United States Department of Labor
Employees' Compensation Appeals Board

R.C., Appellant	)	
and	)	**Docket No. 16-0697**
	)	**Issued: October 14, 2016**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On February 26, 2016 appellant, through counsel, timely appealed September 9 and December 15, 2015 merit decisions of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether OWCP properly terminated appellant's wage-loss compensation and medical benefits as her accepted bilateral carpal tunnel syndrome and left

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

wrist sprain had resolved; and (2) whether appellant's claimed brachial plexopathy, right ulnar neuropathy, left shoulder capsulitis, and left radial neuropathy are causally related to her December 18, 2006 employment injury.

FACTUAL HISTORY

This case has previously been before the Board.[3] Appellant, a 61-year-old mail processing clerk, has an accepted traumatic injury claim (Form CA-1) for left wrist sprain, which occurred on January 9, 2006 (OWCP File No. xxxxxx698). She also has two accepted occupational disease claims involving her upper extremities. In January 2009, OWCP accepted bilateral carpal tunnel syndrome, with a December 18, 2006 date of injury (OWCP File No. xxxxxx519). In May 2010, OWCP accepted aggravation of bilateral carpal tunnel syndrome, which occurred on or about August 6, 2008 (OWCP File No. xxxxxx177).[4]

Appellant last worked on July 26, 2008. Prior to that date, she had been working part-time (four hours), limited-duty, and OWCP paid her four hours of lost wages per day. After she stopped work entirely, appellant filed a notice of recurrence of disability (Form CA-2a) commencing July 26, 2008. By decision dated March 21, 2012, OWCP found that she was only partially disabled, and therefore, paid appellant two hours of lost wages per day effective July 31, 2008.[5]

Appellant's treating physician, Dr. Scott M. Fried, a Board-certified orthopedic surgeon, provided results on examination on August 1 and September 19, 2013, and on both occasions reported that appellant remained symptomatic and was unable to return to regular work activities.

When Dr. Fried saw appellant on November 14, 2013 he reported that appellant remained symptomatic and limited, and was unable to return to her regular work activities. In a March 27,

[3] Docket No. 12-1342 (issued June 11, 2013).

[4] The three above-noted upper extremity claims have been combined under OWCP File No. xxxxxx519 (Master).

[5] OWCP based its decision on the opinion of Dr. Robert F. Draper Jr., a Board-certified orthopedic surgeon and OWCP referral physician, who examined appellant on April 29, 2010 and found her capable of performing six hours of limited-duty work at the time of her July 2008 work stoppage. When the case was last on appeal, the Board found that the issue regarding entitlement to wage-loss compensation for temporary total disability was not in posture for decision. Docket No. 12-1342 (issued June 11, 2013). The Board set aside the March 21, 2012 OWCP decision and remanded the case for further medical development. The Board specifically instructed OWCP to refer appellant for another second opinion evaluation regarding the existence and extent of any employment-related disability on or after July 26, 2008. Dr. Robert A. Smith, a Board-certified orthopedic surgeon and OWCP referral physician, opined that appellant was unable to perform her regular duties, but could work full time with a two-hour restriction on repetitive wrist movements, and an eight-hour, 20-pound limit on pushing, pulling, and lifting. OWCP sought clarification from Dr. Smith regarding whether appellant's condition had worsened on July 26, 2008 to the point that she became totally disabled. In a supplemental report, Dr. Smith explained that, based on his recent examination, he did not consider appellant to be totally disabled or to have experienced a worsening of her accepted condition as of July 26, 2008. By decision dated September 30, 2013, OWCP denied wage-loss compensation for temporary total disability. Appellant requested a hearing, and in an October 7, 2014 decision, an OWCP hearing representative of the Branch of Hearings and Review affirmed OWCP's September 30, 2013 decision. Appellant appealed the hearing representative's October 7, 2014 decision to the Board and, by decision dated May 11, 2015, the Board remanded the case to OWCP for further development, finding Dr. Smith's reports insufficient. *R.C.*, Docket No. 15-0581 (issued May 11, 2015).

2014 follow-up report, Dr. Fried noted that OWCP had recently authorized right carpal tunnel chemoneurolysis. He recommended that appellant remain off work pending the April 22, 2014 procedure. Dr. Fried also indicated that appellant's most recent work capacity evaluation would not support even sedentary work, as she was unable to perform simple grasping or lifting. He further noted that appellant was unable to key more than 48 seconds before stopping due to pain. Dr. Fried was hopeful that the upcoming chemoneurolysis procedure would improve appellant's capabilities.

The April 22, 2014 right carpal tunnel chemoneurolysis revealed, *inter alia*, perineural scarring and flexor tenosynovitis, which according to Dr. Fried was consistent with carpal tunnel and compression neuropathy.

In a July 24, 2014 report, Dr. Fried noted that appellant reported a severe flare-up of the right carpal tunnel, with shooting pain from the right volar wrist into the palm and up through the arm, with tingling and numbness in the middle three digits. Additionally, appellant's thumb was reportedly sore again. She also complained of burning in the ulnar aspect of the right hand. The pain was constant and had reached level 10 over the past week. Dr. Fried claimed that appellant wanted to move forward with surgery. He noted that she was currently out of work due to her injuries and could not return to regular work activities.

OWCP referred appellant for a second opinion examination to determine the extent of appellant's disabilities and her continued work capacity. Dr. Willie E. Thompson, a Board-certified orthopedic surgeon and OWCP referral physician, examined appellant on August 15, 2014. He questioned the accepted condition of bilateral carpal tunnel syndrome. Dr. Thompson found that the medical evidence of record did not continue to support the diagnosis. He reported that physical examination of both hands was "completely within normal limits." Dr. Thompson also indicated that there was no evidence of any injury-related factors of disability or evidence of any nonindustrial preexisting disability. Additionally, he reported that there were no periods of total or partial disability. Dr. Thompson found no objective evidence to document the need to place any physical limitations on appellant. He advised that appellant could immediately return to work without restrictions. Dr. Thompson also indicated that there was no need for additional medical treatment or diagnostic testing. In conclusion, he found that there were "no residuals of any alleged injury to [appellant's] hands or wrists having occurred on December 18, 2006."

In September 2014 OWCP declared a conflict in medical opinion between Dr. Fried and Dr. Thompson, and referred appellant for an impartial medical evaluation to determine the extent of appellant's work capacity and whether he had any residuals of the accepted conditions of left wrist sprain and bilateral carpal tunnel syndrome.

In his October 23, 2014 report, Dr. Walter W. Dearolf III, a Board-certified orthopedic surgeon and impartial medical examiner, noted that there were no objective findings on examination consistent with bilateral carpal tunnel syndrome. He also indicated that appellant's January 9, 2006 left wrist sprain had long since resolved. On physical examination, Dr. Dearolf reported that appellant was in no acute distress. He noted that her neck had full motion and there was no discomfort in the trapezii or the paraspinal cervical musculature. Additionally, both shoulders and both elbows had full range of motion and normal strength. Examination of appellant's hands revealed normal motion at the wrist, metacarpophalangeal, proximal

interphalangeal and distal interphalangeal joints, bilaterally. Dr. Dearolf also reported there was no triggering of her fingers and no atrophy of the thenar or hypothenar eminence on either hand, appellant's sensation was noted to be intact to light touch across all fingers and both the radial and ulnar borders of the forearm, there was good capillary refill, and appellant's hands were notably warm.

Physical examination further revealed negative Tinel's sign at the elbow for the ulnar nerve and negative Tinel's at the wrist on the median nerve, bilaterally. Additionally, Phalen's sign was negative at the wrist, bilaterally. With respect to grip strength, Dr. Dearolf noted that it appeared equal, but mildly weak. Lastly, he noted that appellant exhibited normal bilateral upper extremity strength for biceps, triceps, supination, pronation, and abduction. Dr. Dearolf noted his agreement with Dr. Thompson that appellant's bilateral upper extremity examination was normal.

Dr. Dearolf noted that appellant had not worked for six years and her current physical examination and electromyogram (EMG) study results showed no evidence of carpal tunnel syndrome. Although she had multiple abnormalities on her EMG studies, the results were not indicative of bilateral carpal tunnel syndrome.[6] Dr. Dearolf further noted that appellant's January 9, 2006 left wrist sprain had totally resolved. Accordingly, he found that all of the accepted conditions, as noted in the SOAF, had resolved. Dr. Dearolf concluded that appellant had no residuals from her work injury and accepted conditions.

Regarding appellant's subjective complaints of numbness and tingling in all five fingers, Dr. Dearolf noted they were inconsistent with carpal tunnel syndrome. He also noted the absence of any signs of atrophy or the progression of her disease during appellant's six-year hiatus from work. In light of these factors, Dr. Dearolf did not see any need for further medical treatment for appellant's accepted condition of bilateral carpal tunnel syndrome. He also acknowledged that appellant's subjective complaints and EMG results would limit her ability to perform repetitive activities involving the upper extremities, but that these limitations were not based on the accepted conditions. Dr. Dearolf also believed that appellant was capable of performing the duties of a sales solution team member on a full-time basis. In an accompanying work capacity evaluation (OWCP-5c), the only reported restriction was a 10-pound lifting limitation.

On January 21, 2015 OWCP issued a notice of proposed termination of wage-loss compensation and medical benefits. The proposed action was based on Dr. Dearolf's October 23, 2014 report. OWCP afforded appellant 30 days to submit additional evidence and/or argument in response to its proposed termination of her FECA benefits.

Counsel responded on January 29, 2015. He characterized Dr. Dearolf's report as speculative and noted that he had identified specific work restrictions but failed to provide any rationale for his finding that appellant still required restrictions.

[6] According to Dr. Dearolf, appellant's EMG studies documented abnormalities in her brachial plexus, her posterior interosseous nerve and her ulnar nerves on both sides, but no abnormality in the median nerve. Dr. Dearolf commented that the abnormalities in the nerves noted on the EMG were not part of appellant's accepted condition.

By decision dated March 3, 2015, OWCP terminated appellant's wage-loss compensation and medical benefits effective March 8, 2015.

Counsel timely requested a hearing, which was scheduled for June 25, 2015.

Following the termination decision, OWCP received additional reports from Dr. Fried dated March 6 and 12, and June 11, 2015. In his March 6, 2015 report, Dr. Fried chronicled his treatment of appellant beginning on October 1, 2007. He summarized the results of numerous follow-up examinations through appellant's most recent visit on January 15, 2015.[7] Dr. Fried also reviewed the results of two functional capacity evaluations (FCE), the latest having been conducted on January 29, 2014. Additionally, he discussed various objective studies, including appellant's most recent EMG, which was administered on June 26, 2013, and commented on the results of appellant's April 22, 2014 ultrasound (chemoneurolysis) procedure. Lastly, Dr. Fried reviewed Dr. Dearolf's October 23, 2014 impartial medical evaluation, noted his disagreement with the vast majority of his findings, but concurred in his finding that there was no preexisting disability.

Dr. Fried opined that appellant had ongoing bilateral carpal tunnel syndrome and left wrist sprain, with ongoing dysfunction. He also indicated that appellant developed compensatory proximal symptoms. Appellant's current diagnoses included employment-related bilateral carpal tunnel syndrome with right upper extremity overuse syndrome, left hand/wrist contusion, left wrist TFCC tear, left shoulder capsulitis, and left brachial plexopathy/cervical radiculopathy. Dr. Fried indicated that appellant had evidence of a classic double crush injury and double level nerve involvement. He found that appellant had ongoing dysfunction and she was incapable of performing her previous work. Dr. Fried noted limitations with respect to writing, keying, pushing, pulling, and grasping activities, which he attributed to appellant's unresolved bilateral carpal tunnel syndrome.

In his March 12, 2015 report, Dr. Fried diagnosed bilateral upper extremity sympathetically-mediated pain syndrome, left wrist TFCC tear, left shoulder capsulitis, employment-related bilateral carpal tunnel syndrome with right upper extremity overuse syndrome, bilateral ulnar and radial neuropathy, left hand/wrist contusion, and bilateral posterior occipital neuralgia. Appellant expressed her continued interest in undergoing a repeat neurolysis for the right carpal tunnel. Dr. Fried advised that appellant remained symptomatic and limited, and could not return to her regular work activities. He noted that appellant's limitations were permanent, and advised her to follow-up in three months.

Dr. Fried reiterated the above-noted diagnoses in his June 11, 2015 follow-up examination report. He also noted that appellant's condition was getting progressively worse. Dr. Fried advised her to remain out of work. Additionally, he commented that the most recent FCE did not even allow for sedentary work.

In a decision dated September 9, 2015, the hearing representative affirmed OWCP's termination of benefits effective March 8, 2015. She found Dr. Dearolf's October 23, 2014

[7] When Dr. Fried examined appellant on January 15, 2015, he noted that she remained symptomatic as evidenced by positive Tinel's test, Phalen's test, Roos' test, compression test, and Hunter's test. He also noted that appellant was interested in proceeding with a repeat neurolysis.

report sufficiently probative to establish that appellant's accepted conditions had resolved. While the hearing representative found that OWCP had satisfied its burden to terminate compensation benefits, she advised OWCP to issue a formal determination regarding whether the record supported acceptance of any additional medical conditions. At the June 25, 2015 hearing, counsel argued, among other things, that OWCP had consistently failed to address appellant's long-standing request to expand her claim to include other work-related conditions such as left wrist TFCC, brachial plexopathy, cervical and left shoulder conditions, and a bilateral elbow condition. In her September 9, 2015 decision, the hearing representative noted that the impartial medical examiner had cited positive findings showing the existence of conditions other than carpal tunnel syndrome and, therefore, OWCP should determine whether these conditions were causally related to appellant's 2006 and/or 2008 employment injuries.

In response to the hearing representative's September 9, 2015 directive, OWCP requested Dr. Dearolf's opinion on whether appellant's claim should be expanded to include left shoulder adhesive capsulitis, brachial plexopathy, right ulnar neuropathy, and left radial neuropathy.

In a November 13, 2015 supplemental report, Dr. Dearolf noted that appellant was currently asking to be considered for multiple left upper extremity conditions/claims which had not been present when she stopped working in 2008. He explained that because she had not been working, he saw no explanation as to how these "new" conditions/claims could be related to a carpal tunnel claim dating back over seven years.

By decision dated December 15, 2015, OWCP declined to expand appellant's claim on the basis that the additional conditions were not shown to be employment related. It based its determination on the impartial medical examiner's November 13, 2015 report.

LEGAL PRECEDENT -- ISSUE 1

Once OWCP accepts a claim and pays compensation, it bears the burden to justify modification or termination of benefits.[8] Having determined that an employee has a disability causally related to his federal employment, OWCP may not terminate compensation without establishing either that the disability has ceased or that it is no longer related to the employment.[9] The right to medical benefits for an accepted condition is not limited to the period of entitlement to compensation for disability.[10] To terminate authorization for medical treatment, OWCP must establish that the employee no longer has residuals of an employment-related condition that require further medical treatment.[11]

FECA provides that if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[12] For a conflict to arise the opposing physicians' viewpoints must be of "virtually

[8] *Curtis Hall*, 45 ECAB 316 (1994).

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

[10] *Furman G. Peake*, 41 ECAB 361, 364 (1990); *Thomas Olivarez, Jr.*, 32 ECAB 1019 (1981).

[11] *Calvin S. Mays*, 39 ECAB 993 (1988).

[12] 5 U.S.C. § 8123(a); *see* 20 C.F.R. § 10.321; *Shirley L. Steib*, 46 ECAB 309, 317 (1994).

equal weight and rationale."[13] Where OWCP has referred the case to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well-reasoned and based upon a proper factual background, must be given special weight.[14]

ANALYSIS -- ISSUE 1

Appellant's treating physician, Dr. Fried, believed she was medically disabled and could not return to regular work activities. Dr. Thompson, an OWCP referral physician, found that there were no residuals of any alleged injury to appellant's hands or wrists having occurred on December 18, 2006. Consequently, he advised that she could immediately return to work without restrictions. Dr. Thompson also indicated there was no need for additional medical treatment. Because of the above-noted disagreement between appellant's physician and the second opinion examiner, OWCP declared a conflict in medical opinion.

Dr. Dearolf, the designated impartial medical examiner, provided results on examination on October 23, 2014 and indicated there were no objective findings on examination consistent with carpal tunnel syndrome. He also found that appellant's 2006 left wrist sprain had long since resolved. Dr. Dearolf noted that appellant's bilateral upper extremity examination was normal. He reviewed various medical records and diagnostic studies in the case record. Dr. Dearolf noted that appellant had not worked for six years and her current physical examination and EMG results showed no evidence of carpal tunnel syndrome. Although there were abnormalities on appellant's EMG studies, he advised that her electrodiagnostic abnormalities were not indicative of bilateral carpal tunnel syndrome. Accordingly, Dr. Dearolf found no residuals from her work injury and accepted conditions. He also found there was no need for further medical treatment for the accepted conditions. Dr. Dearolf acknowledged that appellant had work limitations, however, he found those limitations were not related to her accepted conditions.

As noted, when a case is referred to an impartial medical examiner to resolve a conflict, the resulting medical opinion, if sufficiently well-reasoned and based upon a proper factual background, must be given special weight.[15] The Board finds that OWCP properly deferred to Dr. Dearolf's October 23, 2014 opinion. Dr. Dearolf provided a well-reasoned report based on a proper factual and medical history, he accurately summarized the relevant medical evidence, and he relied on the statement of accepted facts. He provided results on examination and provided a thorough review of the relevant medical records. Dr. Dearolf's report included detailed findings on physical examination and medical rationale supporting his opinion. As the impartial medical examiner, his October 23, 2014 opinion is entitled to special weight.[16]

The record includes additional reports from appellant's physician, Dr. Fried. His March 6, 2015 report summarized appellant's treatment dating back to October 1, 2007, and included a critique of the impartial medical examiner's October 23, 2014 opinion. Dr. Fried also

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

[14] *Gary R. Sieber*, 46 ECAB 215 (1994).

[15] *Id*.

[16] *Id.*

provided follow-up examination reports dated March 12 and June 11, 2015. In all of these reports, he continued to diagnose bilateral carpal tunnel syndrome and left wrist/hand contusion, as well as numerous other upper extremity conditions that had not been accepted. Dr. Fried also continued to find appellant disabled from performing her regular work activities. In his most recent June 11, 2015 report, Dr. Fried noted that appellant's latest FCE did not even bare out sedentary work capabilities.

The primary basis of Dr. Fried's disagreement with Dr. Dearolf is that appellant's physician believes she suffered a work-related double crush injury involving the cervical/thoracic spine in addition to median nerve entrapment at both wrists. Dr. Fried acknowledged that appellant's various EMG study results did not demonstrate bilateral median nerve entrapment. However, he relied instead on ultrasound studies as evidence of carpal tunnel syndrome, as well as his own physical examination findings. In contrast, the impartial medical examiner relied on his October 23, 2014 normal physical examination findings, as well as the absence of median nerve entrapment on appellant's EMG studies. Dr. Fried's disagreement with the impartial medical examiner's conclusion does not negate the fact that Dr. Dearolf's opinion is supported by the underlying physical findings and appellant's EMG study results.

Subsequent reports from a physician who was on one side of a medical conflict that has since been resolved would generally be insufficient to overcome the special weight accorded the impartial medical examiner's report and/or insufficient to create a new medical conflict.[17] As a party to the original conflict, Dr. Fried's March 6 and 12, and June 11, 2015 reports are insufficient to overcome the special weight properly accorded Dr. Dearolf's October 23, 2014 opinion, and are similarly insufficient to create a new conflict in medical opinion. Accordingly, the Board finds that OWCP satisfied its burden of proof in terminating appellant's wage-loss compensation and medical benefits with respect to her accepted conditions of left wrist sprain and bilateral carpal tunnel syndrome.

LEGAL PRECEDENT -- ISSUE 2

Where an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.[18] Causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue.[19] A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factor(s) must be based on a complete factual and medical background.[20] Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty, and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factor(s).[21]

[17] *I.J.*, 59 ECAB 408, 414 (2008).

[18] *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004).

[19] *Robert G. Morris*, 48 ECAB 238 (1996).

[20] *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[21] *Id.*

ANALYSIS -- ISSUE 2

Counsel requested to expand the accepted conditions in her December 18, 2006 occupational disease claim to include left shoulder adhesive capsulitis, brachial plexopathy, right ulnar neuropathy, and left radial neuropathy. OWCP addressed the issue of expansion in its December 15, 2015 decision and declined to include any additional upper extremity conditions based on Dr. Dearolf's November 13, 2015 supplemental report.

The Board finds that the case is not in posture for decision with respect to whether appellant's claimed left shoulder adhesive capsulitis, brachial plexopathy, right ulnar neuropathy, and left radial neuropathy are causally related to her accepted employment factors.

First, the Board notes that Dr. Dearolf's opinion is not entitled to deferential treatment as an impartial medical examiner on this particular issue. The conflict he was assigned to resolve did not include whether any additional medical conditions should be accepted.

Second, the Board finds that Dr. Dearolf's November 13, 2015 supplemental report is not well reasoned on the issue of causal relationship. Dr. Dearolf's opinion regarding expansion of the claim is premised on the mistaken belief that appellant's so-called "new symptom complexes" postdated her July 2008 work stoppage. He specifically noted that the "multiple other claims … were not present when [appellant] stopped working in 2008." Also, Dr. Dearolf appears to be confused about the basis for acceptance of any additional conditions. He explained that as appellant had not been working, he saw no reason how these "new" claims were related to a carpal tunnel claim dating back over seven years. The issue is not whether the additional diagnosed conditions are related to appellant's accepted bilateral carpal tunnel syndrome, but whether those conditions are causally related to her accepted employment factors. Thus, while appellant's accepted bilateral carpal tunnel syndrome has since resolved, that fact alone does not preclude acceptance of any of the additional cervical and/or upper extremity conditions. A physician's opinion on causal relationship must be based on a complete factual and medical background and must be supported by medical rationale.[22]

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. The claimant has the burden to establish entitlement to compensation; however, OWCP shares responsibility in the development of the evidence to see that justice is done.[23] Once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[24] The Board finds that OWCP's reliance on Dr. Dearolf's November 13, 2015 supplemental report on this issue was misplaced as he failed to provide a well-reasoned opinion on causal relationship. Accordingly, the case is remanded for further medical development to be followed by a *de novo* decision regarding the requested expansion of appellant's claim.

[22] *Id.*

[23] *William J. Cantrell*, 34 ECAB 1223 (1983).

[24] *Richard F. Williams*, 55 ECAB 343, 346 (2004).

CONCLUSION

OWCP properly terminated appellant's wage-loss compensation and medical benefits, effective March 8, 2015, based on the impartial medical examiner's findings that her accepted left wrist sprain and bilateral carpal tunnel syndrome had resolved. The Board further finds that the case is not in posture for decision regarding the acceptance of additional medical conditions.

ORDER

IT IS HEREBY ORDERED THAT the September 9, 2015 decision of the Office of Workers' Compensation Programs is affirmed. Additionally, the December 15, 2015 decision is set aside, and the case is remanded for further action consistent with this decision.

Issued: October 14, 2016
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board