

FACTUAL HISTORY

The Office accepted that on March 9, 1999 appellant, then a 50-year-old letter carrier, sustained a cervical strain/sprain and left elbow fracture when he slipped and fell on an icy porch. In the March 9, 1999 claim form, appellant described his injuries as “bruised and cut elbow.” After his shift, he was treated at a hospital emergency room, where he was diagnosed with a chip fracture of the left olecranon, a left elbow laceration, neck and thoracic pain. The Office later accepted a herniated C5-6 disc and authorized September 21, 2001 and September 22, 2004 discectomies and fusions.

Appellant was followed by several physicians. In March 1999 reports, Dr. Chris Vasilakis, an attending Board-certified orthopedic surgeon, ordered a brief course of physical therapy to improve biceps strength and bilateral shoulder stiffness. From April 26, 1999 to January 2000, appellant was treated for headaches by Dr. Ted Vana, an attending Board-certified family practitioner, Dr. John Lehman, an attending Board-certified family practitioner and Dr. Maria Simba, an osteopathic physician Board certified in neurology.¹

Dr. Christopher Cai, a Board-certified neurosurgeon, began treating appellant in September 2000 for headaches with right-sided neck pain and right arm paresthesias. Dr. Paul M. Hoover, an attending Board-certified psychiatrist, submitted reports from July to November 2001 diagnosing right-sided C5-6 radicular pain.² On September 21, 2001 Dr. Cai performed a C5-6 anterior cervical discectomy and fusion. Appellant returned to limited-duty work on November 9, 2001.³ He underwent periodic cervical facet block injections in 2002 and 2003.

In June 21 and July 22, 2004 reports, Dr. James Kang, an attending Board-certified neurosurgeon, diagnosed a C5-6 nonunion postdiscectomy. He performed a revision of the C5-6 anterior discectomy and fusion on September 22, 2004. In a December 22, 2004 report, Dr. Kang opined that appellant had left shoulder impingement caused by “neck shoulder syndrome,” and a “neurologic imbalance of the shoulder” precipitated by jamming his left shoulder and neck on March 9, 1999.

Appellant stopped work on February 5, 2005 due to left shoulder and upper extremity symptoms. He claimed compensation for work absences.

In a February 16, 2005 report, Dr. Mark Rodosky, an attending Board-certified orthopedic surgeon, noted that appellant underwent a left acromioclavicular joint resection in the late 1970s, with persistent left shoulder pain and weakness since the March 9, 1999 injury. He obtained bilateral shoulder x-rays showing degenerative arthritis. Dr. Rodosky diagnosed bilateral impingement, left greater than right. An MRI scan of the left shoulder performed on

¹ A May 3, 2000 magnetic resonance imaging (MRI) scan of the cervical spine demonstrated disc bulges at C5-6 and C6-7 with possible right-sided nerve root compression.

² September 20, 2001 x-rays showed degenerative disc disease from C5-7.

³ By decision dated April 30, 2003, the Office determined that the limited-duty letter carrier position appellant had performed since November 2001 properly represented his wage-earning capacity.

February 17, 2005 showed a complete tear of the supraspinatus tendon, superior-posterior labral tear and moderate rotator cuff tendinopathy. On February 23, 2005 Dr. Rodosky recommended left shoulder surgery to repair the rotator cuff tear. He noted that appellant had similar symptoms in his right shoulder. Appellant requested that the Office approve the proposed surgery and reimburse related medical expenses.

In a March 14, 2005 report, an Office medical adviser reviewed the record and advised that the proposed surgery was due to idiopathic degenerative changes, not sequelae of the March 9, 1999 slip and fall. On March 30, 2005 the Office obtained a second opinion examination from Dr. Stephen Bailey, a Board-certified orthopedic surgeon, who noted that appellant did not recall injuring his left shoulder when he fell on March 9, 1999. Dr. Bailey found that there was no pathophysiologic relationship between appellant's shoulder symptoms and the accepted injury.

In April 28, 2005 reports, Dr. Hoover opined that the left rotator cuff tear was likely related to the accepted injury. He submitted periodic reports through September 8, 2008 finding ongoing residuals of the cervical spine and left shoulder conditions.

Dr. Rodosky submitted April 28 and May 6, 2005 reports noting that appellant did not have left shoulder symptoms prior to the March 9, 1999 incident. He diagnosed a full-thickness left rotator cuff tear. On July 26, 2005 Dr. Rodosky performed a left shoulder acromioplasty and rotator cuff repair. The Office did not authorize the procedure.

The Office found a conflict of medical opinion between Dr. Bailey, for the government, and Dr. Hoover, for appellant, regarding the causal relationship of the left shoulder rotator cuff tear and surgery to the accepted injury. To resolve the conflict, it selected Dr. Mark Foster, a Board-certified orthopedic surgeon, as impartial medical examiner, who submitted an August 10, 2005 report attributing the left shoulder condition to "use, surgery and age" as appellant had similar findings in the right shoulder. In a January 24, 2006 supplemental report, Dr. Foster noted that he could not properly examine appellant on August 10, 2005 due to the July 26, 2005 surgical procedure.

Dr. Foster performed a repeat examination on July 1, 2008. He reviewed the medical record and updated statement of accepted facts. Dr. Foster noted findings on examination of limited cervical flexion, decreased left triceps strength and no impingement of the left shoulder. He advised that appellant had idiopathic degeneration to both shoulders and polyneuropathy unrelated to the March 9, 1999 injuries. Dr. Foster commented that there was a "fantasy relationship between neurologic deficit and impingement." In an August 27, 2008 supplemental report, he stated that the accepted conditions had resolved without residuals.

By decision dated December 12, 2008, the Office denied reimbursement of the June 2005 left shoulder surgery, based on Dr. Foster's opinion that the left shoulder conditions were not related to the accepted injury.⁴

⁴ The Office initially denied reimbursement of the left shoulder surgery by decision dated August 19, 2008. Following additional development, in a December 8, 2008 decision, it set aside the August 19, 2008 decision and remanded the case for further development.

In a December 26, 2008 letter, counsel requested a telephonic oral hearing. He asked the Office to subpoena Dr. Foster in order to explain why he found no residuals of the accepted conditions.⁵ By decision dated March 31, 2009, the Office denied appellant's request for subpoena on the grounds that he did not explain why a subpoena was the best or only means to obtain further evidence from Dr. Foster.

At the hearing held on May 15, 2009, counsel asserted that Dr. Foster was biased and that his July 1, 2008 opinion was too stale to resolve the conflict. Appellant and his wife testified that Dr. Foster's secretary told them that Dr. Foster disliked Dr. Kang and Dr. Hoover. Appellant asserted that he did not have residuals of a left clavicle resection performed in the 1970s. He was unaware at the time of the March 9, 1999 injury that he had injured his shoulder.

By decision dated and finalized on July 24, 2009, an Office hearing representative affirmed the December 12, 2008 denial of surgical reimbursement. The hearing representative noted that appellant did not claim a shoulder injury on his initial claim form. Also, appellant's physicians did not report any left shoulder condition until years after the March 9, 1999 fall. The hearing representative accorded the weight of the medical evidence to Dr. Foster, noting that his July 1, 2008 examination was current on the issue of whether the left shoulder condition was causally related to the accepted injuries. The hearing representative also affirmed the March 31, 2009 denial of subpoena.

LEGAL PRECEDENT -- ISSUE 1

Section 8103 of the Federal Employees' Compensation Act⁶ 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 the Office considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation.⁷ In interpreting section 8103, the Board has recognized that the Office has broad discretion in approving services provided under the Act. The only limitation on the Office's authority is that of reasonableness.⁸ 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.⁹

⁵ Counsel first requested that the Office subpoena Dr. Foster in a December 5, 2008 hearing request made pursuant to a December 2, 2008 decision terminating appellant's compensation. By decisions dated December 9, 2008 and April 30, 2009, the Office set aside the December 2, 2008 decision and remanded the case for further development.

⁶ 5 U.S.C. §§ 8101-8193.

⁷ *Id.* at § 8103; *see Thomas W. Stevens*, 50 ECAB 288 (1999).

⁸ *Mira R. Adams*, 48 ECAB 504 (1997).

⁹ *Daniel J. Perea*, 42 ECAB 214 (1990).

In order to be entitled to reimbursement for medical expenses, a claimant must establish that the expenditures were incurred for treatment of the effects of an employment-related injury.¹⁰ This burden of proof includes providing supporting rationalized medical evidence. Thus, in order for surgery to be authorized, appellant must submit evidence to show that these are for a condition causally related to the employment injury and that these were medically warranted. Both of these criteria must be met in order for the Office to authorize payment.¹¹

ANALYSIS -- ISSUE 1

The Office accepted that, when appellant slipped and fell on March 9, 1999, he sustained a left elbow fracture, cervical sprain, and herniated C5-6 disc requiring anterior discectomy and fusion. In his March 9, 1999 claim form, appellant described only a left elbow injury. At oral hearing, he testified that he was unaware on March 9, 1999 that he injured his left shoulder. Appellant requested that the Office authorize left shoulder arthroscopy and reimburse related medical expenses. The Office denied authorization and reimbursement on the grounds that the medical evidence did not establish a causal relationship between a left shoulder injury or condition and the accepted injuries.

The first medical evidence of record diagnosing a left shoulder condition is the December 22, 2004 report of Dr. Kang, an attending Board-certified neurosurgeon. This was some five years after the accepted injury. Dr. Kang opined that appellant's left shoulder impingement was due to a neurologic imbalance from the accepted cervical disc herniation and because he jammed his shoulder on March 9, 1999. As noted, appellant did not claim to have injured his left shoulder on the March 9, 1999 claim form and at hearing. Also, his attending physicians did not mention a left shoulder injury in reports from March 1999 through 2003.

Dr. Rodosky, an attending Board-certified orthopedic surgeon, diagnosed degenerative arthritis to both shoulders and left rotator cuff tears. He performed a left shoulder acromioplasty and rotator cuff repair on July 26, 2005. Regarding causal relationship, Dr. Rodosky noted in April and May 2005 reports that appellant's left shoulder symptoms developed after the March 9, 1999 fall. However, a physician's opinion supporting causal relationship only because a claimant was asymptomatic before an injury is insufficient to establish causal relationship without supporting rationale.¹² Dr. Rodosky did not adequately explain the effect, if any, of the 1970s acromioclavicular resection on appellant's left shoulder as of March 9, 1999. He did not address how the bilateral nature of the diagnosed degenerative disease support causal relationship to the accepted fall on March 9, 1999. This deficiency further lessens the probative value of his opinion.

Dr. Hoover, an attending Board-certified physiatrist, opined on May 4, 2005 that the left rotator cuff tear was likely related to the accepted injury. However, he did not explain his medical reasoning supporting this assertion and it is speculative. Dr. Hoover's opinion is

¹⁰ *Cathy B. Mullin*, 51 ECAB 331 (2000).

¹¹ *Id.*

¹² *Jaja K. Asaramo*, 55 ECAB 2000 (2004).

therefore insufficiently rationalized to establish a causal relationship between the March 9, 1999 injuries and the rotator cuff tear requiring surgical repair.¹³

The Office obtained a second opinion from Dr. Bailey, a Board-certified orthopedic surgeon, who opined on October 30, 2005 that there was no causal relationship between the accepted injuries and the left shoulder conditions corrected by the July 2005 surgery. It found a conflict between Dr. Bailey and Dr. Hoover regarding the causal relationship of the left shoulder surgery to the accepted injuries. The Act, at 5 U.S.C. § 8123, states that, if there is 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. In accordance with 5 U.S.C. § 8123, to resolve the conflict, the Office obtained an impartial medical opinion from Dr. Foster, a Board-certified orthopedic surgeon.

Dr. Foster submitted an August 10, 2005 report attributing the left shoulder condition to “use, surgery and age” as appellant had similar findings in both shoulders. On July 1, 2008 he opined that, based on a review of the complete medical record, statement of accepted facts and his clinical examination, there was no basis for Dr. Kang’s diagnosis of neck and shoulder syndrome. Dr. Foster explained that the left shoulder conditions and surgery were due to age-related degeneration and the prior 1970s surgery, not the accepted injury. The Board finds that his report is well rationalized and based on a complete and accurate factual and medical history. Dr. Foster’s opinion as impartial medical specialist is therefore sufficient to represent the weight of the medical evidence in this case.¹⁴

Appellant did not establish that the left shoulder surgery was causally related to the accepted March 9, 1999 injuries. His physicians did not set forth medical reasoning explaining how and why the accepted injuries would cause a left shoulder condition necessitating surgical repair. Therefore, the Office did not abuse its discretion in denying authorization for the June 2005 left shoulder surgery.¹⁵

On appeal, counsel contends that Dr. Foster’s opinion is of no probative value as he did not find that March and April 1999 physical therapy notes established work-related bilateral shoulder injuries. The physical therapy notes to which counsel refers were not signed or reviewed by a physician. Therefore, they do not constitute probative medical opinion evidence for the purpose of this case.¹⁶ Counsel also requested that the Office appoint a new second opinion examiner. However, the Board finds no defect in the reports of record requiring further medical development.

¹³ *Deborah L. Beatty*, 54 ECAB 340 (2003).

¹⁴ *J.M.*, 58 ECAB 478 (2007).

¹⁵ *Cathy B. Mullin*, *supra* note 10.

¹⁶ The reports of a physical therapist do not constitute competent medical evidence, as a physical therapist is not a physician as defined by section 8101(2) of the Act. 5 U.S.C. § 8101(2); *Vickey C. Randall*, 51 ECAB 357 (2000).

LEGAL PRECEDENT -- ISSUE 2

Section 8126 of the Act provides that the Secretary of Labor, on any matter within her jurisdiction under this subchapter, may issue subpoenas for and compel the attendance of witnesses within a radius of 100 miles.¹⁷ The implementing regulations provide that a claimant may request a subpoena, but the decision to grant or deny such a request is within the discretion of the hearing representative, who may issue subpoenas for the attendance and testimony of witnesses and for the production of books, records, correspondence, papers or other relevant documents. Subpoenas are issued for documents only if they are relevant and cannot be obtained by other means and for witnesses only where oral testimony is the best way to ascertain the facts.¹⁸ In requesting a subpoena, a claimant must explain why the testimony is relevant to the issues in the case and why a subpoena is the best method or opportunity to obtain such evidence because there is no other means by which the testimony could have been obtained.¹⁹ Section 10.619(a)(1) of the implementing regulations provide that a claimant may request a subpoena only as part of the hearings process and no subpoena will be issued under any other part of the claims process.

To request a subpoena, the requestor must submit the request in writing and send it to the hearing representative as early as possible, but no later than 60 days (as evidenced by postmark, electronic marker or other objective date mark) after the date of the original hearing request.²⁰ The Office hearing representative retains discretion on whether to issue a subpoena. The function of the Board on appeal is to determine whether there has been an abuse of discretion.²¹ Abuse of discretion is generally shown through proof of manifest error, a clearly unreasonable exercise of judgment or actions taken which are clearly contrary to logic and probable deductions from established facts.²²

ANALYSIS -- ISSUE 2

Appellant, through counsel, requested in December 5 and 26, 2008 letters that the Office subpoena Dr. Foster, the impartial medical examiner. Counsel explained that the subpoena was necessary so that he could ask Dr. Foster why he did not find residuals of the accepted conditions. However, counsel did not clearly explain why a subpoena was the best method to obtain further evidence concerning Dr. Foster's opinion, as opposed to obtaining a written statement.

On appeal, counsel asserts that the Office wrongfully denied his request for subpoena. As noted, the Board reviews the hearing representative's decision to determine if there was an

¹⁷ 5 U.S.C. § 8126(1).

¹⁸ 20 C.F.R. § 10.619; *Gregorio E. Conde*, 52 ECAB 410 (2001).

¹⁹ *Id.* at § 10.619.

²⁰ *Id.* at § 10.619(a)(1).

²¹ *See Gregorio E. Conde*, *supra* note 18.

²² *Claudio Vazquez*, 52 ECAB 496 (2001); *Martha A. McConnell*, 50 ECAB 128 (1998).

abuse of discretion. The Board finds that the record does not establish an abuse of discretion in this case. Therefore, the Office's March 31, 2009 decision denying appellant's request for subpoena was appropriate under the facts and circumstances of this case.

CONCLUSION

The Board finds that appellant has not established that he sustained a left shoulder injury causally related to the accepted March 9, 1999 left elbow injury. The Board further finds no abuse of discretion in the denial of reimbursement for left shoulder surgery. The Board further finds no abuse of discretion in the denial of appellant's subpoena request.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated and finalized July 24 and March 31, 2009 are affirmed.

Issued: July 26, 2010
Washington, DC

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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