United States Department of Labor
Employees' Compensation Appeals Board

J.R., Appellant	)	
and	)	**Docket No. 18-0603**
	)	**Issued: November 13, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Paoli, 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:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 29, 2018 appellant, through counsel, filed a timely appeal from an August 21, 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 the case.

[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.*

ISSUE

The issue is whether OWCP abused its discretion by denying appellant authorization for right shoulder surgery.

FACTUAL HISTORY

On May 21, 1996 appellant, then a 29-year-old mail processor, filed an occupational disease claim (Form CA-2) alleging that working a sorting machine all day at work caused neck and shoulder conditions. The claim was adjudicated by OWCP under File No. xxxxxx372. Appellant stopped work on June 1, 1996 and returned to full-time limited-duty work on August 26, 1996. On August 27, 1996 OWCP accepted cervical and right shoulder strains.

By decision dated January 22, 1998, OWCP terminated appellant's wage-loss compensation and medical benefits, based on the opinion of Dr. Steven Valentino, a Board-certified osteopath practicing orthopedic surgery, who provided a second opinion evaluation for OWCP in which he advised that appellant's right shoulder strain and cervical strains had resolved.[3]

On February 6, 2003 appellant, then a part-time flexible letter carrier, filed an occupational disease claim (Form CA-2) alleging that employment duties caused pain and numbness in both arms that began in November 2002. The claim was adjudicated by OWCP under File No. xxxxxx913. Dr. Adriana S. Prawak, an osteopath, who is a Board-certified physiatrist, saw appellant in consultation on January 30, 2003 for complaints of bilateral elbow pain. She noted that he denied shoulder pain. Dr. Prawak continued to treat appellant, and diagnosed bilateral biceps tendinitis and medial epicondylitis. On May 22, 2003 OWCP accepted aggravation of bilateral biceps tendinitis and aggravation of bilateral medial epicondylitis. It paid appellant wage-loss compensation from January 27 to April 1, 2003. Lesion of the right ulnar nerve (cubital tunnel syndrome) was later accepted under that claim.

On April 28, 2005 appellant, then a letter carrier, filed a traumatic injury claim (Form CA-1) alleging that, on April 27, 2005, when lifting a parcel at work, he felt a pop and burn in the right side of his neck with subsequent pain which radiated down his right upper extremity. He stopped work on that day. OWCP adjudicated the claim under File No. xxxxxx966. Following an initial denial on July 13, 2005, by decision dated November 7, 2005, a hearing representative with OWCP's Branch of Hearings and Review set aside the July 13, 2005 decision and remanded the case for OWCP to administratively combine File Nos. xxxxxx966 and xxxxxx372. OWCP subsequently combined these two files, with File No. xxxxxx966 serving as the master file.

[3] Dr. Valentino noted that upper extremity examination demonstrated normal range of motion about the shoulders, elbows, wrists and hands. Shoulder examination was negative for instability or impingement. Evaluation of the acromioclavicular joint, clavicle, sternoclavicular joint, rotator cuff, glenohumeral articulation, labral area and bicipital tendon area were normal. Instability, impingement and sulcus sign were negative. There was no evidence of residual shoulder strain. Allen's, Wright's, Roos', Phalen's, reverse Phalen's, ulnar stretch, and Tinel's signs were negative. Tinel's signs specifically over the brachial plexus and thoracic outlet were negative, indicating there was no evidence of thoracic outlet syndrome or brachial plexitis. Additionally, there were no findings to substantiate any evidence of reflex sympathetic dystrophy.

By decision dated February 20, 2007, issued under File No. xxxxxx966, OWCP accepted aggravation of cervical disc disease, cervical radiculopathy, and herniated cervical disc without myelopathy at C5-6, C6-7, and C7-T1. It also authorized cervical spine surgery that was performed on June 7, 2005.

On June 18, 2007 OWCP combined all three files with File No. xxxxxx913 the latter serving as the master file.

Appellant began receiving wage-loss compensation from OWCP on the supplemental rolls for disability from work beginning March 26, 2008, the date that he underwent right ulnar nerve decompression surgery. He briefly returned to work on April 14, 2008, and, thereafter, OWCP placed him on the periodic compensation rolls. Appellant has not returned to work.

Bilateral shoulder x-rays on September 20, 2013 demonstrated no acute fracture or dislocation, and soft tissue were grossly intact. Mild degenerative change was seen at the left acromioclavicular joint space.

In February 2015 appellant began pain management with Dr. Philip S. Kim, Board-certified in anesthesia and pain medicine, for complaints of neck pain radiating to both upper extremities. Dr. Kim implanted an intrathecal pump and catheter on March 1, 2016 and provided follow-up care, noting appellant's continued complaint of severe radiating neck pain.

In an April 7, 2016 report, Dr. Sucharitha Shanmugam, a Board-certified rheumatologist, saw appellant in consultation regarding osteoarthritis in the neck and right hand. She also noted complaints of chronic neck and back pain. Dr. Shanmugam diagnosed chronic neck and back pain, dorsalgia, and trigger finger, right middle finger and injected the middle finger of appellant's right hand. She again injected appellant's right middle finger on October 14, 2016.

Dr. Kim continued to treat appellant for chronic neck and low back pain. On January 13, 2017 he noted that appellant had a new problem, that for two months he had throbbing, stabbing, and achy pain in his right shoulder, worse with movement. Dr. Kim described tenderness of the right shoulder with range of motion, and referred appellant for consultation with Dr. Jack E. Kazanjian, an osteopath, who practices orthopedic surgery.

In a January 24, 2017 report, Dr. Kazanjian noted that appellant was disabled from work due to a work injury and had cervical spine surgery and ulnar nerve decompression surgery in the past. He noted that appellant described continuous upper extremity pain, but did not know if it was from his cervical spine or his shoulder. Arm pain was reproduced with neck motion. Right shoulder range of motion was diminished. X-ray of the right shoulder that day demonstrated no joint narrowing or abnormality. Dr. Kazanjian diagnosed right shoulder pain, chronic pain syndrome, and a history of multiple surgeries and neuropathic pain. He recommended a computerized tomography (CT) arthrogram of the right shoulder. A February 28, 2017 right shoulder CT arthrogram demonstrated a full-thickness tear within the distal supraspinatus tendon.

In a report dated March 2, 2017, Dr. Kazanjian noted that appellant had indicated his right shoulder pain, which was different from his neck pain, was worsening. He reviewed the CT arthrogram and diagnosed right shoulder full-thickness supraspinatus tendon tear and

acromioclavicular joint degenerative joint disease with synovitis. Dr. Kazanjian recommended surgical repair and requested authorization.

On March 21, 2017 OWCP asked its medical adviser to provide an opinion regarding the medical necessity of the requested surgery. It attached a July 22, 2016 addendum to its statement of accepted facts (SOAF). This listed accepted conditions of aggravation of bilateral biceps tendinitis, aggravation of bilateral epicondylitis, lesion of the right ulnar nerve, aggravation of cervical disc disease, cervical radiculopathy, and herniated cervical disc at C5-6, C6-7, and C7-T1 without myelopathy.[4]

In a report dated April 10, 2017, Dr. Todd Fellars, a Board-certified orthopedic surgeon and OWCP medical adviser, indicated that he had reviewed the record including the SOAF. He noted that appellant was not working and discussed his medical history, objective studies, and physical examination findings. Dr. Fellars opined that the proposed right shoulder arthroscopy was not causally related to the accepted medical conditions, noting that a rotator cuff tear had not been accepted and that there was no evidence that it was employment related. He further opined that the proposed arthroscopic surgery was not medically necessary, advising that there was no documentation of focused physical therapy or shoulder injections to support that appellant had failed nonoperative treatment.

By decision dated April 20, 2017, OWCP denied authorization for a right arthroscopic rotator cuff repair.

On April 26, 2017 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review. Counsel submitted a May 17, 2017 operative report which indicated that Dr. Kazanjian performed arthroscopic decompression with acromioplasty of the right shoulder with distal clavicle excision and posterior capsular release. Dr. Kazanjian noted that appellant had a long-standing history of right shoulder pain and described the CT arthrogram findings. Postoperative diagnoses were full-thickness supraspinatus tendon tear, acromioclavicular degenerative joint disease, and impingement syndrome of the right shoulder.

The hearing was held on July 12, 2017. Counsel argued that the SOAF forwarded to OWCP's medical adviser was incomplete because it did not mention appellant's 2002 arm injury and, therefore, Dr. Fellars based his opinion on an incorrect history. He maintained that, at a minimum, a conflict in the medical opinion evidence had been created between the opinions of Dr. Kazanjian and Dr. Fellars.

By decision dated August 21, 2017, OWCP's hearing representative affirmed the April 20, 2017 decision. He found that appellant had not met his burden of proof to establish that a right rotator cuff tear was causally related to an accepted injury, noting that Dr. Kazanjian did not provide an opinion as to whether the rotator cuff tear was caused by an accepted injury. The hearing representative conceded that the SOAF provided Dr. Fellars did not describe appellant's 1996 or 2002 employment injuries accepted for right shoulder strain, but indicated that, under this

[4] On March 29, 2017 OWCP expanded the acceptance of the claim to include adjustment disorder with mixed anxiety and depression, based on a second opinion evaluation completed by Dr. Irving S. Wiesner, a Board-certified psychiatrist.

claim, wage-loss compensation and medical benefits were terminated by OWCP in 1998. He further indicated that appellant had not worked for nine years when the CT scan was completed and, absent rationale by the treating physician, the results of this study were not probative as to causal relationship. The hearing representative discussed Dr. Fellars' findings and concluded that the weight of the medical evidence established that the proposed surgery was not necessary to treat an employment-related condition.

LEGAL PRECEDENT

Section 8103 of FECA provides that the United States shall furnish to an employee who is injured while in the performance of duty, the services, appliances, and supplies prescribed or recommended by a qualified physician, which OWCP considers likely to cure, give relief, reduce the degree, or the period of disability, or aid in lessening the amount of monthly compensation.[5] While OWCP is obligated to pay for treatment of employment-related conditions, the employee has the burden of establishing that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[6]

In interpreting section 8193 of FECA, the Board has recognized that OWCP has broad discretion in approving services provided, with the only limitation on OWCP's authority being that of reasonableness.[7] Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment, or actions taken which are contrary to both logic and probable deductions from established facts. It is not enough to merely show that the evidence could be construed so as to produce a contrary factual conclusion.[8] To be entitled to reimbursement of medical expenses, a claimant has the burden of establishing that the expenditures were incurred for treatment of the effects of an employment-related injury or condition. Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[9] In order for a surgical procedure to be authorized, a claimant must submit evidence to show that the surgery is for a condition causally related to an employment injury and that it is medically warranted. Both of these criteria must be met in order for OWCP to authorize payment.[10]

ANALYSIS

The Board finds that OWCP did not abuse its discretion by denying authorization for right shoulder surgery.

OWCP accepted appellant's 2003 and 2005 claims for aggravation of bilateral biceps tendinitis, aggravation of bilateral epicondylitis, lesion of the right ulnar nerve, aggravation of

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[5] 5 U.S.C. § 8103; *see Thomas W. Stevens*, 50 ECAB 288 (1999).

[6] *Kennett O. Collins, Jr.*, 55 ECAB 648 (2004).

[7] *See D.K.*, 59 ECAB 141 (2007).

[8] *Minnie B. Lewis*, 53 ECAB 606 (2002).

[9] *M.B.*, 58 ECAB 588 (2007).

[10] *R.C.*, 58 ECAB 238 (2006).

cervical disc disease, cervical radiculopathy, herniated cervical disc at C5-6, C6-7, and C7-T1 without myelopathy, and adjustment disorder with mixed anxiety and depression. The 1996 claim, accepted for right shoulder and cervical strains, was terminated by OWCP in 1998 because the accepted conditions had resolved.

For a surgical procedure to be authorized, a claimant must submit evidence sufficient to establish that the surgery is for a condition causally related to an employment injury and that it is medically warranted. Both of these criteria must be met in order for OWCP to authorize payment.[11]

Dr. Kim, who began treating appellant in 2015, first mentioned increased right shoulder pain in January 2017, over eight years after appellant stopped work in April 2008. He did not discuss a cause of appellant's increased right shoulder pain and referred him to Dr. Kazanjian. Medical evidence that does not offer an opinion regarding the cause of an employee's condition is of no probative value on the issue of causal relationship.[12] Thus Dr. Kim's opinion is insufficient to meet appellant's burden of proof.

Dr. Kazanjian first saw appellant on January 24, 2017 and noted that appellant provided a history that he had always had upper extremity pain, but did not know if it was from his cervical spine or his shoulder. He diagnosed right shoulder pain, chronic pain syndrome, and history of multiple cervical spine surgeries, and neuropathic pain. Dr. Kazanjian recommended a CT arthrogram of the right shoulder.

The Board has held that, when diagnostic testing is delayed, uncertainty mounts regarding the cause of the diagnosed condition and a question arises as to whether that testing in fact documents the injury claimed by the employee. The greater the delay in testing, the greater the likelihood that an event not related to employment has caused or worsened the condition for which the employee seeks compensation. When the delay becomes so significant that it calls into question the validity of an affirmative opinion based at least in part on the testing, such delay diminishes the probative value of the opinion offered.[13] In this case a CT arthrogram of the right shoulder was not performed until February 28, 2017, many years after the 1996, 2002, and 2005 employment injuries, and almost nine years after appellant stopped work in April 2008. While the CT arthrogram demonstrated a full-thickness tear within the supraspinatus tendon which was repaired by Dr. Kazanjian on May 17, 2017, in that report he merely indicated that appellant had a long-standing history of right shoulder pain. Dr. Kazanjian did not provide a rationalized opinion explaining how any of the accepted conditions or employment factors caused a right shoulder

[11] *Id*.

[12] *See L.B.,* Docket No. 18-0533 (issued August 27, 2018); *D.K*., Docket No. 17-1549 (issued July 6, 2018).

[13] *Mary A. Ceglia*, 55 ECAB 626 (2004).

rotator cuff tear or the need for surgery.[14] His opinion is, therefore, insufficient to establish that the right shoulder surgery was for an employment-related condition.[15]

As noted by Dr. Fellars, OWCP's medical adviser, a right shoulder rotator cuff tear has not been accepted as employment related. He opined that the surgery was not causally related to the accepted medical conditions. Appellant has the burden to prove that conditions not accepted by OWCP are causally related to the accepted employment injuries through the submission of rationalized medical evidence.[16] He has not submitted such evidence and has, thus, failed to show that the right rotator cuff tear was employment related.[17] OWCP's medical adviser also indicated that the proposed surgery was not medically necessary. He explained that there was no documentation of focused physical therapy or shoulder injections to support that appellant had failed nonoperative treatment.

While counsel asserts on appeal that the SOAF forwarded to Dr. Fellars contained a fatal flaw, because it did not mention a prior 2002 right arm injury, the record indicates that the accepted conditions of the 2002 claim, aggravation of bilateral biceps tendinitis, aggravation of bilateral epicondylitis, and lesion of the right ulnar nerve, were included in the SOAF forwarded to Dr. Fellars. As to the 1996 claim accepted for right shoulder strain, as noted by the hearing representative in his August 21, 2017 decision, this claim was terminated in 1998. Furthermore, as explained above, appellant did not submit a rationalized explanation regarding the cause of the diagnosed right shoulder rotator cuff tear.[18] Thus, contrary to counsel's argument on appeal, no conflict in medical evidence was created.

The only limitation on OWCP's authority in approving or disapproving service under FECA is one of reasonableness.[19] In the instant case, appellant requested right shoulder surgery. His physician Dr. Kazanjian did not provide a rationalized opinion explaining how the recommended surgery was caused by appellant's accepted conditions, and was therefore insufficient to meet appellant's burden of proof.[20] Dr. Fellars, OWCP's medical adviser, clearly opined that the requested surgery was not warranted for the accepted conditions. Absent sufficient explanation as to why the proposed surgery was causally related to the accepted conditions, the Board finds that OWCP acted reasonably in denying appellant's request for right shoulder surgery.[21]

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[14] *See V.S.*, Docket No. 17-0874 (issued December 6, 2017).

[15] *R.C.*, *supra* note 10.

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

[17] *See C.V.*, Docket No. 17-1159 (issued April 6, 2018).

[18] *R.C.*, *supra* note 10.

[19] *D.K, supra* note 7.

[20] *R.C.*, *supra* note 10.

[21] *B.L.*, Docket No. 15-1452 (issued September 20, 2016).

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that OWCP properly exercised its discretion by denying appellant authorization for right shoulder surgery.

ORDER

IT IS HEREBY ORDERED THAT the August 21, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 13, 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