United States Department of Labor
Employees' Compensation Appeals Board

L.K., Appellant	)	
and	)	**Docket No. 21-0147**
	)	**Issued: January 21, 2022**
DEPARTMENT OF VETERANS AFFAIRS, VA MEDICAL CENTER, St. Louis, MO, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On November 10, 2020 appellant, through counsel, filed a timely appeal from a May 28, 2020 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, following the issuance of the May 28, 2020 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* 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. *Id*.

ISSUE

The issue is whether appellant has met her burden of proof to establish a medical condition causally related to the accepted factors of her federal employment.

FACTUAL HISTORY

On June 9, 2017 appellant, then a 50-year-old registered nurse, filed an occupational disease claim (Form CA-2) alleging that she developed left shoulder acromioclavicular (AC) arthritis, biceps tendinitis, impingement syndrome, rotator cuff tear, and adhesive capsulitis from years of repetitive strain due to factors of her federal employment, including years of manual patient handling. She noted that she first became aware of her condition on July 15, 2016 and realized that it was causally related to her federal employment on July 22, 2016. Appellant stopped work on November 22, 2016 and returned to work on January 23, 2017.

On July 22, 2016 appellant was treated by Dr. Sophia Rostovtseva, a Board-certified family practitioner, for a one-week history of left shoulder pain. She reported performing repetitive lifting at work. Dr. Rostovtseva noted tenderness of the left shoulder and bicipital groove and decreased range of motion. She diagnosed bicipital tendinitis of the left shoulder.

In a report dated September 14, 2016, Dr. Brett Grebing, a Board-certified orthopedist, saw appellant in consultation for left shoulder pain. Examination revealed left shoulder crepitus, tenderness over the acromion, positive Hawkins test, positive cross body test, muscle weakness and restricted range of motion. X-rays of the left shoulder revealed a well-aligned joint, minimal degenerative changes, and calcification of the superior portion of the joint consistent with labral pathology. Dr. Grebing diagnosed acute pain of the left shoulder and acute bursitis of the left shoulder.

On October 7, 2016 Dr. Paul Scherer, a Board-certified orthopedist, examined appellant for left shoulder pain that began spontaneously in July 2016. Appellant reported working as an emergency room nurse at the employing establishment and explained that her job required very heavy lifting including lifting patients. Physical examination revealed limited range of motion of the left shoulder, give away weakness with abduction, and tenderness at the supraspinatus tendon insertion. X-rays of the left shoulder revealed no definite abnormalities. Dr. Scherer diagnosed adhesive capsulitis and performed a cortisone injection under fluoroscopic guidance.

Appellant was evaluated by Dr. Aaron P. Omotola, a Board-certified orthopedist, on October 14 and 28, 2016, for left shoulder pain. Dr. Omotola noted findings on examination of left AC joint ecchymosis, abnormal palpation, crepitus, and decreased strength. He diagnosed rotator cuff insufficiency of the left shoulder, AC joint arthritis, and biceps tendinitis of the left shoulder, and complete tear of the left rotator cuff. In other notes also dated October 14 and 28, 2016, Dr. Omotola described appellant's complaints of left shoulder pain beginning in July 2016. Appellant underwent a magnetic resonance imaging (MRI) scan, which revealed a small partial tear of her rotator cuff, AC joint arthritis, and biceps tendinitis. Dr. Omotola recommended arthroscopic left rotator cuff repair. He treated appellant in follow up on November 2, 2016 for AC arthritis, rotator cuff insufficiency, and biceps tendinitis, discussing the risks and benefits of the left shoulder arthroscopy. On November 22, 2016 Dr. Omotola performed a left shoulder arthroscopic biceps tenodesis, subacromial decompression, distal clavicle excision, and

debridement of the rotator cuff partial tear. He diagnosed left shoulder AC arthritis, biceps tendinitis, impingement syndrome, and partial rotator cuff tear.

An MRI scan of the left shoulder dated October 20, 2016 revealed moderate AC joint osteoarthritis with mild impingement upon the supraspinatus muscle, intermediate signal intensity in the distal anterior aspect of the supraspinatus tendon suggestive of tendinopathy/tendinitis without a clearly defined rotator cuff tear seen, and mild joint effusion.

Appellant was treated by Donald W. LeMoine, II, a physician assistant, from December 6, 2016 through March 30, 2017, who indicated that she was status post left shoulder arthroscopy. Mr. LeMoine noted that Dr. Omotola performed a left shoulder biceps tenodesis, subacromial decompression, distal clavicle excision, and debridement of a partial rotator cuff on November 22, 2016. He diagnosed adhesive capsulitis of the left shoulder and status post left shoulder scope and advised that appellant was attending physical therapy treatment. Mr. LeMoine reported that appellant returned to limited duty in January 2017 and regular duty on April 2, 2017.

In a development letter dated July 7, 2017, OWCP informed appellant that the evidence submitted was insufficient to establish her claim. It advised her of the type of factual and medical evidence needed and provided a questionnaire for her completion. OWCP afforded appellant 30 days to respond.

In response to OWCP's questionnaire, appellant provided a description of her work duties, which included lifting up to 50 pounds, sitting, standing, walking, climbing, kneeling, bending/ stooping, twisting, pushing/pulling, simple grasping, fine manipulation, reaching above the shoulder, and operating machinery. She reported caring for bedridden, terminally ill, paraplegic, and quadriplegic patients that require turning and repositioning every two hours. Appellant indicated that psychiatric patients required constant observation for suicidal or homicidal ideation, geriatric patients with dementia and cognitive impairment also required constant monitoring to keep them safe. She performed these activities each shift, typically working six 12-hour shifts and one 8-hour shifts in a two-week period. Appellant provided a job description for an emergency department registered nurse.

By decision dated August 24, 2017, OWCP denied appellant's claim finding that the medical evidence of record was insufficient to establish causal relationship between her left shoulder condition and the accepted factors of her federal employment.

In a progress note dated November 30, 2017, Dr. Omotola indicated that appellant presented status post left shoulder arthroscopy on November 22, 2016. He opined that appellant developed adhesive capsulitis of the left shoulder postoperatively and was receiving aggressive physical therapy three times a week. Findings on examination of the left shoulder revealed a surgical scar/wound healed without infection, abnormal scapulothoracic motion, reduced range of motion, normal stability, and normal sensation. Dr. Omotola diagnosed adhesive capsulitis of the left shoulder and status post subacromial decompression. He recommended a home exercise program, Dyna splint, and activities as tolerated. In a December 1, 2017 report, Dr. Omotola noted that appellant was much improved from her preoperative status. X-rays of the left shoulder revealed no fracture or subluxation dislocation and appeared to be an appropriate postoperative radiograph for distal clavicle excision and subacromial decompression. Dr. Omotola diagnosed chronic left shoulder pain.

OWCP continued to receive additional evidence. Appellant submitted a January 24, 2018 statement from C.J., a registered nurse, who reported working with appellant while he was a student nurse in the emergency room from January 2007 through May 2007. During his tenure, C.J. recalled appellant lifting a 200-pound patient from the back seat of a car who was unresponsive. Also submitted was a statement from E.F., an osteopath, who was appellant's supervising medical service director at the employing establishment and who noted that the day-to-day repetitive stressors and strains of almost a dozen years working as a nurse in the emergency department, handling and lifting heavy, ill, and injured patients, could easily be responsible for chronic debilitating rupture of her rotator cuff tendon.[4]

On July 19, 2018 appellant requested reconsideration.

By decision dated March 6, 2019, OWCP denied modification of the August 24, 2017 decision.

On December 2, 2019 appellant was evaluated by Dr. Arthur C. Sippo, a Board-certified physiatrist, who provided a history of injury. Dr. Sippo indicated that she was over three years out from the original injury in 2016 and opined to a reasonable degree of medical certainty that she reached maximum medical improvement (MMI). In summary, he advised that appellant suffered an acute rotator cuff tear in her left shoulder while applying compression hose to a patient as part of her nursing duties. Dr. Sippo opined that she sustained a work-related injury.

On December 9, 2019 appellant requested reconsideration.

By decision dated December 12, 2019, OWCP denied modification of the March 6, 2019 decision.

Appellant submitted a March 2, 2020 report from Dr. Sippo who had examined her and responded to the denial of her claim. Dr. Sippo asserted that she sustained a left rotator cuff tear and biceps tendinitis on October 16, 2016, while she was fitting compression hose onto a swollen leg of a patient. He indicated that this injury required surgery and led to continuing pain and disability. Dr. Sippo explained that the human shoulder consisted of muscles and supporting structures that operate the movements of the joint and are small with marginal blood supply. He indicated that the shoulder is prone to overuse injuries leading to inflammation in the soft tissues and cumulative trauma to the joint structures stemming from excessive demands. Dr. Sippo noted that the muscles that control the rotation in the shoulder maintain a proper biomechanical relationship between the elements of that joint under stress. He indicated that repetitive lifting, pushing, and pulling of the shoulder lead to severe stress in the muscular, bony, ligamentous, and cartilaginous structures in the shoulder joint and was responsible for damage to the anatomic structures therein. Dr. Sippo noted that this repetitive trauma took a great toll on appellant's body and was responsible for the osteoarthritis in her left shoulder. He further opined that the trauma led to soft tissue strains in her shoulders that caused chronic inflammation in her rotator cuff that made those muscles friable and susceptible to injury such as the injury that occurred on October 16, 2016. Dr. Sippo advised that appellant's work activities resulted in repetitive chronic and acute injuries to her left rotator cuff, which led to the documented tear. He opined that her

[4] Also submitted were several patient communications which documented appellant's telephone calls to her health care providers from October 17, 2016 through January 31, 2017.

shoulder had been painful on and off for a couple of years prior to the incident, which represented wear and tear on the shoulder leading to both osteoarthritis and chronic inflammation which predisposed her to the aforementioned injury.

On March 4, 2020 appellant requested reconsideration.

By decision dated May 28, 2020, OWCP denied modification of the December 12, 2019 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[5] has the burden of proof to establish the essential elements of his or her claim, including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was timely filed within the applicable time limitation period of FECA,[6] that an injury was sustained in the performance of duty as alleged, and that any disability or medical condition for which compensation is claimed is causally related to the employment injury.[7] These are the essential elements of each and every compensation claim, regardless of whether the claim is based upon a traumatic injury or an occupational disease.[8]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the identified employment factors.[9]

Causal relationship is a medical question that requires rationalized medical opinion evidence to resolve the issue.[10] The opinion of the physician must be based on a complete factual and medical background of the claimant, 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 claimant.[11] Neither the mere fact that a disease or condition manifests itself during a period of employment, nor the belief that the

[5] *Supra* note 2.

[6] *E.W.*, Docket No. 19-1393 (issued January 29, 2020); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

[7] *L.C.*, Docket No. 19-1301 (issued January 29, 2020); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[8] 20 C.F.R. § 10.115; *E.S.*, Docket No. 18-1580 (issued January 23, 2020); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

[9] *See T.L.*, Docket No. 18-0778 (issued January 22, 2020); *Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[10] *J.F.*, Docket No. 18-0492 (issued January 16, 2020); *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[11] *A.M.*, Docket No. 18-0562 (issued January 23, 2020); *Leslie C. Moore*, 52 ECAB 132 (2000).

disease or condition was caused or aggravated by employment factors or incidents, is sufficient to establish causal relationship.[12]

ANALYSIS

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

In a report dated March 2, 2020, Dr. Sippo advised that appellant's work activities resulted in repetitive chronic and acute injuries to her left rotator cuff, which led to the documented tear. He reported working with her in the emergency room and described patients who were intoxicated, combative, and who required restraint and she was responsible for moving, controlling, lifting, pulling, and pushing these patients every shift. Dr. Sippo indicated that repetitive lifting, pushing, and pulling of the shoulder led to severe stress in the muscular, bony, ligamentous, and cartilaginous structures in appellant's shoulder joint and was responsible for damage to the anatomic structures. He explained that the human shoulder consisted of muscles and supporting structures that operate the movements of the joint and are small with marginal blood supply. Dr. Sippo indicated that the shoulder is prone to overuse injuries leading to inflammation in the soft tissues and cumulative trauma to the joint structures stemming from excessive demands. He further opined the trauma led to soft tissue strains in appellant's shoulders that caused chronic inflammation in her rotator cuff that made those muscles friable and susceptible to injury such as the injury that occurred on October 16, 2016. Dr. Sippo provided a proper factual and medical history of injury and directly opined that her repetitive job duties were the competent producing cause of her diagnosed left shoulder rotator cuff tear and left shoulder osteoarthritis.

The Board finds that the March 2, 2020 report of Dr. Sippo is sufficient to require further development of the medical evidence in this claim to see that justice is done.[13] The physician is a Board-certified physiatrist and is qualified in his field of medicine to render rationalized opinions on the issue of causal relationship. Dr. Sippo provided a pathophysiological explanation as to how the mechanism of the accepted employment incident was sufficient to have caused her diagnosed conditions and his opinion is uncontroverted. The Board has long held that it is unnecessary that the evidence of record in a case be so conclusive as to suggest causal connection beyond all reasonable doubt. Rather, the evidence required need only convince the adjudicator that the conclusion drawn is rationale, sound, and logical.[14]

It is well established that proceedings under FECA are not adversarial in nature and, while appellant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[15] OWCP has an obligation to see that justice is done.[16]

[12] *E.W.*, *supra* note 6; *Gary L. Fowler*, 45 ECAB 365 (1994).

[13] *J.H.*, Docket No. 18-1637 (issued January 29, 2020); *X.V.*, Docket No. 18-1360 (issued April 12, 2019).

[14] *C.C.*, Docket No. 18-1453 (issued January 28, 2020).

[15] *K.P.*, Docket 18-0056 (issued January 27, 2020); *see also A.P.*, Docket No. 17-0813 (issued January 3, 2018).

[16] *See B.C.*, Docket No. 15-1853 (issued January 19, 2016); *E.J.*, Docket No. 09-1481 (issued February 19, 2010); *John J. Carlone*, 41 ECAB 354 (1989).

The case shall therefore be remanded for OWCP to refer appellant to an appropriate specialist, along with the case record and a statement of accepted facts, for an examination and rationalized medical opinion as to whether the accepted employment injury either caused or aggravated her diagnosed left shoulder condition. If the second opinion physician opines that the left shoulder condition is not causally related to the accepted employment factors, he or she must explain with rationale how or why their opinion differs from that of Dr. Sippo. After this and other such further development of the case record as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the May 28, 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: January 21, 2022
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board