decompression laminectomy was concerned. Appellant complained of some neck pain and headaches that were probably due to her surgery, but Dr. Bae found that she was permanent and stationary in regard to her cervical condition. Dr. Bae noted that appellant would not be able to do any type of productive work based on her rotator cuff pathology and stiff shoulder.

In a January 24, 2007 decision, the Office denied appellant's claim for a left shoulder condition. It found that the opinion of Dr. Bae was equivocal on the issue of causal relation.

[1] The Board notes that there was no appeal from the termination decisions and the Board does not have jurisdiction to review them in this appeal. *See* 20 C.F.R. § 501.2(c).

By decision dated February 23, 2007, the Office denied appellant's claim for compensation beginning October 31, 2006.

Appellant disagreed with the Office's decision and requested an oral hearing, which was held on July 17, 2007. Her attorney contended that her claim should be accepted for other medical conditions set forth in the record. Appellant also argued that appellant was totally disabled due to her numerous complaints.

In a January 18, 2007 report, Dr. Bae advised that appellant was completely healed with regard to the removal of her spinal cord stimulator and cervical laminectomy. He advised that her chief complaint was the left shoulder, which was most likely a rotator cuff tear with impingement. Dr. Bae found weakness in appellant's external rotators, a positive impingement sign and a positive neer sign. He recommended an MRI scan of the shoulder as well as evaluation by a specialist. Dr. Bae stated that there was nothing more he could offer appellant for treatment of her cervical spine. He opined that removal of the spinal cord stimulator did not improve her condition; therefore, if she was previously disabled as of October 30, 2006, she was still disabled since the removal of the stimulator did not give her any improvement. Dr. Bae opined that appellant was permanent and stationary; however, her shoulder condition had progressed and she would probably be disabled. On February 28, 2007 he evaluated a repeat cervical CT scan. Dr. Bae reiterated that appellant was permanent and stationary and stated that he was not qualified to rate her disability status. He advised that she had a left shoulder rotator cuff tear with impingement for which she should be evaluated separately on that basis.

The Office referred appellant to Dr. G.B. HaEri, a Board-certified orthopedic surgeon, for a second opinion examination. In a March 17, 2007 report, Dr. HaEri reviewed appellant's history of injury and medical treatment. He noted tenderness to palpation of the cervical region with no significant muscle spasm and listed findings on range of motion. The right shoulder was reported within normal limits while the left shoulder range of motion was limited secondary to pain. Dr. HaEri found that neurological examination of the upper extremities was grossly intact but noted weakness in grip strength to both hands. He advised that appellant had additional symptoms to her left upper extremity as a result of the surgical procedures. This included occasional headaches, neck pain with radiation to both arms and associated numb feeling in both arms. Dr. HaEri recommended further conservative noninvasive care.

In a May 15, 2007 supplemental report, Dr. HaEri explained that the weakness in grip strength to appellant's hands was due to epidural hematoma formation following the insertion of the dorsal column stimulator and the cervical laminectomy. He stated that the epidural hematoma formation led to central cervical stenosis, which required the decompression laminectomy. Dr. HaEri opined that the decompression of the spinal cord in the cervical region resulted in a permanent partial sensory and motor deficit as demonstrated by subjective complaints of pain and paraesthesia in the arms and the objective finding of a weakened grip in both hands. In a June 21, 2007 supplemental report, he advised that no further medical care was needed for appellant's cervical condition. Since appellant continued to have residuals of neck pain and bilateral upper extremity radiculopathy following the August 29, 2006 cervical laminectomy, she would require a short course of conservative medical care from time to time.

In a September 6, 2007 decision, an Office hearing representative affirmed the February 23, 2007 decision. He noted that, while the record contained additional diagnoses of cervical stenosis, degenerative disc disease, depression and/or anxiety, there was insufficient medical opinion addressing how these conditions related to the accepted injury.

In a March 27, 2008 letter, appellant requested reconsideration, reiterating her request that the Office accept other medical conditions. She submitted medical notes from First Valley Medical Group dated January 20, 2006 to March 26, 2007, a March 5, 2007 report concerning her esophagus, and numerous diagnostic studies pertaining to her left shoulder, thoracic and cervical spine and left knee.

In a January 22, 2008 letter to appellant's representative, Dr. Bae stated that appellant's diagnosis in October 2003 was RSD which was diagnosed based on the chip fracture that she sustained to her right middle finger. He noted that a spinal cord stimulator was initially inserted on November 16, 1998 but needed to be revised three times in 2001. Dr. Bae noted that, due to the lack of proper positioning, appellant's symptoms were aggravated. A CT scan of October 6, 2005 showed complete blockage of the flow at mid C3 which aggravated appellant's condition. When surgery was performed on May 23, 2006, dense scar tissue was noted which caused cervical stenosis at multiple levels and required dissection. A follow-up CT scan of July 5, 2006 revealed a possible epidural hematoma from C2-5. Due to these findings, surgery was performed for a laminectomy of C3-5. What appeared to be a hematoma was actually dense scar tissue. Dr. Bae stated that the new diagnoses which resulted from the surgeries were cervical stenosis and cervical epidural adhesions. He advised that appellant's disability did not resolve after May 23, 2006 as she continued to have RSD symptoms. The dense scar adhesions caused displacement of the spinal cord and added to her original cervical stenosis problem, for which the laminectomy was required. Dr. Bae found that appellant was presently disabled due to the injuries and residuals related to the implant and authorized surgeries.

Dr. Denis Latuno, a Board-certified internist, submitted reports dated June 5 to October 29, 2007. He diagnosed: chronic neck pain secondary to degenerative joint disease; spinal stenosis, failed surgery; left knee pain; hypothyroidism; dyslipidemia; insomnia; depression and anxiety disorder.

In a March 17, 2008 report, Dr. Timothy J. Hunt, a Board-certified orthopedic surgeon, reviewed appellant's medical records and advised that no change in her treatment plan was necessary. On April 14, 2008 he diagnosed: status post right long finger injury on March 28, 1984 with apparent subsequent RSD; status post multiple surgeries for RSD including cervical laminectomies; possible impingement syndrome, bilaterally shoulders; and rule out bilateral carpal tunnel syndrome and/or cubital tunnel syndrome; bilateral de Quervain's tenosynovitis. Dr. Hunt stated that appellant was permanent and stationary but further medical treatment was required. He advised that appellant might have some instability issues with her arms bilaterally and recommended a cervical spine MRI scan with contrast. Dr. Hunt also recommended an EMG and nerve conduction study of appellant's arms for weakness in her intrinsic and thenar muscles, bilaterally. He recommended pain management and physical therapy for her neck, shoulder and wrist. Dr. Hunt opined that the employment injury caused appellant's current complaints and diagnosed conditions. In a May 9, 2008 report, he reiterated his diagnoses.

In a May 19, 2008 report, Dr. Khiem D. Dao, a Board-certified orthopedic surgeon specializing in hand surgery, reviewed the history of injury and listed findings on examination. He diagnosed bilateral hand and wrist diffuse strain/sprain and status post fracture right long finger. Dr. Dao advised that appellant's symptoms were chronic and diffuse and were not amenable to surgical intervention. He also noted that EMG studies were normal.

In an April 9, 2008 report, Dr. Robert A. Rafael, a Board-certified psychiatrist and neurologist, noted the history of injury, medical treatment and listed findings on examination. He diagnosed RSD, bilaterally, right greater than left. Dr. Rafael stated that appellant's stimulator implants were removed due to multiple complications and that there was some residual scarring. He advised that appellant had significant pain, despite her multiple medications. Dr. Rafael found no significant focal reflex change, motor weakness or sensory loss on her neurological examination, but there was a slightly abnormal EMG with bizarre high frequency potentials noted in the left biceps. He questioned whether this could be associated with her previous cervical surgeries and scarring. Dr. Rafael advised that there was no evidence of definite denervation.

By decision dated June 26, 2008, the Office denied modification of its previous decisions.

In a July 1, 2008 letter, appellant's attorney contended that the Office did not consider a June 2, 2008 report from Dr. Hunt. By letter dated July 16, 2008, the Office advised appellant that Dr. Hunt's June 2, 2008 report was received on July 1, 2008 and of record as of July 3, 2008. It noted that, while a June 5, 2008 cervical MRI scan report was received on June 26, 2008, it was not of record until June 30, 2008. The Office advised appellant to pursue her appeal rights if she still disagreed with the June 26, 2008 decision.

In a July 17, 2008 letter, appellant requested reconsideration. In the June 2, 2008 report, Dr. Hunt reevaluated appellant for the March 29, 1984 injuries. He noted that she was last seen on April 22, 2008 and was permanent and stationary. Dr. Hunt noted that she had received a left shoulder injection to reduce pain. He performed a physical examination of the cervical spine and both shoulders. Dr. Hunt repeated his prior diagnostic impressions.

By decision dated October 10, 2008, the Office denied further merit review on the grounds that the evidence was cumulative.

LEGAL PRECEDENT -- ISSUE 1

For each period of disability claimed, the employee has the burden of establishing that she was disabled for work as a result of the accepted employment injury.[2] Whether a particular injury causes an employee to become disabled for work, and the duration of that disability, are medical issues that must be established by a preponderance of probative and reliable medical opinion evidence.[3]

[2] *See Amelia S. Jefferson*, 57 ECAB 183 (2005); *see also David H. Goss*, 32 ECAB 24 (1980).

[3] *See G.T.*, 59 ECAB ___ (Docket No. 07-1345, issued April 11, 2008); *Edward H. Horton*, 41 ECAB 301 (1989).

If medical treatment is performed as a result of an employment injury, an injury caused by such treatment would constitute a compensable consequential injury.[4] The Board has held that surgery which is performed as a result of an employment injury and which causes further impairment constitutes a consequential injury and any related disability is compensable.[5] To meet her burden of proof, a claimant must submit rationalized medical evidence explaining how any claimed condition resulted from the work-related surgery.[6]

Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[7] Rationalized medical evidence includes a physician's medical opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factor. The opinion of the physician must be based on a complete factual and medical background of the claimant, be one of reasonable medical certainty, and must be supported by an explanation of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[8]

ANALYSIS -- ISSUE 1

The Office accepted that appellant sustained a chip fracture of the right middle finger while cleaning a machine on March 29, 1984. It subsequently accepted that she sustained causalgia, reflex sympathetic dystrophy of the right arm, triggering of the left thumb and middle finger and symptoms related to her head and neck. Appellant continued working under light duty until she stopped work in 1987 and received compensation for total disability.

A conflict in medical evidence arose between appellant's attending physician, Dr. Fan, and an Office referral physician, Dr. Roth, as to whether she had residuals of her accepted conditions which disabled her for work. Appellant was referred to Dr. Kiblinger, a Board-certified orthopedic surgeon, selected as the impartial medical specialist. In an August 21, 2002 report, Dr. Kiblinger found that appellant had no identifiable pathology of her right hand, no evidence of carpal tunnel syndrome, reflex sympathetic dystrophy, or causalgia. Examination of appellant's cervical spine and shoulders was characterized by the physician as revealing poor effort with nonphysiologic and bizarre responses on her part. Examination of her hands and fingers was reported as normal, with no trophic changes, swelling, temperature or color changes of the skin without demineralization of the bones of her hands and wrists. Dr. Kiblinger found that appellant's accepted conditions had resolved without any disability or residuals and that she was capable of returning to her regular duty full time without restriction. He noted that appellant's subjective complaints could not be explained on a medical basis.

[4] *See Ruey J. Yu*, 49 ECAB 256 (1997).

[5] *See Melody Friery*, 48 ECAB 525 (1997); *Florence L. Krause*, 33 ECAB 613 (1982).

[6] *See Harry D. Nelson*, 33 ECAB 1122 (1982).

[7] *D.G.*, 59 ECAB ____ (Docket No. 08-1139, issued September 24, 2008).

[8] *Id.*

The Office terminated appellant's compensation benefits for the accepted conditions effective November 3, 2002. As noted, following the September 11, 2003 decision of the Branch of Hearings and Review affirming the termination, appellant did not seek further review before the Board.

The Office reopened appellant's claim in 2006 for medical treatment related to difficulty with a previously authorized spinal cord stimulator. Surgery was performed on May 23, 2006 by Dr. Bae who diagnosed cervical stenosis, retained cervical implant and painful hardware. Dr. Bae performed a revision C5-6 and C7-T1 laminotomy/laminectomy for decompression and removal of the implant. He noted extensive scar tissue during the procedure. A CT scan obtained on July 5, 2006 revealed soft tissue abnormality within the right posterior epidural space extending from the level of C2-3 to C5-6, most likely an epidural hematoma that was displacing the spinal cord and causing moderate canal stenosis. Further surgery was performed by Dr. Bae on August 29, 2006 for cervical stenosis and removal of the epidural adhesions and scar tissue. He found that there was no actual hematoma but thick epidural scar tissue left over from the prior spinal cord stimulator implant. The Office authorized appellant's surgeries by Dr. Bae. It paid compensation for disability due to the malfunctioning spinal cord stimulator from October 23, 2003 to May 23, 2006 and for removal of the spinal cord stimulator and cervical laminectomy from May 23 through October 30, 2006.

Appellant premises her argument for compensation after October 31, 2006 on the fact that she has residuals of her accepted conditions dating back to the 1984 work injury. With regard to this aspect of her claim, the Board notes that the impartial medical report of Dr. Kiblinger found that all residuals of her accepted conditions had resolved as of his examination of March 5, 2002. In the alternative, appellant contends that her disabling residuals are due to the surgeries performed on May 23 and August 29, 2006, which were necessitated by the need to remove the authorized spinal stimulator. She also alleged injury to her left shoulder during the surgical procedures. The Board finds that the case is not in posture for decision on this aspect of her claim.

Dr. Bae addressed his findings on surgery and noted on September 25, 2006 that she complained of a stiff left shoulder. He noted a positive sign of impingement and rotator cuff weakness. Dr. Bae stated that the shoulder condition may have been accentuated during the surgical procedure in which appellant's shoulders were taped down. On October 30, 2006 he advised that a CT scan of the cervical spine was normal as far as the laminectomy surgery was concerned. Appellant complained of persistent neck pain and headaches which he noted were probably due to surgery. Dr. Bae characterized her cervical condition as permanent and stationary, noting that she would not be able to do any type of productive work due to rotator cuff pathology and stiffness of the left shoulder. On January 18, 2007 he stated that appellant was healed with regard to removal of the spinal cord stimulator and cervical laminectomy. Appellant again noted her left shoulder complaint which Dr. Bae stated was most likely a rotator cuff tear. In addressing disability Dr. Bae noted that, if appellant was disabled prior to October 30, 2006, she remained disabled as removal of the stimulator did not provide any improvement. He reiterated his opinion on February 28, 2007, noting that she was permanent and stationary and that he was not qualified to rate her disability status. On January 22, 2008 Dr. Bae stated that appellant's diagnosis in 2003 was reflex sympathetic dystrophy, based on the chip fracture she sustained to her right middle finger. He discussed the surgical procedures of

2006, stating that the new diagnoses of cervical stenosis and cervical epidural adhesions resulted from the surgeries. Dr. Bae found that she was totally disabled due to residuals related to the authorized surgeries.

Appellant was referred by the Office to Dr. HaEri for examination. Dr. HaEri provided findings on examination, noting that appellant had additional symptoms to her left upper extremity as a result of the surgical procedures. He found weakness in grip strength to appellant's hands which he attributed to epidural hematoma formation which led to cervical stenosis. As a result of the surgeries, Dr. HaEri advised that appellant had permanent partial sensory and motor deficit. He recommended conservative medical treatment. Dr. HaEri did not specifically address the period of disability related to the authorized surgeries. Additional medical evidence was received from Dr. Latuno who did not address the issue of disability. Dr. Hunt provided several reports noting that no change to appellant's treatment plan was necessary and recommended additional diagnostic testing. He related appellant's ongoing symptoms back to the 1984 employment injury but did not address the issue of disability attributable to her surgeries in 2006. Dr. Dao and Dr. Rafael reported findings on examination of appellant but did not address the issue of her disability related to the 2006 surgeries.

Appellant has the burden of establishing that her disability after October 30, 2006 is due to residuals of the surgeries authorized in May and August 2006. The medical evidence of record is generally supportive of appellant's claim and is sufficient to require further development by the Office.[9] On remand, the Office should refer appellant to an appropriate specialist for examination and a rationalized medical opinion. After such further development as it deems necessary, the Office should issue a *de novo* decision on appellant's claim for compensation.

CONCLUSION

The Board finds the case is not in posture for decision as to whether appellant's disability after October 31, 2006 is causally related to residuals of her authorized surgeries.[10]

[9] *See John J. Carlone*, 41 ECAB 354 (1989); *Horace Langhorne*, 29 ECAB 820 (1978).

[10] Based on this determination, the second issue in this case is moot.

ORDER

IT IS HEREBY ORDERED THAT the October 10 and June 26, 2008 decisions of the Office of Workers' Compensation Programs be set aside. The case is remanded for further development consistent with this decision.

Issued: April 20, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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