

ISSUE

The issue is whether appellant met his burden of proof to establish that his left shoulder condition was causally related to the August 5, 2013 employment incident.

FACTUAL HISTORY

On August 12, 2013 appellant, then a 56-year-old customs and border patrol officer, filed a traumatic injury claim alleging that on August 5, 2013 he experienced a sharp pain and large lump in his left shoulder when he tried to do a push-up after completing a physical fitness assessment.³

In an August 8, 2013 report, Dr. Marc A. Kaplan, a family practitioner, related appellant's complaints of left shoulder pain on-and-off for years. He noted that the most recent left shoulder pain occurred four days ago. Dr. Kaplan reported that appellant had a prior left shoulder dislocation and rotator cuff tear and had a left shoulder mass for years. Musculoskeletal examination revealed positive left shoulder apprehension test and tenderness to palpation of shoulder pass. Dr. Kaplan also observed left shoulder mass, back and joint pain, left shoulder pain, joint swelling and muscle weakness. He opined that appellant sustained pain in limb. Dr. Kaplan recommended x-rays of the left shoulder and referred appellant to an orthopedist for further evaluation.

In an August 8, 2013 x-ray of the left shoulder, Dr. Steven Walsh, a Board-certified diagnostic radiologist, observed moderate degenerative changes on each side of the inferior acromioclavicular (AC) joint. He also noted 4x6 millimeter (mm) in diameter soft tissue calcification adjacent to the lateral cortex of the humeral head that was consistent with calcific tendinitis. Dr. Walsh diagnosed AC joint degenerative changes and calcific tendinitis.

Appellant was provided an authorization for examination and/or treatment (Form CA-16) dated August 14, 2013 by Robert Munsey, his supervisor, for a left shoulder pulled muscle.⁴ In the attending physician's report (Part B), Dr. Kaplan stated that appellant experienced severe pain and moderate shoulder swelling after physical training. He noted that appellant sustained a shoulder injury about 20 years ago and had minor discomfort until a recent August 5, 2013 injury. Dr. Kaplan diagnosed capsulitis of the left shoulder. He checked "yes" that he believed appellant's condition was caused or aggravated by the described employment activity. Dr. Kaplan noted that appellant was partially disabled from August 5 to September 5, 2013 and recommended that appellant resume light work with restrictions of no lifting or weight bearing of the left arm.

In a September 4, 2013 report, Dr. Kaplan noted appellant's complaints of continued left shoulder pain. He reviewed appellant's history and provided similar examination findings.

³ Appellant filed a previous traumatic injury claim for a June 23, 2010 employment injury (File No. xxxxxx769).

⁴ The Board notes that a properly executed Form CA-16 creates a contractual obligation to pay for the cost of examination or treatment regardless of the action taken on the claim. *See Tracey P. Spillane*, 54 ECAB 608 (2003) and 20 C.F.R. § 10.300(c).

Dr. Kaplan noted swollen bursa of the left shoulder and diagnosed occupational bursitis. In a September 4, 2013 duty status report, he advised appellant to return to light duty on September 4, 2013.

In a September 12, 2013 narrative report, Dr. Jesse Wild, an orthopedic surgeon who specializes in sports medicine, stated that appellant was referred by Dr. Kaplan for evaluation of his left shoulder. He reported that appellant sustained an injury to his left shoulder on August 5, 2013 and complained of considerable pain with any overhead motion. Dr. Wild noted that plain radiographs were essentially negative. He reviewed appellant's history and conducted an examination. Dr. Wild observed pain with forward flexion of the left shoulder, worse with abduction and pain with impingement testing. He reported that appellant's AC joint was minimally tender. Biceps testing was plusminus. Dr. Wild stated that appellant had some perceived weakness and a lot of pain with resisted cuff testing. He opined that appellant had been in quite a bit of pain for over a month and was injured at work. In an attached work status note, Dr. Wild reported that appellant could work light duty as of September 12, 2013.

In an October 9, 2013 magnetic resonance imaging (MRI) scan of the left shoulder, Dr. David P. Klein, a Board-certified diagnostic radiologist, observed mild degenerative callus formation and capsular hypertrophy at the AC joint and a moderate amount of degenerative marrow edema. He noted no rotator cuff tendon tear and intact biceps tendon and labrum. Dr. Klein diagnosed degenerative changes at the AC joint.

In an October 22, 2013 report, Dr. Wild stated that appellant was reevaluated for his left shoulder after a recent injury at work. He noted that an MRI scan demonstrated a rather large mass in the subcutaneous region of the left shoulder, likely consistent with a lipoma. Dr. Wild reported that appellant's rotator cuff appeared to be intact. He opined that the clinical scenario was more consistent with an adhesive capsulitis. Dr. Wild reviewed appellant's history and conducted an examination. He observed a large mass along the top of the left shoulder. Dr. Wild also noted decreased range of motion and significant pain at the end range, consistent with a capsulitis. He recommended a limited MRI scan with and without contrast to further evaluate the mass and a short course of oral steroid.

In a November 13, 2013 MRI scan of the left shoulder, Dr. Chad A. Kohl, a Board-certified diagnostic radiologist, noted appellant's complaints of traumatic left shoulder pain that radiated to the elbow. He observed a six centimeter (cm) encapsulated subcutaneous soft tissue lipoma about the shoulder and moderate AC joint arthrosis. Dr. Kohl also reported a four mm calcification about the posterior humeral head/rotator cuff footprint, suspected to be extruded from prior calcific tendinitis. He stated that there was a thinly-encapsulated subcutaneous fatty tumor with thin internal septations and no evidence of nodularity or signal intensity.

In a November 19, 2013 report, Dr. Wild stated that an MRI scan revealed lipoma across the top of the shoulder and some AC joint arthrosis. He noted that these changes were consistent with a possible prior calcific tendinitis. Dr. Wild reviewed appellant's history and conducted an examination. He observed some limitation to both active and passive motion. Dr. Wild suspected that this could be a mild adhesive capsulitis on top of his calcific tendinitis and AC arthrosis. He recommended a shoulder injection and more physical therapy.

In a letter dated December 26, 2013, OWCP advised appellant that the evidence submitted was insufficient to establish his claim. It requested additional factual evidence to establish that the August 5, 2013 incident occurred as alleged and additional medical evidence to demonstrate that he sustained a diagnosed condition as a result of the alleged incident.

In a December 19, 2013 report, Dr. Wild stated that appellant's shoulder improved after the shoulder injection. Upon examination, he observed increased forward flexion and external rotation, still a significant discrepancy side to side. Dr. Wild opined that appellant's symptoms were likely due to capsulitis, calcific tendinitis. He recommended continued physical therapy.

On January 18, 2014 appellant responded to OWCP's December 26, 2013 development letter. He stated that on April 5, 2013 he underwent a physical therapy (PT) assessment, which consisted of push-ups, sit-ups, pull-ups and 1½ mile run. Appellant explained that after the push-ups he felt some discomfort on his arms and shoulder blades. He was able to complete one pull-up before he informed the instructor of his shoulder pain. Appellant experienced slight pain for the rest of the day and the following day when he trained with weapons. He went to the doctor's office on August 9, 2013. Appellant reported that his prior shoulder problems occurred when he was in the U.S. Army. The injuries included a dislocation in the mid-1980s and a rotator cuff problem in the mid-1990s.

In a decision dated March 20, 2014, OWCP denied appellant's claim. It accepted that the August 5, 2013 incident occurred as alleged and that he sustained a diagnosed condition but denied his claim finding insufficient medical evidence to establish that his left shoulder condition was causally related to the accepted incident.

LEGAL PRECEDENT

An employee seeking benefits under FECA⁵ has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative and substantial evidence⁶ including that he or she sustained an injury in the performance of duty and that any specific condition or disability for work for which he claims compensation is causally related to that employment injury.⁷

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether "fact of injury" has been established.⁸ There are two components involved in establishing the fact of injury. First, the employee must submit sufficient evidence to establish that he actually experienced the employment incident at the time, place and in the manner alleged.⁹ Second, the employee must submit evidence,

⁵ 5 U.S.C. §§ 8101-8193.

⁶ *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

⁷ *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

⁸ *S.P.*, 59 ECAB 184 (2007); *Alvin V. Gadd*, 57 ECAB 172 (2005).

⁹ *Bonnie A. Contreras*, 57 ECAB 364 (2006); *Edward C. Lawrence*, 19 ECAB 442 (1968).

generally only in the form of probative medical evidence, to establish that the employment incident caused a personal injury.¹⁰ An employee may establish that the employment incident occurred as alleged but fail to show that his disability or condition relates to the employment incident.¹¹

Whether an employee sustained an injury in the performance of duty requires the submission of rationalized medical opinion evidence.¹² The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable medical certainty 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.¹³ The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.¹⁴

ANALYSIS

Appellant alleges that on August 5, 2013 he sustained an injury to his left shoulder after performing a push up while completing a PT assessment. The record reflects that appellant sustained previous left shoulder injuries when employed by the military. OWCP accepted that the August 5, 2013 incident occurred as alleged and that he was diagnosed with a left shoulder condition. However, it denied appellant's claim finding insufficient medical evidence to establish that his left shoulder condition was causally related to the August 5, 2013 employment incident. The Board finds that he did not meet his burden of proof to establish his traumatic injury claim.

Appellant was initially examined by Dr. Kaplan. In his reports dated August 8 to September 4, 2013, Dr. Kaplan reviewed appellant's history and noted that he sustained prior left shoulder dislocation and rotator cuff tear a few years ago. Upon examination, he observed left shoulder mass, moderate joint swelling and swollen bursa. In an August 14, 2013 attending physician's report, Dr. Kaplan noted a date-of-injury of August 5, 2013 and diagnosed capsulitis of the left shoulder. He checked "yes" that he believed appellant's condition was caused or aggravated by the described employment activity. The Board finds that Dr. Kaplan provided an accurate date-of-injury and a diagnosis of left shoulder capsulitis. Dr. Kaplan did not, however, describe the employment incident or explain with medical rationale how the specific August 5, 2013 incident caused or contributed to appellant's condition. The Board has held that a physician must provide a narrative description of the identified employment incident and a reasoned opinion on whether the employment incident described caused or contributed to

¹⁰ *David Apgar*, 57 ECAB 137 (2005); *John J. Carlone*, 41 ECAB 354 (1989).

¹¹ *T.H.*, 59 ECAB 388 (2008); *see also Roma A. Mortenson-Kindschi*, 57 ECAB 418 (2006).

¹² *See J.Z.*, 58 ECAB 529 (2007); *Paul E. Thams*, 56 ECAB 503 (2005).

¹³ *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 465 (2005).

¹⁴ *James Mack*, 43 ECAB 321 (1991).

appellant's diagnosed medical condition.¹⁵ Furthermore, although Dr. Kaplan checked "yes" regarding his belief of causal relationship, a physician's opinion on causal relationship that consists only of checking "yes" to a form question, without explanation or rationale, is of diminished probative value and is insufficient to establish a claim.¹⁶ As Dr. Kaplan failed to adequately explain how appellant's left shoulder condition was causally related to the August 5, 2013 employment incident and not an aggravation of a preexisting left shoulder condition, the Board finds that Dr. Kaplan's reports are insufficient to establish appellant's claim.¹⁷

Appellant also received medical treatment from Dr. Wild. In reports dated September 12 to December 19, 2013, Dr. Wild noted that appellant sustained an injury to his shoulder on August 5, 2013. He reviewed appellant's history and noted that an MRI scan revealed a rather large mass in the subcutaneous region of his left shoulder. Upon examination, Dr. Wild observed pain with forward flexion of the left shoulder, worse with abduction and pain with impingement testing. He reported that appellant's biceps testing was plusminus and that his AC joint was minimally tender. Dr. Wild stated that appellant's clinical scenario was consistent with adhesive capsulitis. In a November 19, 2013 report, he opined that appellant's condition could be a mild adhesive capsulitis on top of his calcific tendinitis and AC arthrosis. Although Dr. Wild provided a diagnosis and noted a date-of-injury of August 5, 2013, he does not provide sufficient opinion or explanation regarding the cause of appellant's left shoulder condition. The Board has found that medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.¹⁸

Similarly, the additional diagnostic reports by Drs. Walsh, Klein, Kohl are also insufficient to establish appellant's claim as none of the physicians provide any opinion on the cause of appellant's left shoulder condition.

On appeal, appellant did not provide any arguments. The Board has found that the issue of causal relationship is a medical question that must be established by probative medical opinion from a physician.¹⁹ Because appellant has not provided such medical evidence, the Board finds that he did not meet his burden of proof to establish his claim.

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.

¹⁵ *John W. Montoya*, 54 ECAB 306 (2003).

¹⁶ *D.D.*, 57 ECAB 734, 738 (2006); *Deborah L. Beatty*, 54 ECAB 340 (2003).

¹⁷ In cases where a preexisting condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation, acceleration or precipitation, the physician must provide rationalized medical opinion which differentiates between the effects of the work-related injury or disease and the preexisting condition. See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805(e) (January 2013).

¹⁸ *R.E.*, Docket No. 10-679 (issued November 16, 2010); *K.W.*, 59 ECAB 271 (2007).

¹⁹ *W.W.*, Docket No. 09-1619 (issued June 2, 2010); *David Apgar*, 57 ECAB 137 (2005).

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that his left shoulder condition was causally related to the August 5, 2013 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the March 20, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 1, 2014
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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