United States Department of Labor
Employees' Compensation Appeals Board

M.P., Appellant	)	
and	)	**Docket No. 15-0361**
	)	**Issued: September 27, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Portland, ME, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On December 8, 2014 appellant filed a timely appeal from a July 2, 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.[2]

ISSUES

The issues are: (1) whether appellant met her burden of proof to establish a recurrence of disability commencing April 23, 2013 causally related to her accepted conditions; and (2) whether OWCP properly denied appellant's request for total shoulder replacement surgery.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that appellant submitted additional evidence on appeal and to OWCP after the July 2, 2014 decision was issued. The Board's jurisdiction however is limited to reviewing the evidence that was before OWCP at the time of its final decision. Therefore, the Board lacks jurisdiction to review this additional evidence. 20 C.F.R. § 501.2(c)(1).

FACTUAL HISTORY

On July 6, 2002 appellant, then a 42-year-old account manager, filed an occupational disease claim (Form CA-2) alleging that she developed bilateral carpal tunnel syndrome due to factors of her federal employment, including computer keyboarding. She indicated that she first became aware of her condition on January 11, 2001. On September 27, 2002 OWCP accepted the claim for bilateral carpal tunnel syndrome and left shoulder impingement, paid intermittent medical and wage-loss compensation, and authorized surgery for right carpal tunnel release on December 30, 2002. On February 13, 2003 OWCP authorized left carpal tunnel release surgery, but appellant did not have the surgery at that time.

On July 21, 2005 Dr. Robert Parisien, an orthopedic surgeon, diagnosed impingement of the right shoulder and carpal tunnel syndrome. He noted that appellant used computers for her work and had a flare-up of her pain a couple weeks prior.

In an August 5, 2010 report, Dr. Paul McAfee, an orthopedic surgeon, noted that appellant underwent an anterior lumbar disc replacement at L4-5 in early 2001 and advised that she needed to drive a vehicle that was higher to the ground to ensure proper body mechanics and posture when getting in and out of a car in order to avoid flare-ups of pain.

In reports dated June 8, 2011 through March 28, 2012, Dr. David Johnson, an orthopedic surgeon, diagnosed carpal tunnel syndrome and left shoulder arthritis and advised that appellant would like a surgical solution. He recommended an arthroscopic acromioclavicular joint resection and subacromial decompression of the left shoulder.

The left carpal tunnel release, which was authorized by OWCP, was performed by Dr. Johnson on May 1, 2012. The proposed left shoulder surgical procedures, which were not authorized by OWCP, were also performed by Dr. Johnson on May 1, 2012. On May 24, 2013 OWCP later accepted the additional condition of left shoulder impingement. Appellant received intermittent medical and wage-loss compensation.

Dr. Johnson, in an October 17, 2012 report, released appellant to modified duty on November 1, 2012 with the following restrictions: adjustments to the steering wheel in appellant's car, adjustments to appellant's desk, and voice-activation software to minimize the amount of typing appellant does with her left arm.

Appellant returned to limited-duty work as a modified global account specialist on November 19, 2012 with the following restrictions: sitting and fine manipulation, including keyboarding, no more than four hours per day, intermittently.[3]

In an April 23, 2013 emergency room report, Dr. Matthew Hamonko, a Board-certified emergency medicine physician, noted that appellant had undergone chiropractic manipulation of

[3] Appellant filed a claim for wage-loss compensation (Form CA-7) for the period November 5 to 16, 2012. By decision dated January 16, 2013, OWCP denied the claim as the medical evidence of record was insufficient to establish that she was disabled for the period claimed. Appellant filed a request for reconsideration and by decision dated March 1, 2013, OWCP denied modification of its prior decision.

her neck on April 22, 2013 and woke up with profound numbness to her entire left upper extremity, with very minimal neck soreness, and some mild fatigue to her left arm. Appellant reported that she "had a very similar occurrence a few weeks ago, with chiropractic manipulation of her neck, and had an episode of left upper extremity numbness that resolved." A cervical spine magnetic resonance imaging (MRI) scan revealed a large central disc herniation at L4-5 and mild degenerative changes. Dr. Hamonko diagnosed sub-acute onset of left upper extremity numbness and minimal pain after chiropractic manipulation, without significant myelopathy.

In an April 22, 2013 report, Dr. Johnson diagnosed neck pain and left shoulder pain and indicated that given appellant's significant degenerative changes from 2010 he required more soft tissue information from a left shoulder MRI scan.

Appellant filed a claim for recurrence of disability (Form CA-2a) beginning April 23, 2013. She alleged that she was required to type on her computer keyboard in excess of her medical restrictions due to technical difficulties with her Dragon voice activation software. Appellant claimed that the Dragon software was not compatible with the database she was required to use daily, so she was required to type on her computer. She further indicated that her attending physician, Dr. Johnson, had suggested "chiropractic care to relieve spasm between shoulders."

On the reverse side of the claim form, the employing establishment confirmed that appellant had been provided with Dragon software, which enabled her to enter data into the computer without typing. It denied, however, that she was required to violate her restrictions, indicating that her supervisor cautioned her against typing and instructed her on numerous occasions to do nothing that could aggravate her injury.

In a June 3, 2013 letter, OWCP requested additional evidence in support of the claim and afforded appellant 30 days to respond to its inquiries.

In reports dated May 8 through November 13, 2013, Dr. Johnson diagnosed left shoulder glenohumeral arthritis and opined that appellant's condition was causally related to her employment "because the condition [was] significantly exacerbated by repetitive arm activity, keying, and driving as [appellant was] required to do." He indicated that over time she adopted many compensatory movements that created or exacerbated neck and scapular pain. On July 25, 2013 Dr. Johnson advised that appellant be restricted from driving more than two hours per day and keyboarding more than four hours per day with breaks every half hour using her voice activation. On September 25, 2013 he indicated that appellant continued with modified duty, that she heard a lot of cracking and popping in her shoulder, that turning her steering wheel bothered her when driving, and that she could not lift anything heavy.

In a May 31, 2013 report, Matthew Johnson, a physician assistant, related that appellant had neck pain, left arm pain, and anxiety. He released her to full-time modified duty with restrictions of no driving and limited computer keying.

On June 13, 2013 Dr. Douglas Pavlak, a Board-certified physiatrist, provided results on examination for left arm and shoulder pain, as well as neck pain. He reviewed her medical history and noted that she had worked for the employing establishment for 27 years sorting mail,

delivering mail, doing extensive computer work, and driving. Dr. Pavlak noted examining appellant to determine whether her left arm pain was due to cervical radiculopathy or shoulder pathology. His objective findings included a normal neurological examination, a normal shoulder examination, and an electromyography (EMG) that was negative for any evidence of a C5 radiculopathy. Dr. Pavlak found that the only real abnormality on the EMG was some nonacute denervation changes in the triceps, which was primarily a C6-7 muscle, and opined that these changes were "more likely from spondylosis at C6-7 where there [was] a component of foraminal stenosis on imaging." He diagnosed joint pain, localized in the shoulder, and concluded that there was an "underwhelming amount of evidence for cervical radiculopathy compared to the amount of evidence for shoulder arthropathy." Dr. Pavlak did not dispute the diagnosis of cervical pathology, but found that it was "probably causing less of [appellant's] shoulder pain than her shoulder problem."

In a June 19, 2013 report, Dr. Lee Thibodeau, a Board-certified neurosurgeon, referenced an original work injury to appellant's neck on January 11, 2001 with several exacerbations since that date. He noted that "[a] manipulation on April 22, 2013 made her worse with left neck, shoulder, and arm pain." Dr. Thibodeau found that a cervical MRI scan revealed cervical degenerative changes and a new large central disc herniation at C4-5. He found no signs of myelopathy, but did "believe that [appellant] had an overlay of shoulder issues confounding the causative problem" and explained that some of appellant's pain was likely in a C5 pattern. Dr. Thibodeau diagnosed cervicalgia and displacement of cervical intervertebral disc without myelopathy and restricted her from lifting at work.

Appellant's treating physician requested authorization, on July 2, 2013, for reconstruction surgery of the left shoulder joint.

On July 30, 2013 appellant returned to work as a modified global account manager with restrictions on driving no more than two hours per day, keyboarding with voice activation assist four hours per day intermittently, and sitting eight hours per day intermittently, based on the July 25, 2013 report from Dr. Johnson.

On August 9, 2013 appellant requested authorization for left total shoulder replacement surgery.

In a September 4, 2013 report, Dr. Michelle Delenick, a Board-certified internist, diagnosed left shoulder pain, neck pain, and migraine headache and noted that appellant's neck and left shoulder pain had been ongoing for over a year and that there was a question as to whether it was work related.

On September 15, 2013 an OWCP medical adviser found that the proposed total left shoulder replacement surgery was not clinically indicated as the medical evidence did not establish that it was causally related to appellant's accepted conditions.

In reports dated October 31 and November 14, 2013, Dr. Adam Owen, a Board-certified anesthesiologist and pain medicine specialist, diagnosed left shoulder pain, localized primary osteoarthritis of the shoulder region, cervical disc displacement, neck pain, attention-deficit/hyperactivity disorder, and anxiety.

OWCP referred appellant to Dr. Lawrence Leonard, a Board-certified orthopedic surgeon, for a second opinion evaluation to determine the nature and extent of her employment-related disability. In a November 7, 2013 report, Dr. Leonard reviewed the statement of accepted facts and her medical history and records. Upon physical examination, he found restricted motion of the left shoulder consistent with degenerative arthritis of the left shoulder. Dr. Leonard found no evidence of radiculopathy and no evidence of any residual neurological deficits due to appellant's bilateral carpal tunnel syndrome. He also found no significant problems in the left resected acromioclavicular (AC) joint. Dr. Leonard diagnosed left shoulder degenerative arthritis and degenerative disc disease of the neck with a past history of C5 radiculopathy. He opined that appellant's accepted bilateral carpal tunnel syndrome had resolved without residuals and her left shoulder impingement was not causally related to the degenerative arthritis of the glenohumeral joint. Dr. Leonard explained that she had no pain or tenderness of significance in the left AC joint and that prior to May 2012 she had significant cartilage damage in the left shoulder joint, which progressed into an osteoarthritic problem. Additionally, he noted that appellant was right-handed, so he did not believe that her work caused the degenerative arthritis in her left shoulder joints. Dr. Leonard concluded that she had reached maximum medical improvement and was capable of working full duty without restrictions.

In reports dated January 8 and April 16, 2014, Dr. Johnson reiterated his diagnoses and disagreed with Dr. Leonard's second opinion evaluation. He indicated that appellant had "findings of shoulder arthritis at the time of the arthroscopy a couple of years ago" and had progressed over time to have x-ray findings that were definitively consistent with shoulder arthritis. Dr. Johnson opined that a shoulder replacement was the only treatment that would work well for her despite her young age. On April 16, 2014 he indicated that he had performed an arthroscopy several years ago and noted multiple patches of lost cartilage on the humeral head of appellant's left shoulder. Dr. Johnson opined that this was the beginning of her progressive shoulder arthritis and two subsequent x-rays demonstrated progressive loss of joint space. He further noted that Dr. Leonard was "no longer in the active clinical practice of medicine and [never] did total shoulder arthroplasties during his career." Dr. Johnson concluded that Dr. Leonard's second opinion would likely not be as up-to-date as his own as he had completed a shoulder-specific fellowship and performed hundreds of total shoulder arthroplasties.

On January 14, 2014 Dr. David Keller, a Board-certified osteopathic manipulative medicine specialist, diagnosed cervicalgia and somatic dysfunction and provided appellant with osteopathic manipulation. He believed that her neck pain "began 13 years ago with a date of injury of January 11, 2001, that began after sudden increase in workload, driving a lot" for the employing establishment.

Appellant submitted progress reports dated January 21 and February 5, 2014 from Dr. Owen.

By decision dated July 2, 2014, OWCP denied appellant's recurrence claim, finding that the medical evidence was insufficient to establish disability commencing April 23, 2013 causally related to the accepted employment injuries. It determined that any disability during that period of time would have been attributed to appellant's preexisting arthritis and not due to the accepted condition of shoulder impingement. It further denied her request for a total left shoulder

replacement surgery finding that it was not necessitated by the accepted shoulder impingement condition, but rather due to the underlying, preexisting arthritis.[4]

LEGAL PRECEDENT -- ISSUE 1

A recurrence of disability means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition which has resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness.[5] This term also means an inability to work that takes place when a light-duty assignment made specifically to accommodate an employee's physical limitations due to her work-related injury or illness is withdrawn (except when such withdrawal occurs for reasons of misconduct, nonperformance of job duties, or a reduction-in-force) or when the physical requirements of such an assignment are altered so that they exceed her established physical limitations.[6]

When an employee who is disabled from the job he or she had when injured on account of employment-related residuals returns to a limited-duty position or the medical evidence of record establishes that he or she can perform the limited-duty position, the employee has the burden to establish by the weight of the reliable, probative, and substantial evidence a recurrence of total disability and to show that he or she cannot perform such limited-duty work. As part of this burden, the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the limited-duty job requirements.[7] This burden includes the necessity of furnishing evidence from a qualified physician who concludes, on the basis of a complete and accurate factual and medical history, that the disabling condition is causally related to the employment injury. The medical evidence must demonstrate that the claimed recurrence was caused, precipitated, accelerated, or aggravated by the accepted injury.[8]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[9] The opinion of the

---

[4] By decision dated April 28, 2015, an OWCP hearing representative affirmed the July 2, 2014 decision. The Board and OWCP, however, may not have concurrent jurisdiction over the same issue in a case. Consequently, any decision by OWCP on an issue pending before the Board is null and void. *See Douglas E. Billings*, 41 ECAB 880, 895 (1990). As OWCP issued the April 28, 2015 decision after appellant's appeal to the Board on December 8, 2014 and as it does decide the same issues pending before the Board, recurrence of disability and request for surgery, it is null and void. *See* 20 C.F.R. § 501.2(c)(3). The Board notes, however, that the hearing representative also denied appellant's request to expand her accepted conditions to include arthritis of the left shoulder. As that issue was not on appeal to the Board, it is not affected by this ruling.

[5] 20 C.F.R. § 10.5(x). *See T.S.*, Docket No. 09-1256 (issued April 15, 2010).

[6] *Id.*

[7] *See A.M.*, Docket No. 09-1895 (issued April 23, 2010). *See also Joseph D. Duncan*, 54 ECAB 471, 472 (2003); *Terry R. Hedman*, 38 ECAB 222, 227 (1986).

[8] *See L.F.*, Docket No. 14-1817 (issued February 2, 2015); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.2 (January 2013).

[9] *See I.R.*, Docket No. 09-1229 (issued February 24, 2010); *D.I.*, 59 ECAB 158 (2007).

physician must be based on a complete factual and medical background of the employee, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[10]

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met her burden of proof to establish a recurrence of disability commencing April 23, 2013 causally related to her January 11, 2001 employment injury.

OWCP accepted bilateral carpal tunnel syndrome and left shoulder impingement due to factors of her federal employment. Appellant underwent a right carpal tunnel release on December 30, 2002 and a left carpal tunnel release and left shoulder surgery performed by Dr. Johnson on May 1, 2012. She returned to light-duty work as a modified global account specialist with restrictions on keyboarding with voice activation assistance for four hours per day, intermittently.

On April 25, 2013 appellant filed a notice of recurrence alleging that she was required to type on her computer keyboard in excess of her medical restrictions due to issues with her Dragon voice activation software. She claimed that the Dragon software was not compatible with the database she was required to use daily, so she was required to type on her computer. Appellant advised that her attending physician, Dr. Johnson, had suggested "chiropractic care to relieve spasm between shoulders." The employing establishment denied, however, that she was required to violate her restrictions, indicating that her supervisor cautioned her against typing and instructed her on numerous occasions to do nothing that might aggravate her injury. The Board finds that the evidence submitted by appellant lacks adequate rationale to establish a change in the nature and extent of the injury-related condition or a change in the nature and extent of the limited-duty job requirements.

Dr. Johnson provided reports, beginning April 22, 2013 noting appellant's status, diagnosing left shoulder glenohumeral arthritis, and setting forth work restrictions. He did not specifically address how appellant's disability beginning April 23, 2013 was due to a spontaneous change in her accepted bilateral carpal tunnel syndrome and left shoulder impingement. Instead, Dr. Johnson attributed appellant's condition to an arthritic shoulder condition that OWCP has not accepted as employment related. Thus, these reports are of limited probative value on the matter of whether appellant's accepted conditions caused a recurrence of disability beginning April 23, 2013.

In an April 23, 2013 room, Dr. Hamonko noted that appellant underwent chiropractic manipulation of her neck on April 22, 2013 and woke up with profound numbness to her entire left arm. He diagnosed sub-acute onset of left upper extremity numbness and minimal pain after chiropractic manipulation, without significant myelopathy. However, Dr. Hamonko did not specifically address if appellant had disability beginning April 23, 2013 causally related to the

[10] *See I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 465 (2005).

accepted bilateral carpal tunnel syndrome and left shoulder impingement. Similarly, Dr. Thibodeau, on June 19, 2013, indicated that appellant reported an original work injury to her neck on January 11, 2001 with several exacerbations since that date. He found that "[a] manipulation on April 22, 2013 made her worse with left neck, shoulder, and arm pain" and diagnosed cervicalgia and displacement of cervical intervertebral disc without myelopathy. However, Dr. Thibodeau did not attribute her disability beginning April 23, 2013 to the conditions accepted by OWCP. Consequently, these reports are of limited probative value and are insufficient to establish that appellant had a recurrence of disability beginning April 23, 2013 causally related to her accepted conditions.

OWCP referred appellant to Dr. Leonard for a second opinion evaluation to determine the nature and extent of her employment-related disability. In his November 7, 2013 report, Dr. Leonard reported that he found no evidence of radiculopathy and no evidence of any residual neurological deficits due to appellant's bilateral carpal tunnel syndrome. He also found no significant problems in the left resected AC joint. Dr. Leonard diagnosed left shoulder degenerative arthritis and degenerative disc disease of the neck with a past history of C5 radiculopathy. He opined that appellant's accepted bilateral carpal tunnel syndrome had resolved without residuals and her left shoulder impingement was not causally related to the degenerative arthritis of the glenohumeral joint. Dr. Leonard explained that she had no pain or tenderness of significance in the left AC joint and she had previously significant cartilage damage in the left shoulder joint prior to May 2012, which progressed into an osteoarthritic problem. Additionally, he indicated that appellant was right-handed, so he did not believe that her work caused the degenerative arthritis in her left shoulder joints. Dr. Leonard concluded that she was capable of working full duty without restrictions.

The Board finds that Dr. Leonard had full knowledge of the relevant facts and evaluated the course of appellant's condition. Dr. Leonard is a specialist in the appropriate field. His opinion is based on proper factual and medical history and his report contained a detailed summary of this history. Dr. Leonard addressed the medical records to make his own examination findings to reach a reasoned conclusion regarding appellant's conditions.[11] At the time the recurrence claim was denied, he found no basis on which to establish a causal relationship between the April 22, 2013 chiropractic manipulation, or disability beginning April 23, 2013, and the January 11, 2001 employment injury. Dr. Leonard's opinion as set forth in his November 7, 2013 report is found to be probative evidence and reliable.

Other medical evidence provided by appellant either predates the claimed period of disability beginning April 23, 2013 or does not specifically address how there was a spontaneous change in her accepted bilateral carpal tunnel syndrome and left shoulder impingement which caused disability beginning April 23, 2013.[12] Consequently, this evidence is of diminished

[11] *See Michael S. Mina*, 57 ECAB 379 (2006) (the opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion are facts, which determine the weight to be given to each individual report).

[12] *See S.E.*, Docket No. 08-2214 (issued May 6, 2009) (medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

probative value. Appellant also provided a May 31, 2013 report from Mr. Johnson, a physician assistant. This evidence is of no probative medical value as a physician assistant is not considered a physician under FECA.[13]

For these reasons, the Board finds that appellant did not meet her burden of proof to establish a recurrence of disability beginning April 23, 2013.

LEGAL PRECEDENT -- ISSUE 2

Section 8103(a) of FECA provides that the United States shall furnish to an employee who is injured while in the performance of duty the services, appliances, and supplies prescribed or recommended by a qualified physician that the Secretary of Labor considers likely to cure, give relief, reduce the degree or the period of any disability, or aid in lessening the amount of any monthly compensation.[14] OWCP must therefore exercise discretion in determining whether the particular service, appliance, or supply is likely to affect the purposes specified in FECA.[15] The only limitation on OWCP's authority is that of reasonableness.[16] Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgement, or actions taken which are contrary to both logic and probable deductions from established facts. It is not enough to merely show that the evidence could be construed so as to produce a contrary factual conclusion.[17]

While OWCP is obligated to pay for treatment of employment-related conditions, appellant has the burden of establishing that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[18] Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[19] Therefore, in order to prove that the surgical procedure is warranted, appellant must submit evidence to show that the procedure was for a condition causally related to the employment injury and that the surgery was medically warranted. Both of these criteria must be met in order for OWCP to authorize payment.[20]

[13] 5 U.S.C. § 8101(2). *See also Paul Foster*, 56 ECAB 208, 212 n.12 (2004); *Joseph N. Fassi*, 42 ECAB 677 (1991); *Barbara J. Williams*, 40 ECAB 649 (1989).

[14] 5 U.S.C. § 8103(a).

[15] *F.S.*, Docket No. 14-972 (issued October 15, 2014).

[16] *Daniel J. Perea*, 42 ECAB 214 (1999).

[17] *See Minnie B. Lewis*, 53 ECAB 606 (2002).

[18] *See Kennett O. Collins, Jr.*, 55 ECAB 648 (2004); *Debra S. King*, 44 ECAB 203, 209 (1992).

[19] *K.H.*, Docket No. 15-148 (issued February 24, 2015); *see also M.B.*, 58 ECAB 588 (2007); *Bertha L. Arnold*, 38 ECAB 282 (1986).

[20] *See R.C.*, 58 ECAB 238 (2006); *Cathy B. Millin*, 51 ECAB 331, 333 (2000).

ANALYSIS -- ISSUE 2

The Board finds that OWCP properly denied appellant's request for total left shoulder arthroplasty.

In an October 17, 2012 report, Dr. Johnson diagnosed left shoulder glenohumeral arthritis and opined that appellant's condition was causally related to her employment "because the condition [was] significantly exacerbated by repetitive arm activity, keying, and driving as she [was] required to do." He indicated that over time she adopted many compensatory movements that created or exacerbated neck and scapular pain. Dr. Johnson noted that a shoulder joint arthroplasty will be needed at some point.

In reports dated January 8 and April 16, 2014, Dr. Johnson disagreed with Dr. Leonard's second opinion evaluation. He indicated that appellant had "findings of shoulder arthritis at the time of the arthroscopy a couple of years ago" and had progressed over time to have x-ray findings that were definitively consistent with shoulder arthritis. Dr. Johnson alleged that Dr. Leonard was "no longer in the active clinical practice of medicine and [never] did total shoulder arthroplasties during his career." He concluded that Dr. Leonard's medical opinion would likely not be as current as his own, as he had completed a shoulder-specific fellowship and performed hundreds of total shoulder arthroplasties. Dr. Johnson, however, failed to provide a rationalized opinion explaining how the accepted shoulder impingement would have caused or aggravated the underlying cause for the surgery, arthritis. He simply noted that her arthritis condition occurred while she was at work and was significantly exacerbated by repetitive arm activity, keying, and driving. OWCP has not accepted arthritis as work related. Thus, the Board finds that the reports from Dr. Johnson are insufficient to support appellant's request for surgery.

Dr. Hamonko's April 23, 2013 emergency room report diagnosed subacute onset of left upper extremity numbness and minimal pain after chiropractic manipulation. On June 19, 2013 Dr. Thibodeau indicated that appellant reported an original work injury to her neck on January 11, 2001 with several exacerbations since. He noted that a "manipulation on April 22, 2013 made her worse with left neck, shoulder, and arm pain" and diagnosed cervicalgia and displacement of cervical intervertebral disc without myelopathy. The reports from Drs. Hamonko and Thibodeau failed to provide sufficient medical rationale explaining how appellant's claimed left shoulder arthritic condition is causally related to, or a consequence of, the accepted bilateral carpal tunnel syndrome and left shoulder impingement. Although disability resulting from surgery or treatment authorized by OWCP is compensable.[21] As noted above, OWCP has not accepted that she experienced an employment-related injury on April 22, 2013, nor has OWCP accepted arthritis as work related. Therefore, the Board finds that Drs. Hamonko and Thibodeau's reports are insufficient to establish appellant's request for surgery.

Appellant also submitted reports from Drs. Pavlak, Delenick, Owen, and Keller in support of her claim. The Board has held that medical evidence that does not offer any opinion

[21] *See R.S.*, Docket No. 15-576 (issued June 9, 2015).

on the relevant issue is of limited probative value.[22] The Board finds that this evidence is insufficient to establish the need for shoulder surgery.

As appellant failed to support her request for surgery with rationalized medical evidence establishing a causal relationship between the accepted conditions and the surgery, she has failed to meet her burden of proof. While OWCP is obligated to pay for treatment of employment-related conditions, appellant has the burden of establishing that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[23] The Board finds that OWCP properly relied on the opinion of Dr. Leonard, the second opinion physician. Dr. Leonard provided an accurate history of appellant's work-related injuries, provided thorough results on examination, and provided a rationalized opinion that the accepted left shoulder impingement was playing no role in the present degenerative arthritis. The Board thus finds that OWCP properly exercised its discretion when it denied the left shoulder surgery.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish a recurrence of disability commencing April 23, 2013 causally related to accepted bilateral carpal tunnel syndrome and left shoulder impingement. The Board further finds that OWCP properly exercised its discretion to deny left shoulder surgery causally related to her employment injuries.

[22] *See supra* note 12.

[23] *Supra* note 18.

ORDER

IT IS HEREBY ORDERED THAT the July 2, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 27, 2016
Washington, DC

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

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board