United States Department of Labor
Employees' Compensation Appeals Board

R.M., Appellant	)	
and	)	**Docket No. 14-483**
	)	**Issued: July 8, 2014**
U.S. POSTAL SERVICE, POST OFFICE, North Canton, OH, Employer	)	

Appearances:
Alan J. Shapiro, 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 23, 2013 appellant, through his attorney, filed a timely appeal from an October 29, 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 to review the merits of this case.

ISSUE

The issue is whether appellant sustained right shoulder and knee conditions as a consequence of his November 24, 2010 employment injuries.

FACTUAL HISTORY

OWCP accepted that on November 24, 2010 appellant, then a 61-year-old letter carrier technician, sustained postconcussion syndrome and post-traumatic stress disorder as a result of a motor vehicle accident while in the performance of duty. He stopped work on the date of injury.

[1] 5 U.S.C. § 8101 *et seq.*

Appellant returned to work, but after working a couple of days he stopped work because he experienced dizziness, discovered that he had a blood clot and developed psychological problems.

On September 30, 2011 appellant requested expansion of his claim to include right shoulder and knee strain. In an August 23, 2011 medical report, Dr. Mark J. Shepard, an attending Board-certified orthopedic surgeon, noted that appellant was being evaluated for shoulder and knee pain. He listed a history that appellant was involved in a high speed motor vehicle accident at work approximately nine months ago. Appellant had increasing pain over the last couple of months with activities. Dr. Shepard reviewed a history of appellant's medical treatment and provided findings on physical and x-ray examination. He diagnosed right shoulder and knee strain with a possible intra-articular right knee tear.

In a letter dated November 9, 2011, QTC Medical Services, Inc., OWCP's medical appointment scheduler, notified appellant that he was scheduled for a November 28, 2011 appointment for a second opinion with Dr. Manhal Ghanma, a Board-certified orthopedic surgeon.[2]

In a December 2, 2011 report, Dr. Ghanma advised that there were no objective physical examination findings that appellant had a right knee or shoulder strain as a result of his November 24, 2010 employment injuries. Appellant had preexisting right knee arthritis, which was not related to his accepted work injury. Dr. Ghanma advised that appellant had no residuals of any work-related physical conditions. He stated that appellant was not commenting on any postconcussion syndrome or post-traumatic stress disorder. Dr. Ghanma related that no additional treatment was necessary or appropriate for any ongoing work-related physical conditions. He concluded that appellant could return to his date-of-injury position with no restrictions.

In a May 8, 2012 report, Dr. Shepard listed findings on physical and x-ray examination of appellant's right knee, including a diffuse tearing in the medial meniscus. He advised that appellant had increased pain since the time of his work accident. On July 12, 2012 Dr. Shepard advised that appellant had right shoulder and knee strain and a recurrent diffuse tear of the medial meniscus along with joint effusion of the right knee directly related to his November 24, 2010 employment injuries.

On December 13, 2012 OWCP determined that there was a conflict in the medical opinion evidence between Dr. Shepard and Dr. Ghanma regarding whether appellant sustained a right shoulder and knee sprain as a consequence of his November 24, 2010 employment injuries. By letter dated January 30, 2013, it referred appellant, together with a statement of accepted facts and the medical record, to Dr. James D. Brodell, a Board-certified orthopedic surgeon, for an impartial medical examination.

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[2] On November 17, 2011 appellant advised QTC Medical Services, Inc. that he was unable to attend the scheduled November 28, 2011 medical examination with Dr. Ghanma. By letter dated November 21, 2011, it rescheduled his examination with Dr. Ghanma for December 2, 2011.

In a February 11, 2013 report, Dr. Brodell reviewed the medical record and noted appellant's right shoulder and knee symptoms. He listed a history of the November 24, 2010 employment injuries and appellant's medical treatment. On physical examination of the shoulder, Dr. Brodell reported a short "bull" neck that had mild posterior multifocal tenderness and restricted range of motion. Provocative maneuvers did not cause radicular symptoms. A normal appearing right shoulder had no visible posterior rotator cuff atrophy. Tenderness was present over the acromioclavicular (AC) joint, bicipital tendon and greater tuberosity. Active and passive range of motion was well preserved, but with mildly positive signs of impingement. There was no evidence of instability or rotator cuff insufficiency. Both forearms had numerous small, flaking, scaling and erythematous lesions which had the appearance of eczema. A neurological assessment of the arms showed 2+ and symmetrical reflexes at the elbows and wrists. Sensation was full and all motor groups were working at 5/5 muscle power. Pulses were normally palpable at the wrists. Both hands were clean without appreciable callous formation over the palms.

Examination of the right knee reflected an old-appearing three-inch long curvilinear scar over the medial compartment with overall varus alignment. There was no palpable effusion. Tenderness was present over the medial facet of the patella and along the medial joint line. Active and passive range of motion was 0 to 130 degrees. There was no demonstrable front-to-back or side-to-side instability and quadriceps strength was good. A large Baker's cyst was palpable posteromedially. The ipsilateral hip and ankle moved normally without irritability. A neurological assessment of the lower extremities demonstrated 2+ and symmetrical reflexes at the knees and ankles. Sensation was full and all motor groups were working at 5/5 muscle power. Straight leg raising was negative bilaterally in the sitting position. Normal pulses were palpable at the ankles.

Dr. Brodell reported that an x-ray of the right shoulder revealed advanced narrowing and sclerosis with hypertrophic superior and inferior spur formation of the AC joint. The subacromial space had normal width. The glenohumeral joint appeared normal. X-rays of the right knee showed advanced varus alignment with complete collapse of the medial joint space (bone-on-bone) including sclerosis, irregularity and osteophyte formation. The patellofemoral region also appeared markedly arthritic.

Dr. Brodell diagnosed impingement syndrome with advanced osteoarthritis of the AC joint of the right shoulder and end-stage degenerative joint disease of the right knee (Fairbanks changes). He opined that appellant did not sustain a right shoulder or knee sprain as a result of the November 24, 2010 employment injuries. Dr. Brodell stated that appellant made one emergency room visit and was hospitalized twice on or about the time of the November 24, 2010 accident and was examined by numerous physicians. There was no documentation of symptoms or signs of injury related to the right shoulder or knee in any of these records. Dr. Brodell stated that, in fact, the first mention of difficulty with either the right shoulder or knee did not occur until Dr. Shepherd's evaluation, a full nine months after the car accident. This was far too long of a delay to reasonably draw any cause and effect relationship. Dr. Brodell advised that there were no symptoms, physical findings or imaging results consistent with a diagnosis of sprain of the right shoulder or knee. He further advised that appellant had no residuals of the accepted employment injuries.

Dr. Brodell stated that a sprain was a stretching of the ligaments in or about a joint. Even if such a right shoulder or right knee trauma had been sustained on November 24, 2010, it would have been a self-limiting injury with an anticipated time frame for both symptom resolution and healing of several weeks. Dr. Brodell related that no additional diagnostic testing or treatment was required for the accepted conditions. It was likely that the right shoulder was symptomatic from age-related impingement syndrome. Dr. Brodell explained that as one became older, rotator cuff tendinopathy developed which increased subacromial pressure, thereby tensioning the coracoacromial ligament. Antero-inferior acromial spur formation developed which, along with hypertrophic osteophytes from the AC joint mechanically abrade the supraspinatus tendon (impingement) causing bursal inflammation and the potential for progression of rotator cuff substance failure. Dr. Brodell noted that on or about 1970, when appellant was 21 years old he suffered a football-related right knee injury. At that time, appellant probably ruptured the anterior cruciate ligament (ACL) and severely tore the medial meniscus. This was before the widespread use of arthroscopy and the current method of removing as little meniscus as possible at the time of surgery. So, an open procedure was performed which was a total medial meniscectomy. As commonly the case with an absent meniscus, especially in the setting of chronic ACL insufficiency, the medial articular surfaces completely deteriorated giving rise to a characteristic bow-legged alignment with severe arthritis ("Fairbanks changes"). Dr. Brodell advised that appellant had plenty of trouble with his right shoulder and knee, but it was all age related and/or post-traumatic degenerative pathology that antedated November 24, 2010. He concluded that appellant could return to his letter carrier technician position with no restrictions.

In an April 12, 2013 decision, OWCP denied appellant's claim. It found that the weight of the medical evidence rested with Dr. Brodell who determined that appellant did not sustain a right shoulder or knee injury as a result of his November 24, 2010 employment injuries.

By letter dated April 17, 2013, appellant, through his attorney, requested a telephone hearing with an OWCP hearing representative.

In an April 26, 2013 report, Dr. Shepard reiterated that appellant had been suffering from right shoulder and knee pain since his November 24, 2010 employment injuries. On May 23, 2013 he listed a history that appellant was involved in a high-speed motor vehicle accident at work. Dr. Shepard reiterated his prior opinion that appellant had a right knee medial meniscus tear and right shoulder and knee strain as a direct result of the work accident.

During the August 13, 2013 telephone hearing, appellant stated that he initially had severe head trauma due to his November 24, 2010 work injuries, which was his main concern at that time. He began having problems with his right knee in the summer 2011. Appellant had not returned to work and experienced trouble walking. He was recently referred to an orthopedic specialist for evaluation for a total knee replacement. Appellant's representative contended that Dr. Shepard's May 23, 2013 report supported that appellant's right shoulder and knee conditions were work related.

By decision dated October 29, 2013, an OWCP hearing representative affirmed the April 12, 2013 decision. He found that Dr. Shepard's reports were not sufficiently rationalized and they were not based on an accurate factual background regarding the development of appellant's right shoulder and knee pain. The hearing representative found that this evidence

was insufficient to outweigh the special weight accorded to Dr. Brodell's impartial medical opinion.

LEGAL PRECEDENT

With respect to consequential injuries, it is an accepted principle of workers' compensation law that, when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause which is attributable to the employee's own intentional conduct.[3] The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.[4]

A claimant bears the burden of proof to establish a consequential injury.[5] As part of this burden, he or she must present rationalized medical opinion evidence, based on a complete medical and factual background, establishing causal relationship.[6] Rationalized medical opinion evidence is medical evidence, with stated reasons of a physician, on whether there is a causal relationship between the employee's diagnosed condition and the specified employment factors or incident. The opinion of the physician must be based on a complete factual and medical background of the employee and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[7]

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 the examination.[8] The implementing regulations state that if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[9]

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[3] *Albert F. Ranieri*, 55 ECAB 598 (2004).

[4] *See* A. Larson, *The Law of Workers' Compensation* § 10.01 (November 2000).

[5] *See J.J.*, Docket No. 09-27 (issued February 10, 2009).

[6] *Jennifer Atkerson*, 55 ECAB 317 (2004); *R.C.*, Docket No. 10-1789 (issued April 22, 2001).

[7] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[8] 5 U.S.C. § 8123; *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[9] 20 C.F.R. § 10.321.

It is well established that, when a case is referred to a referee 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.[10]

ANALYSIS

OWCP accepted that on November 24, 2010 appellant sustained postconcussion syndrome and post-traumatic stress disorder while in the performance of duty. Appellant contends that he sustained a right shoulder and knee condition as a result of the accepted employment injuries. The Board finds that he has not submitted sufficient medical evidence to establish his claim.

On December 3, 2012 OWCP properly determined that there was a conflict in the medical evidence between Dr. Shepard, an attending physician, who opined that appellant sustained right shoulder and knee strains as a consequence of the accepted November 24, 2010 employment injuries and Dr. Ghanma, an OWCP referral physician, who opined that there was no relationship between appellant's right shoulder and knee conditions and the accepted employment injuries.

To resolve the conflict, appellant was referred to Dr. Brodell for an impartial medical examination. In a February 11, 2013 report, Dr. Brodell found that appellant's right shoulder and knee conditions were not caused by the accepted November 24, 2010 employment injuries. He reviewed a history of the accepted injuries and appellant's medical treatment and records. On physical and neurological examination of the right shoulder and bilateral upper and lower extremities, Dr. Brodell reported essentially normal findings with the exception of a large Baker's cyst that was palpable posteromedially and tenderness over the medial facet of the patella and along the medial joint line of the right knee. He found that the right shoulder x-ray showed advanced narrowing and sclerosis with hypertrophic superior and inferior spur formation of the AC joint. Dr. Brodell further found that right knee x-rays showed advanced varus alignment with complete collapse of the medial joint space, including sclerosis, irregularity and osteophyte formation. He stated that the knee x-rays also showed a markedly arthritic appearing patellofemoral region. Dr. Brodell diagnosed impingement syndrome with advanced osteoarthritis in the AC joint of the right shoulder and end-stage degenerative joint disease of the right knee (Fairbanks changes). He explained that the physicians who treated appellant on or about the time of the November 24, 2010 employment injuries did not document his right shoulder and knee symptoms or injuries. Dr. Brodell noted that Dr. Shepherd did not mention his right shoulder and knee problems until nine months following the November 24, 2010 employment injuries, which was far too long to establish causal relation. He further explained that there were no symptoms, physical findings or imaging results consistent with a right shoulder or knee sprain. Dr. Brodell described a sprain and advised that, even if appellant had sustained such a condition, it would have resolved and healed within several weeks. He advised that appellant's right shoulder was symptomatic due to age-related impingement syndrome and described in detail the development of the condition. Dr. Brodell attributed appellant's right knee condition to a 1970 sports-related injury, which probably involved a ruptured ACL and

[10] *Gloria J. Godfrey*, 52 ECAB 486, 489 (2001).

severely torn medial meniscus for which he underwent surgery. He explained that it was common in the case of an absent meniscus, especially in the setting of chronic ACL insufficiency, that the medial articular surfaces completely deteriorated which caused a characteristic bow-legged alignment with severe arthritis (Fairbanks changes). Dr. Brodell concluded that appellant did not have any residuals of the accepted employment injuries and could return to his letter carrier technician position with no restrictions and no additional diagnostic testing or medical treatment was necessary.

The Board finds that Dr. Brodell's opinion is sufficiently well rationalized and based upon a proper factual and medical background. The weight of the medical opinion is determined by the opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts of the case, the medical history provided, the care of analysis manifested and the medical rationale expressed in support of stated conclusions.[11] Dr. Brodell fully discussed the history of injury and related his comprehensive examination findings in support of his opinion that appellant did not sustain right shoulder and knee conditions as a consequence of the accepted work injuries. His opinion is entitled to the special weight accorded an impartial medical examiner and constitutes the weight of the medical evidence.

The medical evidence appellant subsequently submitted is insufficient to overcome the special weight accorded Dr. Brodell regarding whether appellant sustained right shoulder and knee conditions as a consequence of the November 24, 2010 employment injuries. In reports dated April 26 and May 23, 2013, Dr. Shepard found that appellant's medial meniscus tear of the right knee and strains of the right shoulder and knee were a direct result of the accepted employment injuries. Reports from a physician who was on one side of a medical conflict that an impartial specialist resolved, are generally insufficient to overcome the weight accorded to the report of the impartial medical examiner or to create a new conflict.[12] Dr. Shepard's additional reports are essentially duplicative of his stated opinion and are insufficient to give rise to a new conflict. As appellant has failed to provide rationalized medical opinion evidence establishing consequential right shoulder and knee injuries as a result of his November 24, 2010 employment injuries, he has failed to meet his burden of proof in this case.[13]

Appellant may submit new evidence or argument as part of 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 sustain right shoulder and knee conditions as a consequence of his November 24, 2010 employment injuries.

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[11] *See Ann C. Leanza*, 48 ECAB 115 (1996).

[12] *I.J., supra* note 7; *Barbara J. Warren*, 51 ECAB 413 (2000).

[13] *See R.S.*, *supra* note 8; *C.S.*, Docket No. 10-214 (issued October 5, 2010).

ORDER

IT IS HEREBY ORDERED THAT the October 29, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 8, 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