United States Department of Labor
Employees' Compensation Appeals Board

E.P., Appellant	)	
	)	
and	)	**Docket No. 14-1298**
	)	**Issued: January 7, 2015**
DEPARTMENT OF EDUCATION, SPECIAL EDUCATION REHABILITATION SERVICES, Washington, DC, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 16, 2014 appellant filed a timely appeal from a May 7, 2014 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.

ISSUES

The issues are: (1) whether OWCP met its burden of proof to terminate appellant's wage-loss compensation benefits effective May 5, 2013; and (2) whether appellant has established continuing employment-related residuals or disability on or after May 5, 2013 as a result of his accepted July 20, 2009 employment injuries.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case was previously before the Board. By decision dated February 26, 2014, the Board remanded the case as OWCP had failed to review newly submitted medical reports. It advised OWCP to issue a *de novo* final decision after properly considering all of the evidence. The findings of fact and conclusions of law from the prior decision and order are hereby incorporated by reference.

On July 27, 2009 appellant, then a 42-year-old management program analyst, filed a traumatic injury claim alleging that on July 20, 2009 he sustained a muscle sprain when a box fell on his shoulder. He sought emergency medical treatment that same date. Appellant stopped work on July 20, 2009 and received wage-loss and compensation benefits.

By decision dated September 24, 2009, OWCP accepted the claim for sprain and contusion of the right shoulder and upper arm.

On September 11, 2009 appellant began seeking treatment with Dr. Nigel M. Azer, a Board-certified orthopedic surgeon, who reported that appellant complained of shoulder pain and diagnosed acromioclavicular (AC) joint separation, right shoulder impingement syndrome, and neuropraxia of the right arm.

On March 18, 2010 Dr. Azer performed arthroscopy of the right shoulder with debridement of the glenoid labrum and an open anterior acromioplasty and distal clavicle excision. The surgery was approved by OWCP. On February 7, 2012 Dr. Azer performed another arthroscopy of the right shoulder with arthroscopic lysis of adhesion and debridement of a retear of the labrum. Both surgeries were approved by OWCP.

In a July 13, 2012 medical report, Dr. Azer noted physical examination revealed 95 degrees forward flexion. At 90 degrees abduction appellant had 80 degrees of external rotation and 85 degrees of internal rotation, noting negative impingement signs, and good rotator cuff strength. Dr. Azer diagnosed status post right shoulder reconstruction, right carpal tunnel syndrome (CTS), brachial plexopathy, and chronic pain syndrome. He restricted appellant from returning to work.

On September 5, 2012 OWCP referred appellant to Dr. Robert A. Smith, a Board-certified orthopedic surgeon, for a second opinion evaluation. Dr. Smith detailed the employment incident, noting that on July 20, 2009 a box full of copy paper fell from a shelf and landed directly on top of appellant's right shoulder. He noted a medical history of no prior shoulder injuries. Dr. Smith provided a detailed review of appellant's medical and diagnostic reports since the onset of injury on July 20, 2009. He reported that the only accepted conditions in the case were sprain and contusion of the right shoulder and upper arm which were consistent with the mechanism of injury. Dr. Smith noted that any diagnoses pertaining to the neck, elbow, and wrist would be unrelated since there was no evidence of any injury to these parts of the body. He determined that appellant also suffered from neuropraxia to the suprascapular nerve, grade 2 AC joint separation, and a right torn labrum as a result of the July 20, 2009 employment incident. Based on the recent electromyogram (EMG) study and clinical examination, Dr. Smith reported that the right suprascapular neuropraxia and sprains and contusions of the right shoulder

and upper arm had resolved. He further stated that the surgical procedures performed were reasonably related since grade 2 AC joint separation and associated labrum injury could have occurred as a direct result of the incident, but that the conditions had resolved as appellant had undergone successful surgery.

Upon physical examination, Dr. Smith reported that appellant did not have any objective clinical findings since his injuries had resolved. He found that appellant declined moving his shoulder in any meaningful way which was contradictory to physical findings made by Dr. Azer in his examination just a few months earlier. Dr. Smith noted that appellant's loss of motion in his right arm seemed to be voluntary and did not appear to be related to any specific pathology since, with strength testing, he appeared to have normal strength of the rotator cuff. He concluded that appellant required no further medical care and could return to full-duty work as a management program analyst which was a sedentary job.

By decision dated October 3, 2012, OWCP accepted appellant's claim for sprain of the right shoulder and upper arm, contusion of shoulder and upper arm, suprascapular neuropraxia (right) shoulder, grade 2 right AC joint separation, and right torn labrum.

On January 2, 2013 OWCP referred appellant, a statement of accepted facts, the case file, a medical conflict statement, and a series of questions to Dr. Robert O. Gordon, a Board-certified orthopedic surgeon, for an impartial referee examination in order to resolve the conflict between Dr. Smith and Dr. Azer regarding appellant's right upper arm and shoulder conditions. Dr. Gordon reviewed appellant's medical history and provided findings on physical examination. Appellant informed Dr. Gordon that on July 20, 2009, a box of copy paper fell off a shelf and struck him on his right shoulder. Dr. Gordon noted that upon physical examination, appellant hardly moved his shoulder which he believed had no physiologic basis, suspecting that his motion limitation was voluntary. Appellant informed Dr. Gordon that though his employment as a management program analyst was not very physical, he could not return to work because it hurt him to sit for prolonged periods of time. Dr. Gordon found that not supported physiologically. He further noted that appellant's medical and diagnostic reports revealed AC joint degenerative change and some superficial irregularity at the labrum, but no evidence of any rotator cuff tear. Upon review of EMG testing, Dr. Gordon stated that the findings made were unrelated to the July 20, 2009 work incident other than the possibility of some suprascapular nerve changes, which had long since resolved as evidenced by a subsequent EMG study and lack of symptoms in that area. He opined that the July 20, 2009 incident caused soft tissue injuries as well as possible mild AC separation which had resolved within a few months after the injury occurred. Dr. Gordon stated that appellant's subjective complaints led to his surgical procedures which were on a functional rather than a physiological basis. The only residual objective findings found were well-healed scars in the right shoulder area. Dr. Gordon concluded that appellant did not require further treatment, there were no limitations on his physical capacity, and that he could resume his normal work activities.

On February 13, 2013 OWCP notified appellant of a proposal to terminate his medical and wage-loss compensation benefits based on Dr. Smith and Dr. Gordon's opinions that appellant was not experiencing any residuals or disability connected to the July 20, 2009 employment injury as his conditions had ceased. Appellant was provided 30 days to submit additional information.

In support of his claim, appellant submitted medical reports dated February 15 and 25, 2012 from Dr. Azer, who provided a diagnosis of status post right shoulder reconstruction, right CTS, brachial plexopathy, and chronic pain syndrome. Dr. Azer opined that appellant had residuals of his neurologic injury that occurred back in 2009 and was unable to perform any activities that would require repetitive use or lifting of his upper extremities on a permanent basis.

By decision dated April 1, 2013, OWCP terminated appellant's medical and wage-loss compensation benefits effective May 5, 2013. It noted that the report of appellant's treating physician was void of objective evidence demonstrating that his injury was ongoing.

On April 26, 2013 appellant requested an oral hearing before the Branch of Hearings and Review. A hearing was held on August 16, 2013.

In a May 8, 2013 medical report, Dr. Azer reported that appellant was unable to work, but was able to occasionally lecture at Howard University due to lack of physical demands while lecturing. He diagnosed status post reconstruction of right shoulder, brachial plexopathy, and right median nerve neuropathy at the wrist. Dr. Azer opined that the majority of appellant's impairment related to his brachial plexus injury and concluded that he did not have the ability or capability to return to work as a management analyst. He recommended an EMG and nerve conduction study (NCS).

By letter dated June 12, 2013, appellant stated that he was submitting additional medical evidence.

In support of his claim, appellant submitted medical reports dated May 20 through October 30, 2013 from a Dr. Daniel R. Ignacio. A May 20, 2013 EMG and NCS revealed right brachial neuritis with denervation along the right arm. In his May 20, 2013 report, Dr. Ignacio stated that on July 20, 2009 appellant was treated in the emergency room for injuries sustained to the neck and right shoulder and received multiple medical treatments including physical therapy, nerve blocks, joint injections, and two surgeries. Despite treatment, appellant complained of worsening right shoulder pain, which radiated to the arm with numbness and weakness, worse with repetitive movements. Dr. Ignacio provided findings on physical examination and diagnosed status post multiple surgeries to the right shoulder with residual pain, chronic right shoulder strain, chronic right brachial neuritis, chronic right AC joint dislocation, and complex regional pain syndrome (CRPS), which were related to the injuries sustained on July 20, 2009. He further stated that appellant could not return to work as an analyst and remained symptomatic.

In a July 11, 2013 medical report, Dr. Annapurni Jayam Trouth, a Board-certified neurologist, reported that he evaluated appellant on July 9, 2013. He noted that appellant complained of severe unbearable pain, and occasional burning, in the right shoulder, arm, forearm, and hand. All symptoms began after appellant sustained a right shoulder injury when a heavy box fell on his shoulder. Dr. Trouth provided detailed review of past medical reports and findings on physical examination. He diagnosed CRPS or reflex sympathetic dystrophy (RSD), which was triggered by trauma to the brachial plexus. Dr. Trouth further stated that appellant

had sensory, motor, and vasomotor problems involving the right brachial plexus and required continued treatment.

In a July 22, 2013 medical report, Dr. Christopher Kalhorn, a Board-certified neurological surgeon, reported that appellant had a history of a prior shoulder injury status post having a box falling on his shoulder. Appellant described a dysesthetic severe burning pain in the right shoulder, forearm, and into the hand. Dr. Kalhorn noted that the character of the pain was consistent with a CRPS. He recommended an MRI scan of the cervical spine.

In a July 31, 2013 medical report, Dr. Ignacio reported that he had a complex clinical course with intractable and progressive painful conditions along the right upper extremity related to the joint injury and nerve damage. He subsequently underwent multiple surgeries to the shoulder. Despite surgery on March 18, 2010 and February 7, 2012, appellant developed severe neuropathic pain and CRPS (causalgia of the right upper extremity), which had been bothering him over the past several years. He had continued pain along the right shoulder and arm, numbness and weakness along the right arm, and severe neuropathic pain that required him to take multiple medications for pain control.

Dr. Ignacio reported that appellant's diagnostic studies included an MRI scan, which confirmed the AC joint dislocation, the tear of the labrum and the tear of the rotator cuff tendon. EMG studies confirmed the right brachial plexus neuropathy and the most recent EMG study demonstrated the chronic and stable right brachial neuritis. Dr. Ignacio reported that, with regard to the prior EMG study which demonstrated right ulnar neuritis, it was simply an extension of the right brachial plexus and a component of the right shoulder nerve injury. Dr. Ignacio diagnosed status post multiple surgeries to the right shoulder with residual pain, chronic injury to the right shoulder (brachial neuritis), chronic sprain of the right shoulder, chronic dislocation of the AC joint, chronic contusions along the right shoulder, and CRPS. He recommended continued medical treatment and noted that appellant was restricted from working as an analyst. Dr. Ignacio further stated that he disagreed with the termination of appellant's benefits and Dr. Smith's September 5, 2012 report. He noted that Dr. Smith's report was subjective as he referred to appellant's clinical situation as voluntary self-limitation. Dr. Ignacio further noted that his report neglected the significant accepted right shoulder nerve injury and multiple surgeries. He further disagreed with Dr. Smith stating that appellant's right shoulder injury and nerve damage had not resolved as evidenced by the recent May 20, 2013 EMG study, which demonstrated the persistence of the right brachial neuritis with associated pain. Dr. Ignacio concluded that appellant required continued medical treatment and was unable to return to work as an analyst due to his limited physical capability.

In an August 13, 2013 medical report, Dr. Daniel R. Kendall, an osteopath, reported that he evaluated appellant for an initial comprehensive pain consultation. He noted a history of a box falling on appellant's right shoulder four years ago. Dr. Kendall provided review of diagnostic testing and noted that a July 2, 2013 MRI scan of the right shoulder revealed abnormal intrasubstance signal along the undersurface of the superior labrum, mild AC joint osteoarthrosis, and probable sequella of and old low grade AC joint injury with no rotator cuff identified. An August 1, 2013 MRI scan of the brachial plexus revealed no acute pathology of the right brachial plexus. An August 1, 2013 MRI scan of the cervical spine revealed minimal central disc protrusions at C3-4 and C5-6. Dr. Kendall diagnosed chronic regional pain

syndrome, cervical disc displacement, brachial neuritis or radiculitis, RSD upper extremity, rotator cuff syndrome, and shoulder pain.

In an August 14, 2013 medical report, Dr. Azer reported that he reviewed appellant's recent diagnostic testing and medical reports. He opined that appellant's clinical picture, diagnostic testing, and two surgeries on his right shoulder were consistent with CRPS. Dr. Azer diagnosed status post reconstruction of right shoulder, brachial plexopathy, right median nerve neuropathy at the wrist, and CRPS of the right arm. He stated that appellant sustained a significant injury to his right shoulder where he was initially diagnosed as having brachial plexopathy, as well as AC joint separation and impingement. Dr. Azer opined that appellant had permanent impairment despite undergoing extensive treatment and would be unable to perform any activities that required repetitive use of his upper extremity.

A medical article discussing CRPS in adults was submitted.

By decision dated November 12, 2013, the Branch of Hearings and Review affirmed the April 1, 2013 decision terminating appellant's medical and wage-loss compensation benefits effective May 5, 2013 and finding that he failed to establish ongoing disability on or after May 5, 2013 causally related to one or more of the accepted employment-related conditions.

As previously noted, by decision dated February 26, 2014, the Board set aside the November 24, 2013 decision finding that OWCP failed to review newly submitted medical reports. The Board remanded the case to OWCP to issue a *de novo* final decision after properly considering all of the evidence.[2]

By decision dated May 7, 2014, the Branch of Hearings and Review affirmed the April 1, 2013 decision terminating appellant's medical and wage-loss compensation benefits. It found that he failed to establish ongoing disability on or after May 5, 2013 causally related to the accepted July 20, 2009 incident or injury sustained as a result thereof. It noted that the weight of the medical evidence rested with the opinions of Dr. Smith and Dr. Gordon.

LEGAL PRECEDENT -- ISSUE 1

Once OWCP has accepted a claim and pays compensation, it bears the burden to justify modification or termination of benefits.[3] Having determined that an employee has a disability causally related to his or her federal employment, OWCP may not terminate compensation without establishing either that the disability has ceased or that it is no longer related to the employment.[4]

The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability compensation.[5] To terminate authorization for medical treatment,

[2] *Id*.

[3] *Bernadine P. Taylor*, 54 ECAB 342 (2003).

[4] *Id.*

[5] *Roger G. Payne*, 55 ECAB 535 (2004).

OWCP must establish that appellant no longer has residuals of an employment-related condition which require further medical treatment.[6] OWCP's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[7]

Section 8123(a) 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.[8] 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.[9]

ANALYSIS -- ISSUE 1

OWCP accepted that appellant sustained a sprain of the right shoulder and upper arm, contusion of shoulder and upper arm, suprascapular neuropraxia (right) shoulder, grade 2 right AC joint separation, and right torn labrum as a result of the July 20, 2009 work-related incident. The issue is whether it properly terminated his benefits effective May 5, 2013, as he was not experiencing any residuals of the July 20, 2009 injury. The Board finds that OWCP properly terminated appellant's compensation benefits.

In a July 13, 2012 medical report, Dr. Azer, appellant's treating physician, diagnosed status post right shoulder reconstruction, right CTS, brachial plexopathy and chronic pain syndrome, and restricted appellant from returning to work.

In a September 5, 2012 report, Dr. Smith, an OWCP second opinion physician, reported that appellant sustained a sprain and contusion of the right shoulder and upper arm, neuropraxia to the suprascapular nerve, grade 2 AC joint separation, and a right torn labrum as a result of the July 20, 2009 employment incident. He explained that the right suprascapular neuropraxia and sprains and contusions of the right shoulder and upper arm had resolved as evidenced by the recent EMG study and clinical examination. Dr. Smith further stated that the AC joint separation, grade 2 and associated labrum injury had resolved as appellant underwent surgery and the torn portion was debrided. He reported that all of appellant's conditions had resolved, he required no further medical care and could return to full-duty work.

OWCP properly found a conflict of medical opinion evidence between Dr. Smith, the second opinion physician, and Dr. Azer, appellant's treating physician, regarding whether his accepted conditions had resolved. It referred appellant to Dr. Gordon, a Board-certified

[6] *Pamela K. Guesford*, 53 ECAB 726 (2002).

[7] *T.P.*, 58 ECAB 524 (2007); *Furman G. Peake*, 41 ECAB 351 (1975).

[8] 5 U.S.C. § 8123(a).

[9] *Nathan L. Harrell*, 41 ECAB 402 (1990).

orthopedic surgeon, for an impartial medical examination to resolve the conflict, pursuant to 5 U.S.C. § 8123(a).

In his January 2, 2013 report, Dr. Gordon reviewed EMG study testing and stated that the findings made were unrelated to the July 20, 2009 work incident other than the possibility of some suprascapular nerve changes, which had long since resolved as evidenced by a subsequent EMG study and lack of symptoms in that area. He opined that the July 20, 2009 incident caused soft tissue injuries as well as possible mild AC joint separation, which had resolved within a few months after the injury occurred. Dr. Gordon stated that appellant's subjective complaints led to his surgical procedures, which were on a functional rather than a physiological basis. The only residual objective findings found were well-healed scars in the right shoulder area. Dr. Gordon concluded that appellant did not require further treatment, there were no limitations on his physical capacity, and that he could resume his normal work activities. His opinion is sufficient to resolve the question of whether appellant continued to suffer from any residuals or disability causally related to his accepted July 20, 2009 injury.[10]

The Board finds that, under the circumstances of this case, the opinion of Dr. Gordon is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight and establishes that appellant's work-related conditions have ceased.[11] Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.[12]

The Board has carefully reviewed the opinion of Dr. Gordon and finds that it has reliability, probative value and convincing quality with respect to its conclusions regarding the relevant issue in the present case. Dr. Gordon reviewed the statement of accepted facts and provided detailed findings regarding appellant's prior medical treatment and test results.[13] He related his comprehensive examination findings in support of his opinions. Dr. Gordon's findings were substantiated by Dr. Smith's report who noted that a recent EMG study, clinical examination, and surgery established that appellant's conditions had resolved. As there were no objective findings related to appellant's right arm and shoulder condition, Dr. Gordon opined that, his disability had ceased, there were no limitations on his physical capacity, and that he could resume his normal work activities. He provided medical rationale for his opinion by explaining that appellant's subjective complaints led to his surgical procedures which were on a functional rather than a physiological basis. Dr. Gordon further provided support for his opinion that appellant's conditions had resolved as evidenced by a subsequent EMG study and lack of symptoms in the right arm and shoulder area. His opinion is sufficiently probative, rationalized, and based upon a proper factual background.[14] Dr. Gordon's report is entitled to special weight

[10] *D.C.*, Docket No. 12-1921 (issued August 13, 2013).

[11] *T.B.*, Docket No. 13-1960 (issued February 18, 2014).

[12] *Solomon Polen*, 51 ECAB 341 (2000). *See* 5 U.S.C. § 8123(a).

[13] *See Melvina Jackson*, 38 ECAB 443 (1987).

[14] *L.S.*, Docket No. 13-716 (issued June 4, 2013).

as the impartial medical examiner and establishes that appellant is not entitled to continued benefits.

Subsequent to Dr. Gordon's report, appellant submitted medical reports dated February 15 and 25, 2012 from Dr. Azer, who provided a diagnosis of status post right shoulder reconstruction, right CTS, brachial plexopathy, and chronic pain syndrome. Dr. Azer opined that appellant had residuals of his neurologic injury that occurred back in 2009 and was unable to perform any activities that would require repetitive use or lifting of his upper extremities on a permanent basis.

The Board notes that Dr. Azer's reports are insufficient to establish appellant's claim as he failed to provide a rationalized opinion that he remained disabled as a result of his accepted July 20, 2009 injuries.[15] Though Dr. Azer generally supported that appellant had residuals of his neurologic injury that occurred back in 2009, his opinion on causal relationship was conclusory without any additional explanation as to how the conditions caused disability or remained symptomatic.[16] Moreover, he was on one side of the conflict that gave rise to the referral to Dr. Gordon.[17] Dr. Azer's reports are insufficient to overcome the opinion of Dr. Gordon or to create a new medical conflict.[18]

Thus, the Board finds that Dr. Gordon's opinion constitutes the weight of the medical evidence. There is no other medical evidence contemporaneous with the termination of appellant's benefits, which supports that he has any continuing residuals or disability related to his accepted work-related injuries.[19] OWCP properly terminated his compensation benefits.[20]

LEGAL PRECEDENT -- ISSUE 2

After termination of compensation benefits clearly warranted on the evidence, the burden for reinstating compensation benefits shifts to the claimant. To prevail, the claimant must establish by the weight of the reliable, probative, and substantial evidence that he had an employment-related disability, which continued after the termination of compensation benefits.[21]

OWCP is not a disinterested arbiter but rather performs the role of adjudicator on the one hand and gatherer of the relevant facts and protector of the compensation fund on the other, a

[15] *J.H.*, Docket No. 12-1848 (issued May 15, 2013).

[16] *See George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of little probative value).

[17] *C.B.*, Docket No. 12-1572 (issued February 21, 2013).

[18] *See Michael Hughes*, 52 ECAB 387 (2001); *Howard Y. Miyashiro*, 43 ECAB 1101, 1115 (1992); *Dorothy Sidwell*, 41 ECAB 857 (1990). The Board notes that Dr. Azer's reports did not contain new findings or rationale on causal relationship upon which a new conflict might be based.

[19] *D.R.*, Docket No. 12-1697 (issued January 29, 2013).

[20] *D.M.*, Docket No. 11-386 (issued February 2, 2012); *Marshall E. White*, 33 ECAB 1666 (1982).

[21] *I.J.*, 59 ECAB 408 (2008).

role that imposes an obligation to see that its administrative processes are impartially and fairly conducted.[22] Although the employee has the burden of establishing entitlement to compensation, OWCP shares responsibility in the development of the evidence.[23]

ANALYSIS -- ISSUE 2

The Board finds that this case is not in posture for a decision on the issue of whether appellant had an employment-related disability on or after May 5, 2013, causally related to his accepted July 20, 2009 employment injuries.

As OWCP met its burden to terminate appellant's medical and wage-loss compensation benefits effective May 5, 2013, the burden shifted to appellant to establish that he had disability causally related to his accepted injury on or after May 5, 2013.

In support of his claim, appellant submitted medical reports dated May 20 through October 30, 2013 from Dr. Ignacio, his treating physician, who noted appellant's history of injury on July 20, 2009 and stated that a May 20, 2013 EMG and NCS revealed right brachial neuritis with denervation along the right arm. Dr. Ignacio reported that with regard to the prior EMG study, which demonstrated right ulnar neuritis, it was simply an extension of the right brachial plexus and a component of the right shoulder nerve injury. He related that appellant received multiple medical treatments including physical therapy, nerve blocks, joint injections, and two surgeries. Despite such treatment modalities, appellant developed severe neuropathic pain and CRPS (causalgia of the right upper extremity), which had been bothering him over the past several years. Dr. Ignacio reported that appellant's diagnostic studies included an MRI scan, which confirmed the AC joint dislocation, the tear of the labrum and the tear of the rotator cuff tendon. He provided findings on physical examination and diagnosed status post multiple surgeries to the right shoulder with residual pain, chronic right shoulder strain, chronic right brachial neuritis, chronic right AC joint dislocation and CRPS, which he opined were related to the injuries sustained on July 20, 2009. Dr. Ignacio reviewed Dr. Smith's second opinion report and disagreed with his findings. He argued that Dr. Smith's report was subjective as he referred to appellant's clinical situation as voluntary self-limitation and neglected the significantly accepted right shoulder nerve injury and multiple surgeries. Dr. Ignacio further disagreed with Dr. Smith stating that appellant's right shoulder injury and nerve damage had not resolved as evidence by the recent May 20, 2013 EMG study, which demonstrated the persistence of the right brachial neuritis with associated pain that appellant described. He noted that appellant had complex damage to the right shoulder not only with the nerve injury but the associated complex regional pain syndrome which had been confirmed by other physicians. Dr. Ignacio concluded that appellant could not return to work as an analyst due to continued severe pain and limited use of the right upper extremity.

In an August 14, 2013 medical report, Dr. Azer reported that he reviewed appellant's recent diagnostic testing and medical reports. He opined that appellant's clinical picture, diagnostic testing and two surgeries on his right shoulder were consistent with complex regional

[22] *Richard F. Williams*, 55 ECAB 343, 346 (2004); *Thomas M. Lee*, 10 ECAB 175, 177 (1958).

[23] *D.N.*, Docket No. 07-1940 (issued June 17, 2008); *Mary A. Barnett*, 17 ECAB 187, 189-90 (1965).

pain syndrome. Dr. Azer diagnosed status post reconstruction of right shoulder, brachial plexopathy, right median nerve neuropathy at the wrist, and complex regional pain syndrome of the right arm. He stated that appellant sustained a significant injury to his right shoulder where he was initially diagnosed as having brachial plexopathy as well as AC joint separation and impingement. Dr. Azer opined that appellant had permanent impairment despite undergoing extensive treatment and would be unable to perform any activities that required repetitive use of his upper extremity.

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.[24] The Board notes that, while none of appellant's physician's reports are completely rationalized, they are consistent in indicating that he continues to experience residuals and/or disability causally related to the July 20, 2009 incident.[25] As appellant's attending physicians, Dr. Ignacio and Dr. Azer provided treatment since the onset of injury in July 2009. Their reports provided detailed findings on physical examination and review of diagnostic testing, with a clear opinion that appellant continued to suffer from residuals and/or disability causally related to the July 20, 2009 incident. Moreover, Dr. Ignacio addressed his disagreement with Dr. Smith's report, providing reasoning for his opinion. While the reports of Dr. Ignacio and Dr. Azer are not sufficient to meet appellant's burden of proof, they raise an uncontroverted inference between his continued disability and the accepted employment incident and are, therefore, sufficient to require OWCP to further develop the medical evidence and the case record.[26]

The Board further notes that the May 7, 2014, OWCP decision found that the weight of the medical evidence rested with the opinions of Dr. Smith and Dr. Gordon. Subsequent to Dr. Smith and Dr. Gordon's examinations, appellant underwent additional diagnostic testing, specifically, a May 20, 2013 EMG study, a July 2, 2013 MRI scan of the right shoulder, an August 1, 2013 MRI scan of the brachial plexus and an August 1, 2013 MRI scan of the cervical spine. Dr. Ignacio and Dr. Azer reviewed these additional studies, which they used to form the basis of their opinion that appellant remained disabled as a result of the July 20, 2009 employment incident. In its May 7, 2014 decision, the hearing representative improperly afforded the weight of the medical evidence to Dr. Smith and Dr. Gordon as the physicians had not been provided an opportunity to review this additional, more recent diagnostic testing.[27]

[24] *A.A.*, 59 ECAB 726 (2008); *Phillip L. Barnes*, 55 ECAB 426 (2004).

[25] *P.A.*, Docket No. 09-319 (issued November 23, 2009).

[26] *See P.K.*, Docket No. 08-2551 (issued June 2, 2009); *see also Virginia Richard, claiming as executrix of the estate of Lionel F. Richard*, 53 ECAB 430 (2002); *Jimmy A. Hammons*, 51 ECAB 219 (1999); *Horace Langhorne*, 29 ECAB 820 (1978).

[27] *Gloria J. Godfrey*, 52 ECAB 486 (2001) (the Board found that the opinion of the impartial medical specialist was no longer afforded special weight as appellant submitted subsequent medical reports which provided findings and opinions based on more recent diagnostic studies, which were not reviewed by the impartial medical specialist).

Thus, the Board finds that there remains an unresolved issue as to whether appellant has continuing disability due to the July 20, 2009 injury.[28] On remand, OWCP should further develop the medical evidence. Following such further development as OWCP deems necessary, it shall issue an appropriate merit decision on appellant's claim.[29]

CONCLUSION

The Board finds that OWCP met its burden of proof to terminate appellant's compensation benefits effective May 5, 2013. The Board further finds that the case is not in posture for a decision as to whether appellant continued to suffer from employment-related residuals or disability on or after May 5, 2013 as a result of his accepted July 20, 2009 employment injuries.

ORDER

IT IS HEREBY ORDERED THAT the May 7, 2014 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part. The case is remanded for further action consistent with this decision of the Board.

Issued: January 7, 2015
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[28] *D.N.*, Docket No. 09-651 (issued April 20, 2010).

[29] *H.G.*, Docket No. 09-512 (issued October 2, 2009).