United States Department of Labor
Employees' Compensation Appeals Board

G.J., claiming as widow of D.J., Appellant	)	
	)	**Docket No. 08-1025**
and	)	**Issued: March 23, 2009**
U.S. POSTAL SERVICE, BRIGHTON POST OFFICE, Brighton, CO, Employer	)	

Appearances:
Timothy Quinn, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On February 22, 2008 appellant, through her attorney, filed a timely appeal of a March 22, 2007 decision of an Office of Workers' Compensation Programs hearing representative denying her claim for death benefits and a January 24, 2008 nonmerit 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 the employee's stroke on October 29, 1998 and his death on October 31, 1998 were causally related to his October 28, 1998 employment-related surgery; and (2) whether the Office properly denied appellant's request for a merit review of her claim pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

This case has previously been before the Board. In a November 16, 2001 decision, the Board set aside the Office's October 20, 2000 and January 16, 2001 decisions which denied

appellant's claim for survivor's benefits.[1] The Board found a conflict in the medical opinion evidence between the employee's attending physician and an Office medical adviser as to whether the employee's stroke and resultant death on October 31, 1998 were causally related to his employment-related surgery on October 28, 1998. The Board remanded the case to the Office for referral to an impartial medical specialist to resolve the conflict in the medical opinion evidence. The facts and the history relevant to the present appeal are set forth.

On August 14, 1998 the Office accepted that the employee, a 48-year-old manual distribution clerk, sustained right wrist tendinitis, carpal tunnel syndrome and lateral epicondylitis on April 9, 1998. It authorized right carpal tunnel release, radial nerve decompression and lateral elbow fasciotomy, which were performed on October 28, 1998. On October 29, 1998 the employee sustained a right cerebral stroke while at home eating breakfast. He was hospitalized and died on October 31, 1998. On March 9, 1999 the employee's widow filed a claim for survivor's benefits contending that her husband's death was caused by the stroke that resulted from complications of his accepted work-related surgery. The death certificate listed the immediate cause of death as cerebrovascular accident.

On January 10, 2002 the Office referred a statement of accepted facts, the case record and question to be addressed, to Dr. Peter S. Quintero, a Board-certified neurologist, for an impartial medical examination. In a February 11, 2002 medical report, Dr. Quintero opined that the employee's stroke and resultant death were not causally related to his October 28, 1998 employment-related surgery.

By decision dated February 22, 2002, the Office denied appellant's claim.[2] It accorded special weight to Dr. Quintero's February 11, 2002 report as an impartial medical specialist.

In a March 8, 2002 letter, appellant, through counsel, requested an oral hearing before an Office hearing representative.

By decision dated January 16, 2003, an Office hearing representative set aside the February 22, 2002 decision and remanded the case to obtain a supplemental report from Dr. Quintero. She found that his opinion was not entitled to special weight because he did not review all the relevant medical evidence and he was not given the Office's definitions of causal relationship for determining whether a relationship existed between the employee's stroke and death and his October 28, 1998 employment-related surgery.

In an April 15, 2003 supplemental report, Dr. Quintero stated that the employee's stroke and resultant death were not caused by the accepted employment-related surgery. The Office issued an April 17, 2003 decision again denying appellant's claim. It accorded special weight to Dr. Quintero's February 11, 2002 and April 15, 2003 reports. In a May 6, 2003 letter, appellant, through counsel, requested an oral hearing.

[1] Docket No. 01-911 (issued November 16, 2001).

[2] The Board notes that the Office's February 22, 2002 decision is not contained in the case record.

In a February 5, 2004 decision, an Office hearing representative set aside the April 17, 2003 decision and remanded the case to the Office. He found that a new conflict in medical opinion evidence arose between Dr. Quintero and Dr. Victoria J. Simpson, a Board-certified anesthesiologist, regarding the issue of whether the presence of a cardiac defect was necessary to allow emboli to move to the brain after the release of a tourniquet. On remand, the hearing representative instructed the Office to refer the case record to an impartial panel of physicians specializing in neurology, internal medicine and anesthesiology.

By letter dated March 23, 2004, the Office referred the case record, a statement of accepted facts and question to be addressed, to Dr. Anthony D. Piccone, a Board-certified anesthesiologist, Dr. Stanley H. Ginsburg, a Board-certified neurologist and Dr. Annu Ramaswamy, a Board-certified internist. Dr. Ginsburg's March 30, 2004 report and Drs. Piccone's and Ramaswamy's April 23, 2004 report found that the employee's stroke and subsequent death were not caused by his employment-related surgery.

By decision dated May 13, 2004, the Office again denied appellant's claim. It accorded special weight to the reports of the impartial medical panel.

On May 31, 2004 appellant, through her attorney, requested an oral hearing. Counsel contended that Dr. Ginsburg was associated with a physician of record who was previously associated with appellant's case. He further contended that Dr. Piccone and Dr. Ramaswamy were not properly selected under the Physician's Directory System (PDS).

By decision dated December 17, 2004, an Office hearing representative, set aside the May 13, 2004 decision and remanded the case to the Office. She found that the impartial physicians of record were not properly selected through the PDS and, thus, constituted second opinion physicians. The Office hearing representative determined that an unresolved conflict remained as to the causal relationship between the employee's stroke and death and his accepted employment-related surgery. On remand, she instructed the Office to utilize the PDS to select a panel of impartial medical specialists to resolve the conflict.

On January 28, 2005 the Office referred the case record, a statement of accepted facts and questions to be addressed, to Dr. Richard B. Green, a Board-certified anesthesiologist, Dr. Sander H. Orent, a Board-certified internist and Dr. Amelia Scott Barrett, a Board-certified neurologist, for impartial medical review. Copies of the PDS note that appellant's zip code was entered as 80631 during the selection process. The record reflects that numerous physicians were contacted and bypassed during the selection process and a notation was made explaining the reason for each bypass. The various reasons included that certain physicians did not perform impartial medical examinations, their telephone numbers had been disconnected or they had moved or retired.

In a February 3, 2005 letter, counsel requested that the Office provide copies of the appointment screen from the PDS pursuant to FECA Bulletin No. 00-01 together with any other documentation regarding the selection of the panel. He also requested the statement of accepted facts and questions posed to each physician. On February 3, 2005 the Office provided counsel with copies of the statement of accepted facts and questions posed to the selected impartial medical specialists.

By letter dated March 3, 2005, the Office advised counsel that the impartial medical specialists did not have all the medical records necessary for completion of their reports. It requested that he provided additional medical evidence, including the actual anesthesia record and the employee's admitting laboratory test results and vital signs. Counsel submitted the requested evidence by letter dated March 14, 2005.

In a February 8, 2005 report, Dr. Orent reviewed the employee's medical records. He opined that the employee's stroke on October 29, 1998 and resultant death on October 30, 1998 were not caused by his October 28, 1998 employment-related surgery. Dr. Orent disagreed with the opinion that prolonged occlusion time with a tourniquet created a thrombus in the employee's extremity, which somehow embolized through his heart to the carotid artery. He stated that this was not only physiologically improbable but essentially impossible. Dr. Orent explained that, in order for the clot to have reached the employee's brain, there would have to be a hole in his heart, *i.e.*, some sort of shunt between the venous and arterial circulations. He related that this was neither present nor proven as fact by test results. Dr. Orent stated that echocardiograms of the heart would certainly have detected the presence of a hole. Given the complete lack of mechanism to explain how such an embolus could travel from a vein in the arm to the brain, it was not possible to postulate a relationship between the surgical procedure and subsequent stroke. Dr. Orent noted that another possibility would have been a complication of anesthesia such that the employee was hypoxic for some period of time. However, there was no documentation to this effect in the medical record. Dr. Orent stated that additional information was required. He wanted to review the actual anesthesia record to be certain that there was no drop in blood pressure or other untoward event during the course of the anesthesia. Dr. Orent also wished to review the employee's admitting laboratory tests and vital signs to be sure that no abnormalities were overlooked prior to the surgery. He opined that, if no abnormalities were demonstrated then, it was more probable than not that the employee's death was caused by a coincidental event and not the October 28, 1998 employment-related surgery.

In a February 23, 2005 report, Dr. Barrett stated that it was well documented in medical literature that up to two percent of patients undergoing surgery including, the employee, was at risk for perioperative stroke. However, the employee's perioperative stroke was due to several risk factors which caused his death. Dr. Barrett reviewed the employee's medical records and death certificate. She disagreed with the theory that the tourniquet time of 60 minutes might have caused a venous embolism that traveled to the right major coronary artery (MCA) through a right-to-left shunt in the heart. Dr. Barrett related that no such stunt was found on transthoracic echocardiogram, which excluded this mechanism as the cause of the stroke. She stated that the employee's nonemployment-related risk factors included obesity, a history of smoking, hypercholesterolemia, a family history of early vascular death and possible diabetes. Dr. Barrett related that it was no coincidence that it occurred one day following surgery based on these risk factors. She opined that although a risk of stroke was associated with surgical procedures, there was no causal relationship between the employee's work-related surgery and his subsequent stroke and death.

In a February 24, 2005 report, Dr. Green stated that the sudden onset of symptoms while eating breakfast was suggestive of an embolus versus thrombotic event which occurred over time. He stated that the embolus could have originated from the arterial or venous circulation. Dr. Green explained the development of clots in the venous system, which later lead to an

embolus affecting pulmonary circulation, could have resulted in shortness of breath or if large enough sudden death. He stated that the use of a tourniquet has been associated with venous thrombosis more likely in the lower extremity rather than in the upper extremity. Dr. Green related that during the employee's surgery, a tourniquet was used for one hour, which was within the acceptable range of less than two hours. He noted that the employee did not complain about any postoperative pain in either his upper or lower extremities. The employee did not have a shunt or patent foramen ovale, which would have resulted in an embolus from venous circulation. Dr. Green also did not have a history of valsalva while eating his breakfast prior to the onset of his symptoms, which would have increased the chances of detecting a patent foramen ovale.

Based on his review of the anesthesia and recovery room records, no significant event occurred during this time period. Dr. Green opined that the general anesthesia was not directly related to the employee's stroke. He noted that cerebral embolisms can occur from the heart but the employee had an echocardiogram in the emergency room, which showed no sign of atrial clot or fibrillation or lesions on the mitral or aortic valves. Dr. Green stated that more than likely the heart was not the source. He indicated that embolic strokes occurred with disease of the internal carotid or at the bifurcation of the internal and external carotid arteries. Studies of the employee's carotid artery showed minimal disease and no emboli from the aorta or major arteries. Dr. Green stated that the employee was not diagnosed with diabetes but he had a fasting glucose of 305 upon arrival at the emergency room, which was above 200 and suggestive of diabetes. The employee's other conditions included a body mass index (BMI) of 34.8, near morbid obesity in a body mass index of more than 35. He had a history of hypercholesterolemia and an elevated sedimentary rate of 46 while the range was from 0 to 20. Dr. Green noted that hypercholesterolemia was associated with vascular disease. Dr. Green stated that increased sedimentary rates were a sign of chronic infection and were associated with increased chance of arterial endothelial damage and, therefore, formation of arterial clots. He noted that stress hormones were released during general anesthesia and unavoidable which increased the chance of clot formation. Dr. Green related that this most likely occurred in the venous system rather than in the arterial system. He opined that anesthesia does have its inherent risk but what happened to the employee was more likely associated with his medical health rather than any specific anesthesia risk or surgery.

In a supplemental report dated March 23, 2005, Dr. Orent reviewed the anesthesia report and employee's records on admission to the hospital on the date of surgery. The employee's blood pressure during anesthesia never dropped below 110 systolic either in the operating or recovery room. Dr. Orent further stated that the employee's pulse oximetry remained at a 96 percent level throughout the entire procedure. There were no complications of intubation or drops in blood pressure that might have resulted in a stroke at a later date. Dr. Orent related that the admission history and physical examination did not contain symptoms suggestive of a risk for stroke prior to the surgery. He did not review any preoperative laboratory tests but, stated that it was unlikely that they would substantially change or alter his previously expressed opinions. Dr. Orent opined that it was more probable than not that the employee's stroke was coincidental to surgery and anesthesia based on his review of the medical records.

By decision dated April 8, 2005, the Office denied appellant's claim. It found that the opinions of Dr. Orent, Dr. Green and Dr. Barrett were entitled to special weight as impartial

medical specialists in finding that the employee's stroke and death on October 30, 1998 were not caused by his October 28, 1998 employment-related surgery. The Office further found that the record established that the physicians were properly selected from the PDS.

On April 25, 2005 appellant, through counsel, requested an oral hearing.

At the August 22, 2006 hearing, counsel contended that the Office failed to utilize the PDS in selecting the impartial medical panel. He contended that the hearing representative improperly denied his request to subpoena a medical examination scheduler used by the Office.[3] Counsel further contended that neither Dr. Orent nor Dr. Green reviewed the anesthesia, recovery room or laboratory test reports. He contended that Dr. Barrett did not address the issue of whether the October 28, 1998 employment-related surgery caused the employee's stroke.

By decision dated March 22, 2007, the Office hearing representative affirmed the April 8, 2005 decision. She accorded special weight to the opinions of Dr. Orent, Dr. Green and Dr. Barrett as impartial medical specialists in finding that the employee's stroke and death were not caused by his October 28, 1998 employment-related surgery.

In a letter dated December 7, 2007, appellant, through counsel, requested reconsideration.[4] Counsel contended that the Office used its second opinion service rather than the PDS to select Dr. Barrett and Dr. Green as impartial medical specialists. He also contended that the statement of accepted facts was incomplete as it did not mention the employee's accepted cervical disc herniation at C5-6, which led to a fusion in 1992. Counsel stated that an Office medical adviser determined that the absence of this condition was relevant. He contended that the opinions of Dr. Orent and Dr. Green were not rationalized and that Dr. Barrett failed to address the issue of whether the employee's work-related surgery caused his stroke. Appellant submitted a deposition of an individual on behalf of plaintiffs who had filed a lawsuit in district court in Denver, Colorado against Medical OPS Management, a company used by the Office to select the impartial medical specialists. The lawsuit alleged that Medical OPS Management was engaged in biased procurement of medical evidence for insurance companies. Appellant submitted a list of neurologists and anesthesiologists skipped by the medical examination scheduler.

By decision dated January 24, 2008, the Office denied appellant's request for reconsideration, finding that the evidence submitted did not warrant further merit review of its prior decisions.

[3] By decision dated July 18, 2006, the hearing representative denied appellant's request to subpoena the medical examination scheduler used by the Office to select the panel of impartial medical specialists.

[4] Prior to appellant's request for reconsideration of the March 22, 2007 decision, she appealed the decision to the Board. By order dated November 29, 2007, the Board dismissed her appeal because she wished to seek reconsideration before the Office. Docket No. 07-1801 (issued November 29, 2007).

LEGAL PRECEDENT -- ISSUE 1

The United States shall pay compensation for the death of an employee resulting from personal injury sustained while in the performance of duty.[5] An appellant has the burden of proving by the weight of the reliable, probative and substantial evidence that the employee's death was causally related to his or her federal employment. This burden includes the necessity of furnishing medical opinion evidence of a cause and effect relationship based on a proper factual and medical background. The opinion of the physician must be one of reasonable medical certainty and must be supported by medical rationale.[6] The mere showing that an employee was receiving compensation for total disability at the time of death does not establish that the employee's death was causally related to his or her federal employment.[7]

Section 8123(a) of the Act[8] provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[9] The implementing regulations states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an Office medical adviser, the Office shall appoint a third physician to make an examination. This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[10]

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.[11]

ANALYSIS -- ISSUE 1

The Board finds that appellant has not established that the employee's stroke on October 29, 1998 or death on October 31, 1998 resulted from his October 28, 1998 employment-related surgery.

The Board on prior appeal found a conflict in medical opinion evidence. The Office properly referred the employee's medical records to a team of impartial medical specialists consisting of Drs. Orent, Barrett and Green to resolve the issue of whether the employee's stroke

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[5] 5 U.S.C. § 8102(a).

[6] *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

[7] *Susanne W. Underwood (Randall L. Underwood)*, 53 ECAB 139 (2001).

[8] 5 U.S.C. §§ 8101-8193.

[9] *Id.* at § 8123(a).

[10] 20 C.F.R. § 10.321.

[11] *Barry Neutuch*, 54 ECAB 313 (2003); *David W. Pickett*, 54 ECAB 272 (2002).

on October 29, 1998 or death on October 31, 1998 were causally related to his October 28, 1998 surgery. In a February 8, 2005 report, Dr. Orent, reviewed the case record in detail. Although he wished to review the anesthesia record to determine whether there was a drop in blood pressure and the employee's admitting laboratory tests and vital signs to determine whether any abnormalities were overlooked prior to surgery, he concluded that it was more probable than not that the employee's death was caused by a coincidental event and not the October 28, 1998 employment-related surgery. Dr. Orent disagreed with the opinion of prior physicians that prolonged occlusion time with a tourniquet created a thrombus in the employee's extremity which somehow embolized through his heart to the carotid artery. He explained that this was not only physiologically improbable but essentially impossible as test results such as, an echocardiogram, did not demonstrate that the employee had a hole in his heart or shunt between the venous and arterial circulations which would have allowed a clot to reach his brain. Dr. Orent also explained that given the complete lack of mechanism to explain how such an embolus could travel from the vein in the arm to the brain, it was not possible for him to postulate a relationship between the surgical procedure and stroke. While he noted that another possibility would have been a complication of anesthesia such that the employee was hypoxic for some period of time, he stated that clearly there was no documentation to this effect in the medical record.

In a supplemental report dated March 23, 2005, Dr. Orent again opined that it was more probable than not that the employee's stroke was coincidental to his surgery and anesthesia based on his review of the anesthesia report and the employee's initial history and physical examination for admission to the hospital on October 28, 1998. He explained that the employee's blood pressure during anesthesia never dropped below 110 systolic either in the operating or recovery room. Dr. Orent further explained that the employee's pulse oximetry remained at a 96 percent level throughout the entire procedure. He related that there were no complications of intubation or as stated any drops in blood pressure that might have resulted in a stroke at a later date. Dr. Orent noted that the admission history and physical did not contain symptoms that might have suggested a risk for stroke prior to the surgery. Although he did not review any preoperative laboratory tests, he opined that it was unlikely that they would substantially change or alter his previously expressed opinions.

In a February 23, 2005 report, Dr. Barrett opined that although a risk of stroke was associated with surgical procedures, there was no causal relationship between the employee's work-related surgery and his subsequent stroke and death based on her review of the case record and his death certificate. She indicated that it was well documented that two percent of patients undergoing surgery, which included the employee, were at risk for perioperative stroke. Dr. Barrett, however, attributed the employee's perioperative stroke to his nonemployment-related risk factors, such as obesity, a history of smoking, hypercholesterolemia, a family history of early vascular death and possible diabetes. She stated that it was no coincidence that the stroke occurred one day following surgery based on these risk factors. Dr. Barrett related that since a transthoracic echocardiogram did not identify a stunt, the tourniquet time of 60 minutes could not have caused a venous embolism to travel to the right MCA via a right-to-left shunt in the heart.

Dr. Green's February 24, 2005 report found that general anesthesia was not directly related to the employee's stroke. He stated that the sudden onset of symptoms while eating

breakfast was suggestive of an embolus versus thrombotic event which occurred over time. Dr. Green explained the development of clots in the venous system which could later lead to an embolus that affected pulmonary circulation resulting in either shortness of breath or sudden death. He stated that the use of a tourniquet has been associated with venous thrombosis more likely in the lower extremity rather than in the upper extremity. Dr. Green, however, stated that the use of a tourniquet for one hour during the employee's surgery was within the acceptable range of less than two hours. He related that the employee did not complain about any postoperative pain in either his upper or lower extremities. In addition, Dr. Green did not find any evidence either a shunt or patent foramen ovale, which would have resulted in an embolus from venous circulation. He noted that the employee did not have a history of valsalva while eating his breakfast prior to the onset of his symptoms, which would have increased the chances of detecting a patent foramen ovale. Based on his review of interpretations of the anesthesia and recovery room records, Dr. Green determined that no significant event occurred during this time period. He stated that more than likely the heart was not the source. Dr. Green related that although cerebral embolisms can occur from the heart, an echocardiogram which was performed in the emergency room did not show a sign of atrial clot or fibrillation or lesions on the mitral or aortic valves. Further, he related that although embolic strokes occurred with disease of the internal carotid or at the bifurcation of the internal and external carotid arteries, the employee's carotid showed minimal disease and no emboli from the aorta or major arteries. Dr. Green opined that anesthesia does have its inherent risk but what happened to the employee was more likely associated with his medical health, which included diabetes, near morbid obesity, hypercholesterolemia and an elevated sedimentary rate, rather than any specific anesthesia risk or surgery. He stated that hypercholesterolemia was associated with vascular disease and that increased sedimentary rates were a sign of chronic infection and were associated with an increased chance of arterial endothelial damage which leads to the formation of arterial clots.

The Board finds that the opinions of Drs. Orent, Barrett and Green are well rationalized and based on a proper factual and medical background and, thus, entitled to special weight afforded impartial medical specialists. They found that the employee's stroke and death on October 31, 1998 were not caused by his October 28, 1998 employment-related surgery. For these reasons, their reports constitute the special weight of the medical opinion evidence afforded an impartial medical specialist.[12]

Counsel contended that Dr. Orent, Dr. Barrett and Dr. Green were not properly selected under the PDS. An impartial medical specialist is selected using a rotational system based on the PDS.[13] The services of all available and qualified Board-certified specialists will be used as far as possible to eliminate any inference of bias or partiality. This is accomplished by selecting specialists in alphabetical order as listed in the roster chosen under the specialty and/or subspecialty heading in the appropriate geographic area and repeating the process when the list is exhausted.[14] The Board notes that appellant's challenge to the selection of Drs. Orent, Barrett

[12] *See Darlene R. Kennedy*, 57 ECAB 414 (2006).

[13] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4.b(1)(May 2003); *L.W.*, 59 ECAB ____ (Docket No. 07-1346, issued April 23, 2008).

[14] *Id.*

and Green did not occur until after issuance of the Office's April 8, 2005 decision which accorded special weight to their opinions. If appellant disagreed with this selection, she should have noted her objections at or near the time the employee's case record was referred to the physicians on January 28, 2005. Counsel complied with the Office's March 3, 2005 request for submission of additional medical evidence for review by the impartial medical panel without stating any objections to their selection. Moreover, the Board notes that the Office followed its procedures and provided the evidence necessary to establish the physicians were selected in a fair and unbiased manner. The record demonstrates that the Office adhered to the selection procedures, that reasons were provided for each physician who was bypassed and that the only zip code utilized was the zip code of appellant's address of record. The Board finds that appellant has not presented sufficient evidence to establish that Dr. Orent, Dr. Barrett and Dr. Green were improperly selected as the impartial medical panel.

LEGAL PRECEDENT -- ISSUE 2

To require the Office to reopen a case for merit review under section 8128 of the Act,[15] the Office's regulations provide that a claimant must: (1) show that the Office erroneously applied or interpreted a specific point of law; (2) advance a relevant legal argument not previously considered by the Office; or (3) constitute relevant and pertinent new evidence not previously considered by the Office.[16] To be entitled to a merit review of an Office 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.[17] 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 of the merits.

ANALYSIS -- ISSUE 2

In a letter dated December 7, 2007, appellant, through counsel, disagreed with the Office hearing representative's March 22, 2007 decision. The relevant issue in the case, whether the employee's stroke and death were caused by the accepted employment-related surgery, is medical in nature.

In the request for reconsideration, counsel argued that the Office used its second opinion service rather than the PDS to select Dr. Barrett and Dr. Green as impartial medical specialists. He contended that the second opinion service was biased. Counsel further argued that the statement of accepted facts was incomplete as it did not mention the employee's accepted cervical disc herniation at C5-6, which led to a fusion in 1992. He stated that an Office medical adviser determined that the absence of this condition was relevant. Counsel contended that the opinions of Dr. Orent and Dr. Green were not rationalized and that Dr. Barrett failed to address the issue of whether the employee's work-related surgery caused his stroke. Evidence that

[15] 5 U.S.C. §§ 8101-8193. Under section 8128 of the Act, the Secretary of Labor may review an award for or against payment of compensation at any time on her own motion or on application. 5 U.S.C. § 8128(a).

[16] 20 C.F.R. § 10.606(b)(1)-(2).

[17] *Id.* at § 10.607(a).

repeats or duplicates evidence already in the case record has no evidentiary value and does not constitute a basis for reopening a case.[18] Counsel's contentions were previously made and addressed by the Office in its prior decisions and, thus, do not constitute relevant and pertinent new evidence not previously considered by the Office. The Board finds that this evidence does not require reopening appellant's claim for further review on the merits.

Appellant submitted a deposition regarding a lawsuit filed against Medical OPS Management alleging that it was engaged in biased procurement of medical evidence for insurance companies and provided a list containing the names of neurologists and anesthesiologists allegedly skipped by the medical examination scheduler. The Board has held that the submission of evidence which does not address the particular issue involved in the case does not constitute a basis for reopening the claim.[19] As the issue in this case is medical in nature, the factual evidence submitted by appellant is not relevant and, thus, insufficient to warrant further merit review of her claim.

The evidence submitted by appellant did not show that the Office erroneously applied or interpreted a specific point of law, advance a relevant legal argument not previously considered by the Office or constitute relevant and pertinent new evidence not previously considered by the Office. As she did not meet any of the necessary regulatory requirements, the Board finds that she is not entitled to further merit review.[20]

CONCLUSION

The Board finds that the employee's stroke and death on October 31, 1998 were not causally related to his October 28, 1998 employment-related surgery. The Board further finds that the Office properly denied appellant's request for a merit review of her claim pursuant to 5 U.S.C. § 8128(a).

[18] *James W. Scott*, 55 ECAB 606, 608 n.4 (2004); *Freddie Mosley*, 54 ECAB 255 (2002).

[19] *D'Wayne Avila*, 57 ECAB 642 (2006).

[20] *See* 20 C.F.R. § 10.608(b); *Richard Yadron*, 57 ECAB 207 (2005).

ORDER

IT IS HEREBY ORDERED THAT the January 24, 2008 and March 22, 2007 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: March 23, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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