United States Department of Labor
Employees' Compensation Appeals Board

D.F., Appellant	)	
and	)	**Docket No. 07-2374**
	)	**Issued: July 9, 2008**
U.S. POSTAL SERVICE, POST OFFICE, Lancaster, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 2, 2007 appellant filed a timely appeal from the Office of Workers' Compensation Programs' decisions dated August 31, 2006 and May 17 and June 20, 2007. Under 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 the Office met its burden of proof to terminate appellant's compensation benefits; and (2) whether appellant has established that she had disability caused by residuals of the accepted employment injury following the termination of compensation.

FACTUAL HISTORY

Appellant, a 61-year-old mail clerk, injured her left arm and shoulder while casing mail on September 25, 2002. The Office accepted the claim for bicipital tendinitis of the left shoulder and commenced paying her compensation for total disability.[1]

[1] In a statement of facts dated February 28, 2003, the Office indicated that the accepted condition was left adhesive capsulitis of the left shoulder.

In order to determine appellant's current condition and to ascertain whether she still suffered residuals from her accepted condition, the Office referred appellant for a second opinion examination with Dr. Perry A. Eagle, Board-certified in orthopedic medicine. In a May 5, 2003 report, Dr. Eagle stated that appellant's complaints and findings were not attributable to any injury listed in the statement of accepted facts. He asserted:

> "[Appellant] does not have findings on today's examination which would be compatible with the diagnosis of adhesive capsulitis of the left shoulder. The patient has a multitude of findings on today's examination which cannot be explained on an anatomic or physiologic basis and are not supportive of any [orthopedic] pathology being present in the left shoulder."

Dr. Eagle stated that degenerative arthritis of the acromioclavicular joint was causing her symptoms, and that this condition was not related to her work duties.

On August 17, 2004 and August 31, 2005, appellant underwent left shoulder surgery.

In a report dated September 20, 2005, Dr. Eagle stated:

> "[Appellant] is in the postoperative state of having had recent surgery. The records surrounding that surgery have not been provided for review. [Appellant] has marked limitation of motion of the left shoulder and significant pain response to multiple facets of the examination."

Dr. Eagle noted that appellant had sustained a rotator cuff tear, a finding which was common in this asymptomatic population of her age group. He advised that her work injury had been accepted as biceps tendinitis and that the torn rotator cuff had not been caused, aggravated or accelerated by employment factors.

In order to determine appellant's current condition and to ascertain whether she still suffered residuals from her accepted condition, the Office referred appellant for a second opinion examination with Dr. Robert A. Smith, Board-certified in general surgery. In an April 25, 2006 report, Dr. Smith stated:

> "In July 2004, [appellant] was seen by Dr. Eagle for an independent examination. [Dr. Eagle] concluded that the tear seen on the imaging studies was not uncommonly seen in people of [appellant's] age and these findings can often be asymptomatic. Since the accepted injury was bicipital tendinitis [he] correctly stated it was difficult to establish that diagnosis because there appeared to be no evidence of any damage to the biceps tendon, which is different from the rotator cuff. [Dr. Eagle] also felt that the diagnosed medical condition was not supported by medical documentation of any direct cause, aggravation, precipitation or acceleration due to [appellant's] work environment. He did feel, however, regardless of the cause she was disabled from her work activities."

* * *

"Certainly, with the accepted condition of biceps tendinitis, I agree with Dr. Eagle that [the] diagnosis cannot be confirmed at this time. Clearly, [appellant] has some rotator cuff disease but this more likely than not is related to her degenerative disease rather than any specific injury or her work environment with [the employing establishment]. The prognosis is fair since she has had two surgeries done to her shoulder including attempted repair of the rotator cuff. At the present time, she expresses complaints of pain about the shoulder with any movement but this appears to be exaggerated given the benign nature of the shoulder examination itself. Clearly, there is no evidence of any complete rupture or any disease in her biceps tendon at this time.

"Therefore, with regard to the accepted condition of biceps tendinitis of the left shoulder, [appellant] has reached maximum medical improvement and would n[o]t require any further treatment for that. She does, however, have degenerative disease of the shoulder and rotator cuff that, in my opinion, more likely than not is unrelated to her work activities but is related to degenerative disease and her age. This in itself would restrict [appellant's] ability to work in a full[-]duty capacity. However, in my opinion, she is not totally disabled. [Appellant] could work in a sedentary capacity with no lifting more than 10 pounds bimanually to the waist level. She should also not be required to reach with the left upper extremity above the horizontal….

"To reiterate, [appellant] appears to have degenerative disease in her shoulder that in my opinion was not caused, aggravated, accelerated or precipitated by the work activities with the [F]ederal [G]overnment or the specific incident that she mentions in August 2002. The accepted condition of left shoulder bicipital tend[i]nitis, in my opinion, has reached maximum medical improvement and would not require any further treatment. As noted above, this diagnosis is unconfirmable since at the present time there is no evidence of any pathology in the biceps tendon.

"In regard to her federal employment, [appellant] would not require any further treatment, testing or activity modification with regard to her left shoulder. She may require further treatment because of her degeneration disease but that would be unrelated. [Appellant] has restrictions to return to work because of her ongoing left shoulder problem but those restrictions would be related to her degenerative disease and not her federal employment."

In a May 10, 2006 report, Dr. Smith stated:

"It is correct to state that my opinion is that [appellant] is not suffering from any residual affects of the accepted work[-]related condition of bicipital tend[i]nitis of the left shoulder as a result of work factors on December 2, 2002. It is also correct to state that in my opinion the accepted condition of biceps tend[i]nitis of the left shoulder as a result of work incident of December 2, 2002 has resolved and is no longer presented objective findings.

"It is also correct to state that my opinion is that [appellant's] current claimed disability is not related to factors of her federal employment with the condition of bicipital tend[i]nitis related to the incident of December 2, 2002. Her current condition with regard to the shoulder is unrelated to her federal work activities."

Dr. Smith advised that his opinions were rendered with a reasonable degree of medical certainty.

On June 2, 2006 the Office issued a notice of proposed termination of compensation to appellant. It found that the weight of the medical evidence, as represented by Dr. Smith's opinion, established that his accepted, employment-related recurring headache condition had resolved. The Office allowed appellant 30 days to submit additional evidence or legal argument in opposition to the proposed termination.

In a report dated June 9, 2006, Dr. Mark Perezous, Board-certified in orthopedic surgery, performed a follow-up, revisional arthroscopy on appellant's left shoulder. He indicated that she required some remedial reconstruction on her shoulder. Dr. Perezous also noted in his report that the biceps tendon was normal.

In an August 1, 2006 report, Dr. Smith stated:

"I saw [appellant] for an orthopedic examination on April 25, 2006. According to the [s]tatement of [a]ccepted [f]acts, the condition accepted by [the Office] in relation to the August 15, 2002 incident was bicipital tend[i]nitis.

"After my April 2006 evaluation, [appellant] continued to have treatment to her shoulder that culminated in a surgery done on June 9, 2006 for the preoperative diagnosis of 'possible retear of the left rotator cuff.' The postoperative diagnosis was 'left rotator cuff retear and adhesions, interarticular and subacromial.' Procedure included arthroscopy of the left shoulder, revision of rotator cuff repair and lysis of adhesions interarticularly and subacromially with a subacromial decompression. According to the body of the operative note, *the biceps tendon was normal.* (Emphasis in the original.)

"Given this information, I would conclude that this particular surgery would not be related to [appellant's] accepted condition of biceps tend[i]nitis. Neither the preoperative nor the postoperative diagnosis mentioned the biceps tendon, but in the body of the report the biceps tendon was noted to be normal during the procedure.

"Given the above information, the surgery performed on June 9, 2006 was not for an accepted condition and therefore would be unrelated to [appellant's] federal employment."

Dr. Smith advised that his opinions were rendered with a reasonable degree of medical certainty.

By decision dated August 31, 2006, the Office terminated appellant's compensation, finding that Dr. Smith's opinion represented the weight of the medical evidence.

On September 6, 2006 appellant requested an oral hearing, which was held on December 20, 2006. During the hearing, which was conducted via teleconference, appellant's attorney argued that the Office had changed the accepted conditions in the claim to include only bicipital tend[i]nitis of the left shoulder. He noted that the February 28, 2003 statement of accepted facts had indicated that appellant's accepted condition was left adhesive capsulitis of the left shoulder. In addition, counsel stated that, on the Form CA-2, appellant claimed that "the significant limitations on her right arm had caused the deterioration of her left arm which is basically a claim … for aggravation of the degenerative process in her left arm." Counsel asserted that since the Office accepted the surgery appellant had performed on her left shoulder in 2004, it essentially "owned" that condition.

Following the hearing appellant submitted reports from 1996, 2002 to 2004, March 22, April 8, 2005 and April 21, 2006 from Dr. James P. Argires, Board-certified in neurosurgery, and reports from June 2004 through April 2005 from Dr. Gerald W. Rothacker, Board-certified in orthopedic surgery. Dr. Argires noted complaints of left shoulder pain and diagnosed left bicipital tend[i]nitis with overuse of the left shoulder.[2] In his April 8, 2005 report, he stated:

> "[Appellant] returns today for follow-up. She has persistent pain and significant left shoulder pain. [Appellant's] pain intensifies with abduction and external rotation of her arm. She has intermittent mild neck pain, but her shoulder pain is her biggest complaint. [Appellant] has had rotator cuff surgery in August of 2004. She was doing well after that surgery until an event that occurred during her rehab where she states that she was doing exercises and during a specific exercise she had recurrence of her preoperative symptoms. [Appellant] has had an updated MRI scan of the cervical spine and returns to review the results of that study.
>
> "On examination today, [appellant] has normal strength but has very limited range of motion in her left shoulder girdle; abduction of the arm causes excruciating pain.
>
> "MR[I scan] of [appellant's] cervical spine reveals postoperative changes at C4-5 on the right, at C4-5 on the left she has neural foraminal narrowing. [Appellant] has an osteophyte and age[-]related multilevel spondylotic changes.
>
> "[Appellant's] MRI scan does show foraminal narrowing at C4-5 which correlates to the deltoid region. The character of [her] pain though really is more consistent

[2] Appellant also submitted a September 30, 2002 report from Dr. David G. Kuntz, a specialist in orthopedic surgery, who noted complaints of left shoulder pain and diagnosed left elbow lateral epidcondyulisitis and left shoulder rotator cuff tendinitis. Dr. Kuntz administered injections of Xyoocain and Kenalog into appellant's left shoulder and left elbow to ameliorate her chronic pain.

with a tendinopathy and a rotator cuff tear that she has had documented by MR[I scan]."

Dr. Argires advised against any further surgical intervention in her neck.

In his April 21, 2006 report, Dr. Argires stated:

"[Appellant] returns to the office today with continued complaints of pain in her left shoulder. She has a decreased range of motion and pain when she abducts and rotates her arm. [Appellant] also complains of neck pain. She has spondylitic change in her neck by a recent MRI [scan] at C4-5 and a Klippel-Feil anomaly at C3-4. [Appellant] has degenerative disc disease at C5-6 and C6-7. She has had bilateral rotator cuff repairs which actually I think was done twice on the left shoulder. [Appellant's] last shoulder surgery was done by Dr. Rothacker in the fall of 2005.

"On examination, [appellant] has pain on abduction and rotation of her arm. [She] remains neurologically intact.

"I recommended interventional pain management options for treatment of [appellant's] underlying cervical spondylosis. I think the majority of her symptoms though are still related to her shoulder tendinopathy. [Appellant] may be developing adhesive capsulitis. I have ordered a[n] MRI scan of her left shoulder…."

In his December 20, 2004 report, Dr. Rothacker stated:

"[Appellant] returned to the office today with the chief complaint of left shoulder pain. She has had a setback. [Appellant] was in therapy two weeks ago and the new therapist was a little more vigorous and really provoked an exacerbation of pain. She now describes burning. [Appellant] even had some dysvascular changes over the shoulder that caused her concern. This has settled somewhat, but it is not back to where it was prior to this…."

By decision dated May 17, 2007, an Office hearing representative affirmed the August 31, 2006 termination decision, finding that the Office met its burden to terminate compensation.

By letter dated June 8, 2007, appellant's attorney requested reconsideration.

In a May 30, 2007 report, Dr. Perezous stated:

"I initially saw [appellant] on May 2, 2006. At that time, she was a 65-year-old woman with a chief complaint of left shoulder pain, neck pain, multiple problems with her right arm for which she has seen Dr. Kuntz in the past. [Appellant] was referred by Dr. Argires with considerable neck pathology. She has had two surgeries to her left rotator cuff status post work injury at the [employing establishment] which occurred on August 15, 2002. There was a tray which was

> stuck and it broke loose. [Appellant] injured her right arm. Her history is well delineated in Dr. Kuntz's notes. [Appellant] also injured her left shoulder at that time. Her shoulder surgeries were performed on August 18, 2004 and August 31, 2005 by Dr. Rothacker…."

Dr. Perezous noted that diagnostic tests revealed a retear of the left rotator cuff, for which appellant underwent surgery on June 6, 2006. He noted that she had no arthritis in the left shoulder and stated that the biceps tendon was normal. Dr. Perezous stated:

> "In my opinion, [appellant] has not recovered from her left shoulder problems that are directly related to her work injury. I do not feel that her main problem is bicipital tend[i]nitis. There was a recurrent tear of the rotator cuff for which I repaired. The biceps tendon was normal. [Appellant] did not have degenerative disease of the joint. She has significant pain and diminished range of motion. I do n[o]t feel that [appellant] would benefit from having to lift with that left arm. I disagree with the second opinion by Dr. Smith in that she does not have degenerative disease in her shoulder in the glenohumeral joint. I do feel [appellant's] neck is also contributing to much of this problem. I do agree with Dr. Smith that she could work in a sedentary capacity. We would have to do a [functional capacity evaluation] to determine how much [appellant] could lift in that fashion, certainly nothing over chest level. I agree that she does not need any further treatment with her shoulder…."

By decision dated June 20, 2007, the Office denied modification of the August 31, 2006 termination decision.

LEGAL PRECEDENT -- ISSUE 1

Once the Office accepts a claim, it has the burden of proving that the disability has ceased or lessened in order to justify termination or modification of compensation benefits.[3] After it has determined that an employee has disability causally related to his or her federal employment, the Office may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.[4]

ANALYSIS -- ISSUE 1

In this case, the Office based its decision to terminate appellant's compensation on the April 25, May 10 and August 1, 2006 reports of Dr. Smith, the Office referral physician. In his April 25, 2006 report, Dr. Smith stated his agreement with Dr. Eagle's findings that the rotator cuff tear shown by diagnostic tests were attributable to appellant's age and to the attendant's degenerative disease process; he opined that these were more likely than not unrelated to her work activities. He further agreed with Dr. Eagle that the accepted injury was bicipital tendinitis and did not involve the rotator cuff, and there did not appear to be any evidence of any damage

[3] *Mohamed Yunis*, 42 ECAB 325, 334 (1991).

[4] *Id.*

to the biceps tendon. Dr. Smith believed that the diagnosed medical condition was not caused, aggravated, precipitated or accelerated by appellant's work environment. He noted that she had complaints of left shoulder pain with any movement but opined that this was exaggerated given the benign nature of the shoulder examination itself. Dr. Smith advised that, with regard to the accepted condition of biceps tendinitis of the left shoulder, appellant had reached maximum medical improvement and would not require any further treatment. He did not consider appellant totally disabled and believed her capable of working in a sedentary capacity with no lifting exceeding 10 pounds, bimanually to the waist level, and no reaching with the left upper extremity above the horizontal. In his May 10, 2006 report, Dr. Smith reiterated that appellant was not suffering from any residual affects of the accepted work-related condition of bicipital tendinitis of the left shoulder as a result of work factors, and that the accepted condition of biceps tendinitis of the left shoulder had resolved and no longer presented objective findings.

In an August 1, 2006 report, Dr. Smith noted that appellant had undergone left shoulder surgery on June 9, 2006, for which the preoperative diagnosis was possible retear of the left rotator cuff and the postoperative diagnosis was left rotator cuff retear and adhesions, interarticular and subacromial. Based on the information provided by Dr. Perezous' June 9, 2006 operative report, he opined that this particular surgery was unrelated to appellant's accepted condition of biceps tendinitis or any factors of her federal employment. Dr. Smith advised that neither the preoperative nor the postoperative diagnosis mentioned the biceps tendon and noted that the report indicated her biceps tendon was normal during the procedure. The Office relied on the opinion of Dr. Smith, finding that appellant had no residuals stemming from her accepted bicipital tendinitis condition and that she had no continuing disability for work resulting from the accepted condition.

The Board finds that the Office properly found that Dr. Smith's referral opinion represented the weight of the medical evidence and negated a causal relationship between appellant's current condition and her accepted left bicipital tendinitis condition. Dr. Smith submitted three thorough, well-rationalized reports which indicated that appellant still had some restrictions due to a nonwork-related degenerative rotator cuff condition in her left shoulder, but had no current disability stemming from her accepted left bicipital tendinitis condition. He therefore properly found that appellant had no longer had any residuals from the accepted condition and his report is sufficiently probative, rationalized and based upon a proper factual background.

Appellant's attorney noted that the February 28, 2003 statement of accepted facts indicated that the Office had accepted a condition of left shoulder capsulitis, a finding which, he contended, it subsequently disregarded and omitted from the medical history presented to Dr. Smith. Therefore, counsel contended, the Office failed to meet its burden to establish that appellant's work-related conditions had resolved. The Board rejects this argument. There is no factual or medical evidence indicating appellant developed such a condition causally related to employment factors. Appellant did not indicate in her Form CA-2 that she had sustained any such condition due to factors of her employment; nor did she file a claim based on such a condition. In his May 5, 2003 report, Dr. Eagle stated that appellant had no findings in his examination compatible with the diagnosis of adhesive capsulitis of the left shoulder that was listed in the statement of accepted facts. As there is no other reference to this condition contained in the record, it appears that the Office erred in listing left shoulder capsulitis as an

accepted condition in the February 28, 2003 statement of accepted facts. However, as the Office properly found that Dr. Smith's well-rationalized opinion negated any causal relationship between appellant's documented, accepted condition of bicipital tendinitis and her employment factors, the Board finds that the listing of left shoulder capsulitis in the February 28, 2003 statement of accepted facts constituted harmless error. The Office therefore properly relied on Dr. Smith's opinion in its August 31, 2006 termination decision.

The Board also notes that, while appellant's attorney alleges that the Office paid for appellant's 2004 surgery and therefore "owns" this condition, the Board has previously held that the mere fact that the Office authorized and paid for some medical treatment does not establish that the condition for which appellant received treatment was employment related.[5]

LEGAL PRECEDENT -- ISSUE 2

After a termination or modification of benefits which is clearly justified on the basis of the evidence, the burden of proof to reinstate compensation benefits rest with the claimant. The claimant must establish by the weight of reliable, probative and substantial evidence that a disability related to employment continued to exist after the termination of benefits.[6] To establish the requisite causal relationship, the claimant must submit a physician's report which contains a review of the factors of employment identified as causing the claimant's condition and, taking those factors into consideration, along with the results of a clinical examination and the medical history of the claimant, state whether these employment factors caused or aggravated the claimant's condition.

ANALYSIS -- ISSUE 2

Following the August 31, 2006 decision, appellant submitted new reports from Drs. Argires, Rothacker and Kuntz. While these physicians noted complaints of left shoulder pain, diagnosed left bicipital tendinitis and left rotator cuff tear with overuse of the left shoulder and indicated that she had underwent several surgeries for her left shoulder, none of them presented a rationalized, probative medical opinion that she had any residuals from the only condition accepted by the Office, left bicipital tendinitis. Dr. Argires noted that on examination appellant had pain on abduction and rotation of her left arm and with movement of her left shoulder. He indicated that most of her complaints were related to tendinopathy in her left shoulder. Drs. Rothacker and Kuntz also indicated that appellant had complaints of left shoulder pain, but did not provide an opinion attributing these complaints to her accepted left bicipital tendinitis condition. Thus the Office hearing representative properly found in his May 17, 2007 decision that appellant had submitted no evidence sufficient to undermine the Office's finding, in its August 31, 2006 termination decision, that the opinion of Dr. Smith represented the weight of the medical evidence.

[5] *Dale E. Jones*, 48 ECAB 648 (1997).

[6] *Franklin D. Haislah*, 52 ECAB 457 (2001); *Manuel Gill*, 52 ECAB 282 (2001); *Howard Y. Miyashiro*, 51 ECAB 253 (1999).

Appellant requested reconsideration and submitted a May 30, 2007 report from Dr. Perezous, who stated that he had been treating her since May 2, 2006 for complaints of left shoulder pain, neck pain and right arm problems. Dr. Perezous advised that appellant had sustained a work injury on August 15, 2002 in which a tray broke loose, injuring her right arm and left shoulder.[7] He noted her history of undergoing left shoulder surgery on August 18, 2004 and August 31, 2005 and indicated that diagnostic tests revealed a retear of the left rotator cuff, for which he performed surgery on June 6, 2006. Dr. Perezous stated that appellant had yet to recover from her left shoulder problems which were directly related to her work injury, though he did not feel that her main problem was bicipital tendinitis. He stated, in fact, that the left biceps tendon was normal. Dr. Perezous also asserted that appellant's neck was also contributing to her problems. He agreed with Dr. Smith's opinion that she could work in a sedentary capacity, after undergoing a functional capacity evaluation to determine how much she could lift, with no lifting over the chest level. Dr. Perezous also agreed that appellant did not require any further treatment for her left shoulder.

Dr. Perezous' May 2007 report does not constitute probative medical opinion showing that appellant had any continuing disability or residuals from her accepted condition. As stated above, the only accepted condition in this case was for left bicipital tendinitis. Dr. Perezous reiterated that the left biceps tendon was normal, which he had initially noted in his June 9, 2006 surgical report. While he stated that he had performed a repair of appellant's left rotator cuff on June 9, 2006 and indicated that she had yet to recover from left shoulder problems which were directly related to her work injury, her left rotator cuff condition was not accepted as work related and the Office did not accept a claim based on the August 2002 work injury referenced by Dr. Perezous. Finally, Dr. Perezous concurred with Dr. Smith's opinion that appellant was able to work in a sedentary capacity, with restrictions, and agreed that appellant did not require any further treatment for the left shoulder. His May 2007 report does not outweigh Dr. Smith's opinion nor does it negate the Office's finding that Dr. Smith's report represented the weight of the medical evidence. Accordingly, the Board finds that the Office properly denied modification of the August 31, 2006 termination decision.

CONCLUSION

Under the circumstances described above, the Board finds that the Office met its burden of proof to terminate appellant's compensation benefits and appellant has not established an employment-related continuing disability following the termination of her benefits.

[7] The record contains numerous references to a right shoulder or right arm condition, which appellant's attorney argued had contributed to the development of appellant's left shoulder condition. However, appellant has never filed a claim based on a right shoulder or right arm condition, and the Office did not accept such a condition.

ORDER

IT IS HEREBY ORDERED THAT the June 20 and May 17, 2007 and August 31, 2006 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: July 9, 2008
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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