United States Department of Labor
Employees' Compensation Appeals Board

D.M., Appellant	)	
and	)	**Docket No. 14-353**
	)	**Issued: April 21, 2014**
DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SECURITY ADMINISTRATION, Ronkonkoma, NY, Employer	)	

Appearances:
Thomas S. Harkins, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 13, 2013 appellant, through his attorney, filed a timely appeal from a June 18, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 met his burden of proof to establish that his partial thickness tear and effusion of the left shoulder are causally related to his accepted July 31, 2004 employment injury.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been on appeal before the Board. In a February 6, 2007 decision, the Board affirmed OWCP's decision, in part, and set aside the decision, in part, as to its refusal to accept additional conditions, due to an unresolved conflict in medical opinion evidence.[2] In a decision dated March 16, 2009, the Board set aside an April 22, 2008 OWCP decision denying appellant's request to expand his claim. The Board found that the conflict in medical opinion remained unresolved due to the insufficiency of the referee physician's report.[3] In an October 19, 2011 decision, the Board set aside OWCP's September 10, 2010 decision denying appellant's request to expand his claim, finding that the referee's opinion was insufficiently rationalized to resolve the medical conflict.[4] The case was remanded for a supplemental report from the impartial medical examiner. In a February 7, 2013 decision, the Board set aside OWCP's February 23, 2012 OWCP decision, which denied appellant's request to expand his claim. The Board found that the impartial specialist's supplemental report was insufficient to resolve the medical conflict regarding conditions causally related to the accepted injury. The Board directed OWCP to refer appellant to a new impartial medical examiner.[5] The facts and history contained in the prior appeals are incorporated by reference.

On March 25, 2013 OWCP referred appellant to Dr. Edmunde Stewart, a Board-certified orthopedic surgeon, to resolve the medical conflict regarding which conditions were causally related to his accepted work injury. In an April 16, 2013 report, Dr. Stewart noted appellant's history and treatment. Cervical spine examination showed no evidence of muscle spasm and no areas of objective tenderness. Forward flexion of the cervical spine was 45 degrees, extension 45 degrees and rotation to the left and right 60 degrees. Upper extremity power was normal and appellant had excellent grasp in both hands with mildly diminished sensation to the pulp of the index finger in the left hand. Left shoulder forward flexion was to 145 degrees, abduction to 100 degrees while external rotation was diminished by 20 degrees and internal rotation was mildly diminished.

Dr. Stewart noted that an October 1, 2004 cervical spine magnetic resonance imaging (MRI) scan showed multiple posterior disc herniations at C3-4, C4-5 and C6-7, straightening of the cervical lordosis indicative of reflex muscle spasm. A November 3, 2004 left shoulder MRI scan showed hypertrophic changes in the acromioclavicular (AC) joint while September 2, 2004 cervical spine x-rays revealed minimal degenerative narrowing at C5-6 and C6-7. Dr. Stewart diagnosed status post cervical sprain; left-sided cervical radiculitis; status post left shoulder strain; degenerative disc disease and degenerative arthritis of the cervical spine, "which would antedate the incident of July 31, 2004"; impingement syndrome, left shoulder; and restrictive tendinitis and capsulitis of the left shoulder. He opined that on July 31, 2004 appellant had a cervical sprain coupled with an episode of cervical radiculitis radiating down his left arm to the

[2] Docket No. 06-1328 (issued February 6, 2007).

[3] Docket No. 08-2016 (issued March 16, 2009).

[4] Docket No. 11-851 (issued October 19, 2011).

[5] Docket No. 12-1734 (issued February 7, 2013).

tip of his left index finger and left shoulder sprain with impingement syndrome and tendinitis. Appellant had no evidence of persistent muscle spasm and no neck pain complaints. He opined that the only cervical residual causally related to the July 31, 2004 incident, with "a fair degree of medical certainty, appear to be the hypoesthesia or diminished sensation to the pulp of his left index finger." Dr. Stewart added that there was "no doubt that [appellant] suffered from a left shoulder sprain with development of impingement syndrome and he now has restrictive tendinitis or capsulitis in the left shoulder region with a moderate amount of restricted motion. This, I would tend not to classify [appellant's diagnosis] as internal derangement of the left shoulder, but rather an alteration in the structures surrounding the left shoulder joint." He opined that, from the onset appellant had cervical muscle spasm but, at present, there was no objective evidence of any restricted cervical spine motion. Dr. Stewart explained that there was a direct relationship between the cervical sprain when appellant checked three 90-pound bags and the cervical muscle spasm, which was present earlier. He indicated that the cervical sprain aggravated the underlying degenerative disc disease and degenerative arthritis and led to muscle spasm. Dr. Stewart explained that the muscle spasm was temporary and no longer present. He advised that appellant did "persist with findings of hypoesthesia of the tip of the left index finger." Dr. Stewart related that the incident of July 31, 2004 caused a sprain of the left shoulder, which led to a "picture of impingement syndrome and restrictive tendinitis or restrictive capsulitis of the left shoulder. The current condition in [appellant's] left shoulder is related to the traumatic incident of [July 31, 2004] materially and substantially affected by underlying and preexistent hypertrophic changes in the [AC] joint with an acromial spur which would antedate the incident of [July 31, 2004]." He advised that moving the three 90-pound bags directly caused the subsequent condition in appellant's left shoulder and opined that the current condition in his left shoulder was causally related to the aggravation of his underlying arthritic changes, which were present in the left shoulder joint. Dr. Stewart opined that the aggravation in the left shoulder joint and the changes currently seen were permanent. He opined that the left shoulder MRI scan study showed no evidence of a partial thickness tear. Dr. Stewart advised that there was no evidence on examination, x-ray or MRI scan of an effusion of the left shoulder. He noted that appellant had evidence of moderate disability, permanent in nature, causally related to a permanent aggravation of his preexisting underlying changes in his cervical spine and left shoulder. Dr. Stewart indicated that appellant was capable of light duty with no lifting, pushing or pulling over 25 pounds and no overhead lifting with his left arm.

On June 18, 2013 OWCP accepted the claim for cervical muscle spasm and internal derangement of the left shoulder.[6]

In a separate June 18, 2013 decision, OWCP denied appellant's claim for a partial thickness tear of the left shoulder and effusion of the left shoulder. It found that Dr. Stewart's report established that these conditions were not causally related to the employment injury.

[6] OWCP noted that all of the accepted conditions included: cervical muscle spasm; internal derangement of the left shoulder; cervical strain; cervical radiculitis, left shoulder strain, temporary aggravation of cervical herniated discs; cervical disc disease and impingement syndrome of the left shoulder.

LEGAL PRECEDENT

When an employee claims that he or she sustained an injury in the performance of duty, the employee must submit sufficient evidence to establish that he or she experienced a specific event, incident or exposure occurring at the time, place and in the manner alleged. The employee must also establish that such event, incident or exposure caused an injury. Once an employee establishes an injury in the performance of duty, he or she has the burden of proof to establish that any subsequent medical condition or disability for work, which the employee claims compensation, is causally related to the accepted injury.[7] To meet his or her burden of proof, an employee must submit a physician's rationalized medical opinion on the issue of whether the alleged injury was caused by the employment incident.[8] Medical conclusions unsupported by rationale are of diminished probative value and are insufficient to establish causal relation.[9]

ANALYSIS

The Board finds that appellant has not established that a partial thickness tear or effusion of the left shoulder is attributable to the July 31, 2004 work injury.

OWCP accepted the claim for: cervical muscle spasm; internal derangement of the left shoulder; cervical strain; cervical radiculitis, left shoulder strain, temporary aggravation of cervical herniated discs; cervical disc disease and impingement syndrome of the left shoulder. It denied appellant's claims for partial thickness tear of the left shoulder and effusion. In its most recent prior decision, the Board found that there remained an unresolved conflict in the medical opinion evidence regarding what conditions were employment related and directed that he be referred to a new impartial specialist. On remand, OWCP referred appellant to Dr. Stewart, a Board-certified orthopedic surgeon to resolve the conflict.

Section 8123(a) of FECA[10] provides, 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.[11]

In his April 16, 2013 report, Dr. Stewart diagnosed status post cervical sprain; left-sided cervical radiculitis; status post left shoulder strain; degenerative disc disease and degenerative arthritis of the cervical spine, "which would antedate the incident of July 31, 2004"; impingement syndrome, left shoulder; and restrictive tendinitis and capsulitis of the left shoulder. He opined that on July 31, 2004 appellant sustained a cervical sprain coupled with an episode of cervical radiculitis radiating to the tip of his left index finger and a left shoulder sprain with

[7] *See Leon Thomas*, 52 ECAB 202 (2001).

[8] *See Gary J. Watling*, 52 ECAB 278 (2001).

[9] *Albert C. Brown*, 52 ECAB 152 (2000).

[10] 5 U.S.C. §§ 8101-8193.

[11] *Id*. at § 8123(a).

impingement syndrome and tendinitis. The only cervical residual of the July 31, 2004 injury was hypoesthesia or diminished sensation to the pulp of his left index finger. Dr. Stewart opined that there was "no doubt" that appellant "suffered from a left shoulder sprain with development of impingement syndrome and he now has restrictive tendinitis or capsulitis in the left shoulder region with a moderate amount of restricted motion." He explained that he would not classify this "as internal derangement of the left shoulder, but rather an alteration in the structures surrounding the left shoulder joint." Dr. Stewart related that the July 31, 2004 incident caused a left shoulder sprain which led to a "picture of impingement syndrome and restrictive tendinitis or restrictive capsulitis of the left shoulder." He opined that the current left shoulder condition was related to the traumatic incident of July 31, 2004, which was materially and substantially affected by underlying and preexistent hypertrophic changes in the AC joint with an acromial spur that predated the July 31, 2004 injury. Dr. Stewart explained that moving the three 90-pound bags directly caused the later condition in appellant's left shoulder and opined that the current left shoulder condition was causally related to the aggravation of his underlying arthritic changes in the left shoulder joint and were permanent. However, he found that there was no evidence of a left shoulder partial thickness tear or effusion on examination, x-ray or MRI scan.

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.[12] The Board finds that the opinion of Dr. Stewart, selected to resolve the conflict in opinion, is well rationalized and based on a proper factual and medical history. Dr. Stewart accurately summarized the relevant medical evidence, provided detailed examination findings and reached conclusions about appellant's condition which comported with his findings.[13] In his April 16, 2013 report, he provided rationale for his opinion with regard to a partial thickness tear of the left shoulder and effusion, explaining that there was no evidence of these conditions on physical examination, x-ray or MRI scan. Dr. Stewart found no basis on which to attribute these conditions to appellant's work injury. As his report is well rationalized and based on a proper factual background, his opinion is entitled to the special weight accorded an impartial medical examiner.[14] OWCP properly relied upon Dr. Stewart's report to find that appellant did not have a partial thickness tear of the left shoulder and effusion that were causally related to his July 31, 2004 work injury.

On appeal, appellant's representative argued that OWCP erred by not accepting all of appellant's disabling injuries. He repeated that the partial thickness tear and effusion of the left shoulder must be accepted and referenced evidence submitted by appellant's treating physicians. However, as found above, the report of Dr. Stewart, the impartial medical specialist, is accorded special weight and resolves the medical conflict on this matter. His report establishes that a partial thickness tear and effusion of the left shoulder are not due to the July 31, 2004 work injury.

[12] *Barbara J. Warren*, 51 ECAB 413 (2000).

[13] *See Manuel Gill*, 52 ECAB 282 (2001).

[14] *See J.M.*, 58 ECAB 478 (2007); *Katheryn E. Demarsh*, 56 ECAB 677 (2005).

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 appellant did not meet his burden of proof to establish that various physical conditions diagnosed by his treating physician as causally related to his accepted July 31, 2004 employment injury.

ORDER

IT IS HEREBY ORDERED THAT the June 18, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 21, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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