United States Department of Labor
Employees' Compensation Appeals Board

B.S., Appellant	)	
and	)	**Docket No. 11-1292**
	)	**Issued: January 19, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Spartanburg, SC, Employer	)	

Appearances:
Kelly Pope Karow, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 19, 2011 appellant, through her representative, filed a timely appeal of a February 11, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP) denying modification of its December 7, 2007 wage-earning capacity determination. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant established that OWCP's December 7, 2007 wage-earning capacity decision should be modified.

FACTUAL HISTORY

OWCP accepted appellant's April 1, 2003 traumatic injury claim (File No. xxxxxx869) for cervical strain and permanent aggravation of cervical spondylosis without myelopathy. It

[1] 5 U.S.C. § 8101 *et seq.*

also accepted her October 8, 2005 occupational disease claim (File No. xxxxxx802) for bilateral shoulder impingement syndrome. On December 19, 2005 OWCP combined appellant's claims, with File No. xxxxxx802 serving as the master file.

On November 10, 2006 Dr. Y. Eugene Mironer, a treating physician, released appellant to return to work full time with permanent restrictions, including pushing, pulling a maximum of 13 pounds and lifting a maximum of 10 pounds. Appellant was also restricted from reaching above shoulder level with the left arm, from standing more than 15 minutes at a time, from walking more than 30 minutes or from sitting longer than 60 minutes.

Appellant accepted a limited-duty position as a modified sales, service and distribution associate and returned to work on January 20, 2007. The physical requirements of the position were within her permanent restrictions as delineated by Dr. Mironer.

In a decision dated December 7, 2007, OWCP found that appellant's actual earnings in the position of modified sales, service and distribution associate fairly and reasonably represented her wage-earning capacity. As she had demonstrated the ability to perform the duties of the job for more than two months, this position was considered suitable. Because her actual earnings met or exceeded the current wages of the job held when injured, it reduced her wage-loss benefits to zero.

On December 21, 2007 appellant submitted a claim for compensation for the period December 8 through 21, 2007.[2]

Appellant submitted reports from Dr. Stephen Kanna, a treating physician. In a December 11, 2007 report, Dr. Kanna noted appellant's continued bilateral shoulder pain, left worse than right. On examination, appellant had pain in pure abduction with Neer and Hawkins impingement test. Dr. Kanna recommended an arthroscopy, subacromial decompression and AC joint resection. He also modified appellant's restrictions to reflect that she could work only four hours per day, with a one-pound lifting restriction. On January 21, 2008 Dr. Kanna noted her complaints of worsening shoulder pain and numbness in both hands. On examination, appellant was unable to move her left shoulder much due to severe pain. Dr. Kanna stated that she was not capable of working at that time.

In a letter dated February 6, 2008, OWCP informed appellant that the evidence of record was insufficient to establish her disability during the claimed period. It informed her that the December 7, 2007 loss of wage-earning capacity decision would remain in effect unless she could establish that the original decision was in error, her medical condition has changed or she had been vocationally rehabilitated. On February 10, 2008 appellant informed OWCP that her condition had worsened in December 2007, and that in January 2008 she experienced increased stiffness in her neck and numbness in her hands.

In a decision dated March 31, 2008, OWCP denied appellant's claim for compensation for the period December 3 through 21, 2007. It found that she had failed to provide medical

[2] Appellant filed subsequent claims for wage loss for various periods beginning December 3, 2007.

evidence establishing disability during that period or to support modification of the December 7, 2007 loss of wage-earning capacity decision.

By decision dated April 4, 2008, OWCP denied modification of the December 7, 2007 wage-earning capacity decision, finding that the medical evidence was insufficient to support a worsening of her medical condition such that she could no longer perform the duties of her modified job. It further found that she was not entitled to wage-loss compensation beginning January 6, 2008.

On April 9, 2008 appellant requested a review of the written record.

By decision dated July 22, 2008, an OWCP hearing representative affirmed the March 31 and April 4, 2008 decisions. He found that appellant had not met her burden to establish that she sustained a material worsening of her neck or shoulder condition that would warrant modification of the December 7, 2007 wage-earning capacity decision or payment of compensation for partial or total disability beginning December 3, 2007.

Appellant was treated by Dr. Marco A. Rodriguez, a treating physician. In a report dated September 16, 2009, Dr. Rodriguez provided a history of injury and treatment, noting that appellant complained of neck pain radiating to the periscapular areas and down into the left shoulder, with paresthesias in the ulnar side of her forearm up to her elbows. He stated that her pain had increased significantly in the past year. On examination, appellant was unable to flex her neck past neutral. Extension was about five degrees. Dr. Rodriguez noted severe spasm in her sternocleidornastoid insertion on her clavicle as well as bilateral trapezius muscles and significant tenderness midline thoracic and bilateral trapezius muscles. There was decreased grip strength, as well as decreased sensibility on the left in the C8 distribution, ulnar forearm, ulnar digits and the left radial hand. Neck range of motion was severely limited as noted with flexion-extension and lateral rotation at 5 to 10 degrees and lateral bending of about 10 degrees. X-rays showed some spondylotic changes in the bilateral facet joints at C5-6, worse at C6-7 and less so at C5-6. C5-6 and C6-7 showed 50 percent loss of disc height with anterior and posterior osteophytes. C4-5 also had osteophytic changes posteriorly and anteriorly. A September 1, 2009 computerized tomography (CT) scan of the thoracic spine revealed marked left-sided scoliosis. There was a loss of kyphotic curvature in the upper thoracic spine, and some degenerative arthropathy of the costovertebral joints at T5-6 through T7-8 on the left side. There was also evidence of advanced degenerative disease at C6-7 causing canal stenosis with osteophytosis. A June 4, 2009 magnetic resonance imaging (MRI) scan revealed multilevel degenerative disc disease, some anterior abutment of the spinal cord at C6-7, minor bulging at C5-6, mild foraminal stenosis at C4-5 on the left, a large posterior disc osteophyte complex with bilateral foraminal stenosis and central stenosis at C6-7, desiccation at all levels of the cervical spine except for C3-4 and definite impingement on the spinal cord. In an October 22, 2009 addendum, Dr. Rodriguez indicated that appellant should be working reduced hours. On November 18, 2009 he opined that appellant would benefit from single-level fusion surgery at C6-7.

In a letter dated November 4, 2009, appellant stated that her physician had restricted her to working only four hours per day. She requested a review of her case in light of the recent nerve conduction test conducted on November 2, 2009 and Dr. Rodriguez' report.

In a January 4, 2010 report, Dr. Rodriguez provided examination findings and diagnosed cervical spondylosis without myelopathy and advanced degeneration at C4-5, C5-6 and C6-7, which he opined were causally related to her accepted injury. He recommended removing appellant from work, due to debilitating pain and surgery to address all levels.

By decision dated January 26, 2010, OWCP denied modification of the December 7, 2007 loss of wage-earning capacity decision on the grounds that the medical evidence was insufficient to establish a worsening of appellant's condition. It further found that she was not entitled to wage-loss compensation for total disability after January 6, 2008.

On January 27, 2010 Dr. Rodriguez opined that appellant's symptoms had worsened due to her accepted injury. He stated that, although there was no radiographic evidence of a worsening of the herniated disc, the pain associated with the condition had definitely worsened. He noted that radiographic evidence often does not correlate with a patient's symptoms.

OWCP referred appellant to Dr. Harrison Latimer, a Board-certified orthopedic surgeon, for an examination and an opinion regarding appellant's work capacity and need for surgery. In a report dated March 17, 2010, Dr. Latimer diagnosed cervical spondylosis without myelopathy, which would not benefit from surgery. He opined that appellant had experienced a temporary aggravation of a preexisting condition, which had resolved by September 18, 2003, at which time it would have returned to the normal progression of her underlying pathology. On examination, there was no evidence of spasm to palpation of the paracervical musculature, trapezius region. Appellant had full range of motion of the right shoulder. There was limited motion in the left shoulder on elevation, with full external rotation. Recent MRI scans showed mild degenerative changes at all levels other than C6-7, which had a nonimpinging bulge. Dr. Latimer stated that the findings on a recent MRI scan were consistent with the October 23, 2001 MRI scan report. Appellant's left shoulder showed some slight tendinopathy changes, but no evidence of bursitis or hypertrophic acromion. Dr. Latimer opined that appellant was not able to return to work as a sales, service and distribution associate, as she had chronic pain syndrome requiring significant narcotic pain medication. He stated that appellant's work restrictions should be consistent with the results of the September 2006 functional capacity evaluation. In an April 28, 2010 addendum, Dr. Latimer opined that appellant did not have bilateral impingement syndrome of the shoulder, based on normal MRI scan findings, and that his restrictions were provided for her preexisting condition.

On March 10, 2010 Dr. Rodriguez stated that appellant's symptoms were worsening, even though she was not working. He reiterated that she required surgery to alleviate her condition.

OWCP found a conflict in medical opinion between Dr. Rodriguez and the second opinion physician, Dr. Latimer, regarding appellant's work capacity as it related to her accepted condition. It referred appellant, together with a statement of accepted facts and the medical record, to Dr. William Lehman, Jr., a Board-certified orthopedic surgeon, in order to resolve the conflict. OWCP asked Dr. Lehman to provide a diagnosis and an opinion as to whether the condition was medically connected to the accepted injury. Dr. Lehman was also asked whether the condition was permanent and, if so, what material change has occurred to alter the course of her underlying disease.

In a report dated September 28, 2010, Dr. Lehman reviewed the medical record and provided examination findings. He found diffuse tenderness along the paraspinals extending into the trapezii bilaterally, left greater than right, and diffuse myofascial tenderness and some tightness subjectively of the paraspinals in particular extending down into the posterior trapezii and elevator to the medial scapular borders. Cervical range of motion showed flexion of 30 degrees, extension 20 degrees, left rotation 30 degrees, right rotation 40 degrees with lateral bending at approximately 25 degrees bilaterally. The left shoulder had some popping on manipulation with some impingement signs and questionably positive O'Brien sign. There was slight popping on manipulation of the right shoulder. The AC joints were somewhat hypertrophic but minimally tender. Range of motion testing of the left shoulder revealed flexion/extension 90/40 degrees; abduction/adduction 80/30 degrees; and internal/external rotation 90/80 degrees. ROM testing of the right shoulder revealed flexion/extension 160/62 degrees; abduction/adduction 140/60 degrees; and internal/external rotation 90/90 degrees. Neurologic function at the upper extremity showed some slight weakness on the left arm as compared to the right, with slightly weak grip and biceps function. Biceps and triceps were 4+-5 on the left. There was no specific sensory deficit to light touch or pinprick, although there were complaints of some paresthesias in the ring and small finger of both hands, more on the left.

Dr. Lehman diagnosed multilevel cervical spondylosis with mild stenosis, particularly at C6-7 without myelopathy or radiculopathy; cervical thoracic myofascial pain syndrome; left greater than right shoulder impingement syndrome, with rotator cuff tendinopathy and arthropathy. He stated that appellant's primary issue was myofascial pain syndrome predominantly involving the neck, with an aggravation of diffuse cervical degenerative disc disease, leading to ongoing radiculitis or nerve irritation without evidence of any myelopathy or true radiculopathy. Dr. Lehman opined that appellant's shoulder problem related to impingement, predominantly due to the AC arthropathy and the rotator cuff tendinopathy. He further opined, to a reasonable degree of medical certainty, that the cervical degenerative disc disease and the rotator cuff tendinopathy and AC joint degenerative changes were directly caused by the work injury, or at least represented aggravation of a previously relatively quiescent problem. In terms of the myofascial problems, Dr. Lehman opined that the injuries created sufficient muscle and ligamental stress and strain, with irritation of the adjacent neurologic structures, leading to loss of fluidity of movement of the myofascial levels used in the process of normal neck motion, leading to the stiffness and chronic pain syndrome. He also found progression in the cervical degenerative disc disease and cervical stenosis, based on serial MRI scan. Dr. Lehman stated that, contrary to Dr. Latimer's suggestions, he did not believe that an aggravation such as appellant's could simply revert back to a normal level of deterioration over time. Rather, the aggravation likely led to more rapid progression of symptoms than would otherwise have occurred, and most likely would do so on a permanent basis. Regarding the left shoulder, although the extent of tendinopathy at the rotator cuff cannot be measured quantitatively, the AC arthropathy with impingement, as well as the deterioration in the tendon structure, combined to create a progressive and permanent aggravation over time. Dr. Lehman opined that anterior cervical fusion would not be substantially helpful in relieving the ongoing symptoms.

Dr. Lehman opined that appellant's current level of function was at most sedentary and, therefore, it would appear that she would not be able to return back to gainful employment at the employing establisment, presumably in any capacity. Appellant's continued residuals from the

injury included pain, weakness, and stiffness at both the left shoulder and cervical spine and in terms of gainful employment, her prognosis for return to anything but sedentary activity was quite limited.

In a work capacity evaluation dated September 28, 2010, Dr. Lehman increased appellant's work restrictions to include: no pushing or pulling; lifting up to three pounds, one hour a day; no reaching with the left arm; sitting, walking, standing no more than 30 minutes; rarely reaching above the shoulder bilaterally; operating a motor vehicle 15 minutes at a time; and limited bending, stooping, climbing and kneeling.

On November 22, 2010 appellant requested reconsideration of the January 26, 2010 decision. Counsel argued that the medical evidence established that appellant's consecutive periods of disability stemmed from her accepted injury as of January 2008.

By decision dated February 11, 2011, OWCP denied modification of its January 26, 2010 decision on the grounds that appellant had not provided sufficient evidence to support that she sustained a material worsening of her work-related medical condition on or after January 6, 2008, which rendered her incapable of performing the duties of a modified sales, service, and distribution associate. The claims examiner reviewed Dr. Lehman's referee report, noting his reference to current diagnostic testing which did not show current material worsening of appellant's conditions; his recommendation against cervical surgery; and his opinion that appellant had the capacity to work at the sedentary level and therefore was not totally disabled from all work. OWCP discounted Dr. Lehman's assumption that appellant could not return to the employing establishment with her current restrictions, noting that prior to her claimed recurrence of disability from work, appellant was being accommodated by the employing establishment in a permanent modified position that was consistent with sedentary work, and there is no evidence that such accommodation would not have continued if she had not stopped working.

LEGAL PRECEDENT

A wage-earning capacity decision is a determination that a specific amount of earnings, either actual earnings or earnings from a selected position, represents a claimant's ability to earn wages.[3] Compensation payments are based on the wage-earning capacity determination and it remains undisturbed until properly modified.[4]

Once the wage-earning capacity of an injured employee is determined, a modification of such determination is not warranted unless there is a material change in the nature and extent of the injury-related condition, the employee has been retrained or otherwise vocationally

[3] *See* 5 U.S.C. § 8115 (determination of wage-earning capacity).

[4] *Sharon C. Clement*, 55 ECAB 552 (2004).

rehabilitated or the original determination was, in fact, erroneous.[5] The burden of proof is on the party attempting to show a modification of wage-earning capacity determination.[6]

Section 8123(a) of FECA provides 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.[7] In situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background must be given special weight.[8]

When OWCP obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, it must secure a supplemental report from the specialist to correct the defect in his original report.[9]

ANALYSIS

Following OWCP's December 7, 2007 loss of wage-earning capacity decision, appellant alleged that her accepted condition had worsened such that she was unable to perform the duties of her light-duty position on which the decision was based.[10] Accordingly, she submitted claims for wage-loss compensation and requested a modification of the December 7, 2007 determination. The Board finds that this case is not in posture for a decision due to an unresolved conflict in medical opinion.

Appellant's treating physicians, Dr. Kanna and Dr. Rodriguez, opined that her neck and shoulder conditions had worsened significantly and that she was unable to work in her modified position. OWCP's second opinion physician, Dr. Latimer, opined on the other hand that appellant had experienced only a temporary aggravation of a preexisting condition, which had resolved by September 18, 2003, at which time it would have returned to the normal progression of her underlying pathology. He recommended work restrictions for her preexisting condition. OWCP found a conflict in medical opinion between appellant's treating physicians and Dr. Latimer and referred appellant to Dr. Lehman for an impartial medical examination in order to resolve the conflict. The Board finds, however, that Dr. Lehman's report is insufficiently rationalized to resolve the conflict in medical opinion.

[5] *Harley Sims, Jr*., 56 ECAB 320 (2005); *Tamra McCauley*, 51 ECAB 375, 377 (2000).

[6] *Id*.

[7] 5 U.S.C. § 8123(a); *see E.H*., Docket No. 08-1270 (issued July 8, 2009).

[8] *V.G*., 59 ECAB 635 (2008).

[9] *Raymond A. Fondots*, 53 ECAB 637, 641 (2002); *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232 (1988); *Ramon K. Ferrin, Jr.* 39 ECAB 736 (1988).

[10] The Board notes that appellant did not allege that the original loss of wage-earning capacity decision was erroneous, nor was any evidence presented that appellant had been rehabilitated.

In his September 28, 2010 report, Dr. Lehman provided examination findings and diagnosed multilevel cervical spondylosis with mild stenosis, particularly at C6-7 without myelopathy or radiculopathy; cervical thoracic myofascial pain syndrome, left greater than right shoulder impingement syndrome, with rotator cuff tendinopathy and arthropathy. He opined that appellant had experienced a permanent aggravation and progression of diffuse cervical degenerative disc disease, leading to ongoing radiculitis or nerve irritation. Dr. Lehman opined that appellant's shoulder problem related to impingement, predominantly due to the AC arthropathy and the rotator cuff tendinopathy and that the cervical degenerative disc disease and the rotator cuff tendinopathy and AC joint degenerative changes were directly caused by the work injury, or at least represented aggravation of a previously relatively quiescent problem. He stated that, contrary to Dr. Latimer's suggestions, he did not believe that an aggravation such as appellant's could simply revert back to a normal level of deterioration over time. Regarding the left shoulder, Dr. Lehman opined that the AC arthropathy with impingement, as well as the deterioration in the tendon structure, combined to create a progressive and permanent aggravation over time. He opined that appellant's current level of function was at most sedentary and that therefore she would not be able to return to gainful employment at the employing establishment in any capacity, and her prognosis for return to anything but sedentary activity was quite limited. Dr. Lehman, then, increased her restrictions to preclude any pushing, pulling or reaching with the left arm; lifting any more than three pounds, one hour a day; or sitting, walking or standing more than 30 minutes.

The Board finds that OWCP's reliance on Dr. Lehman's opinion in denying modification of the December 7, 2007 loss of wage-earning capacity decision was misplaced. The claims examiner found that appellant had not provided sufficient evidence to support that she sustained a material worsening of her work-related medical condition that rendered her incapable of performing the duties of a modified sales, service and distribution associate. But Dr. Lehman specifically stated that she would not be able to return to gainful employment at the employing establishment in any capacity as a result of her accepted injury. Additionally, he provided work restrictions that were not consistent with the requirements of appellant's modified position. Dr. Lehman opined that appellant's work-related injury constituted a permanent aggravation of a preexisting injury, which resulted in a more rapid progression of symptoms than would otherwise have occurred, and most likely would do so on a permanent basis.

Although Dr. Lehman concluded that appellant's neck and shoulder conditions had worsened such that she was unable to perform the duties of her modified job, he did not provide an opinion as to when appellant's condition had deteriorated to that degree, or the duration of any employment-related disability.

In a situation where OWCP secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from such specialist requires clarification or elaboration, OWCP may not regard the opinion as of no particular significance, particularly where it is favorable to the claimant. Under such circumstances, it has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in his original report.[11] The case will be remanded to OWCP for a supplemental

[11] *See Richard L. West*, 30 ECAB 691 (1979); *April Ann Erickson*, 28 ECAB 336 (1977).

opinion from Dr. Lehman, which provides clarification and elaboration. If Dr. Lehman is unwilling or unable to clarify and elaborate on his opinion, the case should be referred to another appropriate impartial medical specialist. After such further development as OWCP deems necessary, an appropriate decision should be issued.

CONCLUSION

The Board finds that this case is not in posture for a decision, as there exists an unresolved conflict in the medical opinion evidence.

ORDER

IT IS HEREBY ORDERED THAT the February 11, 2011 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further development consistent with this decision.

Issued: January 19, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

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

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