United States Department of Labor
Employees' Compensation Appeals Board

F.C., Appellant	)	
and	)	**Docket No. 14-0560**
	)	**Issued: November 12, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Albany, NY, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 14, 2014 appellant filed a timely appeal from an October 22, 2013 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 this case.

ISSUE

The issue is whether OWCP properly terminated appellant's wage-loss compensation and medical benefits effective July 10, 2013 as he no longer had any residuals or disability causally related to his accepted employment-related injury.

FACTUAL HISTORY

On October 28, 2000 appellant, then a 46-year-old mail clerk, filed an occupational disease claim. He claimed that on October 26, 2000 he had developed a left shoulder condition

[1] 5 U.S.C. § 8101 *et seq.*

with neck pain from operating a bar code sorting machine. OWCP accepted appellant's claim for left shoulder strain and paid compensation benefits.

On January 4, 2002 appellant filed a claim for recurrence of total disability on January 2, 2002. OWCP paid compensation for temporary total disability and placed him on the periodic rolls. On April 25, 2002 appellant underwent an authorized left shoulder distal clavicle resection and left shoulder acromioplasty, performed by Dr. Richard L. Uhl, a Board-certified orthopedic surgeon.

Appellant filed a separate occupational disease claim for elbow and wrists conditions as of April 5, 2001 under file number xxxxxx107. OWCP accepted bilateral carpal tunnel syndrome and lateral epicondylitis. In 2002, it consolidated the claims with file number xxxxxx465, as the master file. On October 18, 2002 and on January 3, 2003 Dr. Uhl also performed left and right side carpal tunnel releases, respectively.

In April 2003, Dr. Uhl requested approval for a left lateral epicondylectomy and requested that her claim should be expanded to include a right shoulder condition due to over compensation on the right for weakness on the left. In an April 29, 2003 letter, OWCP advised appellant that the medical evidence was insufficient to support either request.

On July 21, 2003 Dr. Uhl noted that OWCP had denied surgical treatment for the left elbow and workup for the right shoulder and he opined that appellant was totally disabled and not able to work in any meaningful capacity. Appellant was not able to use his hands for any lifting or repetitive motion and had severe pain with any motion of the left elbow. Further, he could not use his shoulders to reach overhead. In a July 14, 2004 report, Dr. Uhl opined that appellant had reached maximum medical improvement on January 1, 2004 but that the problems with his left shoulder, left elbow, and right and left hands had worsened.

OWCP referred appellant for a second opinion to Dr. John Buckner, a Board-certified orthopedic surgeon. In a December 20, 2004 report, Dr. Buckner set forth findings on examination and determined that appellant's work-related conditions had resolved and he could return to work with restrictions for the left shoulder.

In a January 19, 2005 report, Dr. Uhl reviewed Dr. Buckner's report and reiterated that appellant had no useful function of the left upper extremity. He did not alter his earlier opinions.

OWCP found a conflict of medical opinion between Dr. Uhl and Dr. Buckner as to appellant's residual disability and work capacity. It referred appellant to Dr. Paul G. Jones, a Board-certified orthopedic surgeon, for an impartial medical examination. In a May 16, 2005 report, Dr. Jones noted that appellant had poor motion in his left shoulder but was capable of working two hours with his right upper extremity; that he could not work above waist level with his left arm; and that these work restrictions were permanent. In an August 29, 2005 addendum, he noted that he had erroneously listed that appellant could work only two hours a day with restrictions. Dr. Jones clarified that appellant could work eight hours a day. He also noted his agreement with Dr. Uhl's impairment findings for the left and right upper extremities.

In June 2006, OWCP received medical reports from Dr. Kerry Ricker, an osteopath and family medicine physician. Dr. Ricker reported chronic left shoulder pain secondary to a

previous surgery and repetitive trauma from a previous job, ongoing pain, limited flexion and extension of the hands, and left elbow pain.[2]

In progress reports dated 2007 through 2009, Dr. Ricker listed left upper extremity findings of decreased range of motion, weakness, and numbness with little improvement. She opined that appellant remained disabled. In progress reports dated 2010 and 2011, Dr. Ricker opined that he had chronic nerve damage in his wrists, impingement of the left shoulder with loss of range of motion, and arthritis. She opined that appellant continued to be permanently disabled and that there was a direct causal relationship between his disability and his job, which required chronic repetitive movement.

In November 2011, OWCP received an October 25, 2011 left elbow x-ray which was reported as unremarkable. The results of a November 1, 2011 magnetic resonance imagining (MRI) scan of the left elbow revealed a high grade partial thickness tear and tendinopathy of the common extensor tendon.

In a November 9, 2011 report, Dr. Suheil M. Khuri, a Board-certified orthopedic surgeon, provided a history of the injury and found on examination some tenderness over the lateral epicondyle, restricted movement in his shoulder, and pain associated with the previous surgery. He confirmed that the November 1, 2011 MRI scan showed a high grade partial thickness common extensor tendinopathy and partial tearing consistent with lateral epicondylitis, as well as changes in the biceps consistent with a partial tearing or tenosynovitis, with similar changes in the triceps. Dr. Khuri diagnosed chronic left elbow strain and tendinitis, mostly lateral epicondylitis with some biceps and medial epicondylitis. He advised that elbow surgery was not warranted at that time and prescribed physical therapy and steroid injection.

OWCP prepared an updated statement of accepted facts dated February 27, 2012 and referred appellant to Dr. Edwin E. Mohler, a Board-certified orthopedic surgeon, for a second opinion examination. In an April 12, 2012 report, Dr. Mohler reviewed the statement of accepted facts, the medical records of file and a surveillance digital versatile disc (DVD) which had been provided to OWCP by the employing establishment.[3] He noted findings on examination and advised that appellant's pain complaints were in excess of objective findings suggesting symptom magnification. Dr. Mohler outlined his review of appellant's activities on the investigative DVD, noting that appellant used his left arm and extended his left elbow. He stated that the observed activities did not substantiate appellant's statements made to him during the evaluation. Based on appellant's observed activities, Dr. Mohler found no orthopedic rationale for appellant to remain off work. He was unable to justify an orthopedic impairment as it affected the function of appellant's upper extremities in relation to the accepted conditions.

[2] Appellant was separated from the employing establishment and approved for disability retirement as of April 26, 2007.

[3] In a September 23, 2011 investigative memorandum, the employing establishment's Office of the Inspector General had transmitted a DVD containing surveillance video of appellant between March 2010 and April 2011 showing observations of appellant shoveling snow, snow blowing, lifting a snow blower, carrying bricks in each hand, cleaning dog droppings, shopping, lifting, and moving cases of soda, using hand-held power tools, driving, and other tasks. The report indicated that appellant often used both hands and his efforts frequently involved repetitive motions, bending, stooping, lifting, reaching, walking, and standing.

Dr. Mohler noted that the November 2011 MRI scan of the left elbow had no relationship to the accepted claim of October 26, 2000. He concluded that the accepted conditions had resolved and that appellant could work full duty. Dr. Mohler stated that, although appellant had known preexisting impairments, appellant was able to return to his preinjury job as a clerk on a full-time basis. This was evidenced by his potential and the capabilities demonstrated in the observed activities in March 2010, and January, February, March, and April 2011, as those activities negated any current disability.

By notice dated May 24, 2012, OWCP proposed to terminate appellant's wage-loss and medical compensation benefits based on the second opinion report of Dr. Mohler. In a June 11, 2012 letter, appellant requested an extension and a copy of the referenced investigative DVD.

By decision dated July 11, 2012, OWCP terminated his wage-loss and medical compensation benefits effective that date. The weight of the medical evidence was accorded to Dr. Mohler's medical opinion.

On August 8, 2012 appellant requested an oral hearing. By decision dated November 1, 2012, an OWCP hearing representative performed a preliminary review of the case and reversed the July 11, 2012 OWCP decision. He found that Dr. Mohler's opinion was deficient as it was not based on a complete statement of accepted facts and it had failed to provide sufficient rationale for finding that all residuals of the accepted conditions had resolved. The hearing representative requested that OWCP revise its statement of accepted facts and request a supplemental report from Dr. Mohler as to whether residuals remained of the accepted conditions and surgeries. Appellant's benefits were reinstated retroactive to July 11, 2012.

Pursuant to a September 3, 2012 request, on December 4, 2012 OWCP provided appellant a copy of the surveillance DVD.

On remand, OWCP prepared an updated statement of accepted facts that included a description of appellant's job duties as a postal clerk and, on December 18, 2012, it requested clarification from Dr. Mohler. In the November 26, 2012 supplemental report, Dr. Mohler stated that during physical examination, appellant exhibited exaggerated pain behaviors. He found no evidence of tendinitis, no evidence of carpal tunnel syndrome, and no impairment to his vascular status of his upper extremities. There was no atrophy of the musculature of appellant's hand or of his upper extremities and he provided nonphysiological response to sensory examination. Dr. Mohler noted that multiple physicians, who had been treating and examining appellant over the years, had referenced a psychogenic overlay and he provided a list of those physicians. He noted that no residuals remained from the accepted conditions/surgeries as there was a lack of any objective findings on physical examination. Dr. Mohler noted the disconnect between the observed activities on the DVD compared to appellant's presentation to him, as well as other physicians, over the years in concluding that there was no orthopedic rationale preventing him from working in his usual capacity without restrictions. He further stated that given appellant's clinical presentation, lack of identifying evidence of carpal tunnel or tendinitis in his upper extremities on physical examination, and the capabilities he demonstrated on DVD, it did not matter what job he was assigned as he could perform any work without restrictions.

OWCP determined that a conflict in medical opinion existed between the opinions of Dr. Mohler and Dr. Ricker, as to appellant's disability and work capacity. It referred appellant to Dr. Kuhrt Wieneke, Jr., a Board-certified orthopedic surgeon. In an April 22, 2013 report, Dr. Wieneke reviewed the statement of accepted facts, the medical evidence of record, the surveillance DVD and job descriptions. He noted a history of the injury and the accepted conditions of lateral epicondylitis both elbows, carpal tunnel syndrome both wrists and left shoulder sprain with resulting surgery. Dr. Wieneke noted his review of the surveillance photos and reports and noted that in three surveillances, between February and April 2011, appellant was shown with limited use of his left arm to the point of shoveling snow and sweeping snow from his car and snow blower using only his right arm, accompanied by grimacing and limping during these activities. Such pain behavior was not noted in surveillance on three separate days between March 2010 and April 2011. Dr. Wieneke noted that, in the forwarded photos of surveillance, appellant appeared to be using both upper extremities symmetrically, specifically on April 2, 2011, carrying bricks with both hands and, on April 9, 2011, carrying large grocery bags, one in each hand. He noted that, while Dr. Ricker suggested that appellant had rotator cuff surgery on the left, he did not. The surgery was specifically an acromioplasty, as well as a resection of the outer clavicle, which is usually a result of arthritic changes in the acromioclavicular joint. Dr. Wieneke noted that Dr. Ricker was responsible for appellant's medications, including chronic high dose of oral narcotics. He opined that because Dr. Ricker is appellant's treating physician and was using long-term high-dose narcotics as part of the treatment regimen, she loses objectivity.

Dr. Wieneke noted that physicians who had previously evaluated appellant independently had concluded that his pain complaints in his left shoulder, left elbow and both wrists substantially outweighed any physical positive findings. He recommended that appellant be weaned from narcotics, especially in light of the evidence of major symptom magnification. Dr. Wieneke noted that appellant had giveaway weakness in his left shoulder, left elbow and both wrists, all which were accompanied by facial grimacing, loud outcries of pain, sudden jerking motion in both upper and lower extremities and an insistence on remaining in a standing position. He noted that when appellant walked into the examining room, appellant leaned forward and substantially to his right and, when he left the office, he leaned forward and sharply to his left. Dr. Wieneke also observed appellant in the parking lot leaning to his right and not using his left upper extremity which was hanging at his side.

Dr. Wieneke found there was no sensory loss in either hand, no muscle atrophy on the thenar or hypothenar sides and Tinel's sign testing was negative. Wrist flexion and extension testing were negative on both sides and range of motion findings were provided. Both shoulders were symmetrical in appearance, with no forearm or arm atrophy and musculature was normal on palpation, percussion, and resisted activities. Dr. Wieneke stated that appellant's shoulders were stable and there was a mild loss of motion in the left shoulder girdle, but appellant claimed he had no active use of his left shoulder girdle. Strength of pinch and grasp were normal with no sensory deficit on either side. No abnormality was found about either elbow. Dr. Wieneke opined that appellant's behavior was bizarre and he had obvious pain modification.

Dr. Wieneke opined that appellant was not disabled, based on his physical findings nor based on the surgeries performed on his left shoulder and both wrists. He opined that appellant was capable of working full time as a mail processor, according to the position description.

Dr. Wieneke further opined that there was evidence of a left shoulder arthroplasty, acromioclavicular joint, which was a long-term preexisting condition and had little, if any, relationship to the repetitive work activities of a postal clerk. He opined that carpal tunnel syndrome had largely resolved and appellant's two percent impairment of each wrist was appropriate. Dr. Wieneke further opined that there was no remaining evidence of lateral epicondylitis in either elbow. He found that appellant had reached maximum medical improvement, there was no disability from work, and he was capable of returning to his regular work as a postal clerk.

On June 6, 2013 OWCP issued a notice of proposed termination. The special weight of the medical evidence was accorded to the impartial medical opinion of Dr. Wieneke.

In a June 28, 2013 statement, appellant questioned how Dr. Wieneke could observe him coming into his office as he had been dropped off. He argued that Dr. Wieneke's examination was brief and he had misunderstood several of appellant's statements. Appellant argued that Dr. Jones, an impartial medical specialist, had found him disabled due to his injuries in 2005 and that this opinion should outweigh the opinion of Dr. Wieneke.

By decision dated July 10, 2013, OWCP terminated appellant's wage-loss and medical compensation benefits effective that day based on the opinion of Dr. Wieneke.

On July 18, 2013 appellant requested a review of the written record before an OWCP hearing representative. By decision dated October 22, 2013, the hearing representative affirmed the July 10, 2013 termination decision.

LEGAL PRECEDENT

Once OWCP accepts a claim, it has the burden of justifying termination or modification of compensation. After it has been determined that an employee has disability causally related to his or her employment, OWCP may not terminate compensation without establishing that the disability had ceased or that it was no longer related to the employment.[4] Its burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[5] Furthermore, the right to medical benefits for an accepted condition is not limited to the period of entitlement for disability. To terminate authorization for medical treatment, OWCP must establish that a claimant no longer has residuals of an employment-related condition which require further medical treatment.[6]

Section 8123(a) of FECA 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.[7] The implementing regulations

[4] *Jason C. Armstrong*, 40 ECAB 907 (1989).

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

[6] *Mary A. Lowe*, 52 ECAB 223 (2001); *Wiley Richey*, 49 ECAB 166 (1997).

[7] 5 U.S.C. § 8123(a).

state 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 OWCP medical adviser, OWCP shall appoint a third physician to make an examination. 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.[8] In situations where there exist 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.[9]

ANALYSIS

OWCP accepted the claim for left shoulder sprain with left shoulder surgery on April 25, 2002, bilateral/lateral epicondylitis and bilateral carpal tunnel syndrome with releases in 2003. On July 10, 2013 it terminated appellant's compensation benefits effective that day based on the opinion of the impartial medical examiner, Dr. Wieneke. The issue to be determined is whether OWCP met its burden of proof to terminate appellant's medical and wage-loss benefits.

Dr. Mohler, OWCP's second opinion physician, examined appellant in April 2012. In reports dated April 12 and November 25, 2012, he found no objective findings of the accepted conditions and opined that there was no residual impairment or disability from the accepted conditions. Dr. Mohler concluded that, based on his observed activities, appellant could return to his preinjury job as clerk on a full-time basis.

Dr. Ricker, the treating physician, opined that appellant had chronic nerve damage in his wrists and impingement of the left shoulder with loss of range of motion and arthritis and that he continued to be permanently disabled.

To resolve this conflict, OWCP referred appellant to Dr. Wieneke pursuant to 5 U.S.C. § 8123 for an impartial medical opinion. Dr. Wieneke was provided with appellant's medical record, a statement of accepted facts, and the surveillance DVDs. In an April 22, 2013 report, he reviewed appellant's history of injury and medical record, and provided findings on examination. Dr. Wieneke opined that appellant was capable of working full time as a mail processor, according to the position description.

Dr. Wieneke noted that, while there was evidence of a left shoulder arthroplasty in the acromioclavicular joint, it was for a long-term preexisting condition which had little, if any, relationship to repetitive work activities as a postal clerk. He opined that carpal tunnel syndrome had largely resolved with a minor amount of impairment in each wrist and that there was no remaining evidence of lateral epicondylitis in either elbow. Dr. Wieneke opined that appellant had reached maximum medical improvement, there was no evidence of disability from work, and that he was capable of returning to his regular work as a postal clerk. He noted examples of

[8] 20 C.F.R. § 10.321.

[9] *Gloria J. Godfrey*, 52 ECAB 486 (2001); *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

appellant's behavior and opined that he had obvious pain magnification and should be weaned from his long-term, high dose, narcotic use.

The Board finds that the opinion of the impartial medical specialist is based on a complete factual and medical background, is sufficiently well rationalized, and should be accorded special weight in resolving whether appellant has any disabling residuals or disability from his accepted conditions. At the time benefits were terminated, Dr. Wieneke had clearly opined that appellant had no work-related reason for disability. His report also concluded that appellant had exhibited multiple episodes of symptom magnification and secondary gain. Dr. Wieneke's opinion as set forth in his April 22, 2013 report is probative and reliable. Neither appellant nor his treating physician, Dr. Ricker, has submitted evidence of medical treatment since September 2012.

On appeal, appellant argued that OWCP improperly determined the issue of the case and retaliated against him through denial of compensation for his accepted injuries. However, these allegations are unsubstantiated. The intent of FECA is to return an injured employee to gainful employment; it is not a retirement program. The special weight of the medical evidence, as accorded to Dr. Wieneke's opinion, establishes that appellant no longer has any disabling residuals from his accepted injuries and can return to his preinjury position.

CONCLUSION

The Board finds that OWCP properly terminated appellant's compensation for the accepted conditions in this case.

ORDER

IT IS HEREBY ORDERED THAT the October 22, 2013 decision of the Office of Workers' Compensation Programs is affirmed.[10]

Issued: November 12, 2015
Washington, DC

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

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

[10] Michael E. Groom, Alternate Judge, participated in the preparation of this decision but was no longer a member of the Board effective December 27, 2014.