United States Department of Labor
Employees' Compensation Appeals Board

E.K., Appellant	)	
and	)	**Docket No. 14-1364**
	)	**Issued: October 3, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Oakland, CA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 29, 2014 appellant, through counsel, filed a timely appeal from a decision of the Office of Workers' Compensation Programs (OWCP) dated February 12, 2014. 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 has established that she sustained a bilateral shoulder condition causally related to her accepted October 27, 2011 employment injury.

FACTUAL HISTORY

On November 1, 2011 appellant, a 58-year-old mail handler, filed a traumatic injury claim for benefits, alleging that she injured her lower back while lifting a package of mail on October 27, 2011. OWCP accepted the claim for lumbar sprain.

[1] 5 U.S.C. § 8101 *et seq.*

In a November 3, 2011 report, Dr. Michael Hebrard, Board-certified in physical medicine and rehabilitation and appellant's treating physician, stated that appellant was injured on October 27, 2011 when she lifted a package weighing 40 to 50 pounds off a conveyor belt that was between waist and chest high. He advised that the injury occurred when she lifted the package, pulled it toward her, reached, pulled it back toward her, lifted it, twisted at the waist, and walked it to a mail container; she then lifted it up above her shoulders and head and placed it in the container, at which time she felt a pain in her left upper back area. Dr. Hebrard opined that the patient's ongoing condition was attributable to the heavy pulling and lifting of the package. He asserted that the pulling sensation resulted in the injury of her left shoulder and that the subsequently pushing and lifting it above head level aggravated a preexisting left shoulder condition which stemmed from a previous left shoulder surgery. Dr. Hebrard advised that her upper and lower back, particularly the upper thoracic and upper lumbar region, were also strained in that process. He stated that it was medically necessary and appropriate to maximize her functional recovery by controlling the inflammation and swelling around the shoulder and by improving the rate of healing of the soft tissue injuries. Dr. Hebrard prescribed physical therapy three times per week for four weeks to control the swelling, pain, and inflammation during the rehabilitation process with ultrasound, electrical stimulation and light therapy. He placed her on temporary total disability. Dr. Hebrard recommended that appellant undergo a functional capacity evaluation, an electromyelogram and nerve conduction test to rule out cervical versus peripheral radiculopathy and to evaluate for possible peripheral nerve root entrapment in the upper extremities, given the fact the patient is having ongoing symptoms of numbness, tingling and burning sensation in the arms and fingers and pain in the upper extremities. He prescribed a shoulder brace for her left shoulder and a lumbar support to stabilize the anterior and posterior lumbar columns of the lumbar spine with standing, walking, twisting, turning and bending at the waist. Dr. Hebrard diagnosed left shoulder strain, left bicipital tenosynovitis, left shoulder impingement, lumbar strain and thoracic strain.

In a November 14, 2011 report, Dr. Hebrard related that appellant had ongoing issues with her neck, left shoulder and lower back. He reiterated his previously stated diagnoses and advised that she still had achy, dull, stinging, gnawing, throbbing pain that radiated across her neck down to the left arm and across her buttock area from her low back. Appellant related that the pain was severe and constant and worsened with sitting, standing, walking, stooping, crouching, bending and twisting of the head, neck and waist. Dr. Hebrard advised that she had a sitting tolerance of 10 to 15 minutes and sometimes greater depending on her activities and a walking tolerance of greater than 15 to 20 minutes, limited by back spasms, lower extremity pain and muscle spasms throughout the neck, back and shoulder area.

In a January 10, 2012 report, Dr. Hebrard stated that appellant was recovering from a lumbar strain; he stated that he was also evaluating her for left shoulder pain. Appellant described her left shoulder pain as severe, numbing, burning, stabbing, sharp and constant. Dr. Hebrard advised that appellant had a positive impingement test and Speed's test with both the right and left shoulders. Appellant was still having some restricted range of motion of the left shoulder and stated that, given her prior left shoulder surgery, she might have sustained a significant amount of ongoing internal damage to the left shoulder. Dr. Hebrard recommended a magnetic resonance imaging (MRI) scan and arthrogram of the left shoulder to evaluate for possible retear of the rotator cuff and ensure there was no damage to the labrum of the left shoulder.

In a February 7, 2012 report, Dr. Hebrard stated that appellant's reported mechanism of injury on October 27, 2011 was consistent with a scapular injury of the left shoulder. He advised that the findings he made on November 3, 2011 were consistent with a left shoulder strain based on her description of being injured while engaged in overhead pulling and lifting. Dr. Hebrard related that she had a preexisting condition of the left shoulder which was subsequently aggravated by the activities she described as the overall mechanism of injury on October 27, 2011. He advised that the pulling activities, particularly in the left scapular region, aggravated the structure of the shoulder, primarily the bicipital tendon and the rotator cuff, particularly the supraspinatus and possibly the labrum. Dr. Hebrard recommended that it would be reasonable and medically appropriate to have the accepted diagnosis expanded to include the rotator cuff or shoulder strain as previously mentioned and bicipital tenosynovitis of the left shoulder.

In a statement dated March 27, 2012, received by OWCP on September 10, 2012, appellant indicated that although she initially had pain mostly in the lower back as a result of the October 27, 2011 work incident, she also experienced pain in both of her shoulders. She stated that on October 27, 2011 she felt pain in her lower back and both shoulders radiating down both arms while lifting a parcel of mail over her shoulders into a mail container. Appellant asserted that during her initial consultation with Dr. Hebrard she complained of pain in both shoulders radiating down her arms and her back; she advised that with each visit with Dr. Hebrard she stated that her bilateral shoulder pain was increasing. She stated that she was going to file a Form CA-2 for her shoulders in order to obtain the proper medical treatment for her injury. Appellant further stated that she sustained a back injury in 1999, for which she underwent surgery and physical therapy. She related that since her October 2011 work injury she had been in constant pain and discomfort on a daily basis.

In a May 24, 2012 statement of accepted facts, it was indicated that appellant had stopped working on April 8, 2012 because the employing establishment was no longer able to accommodate her work restrictions. Appellant has not returned to work since that time.

In order to determine the nature and extent of her work-related condition and whether she still had residuals stemming from her October 27, 2011 work injury, appellant was referred to Dr. Aubrey A. Swartz, Board-certified in orthopedic surgery, for a second opinion examination.

In a facsimile dated June 5, 2012, OWCP advised Dr. Swartz that appellant was reporting bilateral shoulder symptoms. It asked him to provide an opinion as to whether: (a) she had any bilateral shoulder conditions causally related to the October 27, 2011 work injury; (b) if so, to provide a diagnosis and explanation of causal relationship; and (c) if she did sustain a shoulder condition causally related to the October 27, 2011 work injury, whether this condition had resolved.

In a report dated June 29, 2012, Dr. Swartz stated that appellant had pain in her low back radiating down both gluteal regions into both thighs and pain across her lumbosacral spine. He diagnosed lumbosacral spondylolisthesis with bilateral pars defects; he found, however, that there were no specific objective findings indicating that this preexisting condition was causally related to the accepted October 27, 2011 work injury. Dr. Swartz indicated that appellant had residuals with respect to her preexisting conditions, which were nonindustrial. He did not

provide an opinion as to whether appellant's alleged bilateral shoulder condition was causally related to the October 27, 2011 work injury.

By letter dated August 29, 2012, OWCP scheduled a follow-up appointment for appellant with Dr. Swartz.

In an OWCP memorandum dated September 4, 2012, it was indicated that Dr. Swartz had been contacted and advised to address whether the shoulder condition was connected to the October 27, 2011 work injury.

MRI scan examinations of appellant's left and right shoulders were conducted on October 4, 2012 by Dr. Stacy Uybico, a diagnostic radiologist. Regarding the right shoulder she related that the MRI scan suggested a high-grade tear of the anterior supraspinatus tendon with an interstitial component and possible communication with the articular surface; as well as a markedly attenuated subscapularis tendon suggestive of a high-grade articular surface tear; and chronic tear of the superior labrum extending anterosuperior to posterosuperior (SLAP tear). Regarding the left shoulder MRI scan, Dr. Uybico indicated that the scan showed an interstitial tear along the anterior distal supraspinatus tendon with superimposed moderate tendinosis, moderate infraspinatus tendinosis, and moderate subscapularis tendinosis. The report noted that there was an interstitial tear along the anterior distal supraspinatus tendon with superimposed moderate tendinosis, and a chronic tear of the superior labrum that extends anterosuperior to posterosuperior, with circumferential labral degeneration, moderate acromioclavicular (AC) joint arthrosis, mild tenosynovitis of the extra-articular long head biceps tendon within the bicipital groove.

In an October 10, 2012 report, Dr. Swartz reviewed whether appellant had sustained a bilateral shoulder injury causally related to the accepted October 27, 2011 lower back injury. He stated that he had reviewed the October 4, 2012 MRI scans of the right and left shoulders. Dr. Swartz noted that the results of this test showed multiple tears in the right shoulder including the supraspinatus, subscapularis, and biceps in addition to the labrum; he stated, however, that there was no evidence that all of these tears and degenerative changes in the right shoulder were caused by the October 27, 2011 work injury. With regard to the left shoulder, he stated that there was some tendinosis, probable degradation or possibly tear of the biceps, and chronic tearing of the labrum with labral degeneration; he advised that there was osteoarthritis of the AC joints in both shoulders. Dr. Swartz advised that appellant reported that she was not working because of pain in the low back, the upper back and both of her shoulders, all of which resulted from the October 27, 2011 work injury. He indicated, however, that the October 27, 2011 injury had apparently caused a temporary aggravation of the preexisting pathology of the left shoulder, which included a left shoulder surgery in 1999; this surgery likely produced some chronic changes, including scar tissue, which contributed to the slightly limited motion of the left shoulder in flexion as compared to the right shoulder. Dr. Swartz stated that this temporary aggravation ceased in February 2012, at which time she returned to her pre-October 27, 2011

status. He opined that there was no evidence that the October 27, 2011 injury caused an injury to the right shoulder.[2]

In a report dated November 2, 2012, Dr. Hebrard expressed his disagreement with Dr. Swartz's October 10, 2012 report, particularly that appellant's right shoulder conditions were not causally related to the October 27, 2011 work injury. He stated:

> "It is my opinion with a reasonable degree of medical certainty that [appellant's] patient's condition was not only aggravated by the industrially[-]related injury of October 27, 2011, but this aggravation is an ongoing condition that is not temporary, but is a permanent aggravation because the patient has yet to return back to her baseline level of function. With the MRI scan evidence showing chronic tear of the superior labrum and. my previous documentation that there may be a labral tear, this is consistent both clinically and diagnostically with the MRI scan. It is my opinion with a reasonable degree of medical certainty that her ongoing condition is industrially related. It has and did occur in the course of her employment."

Dr. Hebrard advised that the right shoulder injury was a compensable consequence of the left shoulder; the left shoulder injury accelerated the injury to the right shoulder. He stated that the right shoulder should be evaluated in the context of a work-related injury, causally related to the October 2011 employment injury. Dr. Hebrard recommended an MRI scan of the right shoulder in order to accurately diagnose appellant's condition. He concluded that his clinical evaluation as well as the diagnostic testing results of the MRI scan supported his previous documented physical examination, which indicated that both shoulders were "industrially related" to a high degree of medical certainty.

In a January 25, 2013 report, Dr. Hebrard stated that appellant had a history of having sustained injuries to her shoulders and lumbar spine, as well as her mid and upper back during her usual work activities in October 2011.

By decision dated April 22, 2013, OWCP denied appellant's claim for benefits, finding that she did not sustain a bilateral shoulder condition causally related to her accepted October 27, 2011 employment injury. It found that Dr. Swartz's referral opinion represented the weight of the medical evidence.

On May 4, 2013 appellant requested an oral hearing, which was held on December 4, 2013.

[2] The Board notes that appellant filed a Form CA-2 claim for occupational disease on March 27, 2012, received by OWCP on September 10, 2012, under case number xxxxxx679, alleging that she developed a bilateral shoulder condition causally related to employment factors and that she first became aware of this condition on October 27, 2011. In an OWCP memorandum dated October 18, 2012, it was indicated that the new Form CA-2 was practically identical with the CA-1 except that she added a comment about bilateral shoulder pain. By letter dated October 30, 2012, OWCP informed appellant that it had deleted your case number xxxxxx679 because it was a duplicate of case number xxxxxx672.

At the hearing, appellant testified that when she initially filled out the Form CA-1 she was in extreme pain and was on her way to the hospital; she indicated that she only stated that she injured her back because that was her primary complaint at the time and assumed that her shoulders would be included in the claim. She asserted that she had been having complaints of bilateral shoulder pain ever since and was advised that she needed to include them in her claim in order to have that accepted as condition as well. Appellant eventually filed a Form CA-2 in March 2012 because her shoulders were getting increasingly worse. She also stated that she had tried to have this claim expanded to include her shoulders for many months, but that the employing establishment had not filed the paperwork.

Following the hearing, Dr. Hebrard submitted a December 18, 2013 report in which he reviewed the results of the October 4, 2012 MRI scans performed on appellant's right and left shoulders. He opined that the findings were consistent with the mechanism of injury. Dr. Hebrard advised that the left shoulder MRI scan revealed moderate rotator cuff tendinosis, interstitial tear, interstitial tear along the anterior distal supraspinatus tendon but no definite high-grade or full-thickness rotator cuff tear; chronic tear of the superior labrum extending anterosuperior to posterosuperior with circumferential labral degeneration and moderate AC joint arthrosis; mild tenosynovitis of the extra-articular long head biceps tendon within the bicipital grove. The MRI scan of the right shoulder was suggestive of a high-grade tear of the anterior supraspinatus tendon an interstitial component and possible communication the articular surface. Dr. Hebrard stated that the study showed markedly attenuated subscapularis tendon suggestive of a high-grade articular surface tear with mild fatty atrophy of the subscapularis muscle; he advised that the long head biceps tendon was not visualized, which suggested a chronic tear. Lastly, he asserted that the study demonstrated a chronic SLAP tear, with moderate AC joint arthrosis.

Dr. Hebrard opined that, upon review of the mechanism of injury of overhead lifting and reaching of October 27, 2011 and based on the preexisting, underlying condition of appellant's shoulders, her overhead reaching and lifting on that date caused the head of the humerus to rotate posteriorly and exposed the supraspinatus tendon at the insertion of the anterior portion of head of the humerus, under the acromion. He advised that impingement begins between 70 degrees of forward flexion and abduction to 140 degrees, which is consistent with reaching or above shoulder level. Dr. Hebrard advised that the heaviness of the package caused acute trauma to the areas of the hypovascular zone, leading to further damage. He noted that the MRI scans were done in October 2012, about a year after the October 2011 work incident, and opined that these studies were consistent with chronic degeneration precipitated and aggravated by that specific action in the course of her employment on that date. Dr. Hebrard concluded that the mechanism of injury, the results of the MRI scans and his clinical evaluations were consistent.

By decision dated February 12, 2014, an OWCP hearing representative affirmed the April 22, 2013 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] has the burden of establishing that the essential elements of his or her claim including that any disability and/or specific condition for which compensation is claimed is causally related to the employment injury.[4] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[5]

The Board has held that the mere fact that a condition manifests itself during a period of employment does not raise an inference that there is a causal relationship between the two.[6] An award of compensation may not be based on surmise, conjecture or speculation. Neither, the fact that appellant's condition became apparent during a period of employment nor the belief that her condition was caused, precipitated or aggravated by his employment is sufficient to establish causal relationship.[7] Causal relationship must be established by rationalized medical opinion evidence and appellant failed to submit such evidence.

Appellant has the burden of establishing by the weight of the substantial, reliable and probative evidence, a causal relationship between her claimed bilateral shoulder conditions and her federal employment. This burden includes providing medical evidence from a physician who concludes that the disabling condition is causally related to employment factors and supports that conclusion with sound medical reasoning.[8]

Section 8123(a) 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 an examination.[9] It is well established that, when a case is referred to an impartial medical 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

The Board finds that there is a conflict in medical opinion between Dr. Hebrard and Dr. Swartz concerning whether appellant sustained a bilateral shoulder condition causally related to her accepted October 27, 2011 lumbar strain injury. Dr. Hebrard submitted a November 3, 2011

[3] 5 U.S.C. §§ 8101-8193.

[4] *Joe D. Cameron*, 41 ECAB 153 (1989); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[5] *Victor J. Woodhams*, 41 ECAB 345 (1989).

[6] *See Joe T. Williams*, 44 ECAB 518, 521 (1993).

[7] *Id.*

[8] *See Nicolea Bruso*, 33 ECAB 1138, 1140 (1982).

[9] *Regina T. Pellecchia*, 53 ECAB 155 (2001).

[10] *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

report in which he stated that the lifting incident in which appellant was injured on October 27, 2011 resulted in an injury to her left shoulder, aggravating a preexisting left shoulder condition. He also explained that the left shoulder injury accelerated the injury to the right shoulder. In a January 10, 2012 report, he stated that appellant had positive impingement and Speed's tests of both the left and right shoulders.

OWCP subsequently referred appellant for a second opinion examination with Dr. Swartz. In his October 10, 2012 report, Dr. Swartz opined that appellant did not sustain a bilateral shoulder condition causally related to the October 27, 2011 work injury. He stated that the October 27, 2011 injury had apparently caused a temporary aggravation of the preexisting left shoulder condition, which resolved in February 2012. While he stated that appellant also had tears and degenerative changes in the right shoulder, he opined that there was no evidence that these were causally related to the October 27, 2011 work injury or that the October 27, 2011 injury caused an injury to the right shoulder.

Dr. Hebrard indicated in a November 2, 2012 report that he disagreed with Dr. Swartz's October 10, 2012 report and opined that appellant's left shoulder condition was not only temporarily aggravated by the October 27, 2011 work injury, but was permanently aggravated because she had not returned to her previous level of functional ability. He opined "to a high degree of medical certainty" that based on the results of MRI scans of the left and right shoulders she underwent on October 4, 2012 and his review of her medical history that she had sustained a work-related injury to both shoulders, causally related to the October 27, 2011 employment injury. In his December 18, 2013 report, Dr. Hebrard explained that the overhead lifting and reaching appellant performed on October 27, 2011 caused the head of the humerus to rotate posteriorly and exposed the supraspinatus tendon at the insertion of the anterior portion of the head of the humerus. He noted that impingement began between 70 degrees of flexion and 140 degrees of abduction, which is what appellant performed when reaching at or above shoulder level. Dr. Hebrard explained that the heaviness of the package caused acute trauma to the areas of the hypovascular zone, leading to further damage of appellant's preexisting shoulder conditions. Finally, he explained that appellant's MRI scan studies from October 2012 were consistent with chronic degeneration aggravated by the incident in question. Dr. Hebrard's reports created a conflict in the medical evidence with the reports from Dr. Swartz.

Therefore, in its April 22, 2013 decision, OWCP erred in failing to find that a conflict existed in the medical evidence. Accordingly, the Board will set aside the February 12, 2014 decision of OWCP's hearing representative and remand for referral of appellant, the case record and a statement of accepted facts to an impartial medical specialist to resolve the conflict in medical evidence regarding whether appellant sustained a bilateral shoulder condition causally related to her accepted October 27, 2011 employment injury.

After such further development of the record as it deems necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for decision. The case is remanded for further development of the medical evidence.

ORDER

IT IS HEREBY ORDERED THAT the February 12, 2014 decision of the Office of Workers' Compensation Programs be set aside and the case remanded to OWCP for further action consistent with this decision of the Board.

Issued: October 3, 2014
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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