

the right shoulder as a result of casing and lifting mail at work. She stopped work on April 20, 2010 and has not returned to work.

In a February 1, 2012 operative report, Dr. Laura Ross, a Board-certified orthopedic surgeon, performed arthroscopic right subacromial decompression with debridement of a grade 1 labral tear. Appellant's preoperative diagnosis was impingement syndrome of the right shoulder and her postoperative diagnosis was impingement syndrome with a grade 1 labral tear of the right shoulder. Dr. Ross noted that a subacromial bursectomy was carried out and followed by an evaluation of the rotator cuff which appeared to be completely intact. In a June 14, 2012 medical report, she provided physical examination findings and an impression of status post right shoulder impingement tendinopathy. Dr. Ross opined that appellant could not perform full-duty work. In an October 23, 2012 report, she noted that an electromyogram/nerve conduction velocity study revealed evidence of bilateral carpal tunnel syndrome. A right shoulder magnetic resonance imaging (MRI) scan revealed a moderate-sized articular surface tear of the distal supraspinatus tendon. On physical examination of the right shoulder, Dr. Ross reported limited strength and range of motion. She provided an impression of right rotator cuff tear and recommended a mini arthrotomy with rotator cuff repair. In a general medical and surgical authorization request form dated October 23, 2012 and letter dated January 7, 2013, Dr. Ross requested authorization to perform an open rotator cuff repair of the right shoulder.

OWCP referred appellant for a second opinion examination with Dr. Stanley R. Askin, a Board-certified orthopedic surgeon. In a November 9, 2012 report, Dr. Askin reviewed appellant's history and noted her right upper extremity complaints. He reported essentially normal findings on physical examination with the exception of positive Phalen's and Tinel's signs bilaterally which suggested subclinical carpal tunnel syndrome even though appellant had no symptoms suggestive of this condition. Dr. Askin further reported that she was status post subacromial decompression and debridement of the right shoulder labral tear. He opined that the accepted employment-related conditions were no longer active as Dr. Ross inspected the right cuff arthroscopically and did not find that it was torn. Consequently, with the exception of degenerative changes due to normal aging, there was no rotator cuff tear based on the available evidence. Dr. Askin opined that the accepted labral tear was no longer active as the condition had resolved by the February 1, 2012 surgery. He advised that appellant could no longer perform her rural carrier work duties due to degeneration from her impingement syndrome, but she could perform full-time light-duty work with restrictions set forth in his accompanying work capacity evaluation (Form OWCP-5c) dated November 9, 2012. Dr. Askin opined that additional surgery was not required. He explained that to state otherwise would presume that the previous surgery was performed in a less than medically-standard fashion and he could not make this presumption. Dr. Askin concluded that there was no work-related condition hindering appellant's recovery.

On July 23, 2013 Dr. Ross reported appellant's right shoulder symptoms and examination findings. She provided an impression of right rotator cuff tear of the shoulder with supraclavicular swelling. Dr. Ross reiterated her recommendation that appellant undergo right shoulder surgery to treat this condition.

By letter dated September 10, 2013, OWCP requested that Dr. Askin review Dr. Ross' July 23, 2013 report and provide an opinion regarding whether the suggested right shoulder rotator cuff repair was necessary.

In an addendum report dated October 18, 2013, Dr. Askin related that as he previously noted, it was generally considered illogical to repeat a course of conduct that had not worked previously and to expect a different outcome. If appellant had any condition that could not be treated, then it would be understood that Dr. Ross had been unable to effectuate the desired improvement of her condition. Dr. Askin concluded that the requested surgery was neither medically necessary nor likely to be successful.

On December 23, 2013 OWCP found a conflict in medical opinion between Drs. Ross and Askin as to whether the requested right shoulder surgery was necessary. By letter dated January 22, 2014, it referred appellant, together with a statement of accepted facts, a list of questions, and the medical record, to Dr. Ian B. Fries, a Board-certified orthopedic surgeon, for an impartial medical examination. In a March 17, 2014 report, Dr. Fries provided appellant's history regarding her April 17, 2010 employment injuries and an extensive review of her medical records. He noted that she complained about, among other things, pain and swelling over her right supraclavicular, clavicular, and superior lateral pectoral regions, and burning sensations over her superior scapular area in the right axilla. On physical examination of the neck, right shoulder, and biceps, Dr. Fries reported essentially normal findings with the exception of pain and tenderness on range of motion testing and palpation and in portals and the lateral half of the clavicle, and a significantly limited lift-off test on the right. In addition, appellant pointed out swelling in the right supraclavicular area that could not be appreciated by Dr. Fries. Dr. Fries recommended a new right shoulder MRI scan as the dysfunction she claimed and demonstrated clinically did not match the findings of a September 10, 2012 MRI scan.²

Dr. Fries reviewed right shoulder x-rays dated March 3, 2014 and reported that they were normal. A March 3, 2014 right shoulder MRI scan showed evidence of mild degeneration of the acromioclavicular (AC) joint with a small effusion and some cystic change within the very distal anterior acromion. There was no impingement. Dr. Fries advised that there were clearly degenerative tears of the supraspinatus which were likely worse than on the September 10, 2012 right shoulder MRI scan, but there was no full thickness tear or cuff/muscle retraction. Bone structures were normal. Dr. Fries provided an impression of degenerative rotator cuff tear of the right shoulder, degenerative arthritis of the right AC joint, postarthroscopic subacromial decompression, and debridement of a minor labral tear. He noted that Dr. Ross did not identify a rotator cuff tear upon her February 1, 2012 right shoulder arthroscopy. If the subsequent September 10, 2012 MRI scan was accurate, appellant had developed a new rotator cuff tear that could not be related to the accepted April 17, 2010 employment injury. Dr. Fries noted that rotator cuff tears occurred due to trauma, but they also commonly occurred spontaneously. Minor glenoid labral tears were commonly incidental, often related to degeneration, and not necessarily evidence of trauma. Many were asymptomatic. Dr. Fries noted that a small labral tear was addressed in a prior surgery and any re-tear was not likely related to appellant's remote

² The September 10, 2012 right shoulder MRI scan was normal. There was no evidence of acute fracture, dislocation, or destructive bony lesion. There was also no soft tissue swelling or radiopaque foreign body.

incident. He opined that her right shoulder degenerative rotator cuff tear and degenerative arthritis AC joint were not related to her April 17, 2010 work injury. Dr. Fries found that there were no records of shoulder care from May 28, 2010 to May 18, 2011.³ The rotator cuff was entirely intact during the February 1, 2012 shoulder arthroscopy. An acromioplasty and coracoacromial resection ligament addressed impingement and no impingement was seen on the March 3, 2014 MRI scan. Dr. Fries advised that the current pathology of the rotator cuff and AC joint were most consistent with degeneration and not trauma four years ago. He reviewed appellant's rural carrier duties and responsibilities and opined that while she was permanently disabled from performing her regular work duties such as, loading mail and delivering packages which required lifting more than five pounds with her right upper extremity, she could perform full-time modified-duty work with permanent restrictions. In a March 14, 2014 Form OWCP-5c, Dr. Fries provided her right upper extremity restrictions due to the diagnosed nonemployment-related conditions.

By letter dated April 3, 2014, OWCP requested that Dr. Fries clarify appellant's work restrictions and complete a new Form OWCP-5c.

In a May 22, 2014 letter, Dr. Fries noted that the restrictions, specifically, the lifting restriction, provided in his March 14, 2014 Form OWCP-5c related to appellant's right upper extremity and were based on his review of her rural carrier duties and responsibilities. He recommended that she undergo a functional capacity evaluation (FCE) to determine her work restrictions.

In a June 12, 2014 report, Dr. Ross noted appellant's claim that her continued right shoulder problems were related to her April 17, 2010 employment injury. She reported examination findings and an impression of impingement tendinopathy with partial thickness tears of supraspinatus and infraspinatus tendons of the right shoulder with continued pain. Dr. Ross recommended right shoulder surgery as medically necessary due to the continued pain related to her April 17, 2010 employment injury. In a June 12, 2014 Form OWCP-5c, she reported that appellant was unable to perform her usual job or work eight hours a day with restrictions due to her right shoulder sprain, rotator cuff, and sprain of the right superior glenoid labrum lesion.

A June 30, 2014 FCE report determined that appellant demonstrated an ability to perform, at a minimum, light category work (occasional lift and work of 20 pounds) despite her significant sub-maximum effort in relevant FCE event protocols that were possibly compatible with symptom magnification. Appellant could sort/deliver letters/flat rate envelopes/light packages, collect light mail, review correct address/postage, mark letters if undeliverable, report issues, and perform administrative duties, etc. with certain restrictions.

³ The record indicates that Dr. Michael L. Bernstein, a Board-certified internist, evaluated appellant's right shoulder conditions on May 28, 2010 and her conditions were not evaluated again until May 19, 2011 by Dr. Kenneth P. Heist, a Board-certified orthopedist and second opinion physician, as directed by an OWCP hearing representative who in a March 16, 2011 decision set aside an August 11, 2010 decision and remanded the case to OWCP for further development of the medical evidence.

On July 7, 2014 Dr. Fries reviewed the June 30, 2014 FCE report and agreed with its findings. The report confirmed that appellant was capable of no less than light category work, including occasional lifting and working with 20 pounds even though her less than maximum effort and the FCE results were consistent with symptom magnification resulting in measured limitations that were likely less than her actual physiological capacities. Dr. Fries concluded that objectively, she had the capacity to be employed on a full-time basis. In a Form OWCP-5c dated July 7, 2014, he advised that appellant could not perform her usual work, but she could work eight hours a day with permanent restrictions.

In a July 18, 2014 decision, OWCP denied authorization for right shoulder surgery, finding that the weight of the medical evidence rested with Dr. Fries' impartial medical opinion which established that the requested surgery was not medically necessary due to appellant's accepted April 17, 2010 employment injuries.

By letter dated July 22, 2014, appellant, through counsel, requested an oral hearing before an OWCP hearing representative.

In an October 7, 2014 attending physician's report (Form CA-20), Dr. Ross reiterated her diagnosis of right shoulder rotator cuff tear and indicated with a checkmark her agreement that the diagnosed condition was caused or aggravated by the April 17, 2010 employment injury. She opined that appellant was totally disabled from the date of injury to the present. Dr. Ross reiterated her need to undergo right shoulder surgery. In an October 7, 2014 Form OWCP-5c, she reiterated her prior opinion that appellant was not capable of performing her usual job or working eight hours a day with the noted restrictions due to her right shoulder sprain, rotator cuff, and sprain of the right superior glenoid labrum.

In a February 20, 2015 decision, an OWCP hearing representative affirmed the July 18, 2014 decision denying appellant's request for authorization of surgery. He found that the weight of the medical evidence rested with Dr. Fries' impartial medical opinion.

LEGAL PRECEDENT

Section 8103 of FECA⁴ 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 the monthly compensation.⁵ In interpreting this section of FECA, the Board has recognized that OWCP has broad discretion in approving services provided under FECA. OWCP has the general objective of ensuring that an employee recovers from his or her injury to the fullest extent possible in the shortest amount of time. It therefore has broad administrative discretion in choosing means to achieve this goal. The only limitation on OWCP's authority is that of reasonableness.

⁴ *Id.* at § 8101 *et seq.*

⁵ *Id.* at § 8103.

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.⁶

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.⁷ It is well established that, when a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.⁸

ANALYSIS

OWCP accepted that appellant sustained a right rotator cuff tear, sprain of the right shoulder and upper arm, and a labral tear of the right shoulder while in the performance of duty on April 17, 2010. Dr. Ross, appellant's attending physician, performed arthroscopic right subacromial decompression with debridement of a grade 1 labral tear on February 1, 2012. On October 23, 2012 she requested authorization for appellant to undergo a mini arthrotomy with rotator cuff repair, which she found necessary to treat appellant's right rotator cuff tear. Dr. Ross noted that a right shoulder MRI scan revealed a moderate-sized articular surface tear of the distal supraspinatus tendon. OWCP denied appellant requested authorization for surgery. The Board finds that it did not abuse its discretion by denying authorization for right shoulder surgery.

OWCP determined that a conflict in medical opinion arose between Dr. Ross and Dr. Askin, the second opinion physician, regarding whether the requested right shoulder surgery was causally related to the accepted April 17, 2010 work injuries. To resolve the conflict, it referred appellant, pursuant to section 8123(a) of FECA, to Dr. Fries for an impartial medical examination and an opinion on the matter.

The Board finds that the well-rationalized opinion of Dr. Fries constitutes the special weight of the medical evidence regarding whether the requested mini arthrotomy with rotator cuff repair of the right shoulder would be necessitated by residuals of appellant's accepted April 17, 2010 work injuries.

In his March 17, 2014 report, Dr. Fries accurately described appellant's history and provided a detailed review of her medical records. He reported essentially normal findings on physical examination of the neck, right shoulder, and biceps with the exception of pain and tenderness on range of motion testing and palpation and in portals and the lateral half of the clavicle, and a significantly limited lift-off test on the right. Dr. Fries also reported appellant's claim that she had swelling in the right supraclavicular area, but found that it could not be

⁶ *Daniel J. Perea*, 42 ECAB 214 (1990).

⁷ *Regina T. Pellicchia*, 53 ECAB 155 (2001).

⁸ *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

appreciated. He diagnosed degenerative rotator cuff tear of the right shoulder, degenerative arthritis of the right AC joint, and post-arthroscopic subacromial decompression and debridement of a minor labral tear. Dr. Fries opined that the degenerative rotator cuff tear and degenerative arthritis of the right shoulder were not causally related to the April 17, 2010 employment injuries, and thus, the proposed right shoulder surgery was not warranted.

While Dr. Fries' finding that appellant's degenerative rotator cuff tear of the right shoulder was not caused by the April 17, 2010 employment injuries is contrary to the statement of accepted facts, he explained that there were no current objective findings of a rotator cuff tear as the March 3, 2014 right shoulder x-rays were normal and the right shoulder MRI scan performed on the same day did not show a full-thickness tear, cuff/muscle retraction, or impingement. He further explained that Dr. Ross reported that appellant's rotator cuff was completely intact during the right shoulder surgery she performed on February 1, 2012. In addition, Dr. Fries explained that there were no records indicating that appellant's shoulder was treated from May 28, 2010 to May 18, 2011 and the dysfunction she claimed and demonstrated on examination did not correlate with the September 10, 2012 right shoulder MRI scan which was normal and showed no evidence of acute fracture, dislocation, or destructive bony lesion.

The Board further finds that the additional medical evidence submitted by appellant in response to Dr. Fries' opinion is insufficient to overcome the weight accorded to him as an impartial medical specialist regarding this issue. Dr. Ross' June 12 and October 7, 2014 reports and OWCP-5c forms reiterated her prior opinion that right shoulder surgery was medically necessary due to residuals of appellant's April 17, 2010 employment injuries and that appellant was totally disabled for work due to her right shoulder sprain, rotator cuff, and sprain of the right superior glenoid labrum lesion. While Dr. Ross continued to recommend that appellant have right shoulder surgery, she was on one side of the conflict in medical evidence. The Board has long held that an additional report from a claimant's physician, which essentially repeats earlier findings and conclusions, is insufficient to overcome the weight accorded to an impartial medical specialist's report.⁹ The Board finds that Dr. Fries' opinion that the recommended right shoulder surgery was not medically warranted is entitled to the special weight accorded a referee examiner and represents the weight of the evidence.¹⁰ The evidence establishes that the right shoulder surgery was not medically necessary. OWCP did not abuse its discretion in denying authorization.¹¹

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 denied authorization for surgery.

⁹ *Roger G. Payne*, 55 ECAB 535 (2004).

¹⁰ *Manuel Gill*, 52 ECAB 282 (2001).

¹¹ *L.D.*, 59 ECAB 648 (2008).

ORDER

IT IS HEREBY ORDERED THAT the February 20, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 23, 2015
Washington, DC

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

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

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