U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

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In the Matter of ROXIE G. FOSTER and U.S. POSTAL SERVICE,
POST OFFICE, Venice, CA

*Docket No. 98-1307; Submitted on the Record;*
*Issued May 1, 2000*

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DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
A. PETER KANJORSKI

The issue is whether appellant has established that she sustained a recurrence of disability from October 15 to December 15, 1996 causally related to her September 26, 1986 employment injury.

On January 16, 1987 appellant, then a 40-year-old letter carrier, filed a claim alleging that she sustained a traumatic injury on September 26, 1986 in the performance of duty. The Office of Workers' Compensation Programs accepted appellant's claim for right quadriceps contusion, lumbosacral strain, left shoulder strain, right knee arthritis and adhesive capsulitis of the left shoulder. Appellant returned to limited-duty employment on November 2, 1989 but continued to experience intermittent periods of temporary total disability. The Office accepted that appellant sustained a recurrence of disability on March 1, 1993. Appellant returned to a limited-duty position on July 1, 1993 and accepted a permanent light-duty position with the employing establishment on March 2, 1994.

By decision dated October 13, 1995, the Office denied appellant's request for intermittent wage-loss compensation from January 26 through June 6, 1995 and, in a decision dated April 9, 1996, denied modification of its prior decision.[1]

On October 31, 1996 appellant filed a notice of recurrence of disability on October 15, 1996 causally related to her September 26, 1986 employment injury.

By decision dated March 7, 1997, the Office denied appellant's claim on the grounds that the evidence failed to establish that she sustained a recurrence of disability.

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[1] By decision dated November 16, 1993, the Office granted appellant a schedule award for a 19 percent permanent impairment of the left arm and a 6 percent permanent impairment of the right leg.

The Board has duly reviewed the case record in the present appeal and finds that the case is not in posture for decision due to a conflict in medical opinion.

Where an employee, who is disabled from the job he or she held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence establishes that the employee can perform the light-duty position, the employee has the burden to establish by the weight of the reliable, probative and substantial evidence, a recurrence of total disability and to show that he or she cannot perform such light duty. As part of this burden, the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the light-duty job requirements.[2]

In the present case, appellant sustained right quadriceps contusion, lumbosacral strain, left shoulder strain, right knee arthritis and adhesive capsulitis of the left shoulder due to her September 26, 1986 employment injury. Appellant subsequently returned to work in a limited-duty capacity. There is no evidence in the record establishing any change in the nature and extent of appellant's light-duty position as a cause of her claimed disability from October 15 to December 15, 1996.

In an office visit note date October 15, 1996, Dr. Clarence L. Shields, a Board-certified orthopedic surgeon, diagnosed myofascial pain and recommended that appellant stop work for three weeks. In a report dated October 29, 1996, Dr. Shields diagnosed an employment-related aggravation of appellant's impingement syndrome and found that she was disabled for one month.

In a response to the Office dated October 29, 1996, Dr. Shields related:

> "Medically [appellant] does have an impingement syndrome and periodically has inflammation of the rotator cuff which is what she has at the present time.
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> "She also has cervical osteoarthritic changes in her neck and does have some cervical radiculitis [for] which she is undergoing treatment. The shoulder is painful, as outlined in our history and this is entirely related to her job as a postal clerk."

Dr. Shields diagnosed an aggravation of her impingement syndrome and opined that appellant was "totally disabled at the present time for approximately another month because of the neck and the shoulder producing her symptom complex."

In a report dated November 13, 1996, Dr. William H. Dillin, a Board-certified orthopedic surgeon and appellant's attending physician, noted her complaints of back and right leg pain, diagnosed spondylolisthesis and opined that she was disabled for three weeks.

In a supplemental report dated November 19, 1996, Dr. Dillin diagnosed cervical radiculitis and found that appellant should remain off work until December 4, 1996.

[2] *Terry R. Hedman*, 38 ECAB 222 (1986).

In a letter to the Office dated December 3, 1996, Dr. Shields opined:

> "[Appellant] is totally disabled because of her left shoulder syndrome. It is very common for patients with chronic impingement syndrome and loss of motion to start to increase the movement of their scapula instead of the shoulder joint and as a result will then develop cervical radicular symptoms."

Dr. Shields opined that appellant's current limited-duty employment was appropriate for her physical limitations. He stated:

> "[Appellant's] job restrictions have not contributed to her increase in disability. Her disability is due to the natural progression of the impingement syndrome in patients who develop adhesive capsulitis or loss of motion of the left shoulder. The loss of motion recorded by this examiner on her initial visit is significantly different than when she had her limitations placed on her in 1994. The gradual decrease in the range of motion is consistent with increasing pain and this is due to the natural progression of her disease process."

In an office visit note dated December 11, 1996, Dr. Dillin found that appellant could return to work on December 16, 1996.[3]

In a report dated February 6, 1997, Dr. Russell Compton, a Board-certified orthopedic surgeon and Office referral physician, discussed appellant's history of injury, reviewed her medical records and listed findings on physical examination. He diagnosed "probable ischemic necrosis greater tuberosity humerus, left shoulder per MRI [magnetic resonance imaging] September 9, 1996; adhesive capsulitis left shoulder; facet arthropathy L3-4 and L4-5 and grade I spondylolisthesis, central stensosis, and disc degeneration L5-S1 per MRI November 21, 1996[; and] degenerative arthritis both knees." He stated:

> "With regard to the adhesive capsulitis of the left shoulder, the shoulder possesses less stability and less mechanical protection than any other large joint in the body, and adhesive capsulitis (frozen shoulder) is a condition which may have an insidious onset, may follow a direct or indirect local trauma, or may be a sequel to injuries of the distal part of the limb. After periods of pain and dysfunction, the inflammatory process may subside with resolution of the adhesions, disappearance of pain and restoration of muscle activity…."

[3] In a report dated December 31, 1996, Dr. Shields noted that appellant had returned to work and recommended therapy for cervical radiculitis.

Dr. Compton further related:

> "The findings of degenerative changes in the lumbar spine and knees are preexisting conditions, supported by previous radiographic studies. Specifically, the minimally degenerative arthritis of the knee joints predated the work injury of September 26, 1988.
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> "The diagnosed conditions in the left shoulder are medically connected to the work injury of September 26, 1986 initially by direct cause. Consequently, the left shoulder was aggravated by activities using the left upper extremity. This aggravation is temporary and is expected to resolve with appropriate treatment. It is my opinion that with good response to treatment, full range of motion of the shoulder would be restored in approximately six months. As previously indicated, the pathologic changes may remain static for a very long period of time with persistent pain and dysfunction."

He found that objective findings on MRI and examination were consistent with appellant's subjective complaints of pain. In response to the question posed by the Office regarding whether appellant was able to perform her employment duties from October 15 through December 15, 1996, Dr. Compton stated that appellant "is capable of performing" her limited-duty employment.

The Board finds that there is a conflict in the medical evidence between Drs. Shields and Dillin, appellant's attending physicians and Dr. Compton, an Office referral physician, regarding whether appellant sustained a recurrence of disability from October 15 to December 15, 1996 causally related to her September 26, 1986 employment injury. Section 8123(a) of the Federal Employees' Compensation Act,[4] provides in pertinent part: "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."[5]

Consequently, the case must be remanded so that the Office may refer appellant, together with the case record and a statement of accepted facts, to an appropriate Board-certified specialist for a rationalized medical opinion regarding whether she sustained an employment-related recurrence of disability from October 15 to December 15, 1996. After such development as it deems necessary, the Office shall issue a *de novo* decision.

[4] 5 U.S.C. §§ 8101-8193.

[5] 5 U.S.C. § 8123(a).

The decision of the Office of Workers' Compensation Programs dated March 7, 1997 is set aside and the case is remanded for further proceedings consistent with this opinion by the Board.

Dated, Washington, D.C.
May 1, 2000

Michael J. Walsh
Chairman

David S. Gerson
Member

A. Peter Kanjorski
Alternate Member