

FACTUAL HISTORY

This case has previously been before the Board.² In a March 25, 2013 decision, the Board affirmed a June 12, 2012 OWCP decision suspending appellant's compensation benefits effective December 15, 2011 under 5 U.S.C. § 8123(d) as she failed to attend a scheduled medical examination on November 21, 2011 by Dr. Ronald M. Lampert, a Board-certified orthopedic surgeon and OWCP referral physician. The facts and the circumstances of the case are set forth in the Board's prior decision and are incorporated herein by reference. The relevant facts are set forth below.

On April 1, 2010 appellant, then a 34-year-old city carrier, filed an occupational disease claim alleging that on March 24, 2010 she realized that her left shoulder, left upper back, and left neck pain was caused or aggravated by her federal employment. She attributed her conditions to a change in her workstation and method for performing her work duties. Appellant stated that an extra level was added to her case and she was required to reach across her body and above her shoulders to case mail.

OWCP accepted appellant's claim for sprain of her left shoulder and upper arm, and left superior glenoid labrum lesion. It authorized left shoulder arthroscopy with repair of superior labrum anterior and posterior labral (SLAP) tear, extensive debridement of partial thickness rotator cuff tear, and subacromial decompression performed on October 4, 2010. Appellant has not returned to work.

Appellant ultimately attended a scheduled examination with Dr. Lampert on March 21, 2012. In several reports, including a July 5, 2012 addendum report, Dr. Lampert advised that the results of a June 27, 2012 functional capacity evaluation were inconsistent with appellant's self-limiting behavior. Based on these inconsistent examination findings, he opined that she was at maximum medical improvement (MMI) and could return to her normal letter carrier work duties as described in a March 3, 2011 statement of accepted facts. Dr. Lampert concluded that no further medical treatment was necessary.

In a July 18, 2012 report, Dr. Ravindranath Koopot, an attending Board-certified general and thoracic surgeon, provided a history of appellant's family, social, and medical background. He listed findings on physical examination, assessed thoracic outlet syndrome, and recommended surgery to treat the diagnosed condition. Dr. Koopot noted that appellant had been off work due to her disability and advised that she could eventually return to work following the proposed surgery.

On August 16, 2012 OWCP determined that there was a conflict in medical opinion between Drs. Lampert and Koopot regarding appellant's residuals and work capacity.

By letter dated August 27, 2012, OWCP referred appellant, together with the case record and a statement of accepted facts, to Dr. Marc J. Rosen, a Board-certified orthopedic surgeon, for an impartial medical examination. In a September 27, 2012 report, Dr. Rosen reviewed a history of the accepted employment injuries and appellant's medical treatment. On physical

² Docket No. 12-1892 (issued March 25, 2013).

examination, he found no obvious muscular atrophy in either the left or right upper extremity. Range of motion of the elbow, wrist, and forearm bilaterally was normal. There was a very slight restriction of abduction of the left shoulder compared to the right shoulder with approximately a five-degree discrepancy, the right being completely normal, the left being approximately five degrees less. Internal and external rotation was equal bilaterally. There was evidence on the skin of healed arthroscopic punctures on the left shoulder. Appellant demonstrated normal deep tendon reflexes of the biceps, triceps, and brachioradialis bilaterally. She was unable to grip as firmly on the left as on the right, however, manual motor testing in flexion and extension of the wrist, elbow, forearm, and opposition of the thumb and digits was entirely normal. Sensory testing was inconsistent with appellant's intermittent complaints about different areas of the left arm being less sensate than the right. Pulsations were normal in both left and right upper extremities, 3+ at the brachial artery, and the radial and ulnar arteries in both extremities. An Adson's test was negative bilaterally. There were no signs of any focal neurologic deficits in the left or right upper extremity. There were no focal signs of any vascular impairment of the left or right upper extremity.

Dr. Rosen agreed with Dr. Lampert's assessment of appellant's status. He disagreed with Dr. Koopot's proposed surgical intervention to treat thoracic outlet syndrome. Dr. Rosen did not see any indication from laboratory or clinical findings that appellant's current disability was related to the work injury. He advised that she had reached MMI and that, other than a slight asymmetry of shoulder abduction of less than five degrees, there was no impairment. Dr. Rosen further advised that appellant did not suffer from a work-related consequential thoracic outlet condition requiring the proposed surgery. He stated that, while an Adson's test was not a definitive diagnosis for this condition and it may be limited by an examiner's bias, it was a known fact that some people could demonstrate a positive Adson's test without having true thoracic outlet syndrome. Dr. Rosen nonetheless advised that appellant did not demonstrate any of the clinical symptoms associated with a need for surgery for thoracic outlet syndrome. He did not see any evidence that her condition was aggravated as no temporary or permanent change had occurred to alter the course of any underlying disease.

Dr. Rosen also did not see any objective findings to correlate with appellant's subjective complaints. Appellant had no preexisting conditions and none of these factors contributed to her current subjective or objective findings. Dr. Rosen believed that her current condition was not likely to change and stated that no additional treatment was recommended. He reported that Dr. Koopot's diagnosis of thoracic outlet syndrome and proposed surgery were not related to her industrial injury and preexisted any injury or traumatic event. Dr. Rosen advised that appellant did not have any restrictions that prevented her from returning to her regular work duties. He found that her examination was essentially normal and other than her subjective complaints, no objective evidence of impairment or limitation of function could be identified. Dr. Rosen noted that four electromyogram and nerve conduction velocities (EMG/NCV) studies confirmed normal neurologic function in appellant's upper extremity, yet her examination showed inconsistencies not compatible with this objective data. There was no reason provided as to why appellant could not perform modified-work assignments. She did not suffer any residuals of the accepted conditions other than a five-degree discrepancy in shoulder abduction above the horizontal comparing the left to the right. Both arms, however, demonstrated range of motion well within a normal physiologic position. Dr. Rosen attributed the slight restriction of appellant's left shoulder to the arthroscopic surgery and the presence of the labral repair. He

noted that alteration of the glenoid labrum and tightening of the anterior capsule of the shoulder may very well have produced this condition and minimum range of motion discrepancy. Dr. Rosen concluded that his findings were in concert with Dr. Lampert's findings. In a work capacity evaluation (Form OWCP-5c) dated September 27, 2012, he indicated that appellant could work eight hours a day with certain restrictions for nonwork-related conditions, which included pushing, pulling, and lifting up to 50 pounds.

By letter dated March 4, 2013, OWCP notified appellant that it proposed to terminate her wage-loss compensation benefits based on Dr. Rosen's impartial medical opinion. It allotted 30 days for her to submit additional evidence or argument in disagreement with the proposed action.

In a timely March 25, 2013 narrative statement, appellant contended that Dr. Rosen's report was not entitled to the weight of the medical evidence as it was not rationalized. She contended that his physical findings did not substantiate his medical opinion and there were obvious inconsistencies in his report. Appellant requested, among other things, that Dr. Rosen submit a report explaining and clarifying why she could perform her work duties.

In a March 12, 2013 attending physician's report (Form CA-20), Dr. Koopot identified the date of injury as March 24, 2010 and indicated with an affirmative mark that appellant's improving neurogenic thoracic outlet bilateral obstruction symptoms were aggravated by repetitive movements at work. He indicated that the period of total disability was not applicable as he did not evaluate her for a disability determination, but rather for the clinical correlation of her thoracic outlet obstruction. In a March 13, 2013 narrative report, Dr. Koopot noted appellant's left upper extremity complaints, provided findings on physical examination, reiterated his prior assessment of thoracic outlet syndrome and assessed limb pain. He noted that her pain improved with restricted activity and movement of the left upper extremity, but reported that her release to an unrestricted work position which included weight bearing would present a significant chance of a recurrence of her prior symptoms. Based on these findings, Dr. Koopot did not recommend left-sided upper and lower thoracic outlet decompression surgery at that time. He noted that appellant had not been able to return to work due to persistent left shoulder symptoms and she had been on work restrictions since that time.

In a March 20, 2013 Form CA-20, Dr. Susan C. Sorosky, a Board-certified physiatrist, identified the date of injury as March 24, 2010. She indicated with an affirmative mark that appellant had thoracic outlet syndrome caused or aggravated by an employment activity. Dr. Sorosky explained that the diagnosed condition was caused by repetitive movement of the left upper extremity. She stated that appellant was not evaluated for disability purposes. In a March 22, 2013 progress note, Dr. Sorosky listed findings on physical examination, reviewed diagnostic test results, and assessed diffuse cervicobrachial syndrome and shoulder joint pain. She advised that appellant's history, physical examination, and ancillary findings were consistent with chronic left arm pain and paresthesias likely related to thoracic outlet syndrome. Dr. Sorosky related that clinical ulnar neuritis should also be considered. She stated that these symptoms began after appellant's work-related injury culminating in her October 2010 labral repair. Dr. Sorosky agreed with the recommendations of Dr. Koopot, a Dr. Wheatley,³ and

³ The Board notes that the full name and professional qualifications of Dr. Wheatley are not contained in the case record.

Dr. Byron H. Willis, Jr., a Board-certified radiologist, as related by appellant that she undergo thoracic outlet release and ulnar nerve release.

In a March 27, 2013 addendum to her March 22, 2013 progress note, Dr. Sorosky advised that based on a normal EMG/NCV study for ulnar neuropathy she doubted that this was a clinical pain generator.

On March 20, 2013 Dr. Frank Moussa, a Board-certified orthopedic surgeon, noted appellant's left upper extremity complaints, provided physical examination findings, and diagnosed impingement syndrome, a superior glenoid labrum lesion, and an ulnar nerve injury. He opined that there was nothing more that could be done for her shoulder given the fact that she already had a labral repair.

Also, on March 20, 2013 Dr. Raymond A. Murphy, a Board-certified radiologist, reported that a cervical spine x-ray revealed no fracture, malalignment, or prevertebral soft tissue swelling. He found mild loss of cervical lordosis, mild disc narrowing, and spondylosis deformans at C4-5 and C5-6, mild posterior osseous ridging at C4-5 and C5-6, mild uncovertebral joint arthrosis at C4-5 and C5-6, and a normal atlantodental interval and dens.

In a left shoulder x-ray report dated March 20, 2013, Dr. Adrian Moyer, a Board-certified radiologist, advised that there was no acute bone finding.

In a March 27, 2013 letter, Dr. Candyce D. Williams, a Board-certified internist and physiatrist, noted that appellant had a history of neck, shoulder, and back pain secondary to a motor vehicle accident in 2005 to 2006. She noted a normal sensory examination as there was no evidence of nerve entrapment or sensory loss. Dr. Williams also noted appellant's pain treatment and concluded that she had recovered from this incident and had returned to full-time work.

On April 9, 2013 Dr. Willis reported appellant's left upper extremity symptoms. He recommended a repeat EMG study to determine if her condition had progressed consistent with her clinical picture. Dr. Willis advised that appellant did not appear to have symptoms consistent with neurogenic thoracic outlet syndrome or vascular thoracic outlet syndrome. He ordered a set of cervical x-rays to assess for a small cervical rib that may not be visible on a magnetic resonance imaging (MRI) scan.

In a May 22, 2013 decision, OWCP terminated appellant's wage-loss compensation and medical benefits effective that day. It found that the medical evidence submitted was insufficient to outweigh the special weight accorded to Dr. Rosen's opinion as an impartial medical specialist.

By letters dated June 4 and 12, 2013, appellant requested reconsideration and submitted medical evidence.⁴ In a September 15, 2011 left brachial plexus MRI scan report, Dr. Angela M.

⁴ On June 5, 2013 appellant requested a review of the written record by an OWCP hearing representative regarding OWCP's May 22, 2013 termination decision. By letter dated June 21, 2013, she stated that she wished to withdraw this request and pursue her reconsideration request.

Dagirmanjian, a Board-certified radiologist, advised that the test was unremarkable and unenhanced. Also, on September 15, 2011 she reported that a cervical spine MRI scan showed C4-5 disc-osteophyte complex which resulted in flattening of the ventral aspect of the spinal cord parenchyma which was asymmetric to the right of midline. Dr. Dagirmanjian found C5-6 disc-osteophyte complex with contouring with mild flattening of the ventral aspect of the spinal cord parenchyma. She advised that no neural foraminal stenosis was identified or focal cervical spinal cord parenchymal signal intensity abnormality was seen.

In notes dated September 23 and November 20, 2011, Dr. Moussa listed physical examination findings, reiterated that his prior diagnoses of impingement syndrome and superior glenoid labrum lesion of the left shoulder, and diagnosed left shoulder pain.

In reports and a letter dated August 12 to November 28, 2011 and June 3, 2013, Dr. Sorosky diagnosed left shoulder pain, impingement syndrome, and SLAP lesion, and thoracic outlet syndrome. In the November 28, 2011 letter and June 3, 2013 report, she opined that appellant's SLAP lesion and subsequent surgery, and thoracic outlet syndrome were related to her accepted work injury and repetitive stress motion inherent in her mail carrier job. Dr. Sorosky deferred a determination regarding her current work abilities and job restrictions to Dr. Moussa. In a May 11, 2012 report, she found that an electrodiagnostic study was normal. There was no evidence of left cervical radiculopathy, brachial plexopathy, or other peripheral nerve pathology affecting the left upper extremity, including the ulnar nerve at the elbow as specifically queried by Dr. Willis.

In a partial copy of a report dated April 9, 2012 and a May 14, 2013 progress note, Dr. Willis noted appellant's left upper extremity complaints, provided findings on physical examination, and assessed left ulnar neuropathy. He advised that, although an EMG was negative, clinically she still had symptoms consistent with ulnar nerve irritation. Dr. Willis concluded that appellant was a good candidate for left ulnar nerve decompression. In a June 7, 2013 letter, he advised that she had cubital tunnel syndrome of the left arm as a result of her accepted occupational repetitive stress motion injury which rendered her unfit for duty as a mail carrier. Dr. Willis recommended surgery to repair this condition. He noted that appellant did not have any previous history of trauma to the left upper extremity. Dr. Willis recommended that she not return to her prior mail carrier job while still bearing this disorder. He reported that, if left untreated, then ulnar nerve entrapment at the elbow could result in a progressive motor deficit and ultimately, flexion contracture of the affected fingers. Dr. Willis noted that symptoms which included pain, numbness, and tingling within the ulnar nerve distribution of the hand usually occurred after repetitive elbow motions or from repeated pressure on the elbow while sorting mail which was listed in appellant's mail carrier job description.

In a March 29, 2013 report, Dr. Williams noted appellant's left upper extremity complaints, listed findings on physical examination, and diagnosed neck and shoulder pain. She noted appellant's documented normal neurologic and sensory examinations from 2005 to 2006. Dr. Williams further noted that she had treated appellant for myofascial pain secondary to a motor vehicle accident. She advised that appellant currently had new left shoulder pain and neurologic symptoms in her hand which were not present from 2005 to 2006.

In a June 17, 2013 letter, Ann M. Noser, a licensed professional counselor, stated that appellant had received 11 counseling sessions that began on February 13, 2012.

An unsigned letter dated July 17, 2013 from AZ Neurosurgery and Spine Specialists stated that appellant was scheduled to undergo left ulnar nerve decompression at the elbow on July 30, 2013 by Dr. Willis. In a July 30, 2013 note, Dr. Willis described the left elbow surgery.

By decision dated September 10, 2013, OWCP denied modification of the May 22, 2013 decision. It found that the medical evidence submitted was insufficient to outweigh the special weight accorded to Dr. Rosen's impartial medical opinion.

In a September 18, 2013 letter, appellant again requested reconsideration.

In a September 25, 2013 decision, OWCP denied appellant's request for reconsideration without a merit review of her claim. It found that she had not submitted any relevant or pertinent new evidence.

By letter dated October 15, 2013, appellant requested reconsideration and submitted a September 23, 2013 report from Dr. Sorosky, who described her left elbow symptoms, findings on physical and neurological examination, and reiterated her assessment of diffuse cervicobrachial syndrome and shoulder joint pain. Dr. Sorosky advised that appellant possibly had clinical thoracic outlet syndrome which developed after a work-related injury culminating in the October 2010 labral repair. In an addendum also dated September 23, 2013, she expressed her disagreement with Dr. Rosen's September 21, 2012 findings that appellant's diagnoses were not work related, that she was at maximum medical improvement, she did not have thoracic outlet syndrome, and that she did not need any more treatment. Dr. Sorosky advised that the diagnoses were work related. Given that appellant just had surgery for cubital tunnel and was undergoing physical therapy, she was not at maximum medical improvement. Dr. Sorosky believed that appellant had clinical thoracic outlet syndrome even though EMG/NCV imaging tests had been normal. She concluded that appellant may need additional treatment for this condition.

In an October 10, 2013 report, Dr. Willis noted appellant's left hand symptoms, listed physical examination findings and assessed a routine postoperative course status post left ulnar nerve decompression with resolution of preoperative symptoms.

In a January 8, 2014 decision, OWCP denied modification of the May 22, 2013 decision. It again found that the medical evidence submitted was insufficient to outweigh the special weight accorded to Dr. Rosen's impartial medical opinion.

By letters dated October 27, 2013, February 18, and March 24 and 25, 2014, appellant, through counsel, requested reconsideration before OWCP regarding the suspension of her compensation benefits. She contended that neither the Board's decision nor OWCP's decision explained why she was not entitled to wage-loss compensation from March 21 to June 27, 2012. Appellant stated that her obstruction of the scheduled examination ceased on March 21, 2012 and that she was entitled to compensation as of that date. She related that she was unable to attend the scheduled medical examination due to medical reasons.

In a February 24, 2014 report, Dr. Sorosky reiterated that her prior assessments of primary diffuse cervicobrachial syndrome and shoulder joint pain. She advised that appellant's history and physical examination, and her ancillary findings were consistent with 60 percent improved chronic left arm pain and paresthesias which was multifactorial. Dr. Sorosky noted appellant's March 2010 employment injury and diagnosis of cubital tunnel syndrome, for which she was status post July 2013 cubital tunnel surgery. She advised that appellant was due to return to work on April 14, 2014. Dr. Sorosky opined that her shoulder injury and resultant surgery, and thoracic outlet syndrome were due to the accepted March 24, 2010 work injury. She found appellant unable to complete her normal mail carrier duties at that time. Dr. Sorosky set forth appellant's restrictions and concluded that she would be at MMI upon completion of physical therapy.

In a February 27, 2014 summary of appellant's visit, Dr. Cheryl Villamor Nierva, a Board-certified family practitioner, provided findings on physical examination and diagnosed chronic left shoulder pain and thoracic outlet syndrome. In another report dated February 27, 2014, she diagnosed cubital tunnel syndrome, a superior glenoid labrum lesion, and thoracic outlet syndrome of the left upper extremity. Dr. Villamor Nierva advised that appellant could return to part-time sedentary light-duty office work, four hours a day, on May 1, 2014. She expected appellant to return to full-duty work on June 30, 2014 with restrictions.

By decision dated April 10, 2014, OWCP denied a merit review of the suspension of appellant's compensation benefits because the evidence submitted was cumulative and repetitious, and that she had submitted no new relevant argument.

LEGAL PRECEDENT -- ISSUE 1

According to FECA, once OWCP accepts a claim and pays compensation, it has the burden of justifying termination or modification of an employee's benefits.⁵ It may not terminate compensation without establishing that the disability had ceased or that it was no longer related to the employment.⁶ OWCP's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.⁷ The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability compensation.⁸ To terminate authorization for medical treatment, OWCP must establish that appellant no longer has residuals of an employment-related condition, which require further medical treatment.⁹

⁵ *S.F.*, 59 ECAB 642 (2008); *Kelly Y. Simpson*, 57 ECAB 197 (2005); *Paul L. Stewart*, 54 ECAB 824 (2003).

⁶ *Jason C. Armstrong*, 40 ECAB 907 (1989); *Charles E. Minnis*, 40 ECAB 708 (1989); *Vivien L. Minor*, 37 ECAB 541 (1986).

⁷ *See Del K. Rykert*, 40 ECAB 284, 295-96 (1988).

⁸ *A.P.*, Docket No. 08-1822 (issued August 5, 2009); *T.P.*, 58 ECAB 524 (2007); *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

⁹ *A.P., id.*; *James F. Weikel*, 54 ECAB 660 (2003); *Pamela K. Guesford*, 53 ECAB 727 (2002).

Section 8123(a) of FECA provides that, if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.¹⁰ This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.¹¹ When there exists opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.¹²

ANALYSIS -- ISSUE 1

The Board finds that OWCP met its burden of proof to terminate appellant's compensation and medical benefits on May 22, 2013.

OWCP accepted appellant's claim for sprain of the left shoulder and upper arm and a lesion on the left superior glenoid labrum, and authorized left shoulder arthroscopic surgery performed on October 4, 2010. It terminated her wage-loss compensation and medical benefits effective May 22, 2013 finding that the accepted employment-related conditions had resolved without residuals based on the opinion of the impartial medical examiner, Dr. Rosen.

OWCP referred appellant to Dr. Rosen to resolve a conflict in medical opinion between Drs. Koopot and Lampert. Dr. Koopot, a treating physician, opined that appellant had thoracic outlet syndrome requiring surgery and that she was totally disabled. Dr. Lampert, an OWCP referral physician, opined that appellant had no work-related residuals or disability. The Board affirms the finding of a conflict in medical opinion between Dr. Koopot and Dr. Lampert on the issues of medical residuals and disability. OWCP referred appellant to Dr. Rosen to resolve the conflict under 5 U.S.C. § 8123(a).

In his September 27, 2012 report, Dr. Rosen provided findings based on a physical examination, a review of the statement of accepted facts, and medical history. He determined that appellant no longer suffered residuals of her accepted employment-related left shoulder injuries and did not need any further medical treatment. Dr. Rosen stated that the right and left upper extremities were essentially normal on examination. A very slight restriction of abduction of the left shoulder was noted compared to the right shoulder with approximately a five-degree discrepancy, but both arms demonstrated range of motion well within a normal physiologic position. An inability to grip as firmly on the left as on the right was also noted, however, manual motor testing in flexion and extension of the wrist, elbow, forearm, and opposition of the thumb and digits was entirely normal. Appellant's intermittent complaints about different areas of the left arm being less sensate than the right were inconsistent with normal sensory findings

¹⁰ 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

¹¹ 20 C.F.R. § 10.321.

¹² *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

on examination and a negative Adson's test. Dr. Rosen advised that she did not sustain thoracic outlet syndrome as a consequence of the accepted injuries. He explained that appellant did not demonstrate any symptoms and there were no laboratory or clinical findings of this condition. Dr. Rosen found that she had no disability due to her accepted injuries. He opined that appellant reached maximum medical improvement and that she could return to work full-time regular duty with some lifting restrictions over 50 pounds.

The Board finds that Dr. Rosen had an accurate knowledge of the relevant facts and evaluated the course of appellant's condition. Dr. Rosen is a specialist in the appropriate field. At the time benefits were terminated, he determined that appellant had no work-related residuals or disability for full-time employment. Dr. Rosen's opinion as set forth in his September 27, 2012 report is probative and reliable evidence. The Board finds that his opinion constitutes the special weight of the medical evidence and is sufficient to justify OWCP's termination of compensation and medical benefits for the accepted condition of left shoulder sprain and upper arm and left superior glenoid labrum lesion.

The Board further finds that the medical evidence submitted after Dr. Rosen's impartial medical evaluation report does not overcome the weight of his report or create a conflict in medical evidence. Dr. Sorosky's November 28, 2011 and September 23, 2013 reports found that appellant's superior glenoid labrum lesion of the left shoulder and resultant authorized surgery are causally related to her repetitive work duties. However, she did not provide any medical rationale explaining why the accepted employment-related left shoulder injury and authorized surgery caused continuing residuals. The Board has held that opinions unsupported by rationale are of diminished probative value.¹³ Further, Dr. Sorosky did not offer an opinion on appellant's disability and deferred her opinion on her disability and restrictions, to Dr. Moussa. The Board has held that 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.¹⁴

The above-noted reports from Dr. Sorosky, September 15, 2011 diagnostic test results from Dr. Dagirmanjian, September 23 and November 20, 2011 notes from Dr. Moussa, April 9, 2012 and June 7, 2013 reports, and May 14, 2013 progress note from Dr. Willis, and March 29, 2013 report from Dr. Williams found that appellant had thoracic outlet syndrome, diffuse cervicobrachial syndrome, shoulder joint pain, C5-6 disc-osteophyte complex with contouring with mild flattening of the ventral aspect of the spinal cord parenchyma, left shoulder impingement syndrome and pain, left ulnar neuropathy, cubital tunnel syndrome of the left arm, neck pain. As OWCP had not accepted any additional left shoulder condition or left arm, thoracic, and cervical conditions as employment related, appellant had the burden of proof to establish a nexus between these conditions and the accepted employment injuries.¹⁵

¹³ *T.M.*, Docket No. 08-975 (issued February 6, 2009); *Roma A. Mortenson-Kindschi*, 57 ECAB 418 (2006).

¹⁴ See *K.W.*, 59 ECAB 271 (2007); *A.D.*, 58 ECAB 149 (2006); *Jaja K. Asaramo*, 55 ECAB 200 (2004); *Michael E. Smith*, 50 ECAB 313 (1999).

¹⁵ *T.M.*, *supra* note 13.

Dr. Sorosky opined that appellant's thoracic outlet syndrome was caused by the accepted employment injuries and her repetitive mail carrier duties, but she did not explain her diagnosis in light of contrary diagnostic evidence, normal electrodiagnostic test results, or provide medical rationale to support her opinion on causal relationship.¹⁶ In addition, she diagnosed diffuse cervicobrachial syndrome and shoulder joint pain. Dr. Sorosky disagreed with Dr. Rosen's opinion that appellant's conditions were not work related, but did not provide any rationalized medical opinion stating that the diagnosed conditions and any resultant disability were causally related to the accepted injuries.¹⁷ As noted, she deferred her opinion regarding appellant's work capacity and restrictions to Dr. Moussa.

Similarly, neither Dr. Dagirmanjian nor Dr. Moussa provided any medical opinion addressing whether appellant's cervical and left shoulder conditions were caused by the accepted employment injuries and resulted in her disability for work.¹⁸

Dr. Willis stated that appellant's cubital tunnel syndrome of the left arm and disability for work in her mail carrier position resulted from the accepted employment injuries because she did not have any previous history of trauma to the left upper extremity and that, symptoms of pain, numbness, and tingling within the ulnar nerve distribution of the hand usually occurred after repetitive elbow motions or from repeated pressure on the elbow found in sorting mail which was listed in her job description. However, he did not sufficiently explain how sorting mail caused the purported residuals and disability.¹⁹ Moreover, Dr. Willis did not sufficiently explain his diagnosis of left ulnar neuropathy, which required surgery, in light of a normal EMG study.²⁰

Dr. Williams listed examination findings and diagnosed neck and new left shoulder pain, and neurologic symptoms in the hand. The Board has long held that pain is a symptom, not a compensable medical diagnosis.²¹ Dr. Williams failed to provide any rationale as to whether appellant's neck and shoulder pain resulted in a medical condition.

The June 17, 2013 letter from Ms. Noser, a licensed professional counselor, has no probative medical value. A licensed professional counselor is not a physician under FECA.²²

¹⁶ See cases cited *supra* note 13.

¹⁷ See cases cited *supra* note 14.

¹⁸ *Id.*

¹⁹ See cases cited, *supra* note 13.

²⁰ *Id.*

²¹ *C.F.*, Docket No. 08-1102 (issued October 10, 2008).

²² 5 U.S.C. § 8101(2); *Phillip L. Barnes*, 55 ECAB 426 (2004). The Board notes that OWCP in its discretion may reimburse a claimant for treatment or services provided by a lay psychotherapist if authorized or recommended by a physician for the effects of an accepted condition. Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Services and Supplies*, Chapter 3.400.5 (April 1993). The issue of medical reimbursement is separate and apart from the issue of a layperson's lack of medical competency in providing an opinion on disability or causal relationship.

The unsigned July 17, 2013 letter from AZ Neurosurgery and Spine Specialists has no probative value in establishing that appellant has any continuing employment-related residuals or disability, as it is not clear whether a physician under FECA prepared the reports. It is well established that medical evidence lacking proper identification is of no probative medical value.²³

It is therefore concluded by the Board that OWCP met its burden of proof to terminate appellant's compensation and medical benefits on May 22, 2013.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

LEGAL PRECEDENT -- ISSUE 2

To require OWCP to reopen a case for merit review under section 8128 of FECA,²⁴ OWCP's regulations provide that a claimant must: (1) show that OWCP erroneously applied or interpreted a specific point of law; (2) advance a relevant legal argument not previously considered by OWCP; or (3) constitute relevant and pertinent new evidence not previously considered by it.²⁵ To be entitled to a merit review of an OWCP decision denying or terminating a benefit, a claimant also must file his or her application for review within one year of the date of that decision.²⁶ Section 10.608(b) of the implementing regulations state that any application for review that does not meet at least one of the requirements listed in 20 C.F.R. § 10.606(b)(3) will be denied by OWCP without review of the merits of the claim.²⁷

ANALYSIS -- ISSUE 2

Following the Board's March 25, 2013 decision affirming OWCP's suspension of her compensation benefits effective December 15, 2011 based on her refusal to attend a scheduled medical examination on November 21, 2011 by Dr. Lampert, appellant requested reconsideration before OWCP.

The Board finds that appellant did not show that OWCP erroneously applied or interpreted a specific point of law. Moreover, appellant did not advance a relevant legal argument not previously considered. In her requests for reconsideration, she contended that neither the Board's decision nor OWCP's decision explained why she was not entitled to wage-loss compensation from March 21 to June 27, 2012. The Board explained in its March 25, 2013

²³ *Thomas L. Agee*, 56 ECAB 465 (2005); *Richard F. Williams*, 55 ECAB 343 (2004); *Merton J. Sills*, 39 ECAB 572 (1988).

²⁴ 5 U.S.C. §§ 8101-8193. Under section 8128 of FECA, the Secretary of Labor may review an award for or against payment of compensation at any time on his own motion or on application. 5 U.S.C. § 8128(a).

²⁵ 20 C.F.R. § 10.606(b)(3).

²⁶ *Id.* at § 10.607(a).

²⁷ *Id.* at § 10.608(b); *see also Norman W. Hanson*, 45 ECAB 430 (1994).

decision why appellant's contention was not relevant before the Board. The Board found that the relevant issue was whether OWCP had properly suspended appellant's compensation benefits effective December 15, 2011 under 5 U.S.C. § 8123(d) due to her failure to attend the scheduled medical examination of November 21, 2011. The Board found that appellant had not submitted sufficient evidence to establish that she was incapable of attending the November 21, 2011 examination and, thus, found that OWCP properly suspended her compensation benefits effective December 15, 2011.

Similarly, OWCP explained in its April 10, 2014 decision that appellant's contention regarding her entitlement to further compensation was not relevant. It noted that the Board's March 25, 2013 decision explained that the sole issue was whether OWCP properly suspended her compensation benefits on December 15, 2011 and not when obstruction ceased. OWCP found that appellant's contention was cumulative in nature and had been previously considered in its December 15, 2011, June 12, 2012, and March 25, 2013 decisions.

Appellant further contended that she was entitled to wage-loss compensation from March 21 to June 27, 2012 because her obstruction of the schedule examination ceased on March 21, 2012. As noted, this contention was previously considered by the Board in its March 25, 2013 decision. The Board has held that the submission of evidence or argument which repeats or duplicates evidence or argument already in the case record does not constitute a basis for reopening a case.²⁸ Appellant did not otherwise make any argument to establish an error on a specific point of law. Consequently, she was not entitled to a review of the merits of her claim based on the first and second above-noted requirements under section 10.606(b)(3).²⁹

The Board further finds that appellant did not submit relevant and pertinent new evidence not previously considered. Dr. Sorosky's February 24, 2014 report and Dr. Villamor Nierva's February 27, 2014 reports addressed appellant's left upper extremity conditions, the causal relationship between these conditions and the accepted employment injuries, and appellant's work capacity. This evidence does not address appellant's inability to report to the examination scheduled for November 2011 and is therefore not relevant to the issue of whether she has established good cause for failing to submit to the November 21, 2011 medical examination by Dr. Lampert.³⁰

The Board accordingly finds that appellant did not meet any of the requirements of 20 C.F.R. § 10.606(b)(3). Appellant did not show that OWCP erroneously applied or interpreted a specific point of law, advance a relevant legal argument not previously considered by OWCP or submit relevant and pertinent new evidence not previously considered by OWCP. Pursuant to 20 C.F.R. § 10.608, OWCP properly denied merit review.

On appeal, counsel contended that OWCP's April 10, 2014 decision is contrary to law and fact. As discussed above, appellant did not provide argument or evidence satisfying any of

²⁸ See *A.L.*, Docket No. 08-1730 (issued March 16, 2009).

²⁹ 20 C.F.R. § 10.606(b)(3).

³⁰ *M.E.*, 58 ECAB 694 (2007); *D'Wayne Avila*, 57 ECAB 642 (2006) (the submission of evidence that does not address the relevant issue involved does not constitute a basis for reopening a case).

the three regulatory criteria for reopening a claim. Therefore, OWCP properly denied the request for reconsideration.

On appeal, appellant submitted additional evidence. However, the Board may not consider new evidence on appeal.³¹

CONCLUSION

The Board finds that OWCP properly terminated appellant's wage-loss compensation and medical benefits effective May 22, 2013. The Board further finds that it properly denied her request for further merit review of her claim pursuant to 5 U.S.C. § 8128(a) regarding its suspension of her compensation for failing to attend a scheduled medical examination.

ORDER

IT IS HEREBY ORDERED THAT the April 10 and January 8, 2014 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: May 7, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

³¹ See 20 C.F.R. § 501.2(c)(1).