United States Department of Labor
Employees' Compensation Appeals Board

L.S., Appellant	)	
and	)	**Docket No. 21-0629**
	)	**Issued: April 28, 2022**
DEPARTMENT OF AGRICULTURE, AGRICULTURAL MARKETING SERVICE, Squaw Valley, CA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On February 23, 2021 appellant filed a timely appeal from a September 11, 2020 nonmerit decision of the Office of Workers' Compensation Programs (OWCP).[1] As more than 180 days has elapsed from OWCP's last merit decision, dated September 6, 2019, to the filing of this appeal,

[1] Under the Board's *Rules of Procedure*, an appeal must be filed within 180 days from the date of issuance of an OWCP decision. An appeal is considered filed upon receipt by the Clerk of the Appellate Boards. *See* 20 C.F.R. § 501.3(e)-(f). One hundred and eighty days from September 11, 2020, the date of OWCP's last decision, was March 10, 2021. Because using March 11, 2021, the date the appeal was received by the Clerk of the Appellate Boards, would result in the loss of appeal rights, the date of the postmark is considered the date of filing. The date of the U.S. Postal Service postmark is February 23, 2021, rendering the appeal timely filed. *See* 20 C.F.R. § 501.3(f)(1).

pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board lacks jurisdiction over the merits of this case.[3]

ISSUE

The issue is whether OWCP properly denied appellant's request for reconsideration of the merits of her claim, pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On April 3, 1995 appellant, then a 31-year-old poultry grader, filed a traumatic injury claim (Form CA-1) alleging that on March 15, 1995 she injured her left shoulder when a carpet slipped underneath her feet causing her to fall while in the performance of duty. OWCP accepted her claim for adhesive capsulitis of the left shoulder, bursitis of the left shoulder, other sprain of the left shoulder joint, contusion of the left shoulder, and hypertrophic scar. Appellant underwent OWCP-authorized manipulation under anesthesia of the left shoulder, and stabilization of the biceps tendon on March 22 and July 2, 1996, excision of intact keloid and hypertrophic scar of the left shoulder on October 12, 2004, and arthroscopic evaluation of the left shoulder, acromioplasty and bursectomy on December 3, 2008. She later returned to work in a full-time capacity as a teacher effective August 7, 1999.

By decision dated April 27, 2000, OWCP issued a loss of wage-earning capacity (LWEC) determination based on appellant's actual earnings as a full-time teacher. It found that she had worked in the position for over 60 days, commencing August 7, 1999, and that the employment fairly and reasonably represented her wage-earning capacity.

Appellant was treated by Dr. Mathew T. Provencher, a Board-certified orthopedist, on October 25 and November 1, 2018 for chronic worsening left shoulder pain, clicking, weakness, numbness, and tingling. Dr. Provencher noted a history of a work-related left shoulder injury sustained in 1995 and six subsequent left shoulder surgeries. He diagnosed left shoulder pain. Dr. Provencher treated appellant in follow up on November 5, 2018. He reviewed a magnetic resonance imaging (MRI) scan of the left shoulder performed on November 1, 2018 that revealed mild fatty atrophy of the rotator cuff musculature, severe fatty atrophy of the trapezius musculature and anterior deltoid, and mild-to-moderate supraspinatus and infraspinatus tendinosis with bursal surface fraying. On January 14, 2019 Dr. Provencher diagnosed left muscular atrophy and left distal clavicle osteolysis. He requested authorization to perform a distal clavicle reconstruction.

On February 12, 2019 OWCP authorized left shoulder arthroscopy, which was performed on February 18, 2019 by Dr. Provencher with limited debridement, subacromial decompression, acromioclavicular (AC) reconstruction with iliac crest bone graft, AC joint reconstruction with

[2] 5 U.S.C. § 8101 *et seq*.

[3] The Board notes that, following the September 11, 2020 decision, appellant submitted additional evidence to OWCP. However, the Board's *Rules of Procedures* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal.

semitendinosus allograft, left clavicle osteotomy with bone graft, and left hip iliac crest bone harvest. Dr. Provencher diagnosed passive instability in the left anterior-to-posterior direction of the clavicle of the AC joint, synovitis located in the rotator interval and subacromial space, and frayed posterior superior labrum.

On February 20, 2019 appellant was treated by Dr. Michael Austin Mandrell, a Board-certified emergency room physician, for a severe headache, photophobia, slurred speech, and right hand tingling. She reported having surgery on her clavicle two days prior. Laboratory workup revealed an extremely elevated liver function testing. Dr. Mandrell noted a computerized tomography (CT) scan of the head was unremarkable and a chest x-ray revealed small bilateral pleural effusions. He noted that an ultrasound of the right upper quadrant showed cholelithiasis with gallbladder wall thickening and pericholecystic fluid, which may be the etiology of appellant's elevated liver function testing. Dr. Mandrell diagnosed acute liver failure of uncertain etiology, acute cholecystitis, and acute headache of uncertain etiology and admitted appellant to the intensive care unit (ICU) for further workup and management.

Dr. Omar Mctabi, a Board-certified internist, treated appellant in the ICU on February 21, 2019 for generalized headache, malaise, fatigue, and pain in her left shoulder and hip area. Appellant reported a sixth revision surgery of her left shoulder two days prior and she was discharged with an epidural Bupivacaine pump. She presented to the emergency department and was found to have liver failure. Dr. Mctabi diagnosed acute fulminant liver failure mediated by the epidural Bupivacaine pump, coagulopathy of liver failure, slight leukocytosis, mild thrombocytopenia, headache and generalized malaise, and multiple surgeries left shoulder. He indicated that there were numerous case reports that describe similar instances of late onset liver injury from patients treated with epidural Bupivacaine pump.

Dr. Joseph A. Chapman, a Board-certified internist, performed a gastroenterology consultation on February 21, 2019. He noted that appellant was admitted to the ICU with encephalopathy and diagnosed with acute liver failure. Appellant reported recently undergoing left clavicular surgery on February 18, 2019 and was discharged with an intrathecal Bupivacaine pump. Dr. Chapman opined that the cause of the acute liver failure was unclear. He transferred appellant to a higher level of care facility for further workup and monitoring.

On February 25, 2019 Dr. Todd Carlson, a Board-certified internist, treated appellant upon transfer to a new hospital on February 21, 2019. He diagnosed acute liver injury. Dr. Carlson noted appellant had a history of left shoulder surgeries and chronic dysphagia and was transferred on February 21, 2019 for acute liver failure. He opined that her liver injury was felt to be most likely secondary to Bupivacaine that she was receiving for postoperative anesthesia. Dr. Carlson noted that appellant's liver function tests improved throughout her admission and she was discharged on February 24, 2019.

On March 15, 2019 OWCP expanded the acceptance of appellant's claim to include: other instability left shoulder; open fracture of unspecified part of the left shoulder; sprain of the left AC joint, malignant neoplasm of ribs, sternum, and clavicle; brachial plexus disorders; impingement syndrome of the left shoulder; adhesive capsulitis of the left shoulder; disorder of bursae and tendon in the left shoulder; sprain of the shoulder and upper arm; contusion of left shoulder region, left keloid scar; and other psychogenic pain.

OWCP received additional evidence. Reports dated March 11 and 28, 2019 indicated that Dr. Provencher treated appellant status post left shoulder AC ligament reconstruction on February 18, 2019. Dr. Provencher noted her postoperative course was complicated by elevated liver function test, which was resolving. He diagnosed postoperative shoulder surgery located on the left shoulder joint.

In reports dated April 16 and May 14, 2019, Dr. Rock Navarkal, a Board-certified physiatrist, diagnosed postoperative pain, distal clavicle repair, and left shoulder arthroplasty clavicle insufficiency reconstruction and recommended a course of physical therapy.

OWCP further developed appellant's claim, including referring her to a district medical adviser (DMA), to determine whether she developed acute liver failure as a consequence of the February 18, 2019 surgery for an accepted work-related injury. In an April 29, 2019 report, Dr. David I. Krohn, a Board-certified gastroenterologist serving as the DMA, reviewed the statement of accepted facts (SOAF) and medical records. He noted that he was unable to find research that confirmed Dr. Mctabi's assertion that appellant's liver failure was mediated by exposure to Bupivacaine. Dr. Krohn further noted that Dr. Chapman, who evaluated appellant in consultation, opined that the cause of the acute liver failure was unclear. He noted that appellant was transferred to another hospital and was evaluated by a hematologist; however, the consult note was not included in the medical records. Dr. Krohn noted the discharge summary indicated that appellant's acute liver injury may be due to Bupivacaine intrathecal anesthesia; however, he did not believe that acute liver injury was a well-known complication of Bupivacaine intrathecal anesthesia. He opined that, given the discrepancy in opinion regarding the cause of the acute liver failure, he requested the narrative consultation report from the hematologist be forwarded to him for review.

On July 15, 2019 OWCP referred the case file, a SOAF, and a series of questions to Dr. Rajeshwar Kadian, a Board-certified internist, for a second opinion examination and evaluation as to whether appellant developed acute liver failure as a consequence of the February 18, 2019 left shoulder surgery.

In a July 16, 2019 report, based on the medical records, SOAF and accepted medical practice, Dr. Kadian opined that the diagnosis of acute liver failure as a consequence of left shoulder injury could not be definitively established. He indicated that more specific evidence and testing would be required to correctly respond to the question. Dr. Kadian referenced the discharge summary of April 25, 2019, which stated that the acute liver failure was of uncertain etiology.

Dr. Provencher treated appellant on July 15, 2019 for worsening left shoulder pain and decreased range of motion. He diagnosed adhesive capsulitis and performed a steroid injection into the left shoulder. On August 26, 2019 appellant reported brief relief in left shoulder pain after the injection; however, the pain and decreased range of motion returned. Dr. Provencher diagnosed adhesive capsulitis and recommended a left shoulder scope with debridement and hardware removal to help with pain and range of motion issues.

By decision dated September 6, 2019, OWCP denied expansion of the acceptance of appellant's claim to include the additional condition of acute liver failure.

OWCP received additional evidence. On September 11, 2019 Dr. Provencher performed: a left shoulder arthroscopic capsular release of the rotator interval, anterior capsule, inferior capsule, and posterior capsule; extensive arthroscopic debridement of the rotator interval and subacromial space; subacromial decompression; hardware removal of the left distal clavicle; and manipulation under anesthesia. He diagnosed impingement with extensive synovitis and adhesions, synovitis throughout, and capsular contraction.

In support of her claim, appellant submitted a September 30, 2019 report from Dr. Provencher who noted performing a distal clavicle reconstruction, iliac crest graft, plating of the clavicle, and allograft reconstruction. Dr. Provencher noted that, subsequent to the surgery, appellant developed headaches and slurred speech and was admitted to the hospital due to a high liver function test. He noted that appellant's condition was believed to be related to her postoperative recovery and potential Bupivacaine administration from the anesthetic block. Dr. Provencher opined that on a more probable than not basis appellant's emergency room visit and hospital admission were due to a high liver function test, headache, and slurred speech associated with her surgical treatment to fix her left shoulder.

In a January 27, 2020 report, Dr. Bahri M. Bilir, Board-certified in gastroenterology and transplant hepatology, noted treating appellant on February 23, 2019. He advised that appellant was transferred due to drug-induced liver disease and acute liver failure. Dr. Bilir noted that Bupivacaine caused liver disease and acute liver failure.

On August 13, 2020 appellant requested reconsideration *via* a May 15, 2020 statement. She asserted that Dr. Kadian's report was insufficient to deny the expansion of the acceptance of her claim to include acute liver failure because he indicated that more evidence and testing would be needed to provide his opinion. Appellant further noted that he did not indicate or discuss any points of disagreement with the diagnosis. She asserted that Dr. Mctabi treated her and diagnosed acute fulminate liver failure.

By decision dated August 26, 2020, OWCP denied appellant's request for reconsideration of the merits of her claim, pursuant to 5 U.S.C. § 8128(a). It indicated that the evidence reviewed in support of her reconsideration request included a May 15, 2020 statement requesting reconsideration of her claim.

Appellant requested reconsideration and submitted additional medical evidence.

Appellant attended physical therapy treatment on August 10, 2020.

In a statement dated September 3, 2020, appellant responded to OWCP's decision dated August 26, 2020 and indicated that she submitted new evidence from her treating hepatologist and orthopedic surgeon. She requested that all of the evidence be reviewed and considered. Appellant submitted numerous medical records for a hospital admission from September 11 through 12, 2019. Included in these records was a September 11, 2019 operative report from Dr. Provencher who performed a left shoulder arthroscopy capsular release, extensive arthroscopic debridement, subacromial decompression, hardware removal of the left distal clavicle, a history and physical, discharge summary, diagnostic radiology reports, medication administration records, and anesthesia and sedation records.

By decision dated September 11, 2020, OWCP summarily denied appellant's request for reconsideration.

LEGAL PRECEDENT

Section 8128(a) of FECA vests OWCP with discretionary authority to determine whether to review an award for or against compensation. The Secretary of Labor may review an award for or against compensation at any time on his or her own motion or on application.[4]

To require OWCP to reopen a case for merit review pursuant to FECA, the claimant must provide evidence or an argument which: (1) shows that OWCP erroneously applied or interpreted a specific point of law; (2) advances a relevant legal argument not previously considered by OWCP; or (3) constitutes relevant and pertinent new evidence not previously considered by OWCP.[5]

A request for reconsideration must be received by OWCP within one year of the date of OWCP's decision for which review is sought.[6] If it chooses to grant reconsideration, it reopens and reviews the case on its merits.[7] If the request is timely, but fails to meet at least one of the requirements for reconsideration, OWCP will deny the request for reconsideration without reopening the case for review on the merits.[8]

ANALYSIS

The Board finds that OWCP improperly denied appellant's request for reconsideration of the merits of her claim.

With her timely request for reconsideration, appellant submitted numerous medical records. Included were a physical therapy treatment note dated August 10, 2020 and records from a hospital admission from September 11 through 12, 2019. The hospital admission records included an operative report from Dr. Provencher dated September 11, 2019, a history and physical, discharge summary, diagnostic radiology reports, medication administration record, and anesthesia and sedation records.

[4] *Id.* at § 8128(a); *see M.S.*, Docket No. 19-1001 (issued December 9, 2019); *L.D.*, Docket No. 18-1468 (issued February 11, 2019); *see also V.P.*, Docket No. 17-1287 (issued October 10, 2017); *W.C.*, 59 ECAB 372 (2008).

[5] 20 C.F.R. § 10.606(b)(3); *see L.D.*, *id.*; *see also K.L.*, Docket No. 17-1479 (issued December 20, 2017); *C.N.*, Docket No. 08-1569 (issued December 9, 2008).

[6] *Id.* at § 10.607(a). The one-year period begins on the next day after the date of the original contested decision. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Reconsiderations*, Chapter 2.1602.4 (September 2020). Timeliness is determined by the document receipt date of the request for reconsideration as indicated by the received date in the Integrated Federal Employees' Compensation System (iFECS). *Id.* at Chapter 2.1602.4b.

[7] *Id.* at § 10.608(a); *see also M.S.*, 59 ECAB 231 (2007).

[8] *Id.* at § 10.608(b); *M.S.*, Docket No. 19-0291 (issued June 21, 2019); *E.R.*, Docket No. 09-1655 (issued March 18, 2010).

Section 8124(a) of FECA provides: OWCP shall determine and make a finding of fact and make an award for or against payment of compensation.[9] Section 10.126 of Title 20 of the Code of Federal Regulations provide: "The decision [of the Director of OWCP] shall contain findings of fact and a statement of reasons."[10] Moreover, the Federal (FECA) Procedure Manual provides that the claims examiner's "evaluation of the evidence should be clear and detailed so that the reader understands the reason for the disallowance of the benefit and the evidence necessary to overcome the defect of the claim."[11]

OWCP did not reference nor discuss any of the new medical evidence submitted in support of appellant's timely August 31, 2020 reconsideration request in its September 11, 2020 decision. It, therefore, did not discharge its responsibility to set forth findings of fact and a clear statement of reasons explaining the disposition so that appellant could understand the basis for the decision, *i.e.*, why the new medical evidence had not met any of the requirements of 20 C.F.R. § 10.606(b)(3), requiring OWCP to reopen the case for review of the merits of the claim.[12]

Accordingly, the Board will set aside the September 11, 2020 decision and remand the case for OWCP to review the evidence submitted in support of appellant's reconsideration request and make findings of fact and provide reasons for its decision, pursuant to the standards set forth in section 5 U.S.C. § 8124(a) and 20 C.F.R. § 10.126. After this and other such further development as deemed necessary, it shall issue an appropriate merit decision.

CONCLUSION

The Board finds that OWCP improperly denied appellant's request for reconsideration of the merits of her claim.

[9] 5 U.S.C. § 8124(a); *see J.J.*, Docket No. 19-0448 (issued December 30, 2019); *see Hubert Jones, Jr.*, 57 ECAB 467 (2006).

[10] 20 C.F.R. § 10.126.

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Disallowances*, Chapter 2.1400.5c(3) (February 2013).

[12] *See J.M.*, Docket No. 18-0729 (issued October 17, 2019); *J.J.*, Docket No. 11-1958 (issued June 27, 2012).

ORDER

IT IS HEREBY ORDERED THAT the September 11, 2020 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: April 28, 2022
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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