United States Department of Labor
Employees' Compensation Appeals Board

W.B., Appellant	)	
and	)	**Docket No. 17-1994**
	)	**Issued: June 8, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Jersey City, NJ, Employer	)	

Appearances:
Michael D. Overman, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 26, 2017 appellant, through counsel, filed a timely appeal from a June 12, 2017 merit decision 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.[3]

[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.*

[3] The Board notes that appellant submitted additional evidence after OWCP rendered its June 12, 2017 decision. The Board's jurisdiction is limited to the evidence that was before OWCP at the time of its final decision. Therefore, the Board is precluded from reviewing this additional evidence for the first time on appeal. 20 C.F.R. § 501.2(c)(1).

ISSUE

The issue is whether appellant has established that the acceptance of her claim should be expanded to include the additional right shoulder diagnoses of tear of the distal supraspinatus tendon, right rotator cuff tendinitis, or aggravation of osteoarthritis.

On appeal appellant, through counsel, argues that OWCP erred in relying on the opinion of the second opinion physician to deny expansion of the acceptance of the claim. Counsel contends that this opinion was not sufficiently well reasoned and contradictory in nature. He suggests that the opinions of appellant's treating physicians are of at least equal value when compared to the second opinion physician and that therefore OWCP's decision should be reversed and the matter referred to an impartial medical examiner to resolve the conflict in the medical opinion evidence.

FACTUAL HISTORY

On December 25, 2015 appellant, then a 43-year-old mail handler, filed a traumatic injury claim (Form CA-1) alleging that on December 22, 2015 she injured her right upper arm while moving heavy boxes in the performance of duty. She finished her work shift on that date. Appellant's next scheduled work date was December 25, 2015, and she went to work on that date, but she did not finish her shift. She filed a claim for wage-loss compensation starting December 25, 2015.

The employing establishment issued an authorization for examination and/or treatment (Form CA-16) on December 25, 2015 for treatment at Bayonne Medical Center. On the attending physician's portion of the form, Dr. Neil Raswant, an osteopath in the emergency department, indicated that he treated appellant for right biceps contusion, and checked a box marked "yes" that this condition resulted from employment activity. In a narrative report of the same date, Dr. Raswant diagnosed right upper arm contusion.

An x-ray taken at Bayonne Medical Center also on December 25, 2015 was interpreted by Dr. Robert N. Waxman, a Board-certified radiologist, as within normal limits.

In an attending physician's report (Form CA-20) dated December 28, 2015, Dr. Mark A. P. Filippone, appellant's treating Board-certified physiatrist, diagnosed contusion of the right arm, shoulder, and possibly cervical spine. He checked a box marked "yes" indicating that this condition was caused by an employment activity.

On January 15, 2016 OWCP accepted appellant's claim for right shoulder contusion and right upper arm contusion.

In a December 28, 2015 report received by OWCP on February 17, 2016, Dr. Filippone reviewed appellant's discharge note from the hospital, but stated that he was not provided any other medical reports or diagnostic studies. He noted that on December 22, 2015 a heavy box fell on appellant from approximately six and one-half feet and struck her anterior right mid-to-distal third of her right biceps with great force. Dr. Filippone noted that appellant denied any prior problems with her neck, shoulder, or right upper extremity. He provided his findings from

appellant's physical examination, and diagnosed contusion to the right biceps muscle area and internal derangement of the shoulder, with a possible cervical spine injury. Dr. Filippone noted that appellant was temporarily totally disabled from work. Regarding causal relationship, he opined that appellant's injury to her right upper extremity and shoulder, and possibly cervical spine, were directly and solely the result of being hit by a falling heavy box on December 22, 2015. Dr. Filippone noted that hopefully her condition was nothing more than soft tissue injury and that she would be able to return to work after her next medical evaluation.

Dr. Filippone continued to submit monthly progress reports. In a February 5, 2016 progress report, he noted that appellant was clinically manifesting a progressive frozen right shoulder. Dr. Filippone raised the question as to whether or not she was developing reflex sympathetic dystrophy in the right upper extremity as even light-touch sensation to the hand and wrist caused her to withdraw painfully. He noted that appellant remained totally disabled from work. Dr. Filippone contended that the cervical spine injury component of this injury should be accepted by OWCP.

A series of diagnostic studies were taken on February 11, 2016 and were interpreted by Dr. Barry Julius, a Board-certified radiologist. A magnetic resonance imaging (MRI) scan of the right shoulder was interpreted by Dr. Julius as showing distal supraspinatus tendinosis versus low grade partial tear, small subdeltoid bursal fluid, and moderate osteoarthritis of the acromioclavicular joint. An MRI scan of the right humerus was interpreted by Dr. Julius as showing low grade tear *versus* tendinosis in the distal supraspinous tendon on right shoulder, moderate osteoarthritis of acromioclavicular joint, and no acute right humeral pathology. An x-ray of the cervical spine was interpreted by Dr. Julius as evincing no acute osseous pathology, no ligamentous instability, and minimal spondylosis of the cervical spine. An x-ray of the right humerus was interpreted by Dr. Julius as showing no acute osseous pathology and mild osteoarthritis of the right acromioclavicular joint.

Appellant submitted a claim for compensation (Form CA-7) for lost wages or disability, commencing December 25, 2015.

In a March 16, 2016 report, Dr. Richard P. Mackessy, a Board-certified orthopedic surgeon, reviewed the history of appellant's employment injury, x-rays, and MRI scans. He noted that some boxes fell on appellant during her employment on December 22, 2015. Dr. Mackessy noted that she has been off work since that time. He opined that appellant had right rotator cuff tendinitis. On April 7, 2016 Dr. Mackessy indicated that she could return to work with restrictions.

By decision dated April 8, 2016, OWCP denied expansion of appellant's claim to include the additional diagnoses of internal derangement of the right shoulder and right rotator cuff tendinitis. It also indicated that, although appellant's physician noted cervical spine injury, he did not provide a medical diagnosis for a cervical issue.

By decision dated April 18, 2016, OWCP denied appellant's claim for compensation for disability commencing December 25, 2015.

By letter dated April 12, 2016, counsel for appellant requested, *inter alia*, that appellant's accepted conditions be expanded to include tear of the distal supraspinatus tendon and aggravation of osteoarthritis in the right shoulder as outlined in the MRI scan findings dated February 11, 2016.

On April 20, 2016 appellant, through counsel, requested a hearing before an OWCP hearing representative regarding the April 8, 2016 decision, which denied expansion of the acceptance of appellant's claim.

In a medical opinion dated March 4, 2016, but not received by OWCP until May 2, 2016, Dr. Filippone reviewed the findings in the radiology reports of Dr. Julius and noted that he concurred with these findings.

In a medical opinion dated April 6, 2016, Dr. Filippone expressed his dismay over OWCP's comments about his prior reports, and recited his credentials. He contended that appellant's right shoulder was not improving and that she remained totally disabled. Dr. Filippone asked for authorization for him to personally and solely perform electromyogram/nerve conduction velocity (EMG/NCV) studies of appellant's upper and lower extremities to ascertain the nature, extent, and level of any spinal nerve entrapment, or any more distal nerve entrapment. He opined that, as per his initial consultation of December 28, 2015, appellant was grossly injured. Dr. Filippone noted that she was smacked by a 70-pound box that fell from a height, which struck appellant's anterior right mid and distal third of the right biceps with great force, but did not hit her head or render her unconscious. In an August 30, 2016 report, he noted that he was allowing appellant to return to work with restrictions, and that he would reexamine her in three weeks and determine whether she could return to full-time regular duty.

During the hearing held on September 28, 2016, the hearing representative indicated that she would be addressing both the April 8, 2016 decision denying appellant's request to expand the acceptance of her claim to include internal derangement of the right shoulder and rotator cuff tendinitis, and the April 18, 2016 decision denying wage-loss compensation. Appellant testified that she had no prior injuries involving her right upper extremity. She described her employment duties. Appellant testified that on December 22, 2015 she was working dumping the mail on the belt and boxes that were stacked high up over her head fell down and hit her. She estimated that the boxes weighed approximately70 pounds. Appellant stated that when she was hit she felt a pull, but she kept working because she did not feel anything until morning. She described her follow-up medical treatment.

In a September 20, 2016 report, Dr. Filippone summarized his treatment of appellant, noted that appellant's symptoms remained unchanged, and that she continued to complain of pain in the right arm and shoulder. He noted that there was no interval or intercurrent history of trauma or injury. Dr. Filippone reported that he originally saw appellant on December 28, 2015. He indicated that appellant told him that she was hit by a heavy box that may have weighed up to 70 pounds and fell from a height of at least six and one-half feet striking the anterior mid-to distal third of the right biceps with great force and downwards vector, which would be instantly transmitted across the right shoulder joint. Dr. Filippone indicated that appellant complained of right shoulder pain and right arm pain, specifically at the right mid biceps area and that she had no prior history of injury. He discussed appellant's range of motion. Dr. Filippone noted that appellant's MRI scan showed a distal supraspinatus tendinous *versus* a low-grade partial tear of

subdeltoid and small subdeltoid bursal fluid. He noted that this would be totally consistent with a downward force vector on the adjacent humerus which terminates cephalad in the shoulder.

By decision dated November 9, 2016, the hearing representative determined that the reports of Drs. Filippone and Mackessy were sufficient to require further development of the record. She remanded the case for referral to a second opinion physician.

On December 1, 2016 OWCP referred appellant to Dr. Timothy Henderson, a Board-certified orthopedic surgeon, for a second opinion examination and evaluation. Appellant did not attend the appointment scheduled for December 10, 2016. Therefore, OWCP issued a notice of proposed suspension. However, as noted, in a letter to OWCP from counsel dated January 20, 2017 and verified by a letter from appellant, the original notice was sent to appellant's old address whereas the proposed suspension was sent to her correct address. Counsel noted that appellant was willing to comply with the examination. Accordingly, OWCP scheduled a new appointment for appellant with Dr. Henderson.

In a February 20, 2017 report, Dr. Henderson reviewed appellant's medical history and discussed the findings of his physical examination conducted on that date. He noted that appellant's residuals were not disabling and that she should return to full-duty work at that time. Dr. Henderson noted that appellant was tender to palpation over her greater tuberosity on the right and had slight tenderness to palpitation over the long head of the biceps tendon. He opined that appellant had mild disability related to her employment condition. Dr. Henderson noted that appellant still required treatment for her employment-related condition, and recommended physical therapy. However, he noted that she could return to full-duty work at that time.

By letter dated March 6, 2017, OWCP asked Dr. Henderson to opine whether the acceptance of appellant's claim should be expanded to include rotator cuff tear, cervical injury, or any other condition causally related to the accepted employment injury of December 22, 2015. In a March 8, 2017 follow-up, Dr. Henderson opined that appellant's claim should not be accepted for right shoulder rotator cuff tear. He noted that the MRI scan performed subsequent to the injury revealed distal supraspinatus tendinosis *versus* low-grade partial tear, small subdeltoid bursal fluid, and moderate osteoarthritis of the acromioclavicular joint. Dr. Henderson noted that appellant was tender on palpation over the long head of the biceps tendon. He further noted appellant's measurements for range of motion. Dr. Henderson opined that appellant's physical examination did not reveal rotator cuff tear and therefore the acceptance of the claim should not be expanded to include rotator cuff tear.

By decision dated March 9, 2017, OWCP denied expansion of the acceptance of appellant's claim to include an additional diagnosis because it found that the evidence of record did not demonstrate that the diagnosed medical conditions were causally related to the established work injury as required for coverage under FECA.

On March 16, 2017 appellant, through counsel, requested a hearing before an OWCP hearing representative.

During the hearing held on May 9, 2017, appellant was not present, but was represented by counsel. Counsel argued that Dr. Henderson's opinion was internally inconsistent and at the very least not sufficiently well reasoned to constitute the weight of the medical evidence.

By decision dated June 12, 2017, the hearing representative affirmed the March 9, 2017 decision. She determined that Dr. Henderson's second opinion made it clear that diagnostic testing did not support a diagnosis of rotator cuff tear, and there was no well-rationalized medical documentation supporting a shoulder diagnosis more severe than that accepted in the claim.[4]

LEGAL PRECEDENT

An employee has the burden of proof to establish that any specific condition or disability for which compensation is claimed is causally related to the employment injury.[5] Causal relationship is a medical issue, and the medical evidence required to establish causal relationship is rationalized medical evidence.[6] The opinion of the physician must be based on a complete factual and medical background of the claim, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[7] Neither the fact that a disease or condition manifests itself during a period of employment, nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[8]

Section 8123(a) of FECA provides that if there is a 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.[9] The implementing regulations state that if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either the second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination.[10] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[11]

[4] The June 12, 2017 decision did not address the denial of appellant's wage-loss claim.

[5] *Kenneth R. Love*, 50 ECAB 276 (1999).

[6] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[7] *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

[8] *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

[9] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2006).

[10] 20 C.F.R. § 10.321.

[11] *V.G.*, 59 ECAB 701 (2008).

ANALYSIS

The Board finds that this case is not in posture for decision, as there is an unresolved conflict in medical opinion between Dr. Henderson, OWCP's referral physician, and Dr. Filippone, appellant's treating physician, regarding whether appellant sustained additional right shoulder conditions as a result of the December 22, 2015 accepted work injury.

OWCP accepted appellant's claim for right shoulder contusion and right upper arm contusion. Appellant's treating physician, Dr. Filippone, examined appellant on a monthly basis starting on December 28, 2015. He submitted multiple reports detailing appellant's accepted employment injury of December 22, 2015. Dr. Filippone noted that appellant was hit by a heavy box that may have weighed up to 70 pounds and fell from a height of at least six and one-half feet striking the anterior mid-to-distal third of the right biceps with great force and that the downwards vector would be instantly transmitted across the shoulder joint. He also has provided comprehensive physical examination findings. Dr. Filippone noted, *inter alia*, pain in the right shoulder and the right arm, including the right mid biceps area, and noted limitations on appellant's range of motion. He also ordered diagnostic tests which were interpreted by Dr. Julius on February 11, 2016, and Dr. Filippone noted that he agreed with the findings of Dr. Julius. Dr. Filippone reported that appellant had no complaints of right shoulder pain prior to the employment injury. He noted that appellant's MRI scan showed a distal supraspinatus tendinous *versus* a low-grade partial tear of the subdeltoid and small deltoid bursal fluid. Dr. Filippone explained that this would be totally consistent with a downward force vector on the adjacent humerus, which terminates in the cephalad in the shoulder.

By contrast, the second opinion physician, Dr. Henderson, noted that appellant was tender to palpitation over her greater tuberosity on the right and had slight tenderness to palpitation over the long head of the biceps tendon. He discussed appellant's range of motion measurements. Dr. Henderson noted that appellant still required treatment for her employment-related condition. He concluded that, while appellant's MRI scan of the right shoulder revealed distal supraspinatus tendinosis *versus* low-grade partial tear, small subdeltoid bursal fluid, and moderate osteoarthritis of the acromioclavicular joint, her physical examination did not reveal a rotator cuff tear.

The Board finds that the reports of Dr. Henderson are in equipoise with the reports of Dr. Filippone with regard to which medical diagnoses are causally related to appellant's accepted employment injury of December 22, 2015.[12] Both physicians provide a description of the employment injury and both discuss the medical evidence and their physical findings. The Board, therefore, finds that a conflict in medical opinion has been created regarding whether appellant's internal derangement of the right shoulder, or right rotator cuff tendinitis were causally related to the accepted employment injury of December 22, 2015. Section 8123 of FECA provides that if there is a disagreement between the physician making the examination for the United States and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[13]

[12] *See S.N.*, Docket No. 17-1589 (issued January 3, 2018).

[13] 5 U.S.C. § 8123(a); *see also A.D.*, Docket No. 17-1855 (issued February 26, 2018).

The case will be remanded to OWCP to refer appellant, the medical record, and a statement of accepted facts, to an appropriate specialist, to obtain an impartial medical opinion regarding whether the accepted December 22, 2015 work injury caused or aggravated the diagnosed internal derangement of the right shoulder, right rotator cuff tendinitis, or any other medical condition of appellant's right shoulder. Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision.[14]

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the June 12, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for further action consistent with this decision.

Issued: June 8, 2018
Washington, DC

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

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

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

[14] The Board notes that a Form CA-16 authorization for examination and/or treatment was issued by the employing establishment on May 8, 2015. When the employing establishment properly executes a Form CA-16 which authorizes medical treatment as a result of an employee's claim for an employment-related injury, the Form CA-16 creates a contractual obligation, which does not involve the employee directly, to pay for the cost of the examination or treatment regardless of the action taken on the claim. The period for which treatment is authorized by a Form CA-16 is limited to 60 days from the date of issuance, unless terminated earlier by OWCP. *See* 20 C.F.R. § 10.300(c); *Tracy P. Spillane*, 54 ECAB 608, 610 (2003).