

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of BECKY GIGER and U.S. POSTAL SERVICE,
BULK MAIL CENTER, Kansas City, KS

*Docket No. 02-887; Submitted on the Record;
Issued October 23, 2002*

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issues are: (1) whether the Office of Workers' Compensation Programs properly terminated appellant's medical benefits; and (2) whether the Office properly denied appellant's request for reconsideration.

On August 8, 1997 appellant, then a 43-year-old distribution clerk, filed a claim for pain and weakness in her arms, which she related to repetitive motion of the arms. The Office accepted her claim for carpal tunnel syndrome in the right arm and ulnar neuropathy of the left elbow. Appellant underwent surgery on January 12, 1998 for anterior transposition of the ulnar nerve. The Office authorized leave buy back for the period January 14 through 23, 1998.

On April 18, 1998 appellant filed a claim for pain, discomfort and muscle spasms in the left shoulder. She stated that on March 21 and 22, 1998 she was lifting mail sacks, weighing 40 to 60 pounds and keying mail. The Office initially denied appellant's claim for her left shoulder condition in a June 26, 1998 decision, on the grounds that she had not submitted sufficient medical evidence to relate the shoulder condition to her employment. In an October 23, 1998 decision, the Office denied appellant's request for reconsideration on the grounds that she had not submitted medical evidence, which was relevant to the issue of whether her condition was causally related to her employment. In a November 18, 1998 report, Dr. Karolyn D. Cook, a Board-certified family practitioner, indicated that a November 11, 1998 electromyogram (EMG) showed a suprascapular nerve entrapment in the left arm. Dr. Cook related appellant's condition to her employment. In a January 13, 1999 decision, the Office vacated its prior decisions and accepted appellant's claim for left shoulder impingement syndrome.

In a March 28, 2001 decision, the Office terminated appellant's medical benefits and any further compensation on the grounds that the weight of the medical evidence showed that her work-related disability had resolved and she was no longer disabled for work. In a June 26, 2001 letter, appellant's representative requested reconsideration of the Office's decision on the grounds that the impartial medical specialist was improperly selected. In a November 1, 2001

merit decision, the Office denied appellant's request for modification of the prior decision. Appellant again requested reconsideration. In a December 17, 2001 decision, the Office denied appellant's request for reconsideration on the grounds that the argument submitted was cumulative and, therefore, insufficient to warrant reconsideration of the Office's decision.

The Board finds that the Office properly terminated appellant's medical benefits.

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation benefits. After it has determined that an employee has disability causally related to his or her federal employment, the Office may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.¹

In a February 16, 1999 form report, Dr. Cook indicated that appellant could work eight hours a day with a restriction on lifting and no repetitive motion with the left shoulder. In a March 26, 1999 report, Dr. Daniel D. Schaper, Board-certified orthopedic surgeon, stated that appellant had a history of chronic shoulder pain. Dr. Schaper indicated that appellant had a mildly positive sign for rotator cuff impingement. He reported that a magnetic resonance imaging (MRI) scan of the left shoulder was negative except for a slight downward sloping of the acromion and small beaking. Dr. Schaper diagnosed left shoulder pain of uncertain cause. He stated that the posterior shoulder pain might be related to chronic fibromyalgia or occult cervical radiculopathy. Dr. Schaper commented that the lateral shoulder pain might be related to rotator cuff tendinitis. He suggested that appellant also had very mild left carpal tunnel syndrome. Dr. Schaper commented that these diagnoses were at or below the threshold for clear diagnosis. He recommended injection of medication into the shoulder and continuation of the same work status. In an April 9, 1999 report, he stated that appellant had left shoulder pain of uncertain cause. Dr. Schaper suggested that appellant might have mild cervical radiculopathy, suprascapular nerve entrapment, fibromyalgia or possible mild carpal tunnel syndrome. He recommended a second opinion.

The Office referred appellant, together with a statement of accepted facts and the case record, to Dr. William Reed, a Board-certified surgeon, for an examination and second opinion. In an April 27, 1999 report, Dr. Reed stated that a 1998 EMG showed resolution of the ulnar nerve compression neuropathy. He noted that a cervical MRI scan was normal while a left shoulder MRI scan showed very mild tendinitis findings and a type II acromion but no definitive acromial impingement. Dr. Reed commented that appellant's pain was more in the posterior scapulothoracic area corresponding to the superior rhomboids and trapezius muscles. He stated that on examination rotator cuff strength and range of motion was normal. Dr. Reed found no significant crepitus in the shoulder with internal an external rotation performed in abduction. He diagnosed left scapulothoracic pain, probably rhomboid in origin, secondary to poor posture. Dr. Reed recommended a thoracic MRI scan to rule out any thoracic disc herniation.

An April 30, 1999 thoracic MRI scan was negative. In a May 19, 1999 report, Dr. Reed stated that appellant was complaining of pain in the absence of any physical examination or radiographic abnormalities. He indicated that appellant could return to her regular work duties.

¹ *Jason C. Armstrong*, 40 ECAB 907 (1989).

Dr. Reed concluded that appellant had reached maximal medical improvement with no treatment indicated since the cause of pain remained undiagnosed. He stated that appellant's condition was related to her posture and obesity.

In a May 27, 1999 report, Dr. Schaper stated that appellant had pain in the back of the shoulder and on the top of her shoulder anteriorly and laterally down into the humeral area. He stated that the pain was not primarily caused by posture or obesity but that these factors probably aggravated the condition. Dr. Schaper diagnosed chronic shoulder pain syndrome of uncertain cause. He restricted appellant to no lifting over 20 pounds and no repetitive use of the left shoulder.

In a January 3, 2000 report, Dr. Vito J. Carabetta, a Board-certified physiatrist, stated that appellant had a normal EMG study of both arms, including the left shoulder.

In an August 24, 2000 report, Dr. Ira H. Fishman, an osteopath, stated that examination of appellant showed residual muscular tightness and trigger point discomfort referable to appellant's left upper thoracic strain and associated myofascial pain syndrome. Dr. Fishman noted that appellant had discomfort with internal rotation and rotation of the left shoulder which was suggestive of impingement syndrome. He recommended a repeat EMG of the left suprascapular nerve to determine if there was entrapment of the nerve.

The Office referred appellant, together with a statement of accepted facts and the case record, to Dr. James Armstrong, a Board-certified orthopedic surgeon, to resolve the conflict in the medical evidence between Drs. Schaper and Reed. In an August 16, 2000 report, Dr. Armstrong stated that there was no medical history supporting appellant's complaints of discomfort in the left hand, forearm, elbow and upper arm as a result of the employment injury. He indicated that the complaints concerning the left neck and left posterior shoulder region were without any incident of trauma. Dr. Armstrong noted that x-rays and MRI scans were normal. He stated that there were no objective signs of cervical nerve root impingement. Dr. Armstrong concluded that there was nothing to support an etiology of appellant's current complaint except subjective complaints made by her. He diagnosed appellant's condition as a transient muscle strain about the left posterior shoulder. Dr. Armstrong reported that MRI scans, EMG studies, x-rays of the cervical and thoracic spine and physical examinations had all been normal. He commented that in his examination there were multiple signs that showed lack of credibility. Dr. Armstrong concluded that the transient left shoulder strain had resolved. He stated that no nerve root impingement had been found. Dr. Armstrong reviewed appellant's medical history and stated that he did not find that appellant's left neck and shoulder pain had been aggravated by any preexisting condition. He stated that appellant had recovered from her employment injuries by the time she saw Dr. Schaper on March 26, 1999 and Dr. Reed on April 21, 1999. He commented that appellant's physical examination was normal. He concluded that appellant was not disabled and could performed the duties of a distribution clerk.

In a September 8, 2000 report, Dr. Fishman stated that nerve conduction testing was indicative of left suprascapular nerve entrapment, most probably at the left suprascapular notch. He commented that there was no evidence of peripheral nerve entrapment or peripheral neuropathy in the left arm. Dr. Fishman reported that an EMG study of the C5 through T1

paraspinals was normal without evidence of radiculopathy, plexopathy, myopathy or peripheral neuropathy. He recommended a surgery consult.

In an October 18, 2000 report, Dr. Mark R. Rasmussen, a Board-certified orthopedic surgeon, stated that a review of past MRI scans did not show any gross abnormality of the rotator cuff. Dr. Rasmussen reported x-rays showed a type 2 acromion and mild acromioclavicular joint athrosis. He diagnosed chronic left shoulder pain, most likely secondary to overuse. Dr. Rasmussen attributed part of appellant's condition to rotator cuff tendinitis. In an October 27, 2000 note, he noted the EMG findings of Dr. Fishman and stated that, in the absence of a suprascapular notch cyst, some people had entrapment of the suprascapular nerve as it went through the transverse scapular ligament.

The Office sent Dr. Armstrong a copy of Dr. Fishman's September 8, 2000 EMG findings. In a November 2, 2000 report, Dr. Armstrong stated that the left suprascapular nerve was primarily motor. He noted that the nerve exits from the more superior and proximal aspect of the upper trunk of the brachioplexus. Dr. Armstrong indicated that injury to the nerve usually occurred from a direct blow, of which there was no history in appellant's case. He commented that any significant pathology along the suprascapular nerve should show other abnormal physical findings appropriate to the cervical nerve roots involved. Dr. Armstrong pointed out, however, that there were no physical, radiological or EMG findings to support cervical nerve root involvement or abnormal suprascapular nerve function. He noted that the medical evidence showed appellant received injections into the suprascapular nerve region without any change in her symptoms. Dr. Armstrong stated that this finding indicated either the complaints were real based on suprascapular nerve pathology or the suprascapular injections were not close enough to the pain. He indicated that there was no evidence to suggest a neurological basis for appellant's pain and, since experts had injected been performed by experts, a lack of clinical response indicated that the suprascapular nerve was not involved. Dr. Armstrong attributed appellant's EMG findings to the multiple injections that appellant had received in the region, which may have been enough to cause the EMG findings. He stated that there was no clinical reason for any impingement of the suprascapular nerve. Dr. Armstrong commented that Dr. Fishman's EMG and nerve conduction findings, in the face of other normal evaluations of appellant, did not support a diagnosis of left suprascapular nerve entrapment.

In a January 18, 2001 report, Dr. Steven Hess, a Board-certified neurosurgeon, noted the EMG findings of Dr. Fishman. Dr. Hess concluded that appellant had a chronic repetitive injury to the left shoulder which may have resulted in left suprascapular nerve entrapment.

Dr. Cook initially diagnosed an impingement on the suprascapular nerve which she related to the employment injury. Dr. Reed concluded that appellant's complaints had no objective basis and attributed her condition to obesity and posture. Dr. Shaper stated that he could not determine the cause of appellant's shoulder pain but indicated that obesity and posture probably aggravated appellant's condition. Dr. Armstrong, acting as an impartial medical specialist, noted numerous inconsistencies in appellant's examination which detracted from her credibility. He found no objective basis for appellant's complaints of a left shoulder condition and concluded that she could return to full duty in her preinjury position. He concluded that appellant had a transient muscle strain that had resolved. Dr. Fishman subsequently reported that a nerve conduction study had shown impingement of the suprascapular nerve. One previous

EMG had been normal and another EMG has shown impingement of the suprascapular nerve. Dr. Armstrong, in a well-reasoned report, reviewed Dr. Fishman's results and found that the finding of a suprascapular nerve impingement was not consistent with the other findings of appellant's left shoulder region. He, therefore, repeated his conclusion that appellant was not disabled for work and had no employment-related condition. In situations where there exists opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial 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.² In this case, Dr. Armstrong had an accurate medical history of appellant's condition and, in well-reasoned reports, concluded that appellant's left shoulder condition was no longer disabling and was not related to appellant's employment injury. His report, therefore, is entitled to special weight and, under the circumstances of this case constitutes the weight of the medical evidence.

Drs. Fishman, Rasmussen and Hess concluded that appellant had an overuse or repetitive motion injury to the shoulder. None of these physicians, however, cited any objective medical evidence in support of this diagnosis. The physicians did not provide any explanation in support of the diagnosis and did not discuss how appellant's condition was related to his employment. Their reports, therefore, have little probative value and are insufficient to overcome the weight of Dr. Armstrong's report.

Appellant's attorney, in requesting reconsideration, contended that Dr. Armstrong was improperly selected as an impartial specialist, as set forth in the Office's procedures. The attorney stated that appellant's home zip code was not used by the Office's computer program in finding an appropriate impartial medical specialist closest to appellant's home, as required by the Office.³ He contended that there was no documentation in the file to justify the Office's failure to use appellant's zip code area in finding an impartial medical specialist. He also stated that a copy of the physician's directory system display in appellant's case showed that Dr. Armstrong was to have been bypassed at the time appellant was referred to him. The attorney noted that the Office, in response to the latter point, had indicated that there was a display error in the physician's directory system that was corrected. In its decision denying the request for reconsideration, the Office indicated that use of appellant's zip code produced only one available appropriate physician within appellant's zip code. The Office stated that the physician had affiliations with other physicians who had treated appellant and, therefore, could not be selected as an impartial medical specialist. The Office indicated that Dr. Armstrong was in the next zip code area used. Based on the evidence before the Office at the time of its November 1, 2001 decision, the Office acted properly in using its internal procedures to select Dr. Armstrong based on its findings that Dr. Armstrong was in a zip code area that was next to appellant's zip code area and that the only physician available in appellant's zip code was affiliated with physicians who had previously treated appellant and could not serve as an impartial medical specialist. Appellant, therefore, failed to show that Dr. Armstrong was not properly selected as an impartial medical specialist.

² *James P. Roberts*, 31 ECAB 1010 (1980).

³ FECA Bulletin 00-01 (issued November 5, 1999).

The Board finds that the Office properly denied appellant's request for reconsideration.

Section 8128(a) of the Federal Employees' Compensation Act vests the Office with discretionary authority to determine whether it will review an award for or against compensation, either under its own authority or on application by a claimant. Under 20 C.F.R. §10.606(b), a claimant may obtain review of the merits of his claim by showing that the Office erroneously applied or interpreted a point of law, advanced a point of law not previously considered by the Office, or submitted relevant and pertinent evidence not previously considered by the Office. Section 10.608(b) provides that, when an application for review of the merits of a claim does not meet at least one of these three requirements, the Office will deny the application for review without reviewing the merits of the claim.⁴ Evidence that repeats or duplicates evidence already in the case record has no evidentiary value and does not constitute a basis for reopening a case.⁵ Evidence that does not address the particular issue involved also does not constitute a basis for reopening a case.⁶ When a claimant fails to meet one of the above standards, the Office will deny the application for reconsideration without reopening the case for review on the merits.⁷

In his request for reconsideration, appellant's attorney's additional evidence and arguments in support of his contention that Dr. Armstrong was improperly selected as an impartial medical specialist. He stated that the zip code used, 66200, was only one of several neighboring zip codes to appellant's area, 66111, that could be used to select an impartial medical specialist. He contended that the Office did not justify the use of that particular zip code area to find an appropriate impartial medical specialist. He also stated that Dr. Armstrong did not use the zip code 62000 for his office but used the zip code 66762 and just used the offices of another physician, in the zip code area 66214, to conduct the examination of appellant. He also contended that Dr. Glen Horton was only associated with the University of Kansas Medical Center, where appellant underwent surgery and, therefore, was not in partnership with anyone who had previously treated appellant. The evidence and arguments presented by appellant's attorney, however, are repetitive of the evidence and arguments he presented in the first request for reconsideration which the Office denied in a merit review. The repetitive arguments and evidence are insufficient to require reopening appellant's case for further review. The Office, therefore, properly denied appellant's request for reconsideration.

⁴ 20 C.F.R. § 10.608(b).

⁵ *Eugene F. Butler*, 36 ECAB 393, 398 (1984); *Bruce E. Martin*, 35 ECAB 1090, 1093-94 (1984).

⁶ *Edward Matthew Diekemper*, 31 ECAB 224-25 (1979).

⁷ 20 C.F.R. § 10.608(b).

The decisions of the Office of Workers' Compensation Programs dated December 17, November 1 and March 28, 2001 are hereby affirmed.

Dated, Washington, DC
October 23, 2002

Michael J. Walsh
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member