United States Department of Labor
Employees' Compensation Appeals Board

L.C., Appellant	)	
and	)	**Docket No. 12-972**
	)	**Issued: November 9, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Long Island City, NY, Employer	)	

Appearances:
Paul Kalker, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On March 28, 2012 appellant, through counsel, filed a timely appeal from the March 6, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether OWCP properly reduced appellant's compensation to zero for failing to cooperate with the early stages of vocational rehabilitation efforts.

FACTUAL HISTORY

On May 17, 2003 appellant, then a 46-year-old letter carrier, experienced pain in his neck, shoulder and down his left arm as he was pushing his mail cart. OWCP accepted his claim for left shoulder sprain and neck strain and expanded his claim to include left rotator cuff

[1] 5 U.S.C. §§ 8101-8193.

strain/sprain and tear, left carpal tunnel syndrome and cervical radiculitis. Appellant stopped work on May 20, 2003 and returned to full-time light duty on May 23, 2003 and stopped completely on September 4, 2004. He was paid compensation and medical benefits.

Appellant came under the treatment of Dr. Michael C. Schwartz, a Board-certified orthopedist, on September 14, 2004 for a left shoulder injury sustained at work. On September 14, 2004 Dr. Schwartz performed an authorized left shoulder arthroscopic subacromial decompression, partial distal clavicle excision, rotator cuff debridement and labral debridement. He diagnosed chondromalacia of glenohumeral joint, impingement rotator cuff tendinitis, partial rotator cuff tear and Type 1 superior labrum anterior position (SLAP) tear. On January 6, 2006 Dr. Schwartz treated appellant for persistent acromioclavicular joint pain and diagnosed left shoulder acromioclavicular arthritis with continued rotator cuff tendinitis. On March 30, 2006 he performed a left shoulder arthroscopic debridement, SLAP tear repair and open distal clavicle excision. Dr. Schwartz diagnosed left shoulder pain with evidence of acromioclavicular joint arthritis and a Type 2 SLAP tear.

On May 22, 2008 appellant underwent an electromyogram (EMG) which revealed acute and chronic left C7 and C8, T1 radiculopathy and mild bilateral carpal tunnel syndrome. A magnetic resonance imaging (MRI) scan of the left shoulder revealed bursal surface partial tear of the supraspinatus tendon of the humeral head, osteoarthritis of the glenohumeral joint with spurring and tenosynovitis of the long head of the biceps tendon.

Appellant came under the care of Dr. Sanjay B. Shah, a Board-certified internist, on September 3, 2010, who treated him for chronic neck and left shoulder pain after a 2003 work injury. On September 21, 2010 Dr. Shah performed nerve conduction studies that revealed mild bilateral carpal tunnel syndrome affecting sensory and motor components.

On September 27, 2010 OWCP referred appellant to Dr. Jonathan Black, a Board-certified orthopedic surgeon and an OWCP referral physician, who opined that there were no objective findings of orthopedic residuals of the compensable medical conditions of left rotator cuff tear and cervical radiculitis. Dr. Black, in his October 20, 2010 report, noted that the EMG studies suggest moderate left median neuropathy with no resolution of the impingement syndrome. He noted that appellant would not be capable of performing his regular duties as a letter carrier without restrictions. Dr. Black noted that appellant reached maximum medical improvement and would benefit from vocational rehabilitation. In a work capacity evaluation, he noted that appellant could return to work full time with permanent restrictions.

In an October 28, 2010 memorandum, OWCP noted that Dr. Black's October 20, 2010 report supported that appellant could work full time with permanent restrictions. Dr. Black opined that appellant was a candidate for vocational rehabilitation.

On October 29, 2010 OWCP referred appellant for vocational rehabilitation. In vocational rehabilitation reports dated November 30, 2010, the counselor noted speaking with appellant on November 12, 2010 and visiting his home on November 16, 2010. She noted transferable skills as a stockbroker and mail carrier. Appellant underwent test of adult basic education on November 29, 2010 and scored very high in all basic academic areas for vocational and technical training and discussed areas of training in a college or vocational school.

Appellant submitted an MRI scan of the cervical spine dated December 13, 2010, which revealed left neural foraminal narrowing at C2-3, C3-4, C4-5, mild stenosis due to degenerative changes at C5-6 and a small broad-based disc bulge at C6-7.

In a February 18, 2011 report, the rehabilitation counselor noted meeting appellant on January 26, 2011 at Workforce Central Florida to discuss literature about courses at a vocational school. Appellant showed interest in accounting operation and business occupation, however, expressed concern over performing constant typing with his bilateral carpal tunnel syndrome. On February 11, 2011 he contacted the counselor and reported typing on the computer using different programs provided and determined that it was too much for his carpal tunnel syndrome, that after 10 to 20 minutes on the computer he had pain (both in the wrists and cervical area) and had to stop typing. On February 14, 2011 a rehabilitation counselor at the vocational school confirmed that all the business courses required constant typing and believed that a candidate with bilateral carpal tunnel syndrome would find it difficult to complete the courses and find work. The counselor at Workforce Central Florida also agreed that carpal tunnel syndrome would be an obstacle to be retrained or accepted into the accounting and bookkeeping field. The rehabilitation counselor recommended a job search. In a January 26, 2011 rehabilitation report, the counselor noted that appellant was very motivated and actively participated in school research but was concerned over his carpal tunnel syndrome.

In a letter dated March 13, 2011, appellant, through his attorney, advised that, as a result of his most recent medical examination, he was unable to medically or physically perform work duties at a sedentary level. He submitted a March 1, 2011 report from Dr. Shah who noted a history of appellant's work injury on May 17, 2003 when he was pushing a mail cart at work and felt pain in his left side and neck. Dr. Shah noted treating appellant on multiple occasions and diagnosed cervicalgia and bilateral carpal tunnel syndrome. He noted that appellant was asked to participate in vocational rehabilitation coursework classes leading to sedentary work opportunities. Dr. Shah noted that appellant was medically unable to participate in such classes. He noted a September 12, 2010 nerve conduction study confirmed bilateral carpal tunnel syndrome and the left and right median motor nerves showed reduced amplitude and decreased conduction velocity. Dr. Shah noted that the conditions were related to the work factors of May 17, 2003. He stated that the left median antisensory nerve showed prolonged distal peak latency and also decreased conduction velocity. Dr. Shah indicated that the diagnosis affected his sensory and motor components and made it difficult to perform sedentary occupations that would require fine motor skills such as picking up a pen, writing or typing on a computer as well as holding a receiver to his ear. He opined that, if appellant were to start sedentary work, the result would lead to lumbosacral radiculitis and long-term use would exacerbate his cervicalgia. Dr. Shah stated that appellant required bilateral wrist braces. He advised that appellant continued to complain of pain in the neck, arms and hands and required the use of pain medication. Dr. Shah noted that appellant had a history of a left rotator cuff tear with surgical repair. He opined that appellant was permanently disabled as a result of his injuries sustained at work and any return to employment would be detrimental to his condition and would worsen the carpal tunnel syndrome and cervical strain.

A March 29, 2011 letter from the rehabilitation specialist to OWCP noted efforts to develop a retraining program were not effective as appellant alleged extreme pain due to his

compensable injuries and complaints of bilateral carpal tunnel syndrome. The specialist noted that appellant's physician, Dr. Shah, advised on March 1, 2011 that appellant could not work. The rehabilitation specialist indicated that based on appellant's complaints he did not believe the rehabilitation counselor could develop a plan for appellant which would assist him in obtaining new employment.

In a rehabilitation report dated April 4, 2011, the rehabilitation counselor noted that the case was in interrupted status due to appellant's physician's opinion that he was unable to perform sedentary work.

In a report dated April 14, 2011, Dr. Shah diagnosed cervicalgia, carpal tunnel syndrome, ankle/foot pain and hypertensive heart disease.

On August 11, 2011 OWCP referred appellant to Dr. Richard Steinfeld a Board-certified orthopedist, for a second opinion. In a September 14, 2011 report, Dr. Steinfeld noted that examination revealed an obese male, well-healed left shoulder arthroscopic sites, positive supraspinatus and Hawkins' tests, negative Tinel's sign and negative carpal tunnel compression test. He diagnosed chronic left shoulder pain, status post left shoulder arthroscopy and left carpal tunnel syndrome. Dr. Steinfeld opined that appellant could work and perform occasional fingering, handling and keyboarding activities but would be limited in heavy, repetitive overhead activities over 20 pounds. He believed appellant could be gainfully employed at a sedentary level. Dr. Steinfeld opined that appellant's subjective complaints outweighed objective findings. He noted that the September 21, 2010 EMG suggested only mild carpal tunnel syndrome and he found no reason that appellant could not continue vocational rehabilitation. In a work capacity evaluation, Dr. Steinfeld noted that appellant could work eight hours a day with permanent restrictions on reaching above the shoulder limited to four hours, pushing, pulling and lifting limited to four hours and 20 pounds.

In a September 19, 2011 memorandum, OWCP advised the rehabilitation specialist that appellant was capable of working eight hours per day of sedentary work pursuant to the second opinion physician and recommended that vocational rehabilitation services resume.

Appellant submitted a June 23, 2011 work capacity evaluation from Dr. Shah who noted that appellant was unable to perform his usual job and could not work eight hours per day. Dr. Shah opined that appellant reached maximum medical improvement and had permanent restrictions. He noted that sitting, walking, standing, reaching, reaching above the shoulder, bending and stooping were limited to one hour per day, repetitive movements of the wrist and elbow, pushing, pulling, lifting and squatting were limited to one hour. In a July 22, 2011 report, Dr. Shah advised that appellant had bilateral carpal tunnel syndrome.

On December 6, 2011 OWCP requested clarification from Dr. Steinfeld regarding his work capacity evaluation as some of the tasks were left blank. In a supplemental work capacity evaluation, Dr. Steinfeld noted that appellant could work eight hours a day with permanent restrictions of reaching and reaching above the shoulder limited to four hours, pushing, pulling and lifting limited to four hours and 20 pounds with no other restrictions.

In a memorandum dated December 22, 2011, the claims examiner noted that Dr. Steinfeld's opinion represented the weight of the evidence and opined that appellant was capable of working eight hours per day with permanent restrictions.

On December 23, 2011 OWCP advised appellant that a rehabilitation counselor had been assigned to him and would soon be contacting him. Appellant was informed that he was expected to cooperate fully with the rehabilitation counselor. On a January 11, 2012 call to OWCP's telephone bank, the rehabilitation counselor advised that she had been contacted by appellant's attorney noting that appellant would not participate in vocational rehabilitation efforts.

In a rehabilitation action report dated January 12, 2012 and a vocational rehabilitation report dated January 23, 2012, the counselor noting contacting appellant on December 27 and 28, 2011 by telephone and sent him a letter on December 28, 2011 regarding scheduling an interview. On January 3, 2012 she received a call from appellant's attorney noting that appellant was not able to participate in vocational rehabilitation on the advice of his physician. The counselor contacted appellant's attorney on January 11, 2012 and the attorney requested that she not contact appellant.

On January 25, 2012 OWCP advised appellant that it was notified that he was impeding vocational rehabilitation efforts. It informed him that failure to participate in the essential preparatory efforts of vocational rehabilitation (such as interviews, testing, counseling, guidance and work evaluation) without good cause would be construed as a refusal to apply for or undergo rehabilitation. OWCP notified him that 5 U.S.C. § 8113(b) provided that, if an individual without good cause fails to apply for and undergo vocational rehabilitation when so directed, and it finds that in the absence of the failure the individual's wage-earning capacity would probably have substantially increased, it may reduce prospectively the compensation based on what probably would have been the individual's wage-earning capacity had he not failed to apply for and undergo vocational rehabilitation. Appellant was provided 30 days to submit evidence and argument if he felt he had good reason for not participating in the rehabilitation effort. OWCP advised him that, after any evidence submitted was evaluated, further action would be taken without additional notice to him. If appellant did not comply with the instructions within 30 days, the rehabilitation effort would be terminated and his compensation reduced.

On February 9, 2012 appellant's attorney asserted that appellant could not medically undergo vocational rehabilitation. He stated that appellant had not failed to contact his counselor or keep appointments and any alleged failure to participate was due to good cause. Appellant noted that OWCP accepted left carpal tunnel syndrome but did not accept right carpal tunnel syndrome as work related in spite of Dr. Shah's reports. He asserted that his right hand condition should be considered with regard to his ability to undergo vocational rehabilitation.

In a March 6, 2012 decision, OWCP reduced appellant's compensation to zero finding that he had failed to participate in the early but necessary vocational rehabilitation efforts which would permit OWCP to determine his wage-earning capacity. It found that vocational rehabilitation efforts would have returned him to work at the same or higher wages than the

position he held when injured. Appellant was advised that this reduction would continue until he underwent the vocational testing or showed good cause for not complying.

LEGAL PRECEDENT

Section 8113(b) of FECA provides:

> "If an individual without good cause fails to apply for and undergo vocational rehabilitation when so directed under section 8104 of this title, the Secretary, on review under section 8128 of this title and after finding that in the absence of the failure the wage-earning capacity of the individual would probably have substantially increased, may reduce prospectively the monetary compensation of the individual in accordance with what would probably have been his wage-earning capacity in the absence of the failure, until the individual in good faith complies with the direction of the Secretary."[2]

Section 10.124(f) of OWCP's regulations further provide:

> "Pursuant to 5 U.S.C. § 8104(a), OWCP may direct a permanently disabled employee to undergo vocational rehabilitation.... If an employee without good cause fails or refuses to apply for, undergo, participate in or continue participation in the early but necessary stages of a vocational rehabilitation effort (*i.e.*, interviews, testing, counseling and work evaluations), OWCP cannot determine what would have been the employee's wage-earning capacity had there not been such failure or refusal. It will be assumed, therefore, in the absence of evidence to the contrary, that the vocational rehabilitation effort would have resulted in a return to work with no loss of wage-earning capacity and OWCP will reduce the employee's monetary compensation accordingly. Any reduction in the employee's compensation under the provisions of this paragraph shall continue until the employee in good faith complies with the direction of OWCP."[3]

ANALYSIS

Once OWCP has made a determination that an employee is totally disabled as a result of an employment injury and pays compensation, it has the burden of justifying a subsequent reduction of benefits.[4] It reduced appellant's compensation based on his failure to participate in vocational rehabilitation. The Board finds that OWCP did not meet its burden of proof to reduce appellant's compensation.

As noted, OWCP must initially determine the employee's medical condition and work restrictions before selecting an appropriate position that reflects his vocational wage-earning

[2] 5 U.S.C. § 8113(b).

[3] 20 C.F.R. § 10.124(f).

[4] *M.A.*, 59 ECAB 624, 631 (2008).

capacity.[5] The medical evidence upon which OWCP relies must provide a detailed description of appellant's condition and the evaluation must be reasonably current.[6] OWCP relied on Dr. Steinfeld, OWCP's referral physician's September 14, 2011 work restrictions but did not address Dr. Shah's more restrictive June 23, 2011 work limitations.

In contrast to Dr. Steinfeld, Dr. Shah, appellant's physician, imposed greater restrictions with respect to reaching, reaching above the shoulder, pushing, pulling and lifting. He also imposed limitations with respect to sitting, walking, standing, twisting, bending and stooping, operating a motor vehicle, repetitive movements of the wrist and elbow, squatting, kneeling and climbing. The restrictions differ from Dr. Steinfeld's September 14, 2011 work capacity evaluation (OWCP-5c).

FECA provides that, if there is disagreement between an OWCP-designated examining physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[7] For a conflict to arise, the opposing physician's viewpoints must be of virtually equal weight and rationale.[8] The Board finds there is an unresolved conflict in medical opinion regarding appellant's work restrictions between Dr. Steinfeld and Dr. Shah. Also, OWCP did not address whether appellant's nonaccepted right carpal tunnel condition impacted his ability to participate in vocational rehabilitation or perform a position. Dr. Shah noted in his March 1 and July 22, 2011 reports that appellant was significantly limited in his activity due his bilateral carpal tunnel syndrome. He noted that appellant was asked to participate in vocational rehabilitation coursework classes leading to sedentary work opportunities; however, he was medically unable to participate in such classes. Dr. Shah noted that the September 21, 2010 nerve conduction study confirmed bilateral carpal tunnel syndrome and the left and right median motor nerves showed reduced amplitude and decreased conduction velocity. He noted that the conditions were related to the work factors of May 17, 2003. Dr. Shah indicated that the diagnoses affected his sensory and motor components and made it difficult to perform sedentary occupations that would require fine motor skills such as picking up a pen, writing or typing on a computer as well as holding a receiver to his ear.

As such, OWCP improperly reduced appellant's compensation for failure to participate in vocational rehabilitation efforts as there exists an unresolved medical conflict.[9]

[5] *Id.*

[6] *Id.*

[7] 5 U.S.C. § 8123(a); *see* 20 C.F.R. § 10.321; *Shirley L. Steib*, 46 ECAB 309, 317 (1994).

[8] *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

[9] *K.R.*, Docket No. 11-1746 (issued August 16, 2012) (where the Board found that there was an unresolved conflict in medical opinion regarding appellant's work restrictions between the referral physician and appellant's treating physician and therefore OWCP failed to satisfy its burden in reducing appellant's wage-loss compensation for failure to participate in vocational rehabilitation).

CONCLUSION

The Board finds that OWCP improperly reduced appellant's compensation to reflect a loss of wage-earning capacity for his failure to cooperate in vocational rehabilitation efforts.

ORDER

IT IS HEREBY ORDERED THAT the March 6, 2012 decision of the Office of Workers' Compensation Programs is reversed.

Issued: November 9, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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