



## **FACTUAL HISTORY**

On September 23, 2008 appellant, then a 40-year-old rural carrier associate, filed a traumatic injury claim alleging that on September 20, 2008 she injured her right shoulder while lifting telephone books. OWCP accepted the claim for closed dislocation and sprain (rotator cuff) of the right shoulder. Appellant stopped work on September 20, 2008 and returned to light duty in October 2008.

On February 19, 2009 appellant underwent right shoulder arthroscopy with intra-articular debridement, subacromial decompression with acromioplasty, and acromioclavicular (AC) joint resection performed by Dr. Timothy J. Treible, a Board-certified orthopedic surgeon.

On January 5, 2010 the employing establishment advised that it could no longer accommodate appellant's restrictions and OWCP began paying compensation for temporary total disability on the periodic rolls.

On August 27, 2010 appellant underwent arthroscopic debridement synovitis and chondromalacia of glenohumeral joint anteriorly and arthroscopic subacromial decompression performed by Dr. Ronald R. Bowman, a Board-certified orthopedic surgeon. OWCP paid compensation for her disability. Appellant had a history of preexisting congenital multidirectional instability and degenerative joint disease of the right glenohumeral joint secondary to the congenital multidirectional instability of both shoulders.

In a January 20, 2009 report, Dr. Treible noted the history of the September 20, 2008 work injury and that appellant was cleared to have proposed repeat shoulder arthroscopy. He noted that she had a significant past medical history and that a right shoulder arthroscopy was previously performed on January 23, 2002 with debridement of a small labral tear and thermal capsulorrhaphy for shoulder instability. Dr. Treible stated that appellant had recovered nicely and did not have any significant issues with her shoulder before her September 20, 2008 injury.

Dr. Paul M. Puziss, a Board-certified orthopedic surgeon, followed appellant after her February 2009 and August 2010 right shoulder surgeries. Following the August 27, 2010 right shoulder surgery, he diagnosed status post arthroscopic right acromioplasty with joint debridement of arthritis and synovitis and degenerative arthritis, right shoulder joint with chondromalacia humeral head. Dr. Puziss opined that appellant was disabled from work.

On December 1, 2010 OWCP received two digital video discs (DVDs) and an investigative memorandum from the employing establishment's Office of the Inspector General (OIG). The surveillance videos were dated August 25 and September 30, 2010.

In May 2011, OWCP referred appellant for a second opinion examination. In a June 4, 2011 report, Dr. Aleksander Curcin, a Board-certified orthopedic surgeon and OWCP referral physician, noted the history of injury and his review of the medical records, the statement of accepted facts, and the DVDs. Examination findings were provided. Dr. Curcin advised that appellant's accepted work-related conditions were sprain of right upper arm and right shoulder rotator cuff tear. He also diagnosed chondromalacia humeral head and degenerative cyst tendinopathy of the supraspinatus as preexisting conditions not causally related to the

September 20, 2008 work injury. Based on his examination, review of the records, and review of the surveillance video, Dr. Curcin opined that appellant fully recovered from any effects of the September 20, 2008 work incident and was capable of performing her date-of-injury position with no restrictions. No further treatment was recommended. A June 4, 2011 work capacity evaluation was attached.

In a July 15, 2011 report, Dr. Puziss, a Board-certified orthopedic surgeon, noted examination findings, which included right shoulder flexion 140, abduction 140, right scapular winging, supraspinatus impingement sign 2+, and Hawkins 3 to 4+. He stated that appellant was not totally rehabilitated and required physical therapy. Dr. Puziss noted that Dr. Curcin's findings were very generic and based on inadequate examination. He stated that appellant had objective findings of right shoulder impairment and could not return to unrestricted duties; however, she was capable of light work regarding the right shoulder.

OWCP declared a conflict in medical opinion between Dr. Puziss and Dr. Curcin and referred appellant, along with the medical record, statement of accepted facts, and a list of questions, to Dr. Mark Leadbetter, an orthopedic surgeon, for an impartial medical examination. In a September 26, 2011 report, Dr. Leadbetter noted the history of injury, his review of the medical records and surveillance DVDs from the OIG dated May 18 and 19, August 25 and September 30, 2010, noted appellant's complaints, and set forth examination findings. A diagnostic impression of preexisting congenital multidirectional instability of both shoulders; degenerative joint disease of the right glenohumeral joint; and dislocation of the right shoulder and right shoulder sprain (administratively accepted as work related) were provided. Dr. Leadbetter found that appellant's treating physicians ignored appellant's past medical history of congenital multidirectional instabilities in both shoulders, which led to an injury in 2001 and subsequent surgery in 2002. He noted that the 2002 surgery was an attempt at capsular shrinkage on the right shoulder, but these events have been ignored by the treating physicians after 2002. Dr. Leadbetter opined that the September 20, 2008 work injury was a recurrence of the same injury that occurred in 2001. Appellant underwent another subluxation of the right shoulder previously due to her multidirectional instability of the right shoulder, which was attempted to be fixed in 2002. Dr. Leadbetter opined that capsular shrinkage for this type of condition has a poor track record and was not the surgery of choice for this condition. He noted that the records he reviewed showed no evidence of a dislocation of the right shoulder on September 20, 2008; rather, appellant sustained a glenohumeral subluxation of her right shoulder secondary to her congenital multidirectional instability since she has the same findings in her left shoulder. Dr. Leadbetter opined that the administratively accepted conditions have resolved since sprains do not require three years to heal and the subluxation of the right shoulder should have healed within four to six weeks. He opined that, with regard to the September 20, 2008 work injury, appellant was able to work without restrictions and that she did not require continued medical care. Dr. Leadbetter noted that the OIG surveillance videos showed that she was able to perform relatively vigorous activities which she had denied at the time of his examination, and apparently at the time of Dr. Curcin's examination. He also noted that the videos were considered objective in nature and did not require much in the way of subjective interpretation. A work capacity evaluation was attached.

Dr. Puziss continued to report right shoulder symptoms. Additional impressions of severe right scapular winging due to severe serratus weakness contributing to impingement, shoulder pain; and right shoulder girdle myofascial pain syndrome were provided.

By notice dated February 15, 2012, OWCP proposed to terminate medical benefits and compensation for wage loss based on the weight of medical evidence of Dr. Leadbetter's finding that there were no longer any residuals or disability causally related to the September 20, 2008 work injury. Appellant was afforded time to make further submission.

Evidence previously of record was provided along with new evidence, which included: a March 3, 2012 Form CA-2, notice of occupational disease, for right shoulder with statements from appellant, medical authorization requests, undated Form CA-17, information on bio-ice.

In a February 21, 2012 report, Dr. Puziss continued to opine that appellant was partially disabled and could not use her right shoulder for work. Authorization for electromyogram studies and cervical magnetic resonance imaging (MRI) scan were requested.

By decision dated March 21, 2012, OWCP terminated appellant's claim for medical and wage-loss benefits effective March 21, 2012.

In a March 4, 2012 letter, appellant disagreed with the proposed termination. On April 5, 2012 OWCP received her request for a review of the written record. Appellant submitted a narrative statement dated April 6, 2012, physical therapy reports, and copies of evidence previously of record. Dr. Puziss continued to opine that she was partially disabled and could not use her right shoulder for work.

By decision dated May 25, 2012, OWCP's Branch of Hearings and Review vacated the March 21, 2012 decision and remanded the claim, as OWCP had not properly provided appellant with copies of the surveillance DVDs and had not allowed her to submit comments regarding those materials.

On August 6, 2012 OWCP submitted the surveillance DVDs for appellant's review. Appellant was afforded 30 days to submit comments or explanation on the accuracy of the images.

Additional evidence submitted into the record included: an August 31, 2012 statement from appellant, in which she argued that none of the activities performed on the surveillance DVDs were in violation of her work restrictions and the activities could not be compared to an eight-hour work shift; appellant's questions to Dr. Puziss dated August 30, 2012; medical authorization requests, July 30 and August 30, 2012 reports from Dr. Puziss; a May 29, 2012 report from Dr. Najera; and an April 26, 2012 report from Dr. Steward, which did not include any additional medical information, and an article entitled Injury Postal and Federal Employees regarding aggravated preexisting conditions.

In his July 30, 2012 report, Dr. Puziss noted that appellant reiterated today that she did not have any problems with her right shoulder following her original surgery by Dr. Treible (arthroscopy, labral debridement, and thermal capsulorrhaphy). He opined that she was able to work sedentarily with regard to her right shoulder with permanent restrictions stemming from the

work injury and degenerative arthritis. In his August 30, 2012 report, Dr. Puziss opined that appellant's degenerative arthritis was most likely the result of her original right shoulder surgery of January 30, 2002. He noted that she had a thermal capsulorrhaphy.

By decision dated September 17, 2012, OWCP terminated appellant's medical benefits and compensation for wage loss effective September 23, 2012.

On September 27, 2012 appellant requested a review of the written record. By decision dated January 15, 2013, an OWCP hearing representative reversed OWCP's September 17, 2012 decision as appellant had not been issued a pretermination notice. OWCP was directed to reinstate benefits retroactively and to issue an appropriate pretermination notice.

On January 28, 2013 OWCP issued a notice of proposed termination of medical and wage-loss compensation benefits based on the weight of the medical evidence of impartial medical specialist, Dr. Leadbetter, who found that there were no longer residuals or disability causally related to the September 20, 2008 traumatic injury. New medical reports provided by the emergency department from Dr. Yo Atteberry, a Board-certified emergency physician, dated September 23, 2012, who diagnosed acute exacerbation of chronic right shoulder pain, right arm pain, and C7 radiculopathy, and Dr. Michelle Shaw, a Board-certified emergency physician, dated October 22, 2012, who diagnosed right shoulder pain were considered.

In response to the January 28, 2013 proposed termination of benefits, OWCP received duplicative evidence already of record along with physical therapy notes, and an emergency department medication form.

In a February 7, 2013 report, Dr. Puziss stated that appellant has a bilateral multidirectional shoulder laxity, which was aggravated by her subluxation injury of September 20, 2008. He indicated that, prior to that injury, she had healed completely since Dr. Treible's original electrothermal capsulorrhaphy in 2002. Appellant required no physical therapy following that surgery and had an excellent clinical result until her next injury at work, from which she never totally recovered. Dr. Puziss indicated that she has developed degenerative arthritis as a result of a combination of her multidirectional laxity, but, more importantly, the superimposed work injuries, particularly the injury of September 20, 2008. When he first saw appellant on December 7, 2009, he felt that it was not her arthritis that was painful since it was minimal at that time, but noted that her arthritis had continued to progress, as noted to be worsened by Dr. Bowman at the time of his August 27, 2010 surgery. Dr. Puziss indicated that another explanation for her degenerative arthritis of the right shoulder would be the electrothermal capsulorrhaphy, which sometimes causes some chondrolysis, but he suspected that may not be the case since too many years have passed between her electrothermal capsulorrhaphy and her next injury, where she was found to have only minimal arthritis. He indicated that appellant's arthritis had progressed over the last four to five years since the work injury.

By decision dated March 5, 2013, OWCP finalized the termination of medical and wage-loss benefits effective March 10, 2013. The weight of the medical evidence continued to rest with Dr. Leadbetter, the impartial medical specialist.

On April 3, 2013 OWCP received appellant's request for review of the written record. In a March 22, 2013 letter, appellant requested review of all prior ICD9 codes, with copies from the ACS Web Processing Portal. Emergency department records dated September 23 and October 22, 2012 and April 18, 2013 were received along with physical therapist notes.

In a March 22, 2013 report, Dr. Jonathan Greenleaf, a Board-certified orthopedic surgeon, provided a description of appellant's original injury working as a chef at a restaurant and her September 20, 2008 work injury delivering telephone books. He set forth her medical treatment and noted her ongoing complaints. Examination findings were provided along with x-ray findings. An impression of right shoulder glenohumeral degenerative arthrosis and a 44-year-old female secondary to a work-related exposure and osteoarthritis, localized, primary, shoulder region degenerative joint disease OR at the AC joint right new was provided. Dr. Greenleaf advised that appellant was a candidate for resurfacing procedures.

By decision dated July 8, 2013, an OWCP hearing representative affirmed the March 5, 2013 termination decision.

On June 3, 2014 appellant requested reconsideration. In support of her request, she submitted a December 5, 1988 employing establishment report of medical examination/history; an April 29, 2002 medical arbiter's report; an October 29, 2012 grievance addendum from the NALC; an October 5, 2001 x-ray report; MRI scan reports dated June 21, 2001 and May 15, 2014; an undated social security authorization to disclose form; a July 8, 2013 emergency room report diagnosing chronic pain in right shoulder, and physical therapy reports.

In a May 15, 2014 report, Dr. Geoffrey Baum, an orthopedic surgeon, noted that appellant presented with intermittent limited range of motion of the right shoulder with significant pain behavior and awkward positioning of the shoulder to reduce pain during the examination. An impression of congenital bilateral shoulder instability by history, right shoulder sprain 2001, with full recovery without impairment; right shoulder sprain of 2008 with undiagnosed preexisting glenohumeral degeneration made symptomatic by the work exposure, with a residual right glenohumeral instability following treatment by Dr. Treitble with glenohumeral capsulorrhaphy. Dr. Baum noted history of June 1, 2001 right shoulder injury while working as a lead in catering, her medical treatment and that she was considered medically stationary without impairment and was released for full activity after arthroscopic surgery on January 23, 2002. He also noted the history of the September 20, 2008 work injury which occurred as a result of repetition while delivering telephone books and her medical course. Dr. Baum indicated his review of the medical records and stated that the question that remains in his mind is when appellant's degenerative joint disease occurred at the right shoulder and this was the need for continued medical treatment. He stated that it was obvious that the condition did not commence on September 20, 2008, so there was likely a preexisting asymptomatic degenerative joint disease of the right shoulder, along with persistent or recurrent instability producing the painful condition for which she continues to seek treatment. Dr. Baum opined that appellant's congenital instability precipitated the glenohumeral arthritis, and that the injury of September 20, 2008, repetitively placing telephone books into mail boxes, was the precipitating event for the need for treatment. He concluded that "were it not for the glenohumeral degeneration and instability, the activity that she was doing on September 20, 2008 would likely not have caused [appellant] to have a painful right shoulder condition."

By decision dated July 1, 2014, OWCP denied modification of its prior decision.

### **LEGAL PRECEDENT -- ISSUE 1**

Once OWCP accepts a claim, it has the burden of justifying termination or modification of compensation. After it has been determined that, an employee has disability causally related to his or her employment, OWCP may not terminate compensation without establishing that the disability had ceased or that it was no longer related to the employment.<sup>2</sup> OWCP's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.<sup>3</sup> Furthermore, the right to medical benefits for an accepted condition is not limited to the period of entitlement for disability. To terminate authorization for medical treatment, OWCP must establish that a claimant no longer has residuals of an employment-related condition that requires further medical treatment.<sup>4</sup>

Section 8123(a) of FECA 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.<sup>5</sup> 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.<sup>6</sup> In situations where there exist 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 upon a proper factual background, must be given special weight.<sup>7</sup>

### **ANALYSIS -- ISSUE 1**

OWCP accepted that on September 20, 2008 appellant sustained a right shoulder rotator cuff sprain and closed dislocation and authorized shoulder surgeries in February 2009 and August 2010. Dr. Puziss, appellant's treating orthopedic surgeon, continued to report that she was unable to work her date-of-injury position and that she required medical treatment for additional diagnoses that were not accepted as injury related. Dr. Curcin, a second opinion orthopedic surgeon, opined that the accepted conditions had resolved and appellant could perform unrestricted work. He did not establish any other diagnoses as injury related. Accordingly, OWCP properly referred appellant to Dr. Leadbetter for an impartial medical examination to resolve the conflict in medical opinion evidence, pursuant to 5 U.S.C. § 8123(a).

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<sup>2</sup> *Jason C. Armstrong*, 40 ECAB 907 (1989).

<sup>3</sup> *See Del K. Rykert*, 40 ECAB 284, 295-96 (1988).

<sup>4</sup> *Mary A. Lowe*, 52 ECAB 223 (2001); *Wiley Richey*, 49 ECAB 166 (1997).

<sup>5</sup> 5 U.S.C. § 8123(a).

<sup>6</sup> 20 C.F.R. § 10.321.

<sup>7</sup> *Gloria J. Godfrey*, 52 ECAB 486 (2001); *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

Following several procedural errors which OWCP corrected, OWCP terminated appellant's wage-loss compensation and medical benefits effective March 10, 2013 finding that Dr. Leadbetter's report constituted the weight of the evidence that she had no further employment-related disability.

The Board finds that OWCP met its burden of proof to terminate appellant's medical and wage-loss compensation benefits based on the September 26, 2011 report of Dr. Leadbetter who reviewed her medical history, the statement of accepted facts, examined her, and found no objective evidence to support ongoing employment-related residuals or disability due to the accepted conditions of a right shoulder rotator cuff sprain and closed dislocation. Dr. Leadbetter provided a diagnostic impression of preexisting congenital multidirectional instability of both shoulders; degenerative joint disease of the right glenohumeral joint; and dislocation of the right shoulder and right shoulder sprain (administratively accepted as work related). He stated that the records he reviewed showed no evidence of a dislocation of the right shoulder on September 20, 2008; rather, appellant sustained a glenohumeral subluxation of her right shoulder secondary to her congenital multidirectional instability as she has the same findings in her left shoulder. Dr. Leadbetter opined that the administratively accepted conditions resolved since sprains did not require three years to heal and the subluxation of the right shoulder should have healed within four to six weeks. He advised that appellant's treating physicians have ignored her past medical history of congenital multidirectional instabilities in both shoulders, which led to an injury in 2001 and subsequent surgery in 2002, which was an attempt at capsular shrinkage on the right shoulder. Dr. Leadbetter opined that, on September 20, 2008, appellant underwent another subluxation of the right shoulder delivering telephone books due to her multidirectional instability of the right shoulder, which was attempted to be fixed in 2002. Based on his examination findings, review of her medical record, and the surveillance videos, he opined that with regard to the September 20, 2008 work injury she was able to work without restrictions and that she did not require continued medical care. Dr. Leadbetter noted that the surveillance videos reviewed showed that appellant was able to perform relatively vigorous activities, which she denied at the time of his examination and apparently at the time of Dr. Curcin's examination, and that the videos were considered objective in nature and did not require much in the way of subjective interpretation.

The Board finds that, as Dr. Leadbetter's report is well rationalized and based on a complete and accurate history, a complete statement of accepted facts and the entire case record, including surveillance videos. Dr. Leadbetter examined appellant thoroughly, reviewed the medical records, and reported accurate medical and employment histories. Thus, his opinion that the accepted conditions have resolved without residuals is entitled to special weight.<sup>8</sup>

The additional medical evidence submitted in response to Dr. Leadbetter's report is insufficient to overcome the weight accorded to him as an impartial medical specialist regarding this issue. While Dr. Puziss submitted additional reports, to include his August 30, 2012 and February 7, 2013 reports, he had been on one side of the conflict in medical opinion regarding whether additional diagnoses were employment related. Reports from a physician who was on one side of a medical conflict that an impartial medical specialist resolved, are generally

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<sup>8</sup> See *Bryan O. Crane*, 56 ECAB 713 (2005).

insufficient to overcome the weight accorded to the opinion of the impartial physician or to create a new conflict.<sup>9</sup> In his August 30, 2012 report, Dr. Puziss opined that appellant's degenerative arthritis was most likely the result of her original right shoulder surgery of January 30, 2002. In his February 7, 2013 report, he stated that her bilateral multidirectional shoulder laxity was aggravated by her subluxation injury of September 20, 2008. Dr. Puziss also stated that appellant developed degenerative arthritis as a result of a combination of her multidirectional laxity, but, more importantly, the superimposed work injuries, particularly the injury of September 20, 2008. He noted that her arthritis was minimal when he first saw her on December 7, 2009, but continued to progress and was noted to be worsened by Dr. Bowman at the time of his August 27, 2010 surgery. Dr. Puziss indicated that another explanation for her degenerative arthritis of the right shoulder would be the electrothermal capsulorrhaphy, which sometimes causes chondrolysis, but he suspected that may not be the case since too many years have passed between her electrothermal capsulorrhaphy and her next injury, where she was found to have only minimal arthritis. He indicated that appellant's arthritis had progressed over the last four to five years since the work injury. As noted, OWCP only accepted right shoulder dislocation and rotator cuff strain. Dr. Puziss did not indicate that the accepted conditions were still active and disabling. While he discussed appellant's degenerative arthritis condition, he originally opined it was the result of her original right shoulder surgery of January 30, 2002, but then opined it was a result of a combination of her multidirectional laxity and the superimposed work injuries, particularly the injury of September 20, 2008. Dr. Puziss provided no medical rationale as to why he changed his opinion or provided any medical rationale explaining how delivering telephone books over the course of one day precipitated the diagnosed degenerative arthritis condition and how the accepted event materially worsened the preexisting bilateral shoulder condition and what the worsening consisted of. There are no other medical reports establishing that appellant's additional shoulder conditions are causally related to her September 20, 2008 work injury.

The other medical evidence submitted to OWCP, including diagnostic testing, is insufficient to overcome the weight of the medial evidence provided by Dr. Leadbetter's impartial medical opinion that the accepted conditions had resolved without disability as no new information was provided regarding appellant's accepted conditions. The additional evidence also failed to address whether appellant has established that she had any additional conditions or disability causally related to her accepted work injury. The physical therapy reports are of no probative medical value as physical therapists are not considered physicians under FECA.<sup>10</sup>

Therefore, the Board finds that OWCP properly terminated appellant's wage-loss and medical compensation benefits effective March 10, 2013, as the weight of the competent medical evidence established that the accepted September 20, 2008 closed dislocation and sprain (rotator cuff) of the right shoulder had resolved without residuals. OWCP also properly denied her request to expand her claim as she has not met her burden of proof to establish that she had any additional conditions or disability causally related to her accepted work injury.

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<sup>9</sup> *Jaja K. Asaramo*, 55 ECAB 200 (2004).

<sup>10</sup> *David P. Sawchuk*, 57 ECAB 316 (2006). Section 8101(2) of FECA provides that physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. See *Roy L. Humphrey*, 57 ECAB 238 (2005).

On appeal, appellant contends that her preexisting shoulder conditions and her surveillance videos should not be part of her record. However, her preexisting shoulder conditions are part of her medical history and are relevant to the determinations of whether any additional shoulder conditions claimed are causally related to the September 20, 2008 work injury. The surveillance videos can be helpful for a physician to assess the nature of appellant's right arm condition before and after her August 20, 2010 surgery. While OWCP had a responsibility to make the claimant aware that it was providing video evidence to a medical expert, any delay in providing the materials to her was not prejudicial as opinion of the impartial specialist was clearly based on more than a review of the video and she did not challenge that she was the person being taped performing activities.<sup>11</sup> In this case, appellant submitted no evidence to contradict the activities shown on the surveillance videos. As noted in *F.S.*, investigative practices on an employing establishment's OIG are not within the jurisdiction of the Board.<sup>12</sup> However, the authority of the Board extends to the claims administration of OWCP. As explained in the Board precedent and in OWCP procedure manual, the Board will consider questions of evidence and claims processing under the provisions of FECA.

Appellant may submit evidence or argument with a written request for reconsideration 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.

### **LEGAL PRECEDENT -- ISSUE 2**

Once OWCP properly terminates appellant's compensation benefits, the burden shifts to appellant to establish that she has continuing disability after that date related to her accepted injury.<sup>13</sup> To establish a causal relationship between the condition as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence based on a complete medical and factual background, supporting such a causal relationship.<sup>14</sup> Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.<sup>15</sup>

### **ANALYSIS -- ISSUE 2**

The Board finds that appellant submitted insufficient medical evidence to establish residuals of the accepted conditions after March 10, 2013, due to the September 20, 2008 employment injury.

In his March 22, 2013 report, Dr. Greenleaf provided a description of appellant's original injury and her September 20, 2008 work injury. Examination findings were provided and an

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<sup>11</sup> *J.M.*, 58 ECAB 478 (2007).

<sup>12</sup> Docket No. 11-863 (issued September 26, 2013).

<sup>13</sup> *See Manuel Gill*, 52 ECAB 282 (2001).

<sup>14</sup> *Id.*

<sup>15</sup> *Paul Foster*, 56 ECAB 208 (2004); *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

impression of right shoulder glenohumeral degenerative arthrosis secondary to a work-related exposure and osteoarthritis, localized, primary, shoulder region degenerative joint disease OR at the AC joint right new was provided. Dr. Greenleaf, however, did not clarify whether the diagnosed right shoulder glenohumeral degenerative arthrosis was related to the work injury appellant experienced in the private sector working as a chef or her September 20, 2008 federal employment injury. He also failed to provide any medical rationale explaining how delivering telephone books in the course of one day, September 20, 2008, would result in right shoulder glenohumeral degenerative arthrosis. A mere conclusion without the necessary medical rationale to explain how and why the physician believes that appellant's accepted exposure could result in a diagnosed condition is not sufficient to meet appellant's burden of proof. The medical evidence must also include rationale explaining how the physician reached the conclusion he or she is supporting, which Dr. Greenleaf failed to do.<sup>16</sup> As such, Dr. Greenleaf's report is insufficient to meet appellant's burden of proof.

In his May 15, 2014 report, Dr. Baum provided an impression of congenital bilateral shoulder instability by history, right shoulder sprain 2001, with full recovery without impairment; right shoulder sprain 2008 with undiagnosed preexisting glenohumeral degeneration made symptomatic by the work exposure, with a residual right glenohumeral instability following treatment by Dr. Treitble with glenohumeral capsulorrhaphy. He noted appellant's history of June 1, 2001 right shoulder injury while working as a lead in catering, that she was considered medically stationary without impairment and was released for full activity after arthroscopic surgery January 23, 2002, and the history of the September 20, 2008 work injury. Dr. Baum stated that her degenerative shoulder joint disease at the right shoulder was likely a preexisting asymptomatic degenerative joint disease of the right shoulder, along with persistent or recurrent instability producing the painful condition for which appellant continues to seek treatment. He opined that appellant's congenital instability precipitated the glenohumeral arthritis, and that the injury of September 20, 2008, repetitively placing telephone books into mailboxes, was the precipitating event for the need for treatment. Dr. Baum concluded that "were it not for the glenohumeral degeneration and instability, the activity that she was doing on September 20, 2008 would likely not have caused this patient to have a painful right shoulder condition." He, however, does not provide any medical rationale explaining how delivering telephone books over the course of one day precipitated the diagnosed glenohumeral arthritis, how that event materially worsened the preexisting bilateral shoulder condition, or what worsening was identified. As previously noted, a mere conclusion without the necessary medical rationale to explain how and why the physician believes that appellant's accepted exposure could result in a diagnosed condition is not sufficient to meet appellant's burden of proof.<sup>17</sup> As such, Dr. Greenleaf's report is insufficient to meet appellant's burden of proof.

There is no other medical evidence of record from a physician which gives reasoned support that appellant had any employment-related residuals or disability after March 10, 2013.

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<sup>16</sup> See *T.M.*, Docket No. 08-975 (issued February 6, 2009) (a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

<sup>17</sup> *Id.*

**CONCLUSION**

The Board finds that OWCP met its burden of proof to terminate appellant's compensation benefits effective March 10, 2013 on the grounds that she no longer had any residuals or disability causally related to her accepted September 20, 2008 employment-related injuries. The Board further finds that appellant did not meet her burden of proof to establish that she had any employment-related residuals or disability after March 10, 2013.

**ORDER**

**IT IS HEREBY ORDERED THAT** the July 1, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 14, 2015  
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge  
Employees' Compensation Appeals Board

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