U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of SHARON R. WILCOX and U.S. POSTAL SERVICE,
POST OFFICE, Aztec, NM

Docket No. 98-2281; Submitted on the Record;
Issued June 8, 2000

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether the Office of Workers' Compensation Programs' refusal to reopen appellant's case for a merit review of her claim under 5 U.S.C. § 8128 constituted an abuse of discretion.

On January 6, 1989 appellant, then a 47-year-old rural carrier associate, filed a notice of traumatic injury alleging that on December 24, 1988 she slipped on some snow and injured her right knee, right wrist, right hand and right thumb in the course of her federal employment. The Office accepted the claim for a right wrist and hand sprain. Appellant returned to light-duty work on December 27, 1988.

On January 15, 1990 Dr. J.W. Ragsdale, a clinical psychologist, reviewed appellant's history and conducted a psychological evaluation. He concluded that appellant was adversely affected by her employment injury on December 24, 1988. Dr. Ragsdale stated that an isolated injury of appellant's right hand evolved into a greater disability. He noted no objective findings of an organic cause of appellant's pain. Dr. Ragsdale diagnosed chronic pain, however, and stated that appellant remained disabled.

On January 22, 1990 appellant filed a notice of recurrence of disability alleging that she suffered a recurrence on August 19, 1989. The Office subsequently accepted the claim for reflex dystrophy and appellant received compensation for total temporary disability.

On October 2, 1990 Dr. William Power, a Board-certified neurologist, reviewed appellant's history and performed a complete physical examination. Dr. Power noted that a diagnosis of reflex sympathetic dystrophy of the right upper extremity had previously been established and that he did not attempt to evaluate the validity of that diagnosis. He noted, however, that appellant's behavior supported the diagnosis and that her inability to move her right upper extremity precluded employment. Dr. Power also diagnosed disabling anxiety, depression and associated somatization, which also precluded employment.

On October 26, 1990 Dr. Power indicated that appellant had reflex sympathetic dystrophy and that the condition had not resolved. He indicated that his evaluation was complicated by appellant's emotional problems.

On June 8, 1992 Dr. James F. Carlin, a Board-certified psychiatrist and neurologist, reviewed appellant's history and conducted a psychiatric examination at the request of the Office. His mental status examination revealed a significant discrepancy between the content of appellant's speech and the mood and affective responses. Dr. Carlin diagnosed somatoform pain disorder, a preoccupation with pain in the absence of adequate physical findings. He noted that the cause of the disorder was unknown, but that it often followed physical trauma, such as appellant's employment injury.

On August 18, 1994 Dr. Power indicated that appellant continued to complain of severe, disabling pain in her right wrist. He noted complaints of shaking of her extremities, desensitization of the right side of her face, photophobia, especially involving the right eye, stars in the vision of the right eye, Horner's syndrome, coughing spasms and a feeling of blood pumping while lying down. Dr. Power's examination revealed blepharospasm on the right without genuine ptosis of the right eyelid. He noted decreased pin sensation on appellant's right cheek, scalp and neck. Dr. Power's motor examination revealed variable tremulousness of the limbs and weakness of the upper limbs, particular on the right side. His sensory examination revealed marked protective behavior. Dr. Power diagnosed reflex sympathetic dystrophy, but noted that the diagnosis was not supported by altered sweating or temperature, vasomotor changes or dystrophic skin changes. He also found no evidence of Horner's syndrome and that it would not promote photophobia anyway. Dr. Power noted that appellant's tremulousness should have been confined to the affected limb instead of all of her extremities. He stated that depression and anxiety could be contributing to the symptoms and disability. Finally, Dr. Power stated that his diagnosis should be supported by x-rays and bone scans of the right hand and wrist because his current diagnosis was based solely on appellant's pain related behavior.

On August 26, 1994 Dr. R. Michael Henderson, a Board-certified radiologist, interpreted a bone scan of appellant's right wrist and hand. He indicated that the bone scan showed no significant arthritic changes, cortical erosion, subperiosteal destructive changes or other abnormalitites.

On November 15, 1995 Dr. Power recorded appellant's symptoms and conducted a physical examination. He noted variable tremulousness of appellant's extremities and extreme complaints of pain with movement. Dr. Power noted blepharospasm, but no ptosis of the eyelids. He recorded variable signs of asymmetry of appellant's face. Dr. Power noted subjectively diminished pin sensation in the right cheek, but not the forehead. He recorded give way dorsiflexion of both feet and pain upon the testing of the upper extremities. Dr. Power noted no abnormal sweating or skin coloring. He stated that an August 1994 bone scan was normal. Dr. Power diagnosed chronic pain and tremulousness. He stated that there was no evidence of reflex sympathetic dystrophy. He stated that his examinations revealed a nonorganic symptomology and an effort to convince him of the presence of physical abnormalities. Dr. Power concluded that there was likely a significant degree of underlying anxiety and

depression, which contributed to her multiple complaints and disability. He stated that appellant remained completely disabled.

On January 26, 1996 Dr. Power indicated that appellant's symptoms and behaviors were inconsistent with a diagnosis of reflex sympathetic dystrophy. He further indicated that appellant's wrist or hand sprain resolved long ago. Dr. Power noted that the few objective criteria for reflex sympathetic dystrophy; alterations of skin and hair texture, limb texture, sweating or abnormal bone scans were not found in appellant.

On March 14, 1996 the Office issued a "notice of proposed termination of compensation," on the basis that the weight of the medical evidence demonstrated that residuals of the December 24, 1988 work injury had ceased. In an accompanying memorandum, the Office indicated that it relied on the reports of Dr. Power in reaching this conclusion.

By decision dated April 16, 1996, the Office rejected appellant's claim because the weight of the medical evidence demonstrated that the residuals of the work injury had ceased.

On April 30, 1996 appellant requested an oral hearing, which she subsequently changed to a request for a review of the written record.

On May 14, 1996 Dr. George R. Swajian, a doctor of osteopathy, reviewed appellant's history and conducted a physical examination. He indicated that appellant's symptomology and clinical findings were consistent with reflex sympathetic dystrophy. Dr. Swajian stated that the condition should be examined further and recommended a body bone scan to establish a diagnosis.

On May 23, 1996 Dr. James R. Mulkey, an oral and maxillofacial surgeon, stated that appellant experienced a loss of bone around some dental work, but that he could not explain the loss.

On July 12, 1996 Dr. Swajian interpreted appellant's August 26, 1994 bone scan as showing some abnormalities. He opined that there was a definite abnormality in the right wrist and hand. Dr. Swajian, therefore, found that there was a high probability that appellant had reflex sympathetic dystrophy. He recommended further testing, including a more recent bone scan.

On July 26, 1996 Dr. Carlos Balcazar, a Board-certified psychiatrist and neurologist, conducted a psychiatric examination of appellant. He noted appellant's complaints of generalized pain, beginning with her injury in 1988. Dr. Balcazar stated that her symptoms have since intensified and noted her history of sympathetic reflex dystrophy. He diagnosed dysthymic disorder, histrionic personality disorder, sympathetic reflex disorder pursuant to a previous diagnosis and psychological stressors. Dr. Balcazar concluded that appellant experienced pain of an organic nature, but her reaction to the pain was tinted by her histrionic features. He found that appellant remained disabled.

By decision dated April 1, 1997, the Office hearing representative affirmed the Office's April 16, 1996 decision, terminating benefits. The hearing representative weighed the medical

reports of record and found that the opinion of Dr. Power constituted the weight of the medical evidence because his opinion was supported by an accurate factual and medical background, was well explained and was supported by the objective evidence of record.

On April 1, 1998 appellant requested reconsideration, arguing in a lengthy letter that the medical evidence of record was insufficient to establish that she no longer suffered residuals from her accepted condition. Although appellant indicated that she would submit additional evidence, such evidence was not provided.

By decision dated April 15, 1998, the Office found that the evidence submitted in support of appellant's request for reconsideration was not sufficient to require a merit review of the case. The Office noted that appellant failed to submit new evidence and that she offered no new legal contentions.

The only decision before the Board on this appeal is that of the Office dated April 15, 1998 in which the Office declined to reopen appellant's case for a merit review because she failed to submit new evidence or offer new legal contentions. Since more than one year has elapsed from the date of issuance of the Office's April 1, 1997 and April 16, 1996 decisions to the date of the filing of appellant's appeal on July 15, 1998, the Board lacks jurisdiction to review those decisions.[1]

The Board finds that the Office did not abuse its discretion by refusing to reopen appellant's claim for a merit review on April 15, 1998.

Under section 8128(a) of the Federal Employees' Compensation Act,[2] the Office has the discretion to reopen a case for review on the merits. The Office must exercise this discretion in accordance with the guidelines set forth in section 10.138(b)(1) of the implementing federal regulations,[3] which provides that a claimant may obtain review of the merits of the claim by:

"(i) Showing that the Office erroneously applied or interpreted a point of law; or

"(ii) Advancing a point of law or a fact not previously considered by the Office; or

"(iii) Submitting relevant and pertinent evidence not previously considered by the Office."

Section 10.138(b)(2) provides that any application for review of the merits of the claim, which does not meet at least one of the requirements listed in paragraphs (b)(1)(i) through (iii) of this section will be denied by the Office without review of the merits of the claim.[4]

[1] *See* 20 C.F.R. § 501.3(d).

[2] 5 U.S.C. § 8128(a).

[3] 20 C.F.R. § 10.138(b)(1).

[4] 20 C.F.R. § 10.138(b)(2).

In the instant case, appellant failed to submit any new evidence to support her contention that the Office erred in terminating her benefits. Moreover, appellant fails to support her request for reconsideration with any new legal arguments. Rather, she merely reasserts that the medical evidence of record establishes that the Office did not meet its burden to terminate her benefits. Because the Office previously considered and weighed this medical evidence, the Office properly determined that appellant's arguments were insufficient to warrant a merit review.

The decision of the Office of Workers' Compensation Programs dated April 15, 1998 is affirmed.

Dated, Washington, D.C.
June 8, 2000

George E. Rivers
Member

David S. Gerson
Member

Willie T.C. Thomas
Alternate Member