United States Department of Labor
Employees' Compensation Appeals Board

L.L., Appellant	)	
	)	**Docket No. 17-0908**
and	)	**Issued: September 11, 2017**
DEPARTMENT OF TRANSPORTATION, FEDERAL AVIATION ADMINISTRATION, Camp Springs, MD, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 21, 2017 appellant, through counsel, filed a timely appeal from a November 10, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met his burden of proof to establish a recurrence of his medical condition on October 13, 2015 causally related to his accepted January 30, 2014 employment injuries.

FACTUAL HISTORY

OWCP accepted that on January 30, 2014 appellant, then a 58-year-old airway transportation systems specialist, sustained a left shoulder and upper arm rotator cuff sprain when he slipped and fell on ice while exiting his work van. Appellant did not stop work at that time.

In therapy orders dated October 21, 2015, Dr. Harlan Taliaferro, an attending Board-certified orthopedic surgeon, diagnosed incomplete tear of the left rotator cuff and ordered physical therapy, twice a week for six weeks, to treat appellant's condition. He also requested authorization for appellant's physical therapy.

In an October 29, 2015 response letter, OWCP advised appellant to file a recurrence claim (Form CA-2a). It noted that he had last received medical care on March 10, 2015 for his work-related condition.[3] OWCP informed appellant of the type of factual and medical evidence needed to establish his recurrence claim. It particularly requested that he submit a physician's reasoned opinion addressing the causal relationship between his current medical condition, need for treatment, and the accepted employment injury.

In an October 20, 2015 report, Dr. Taliaferro noted that appellant had a recurrence of left shoulder pain. He was lifting a golf bag and noted increased pain in his left shoulder. Dr. Taliaferro noted a history of appellant's medical, family, and social background. He discussed findings on physical examination and reiterated his prior diagnosis of incomplete tear of the left rotator cuff. Dr. Taliaferro again recommended physical therapy. He also recommended a repeat magnetic resonance imaging (MRI) scan.

In an October 27, 2015 MRI scan report, Dr. David Kowarski, a Board-certified radiologist, noted an impression of lateral arch stenosis with low-grade subdeltoid space inflammation, painful peritendinitis, supraspinatus tendon anterior insertional chronic hypertrophic tendinosis without tear, hidden lesion, glenohumeral joint degenerative joint disease (DJD), and mild adhesive capsulitis as clinically correlated.

By letter dated November 3, 2015, appellant asserted that medical treatment was necessary because his shoulder never stopped hurting and his condition became intolerable after receiving a cortisone shot and physical therapy. He noted his hobbies and maintained that he did not have any new injuries.

[3] In a March 10, 2015 medical report, Dr. Taliaferro examined appellant and assessed partial tear of the left rotator cuff. He indicated that appellant would stop physical therapy and continue with home exercises for another month.

On November 3, 2015 Dr. Taliaferro reported that appellant was still having left shoulder pain which was likely aggravated by his recent lifting injury. He reviewed the October 27, 2015 MRI scan findings and discussed findings on examination. Dr. Taliaferro restated his assessment of partial tear of the left rotator cuff. He recommended physical therapy and a repeat subacromial cortisone injection. Dr. Taliaferro addressed the possibilty of shoulder arthroscopy/subacromial decompression with extensive debridement and/or possible repair of the subscapularis tendon with biceps tenotomy/tenodesis, as indicated.

In a November 18, 2015 report, Dr. Taliaferro noted a history that on January 30, 2014 appellant slipped and fell on ice landing on his left shoulder while at work. He indicated that appellant was originally seen by his partner, Dr. Uday Patel, a Board-certified orthopedic surgeon, following this injury. Dr. Taliaferro noted that Dr. Patel suspected a rotator cuff tear. He reviewed a March 12, 2014 left shoulder MRI scan study which showed partial tearing involving the subscapularis tendon with medial subluxation of the long head of the biceps into the superior subscapularis, tendinosis of the supraspinatus tendon, acromioclavicular arthrosis with painful edema, and low-grade posterior glenohumeral joint DJD. Dr. Taliaferro related that he began treating appellant on March 19, 2014. He referenced his October 20, 2015 evaluation and belief, at that time, that appellant's lifting incident may have exacerbated his shoulder condition. Dr. Taliaferro reviewed the findings of the October 27, 2015 left shoulder MRI scan. He noted the continued need for additional physical therapy and requested authorization for a repeat cortisone shoulder injection. Dr. Taliaferro again advised appellant about the possibility of undergoing left shoulder surgery if these treatment options failed. He opined that appellant's January 30, 2014 work-related slip and fall was causally related to his original diagnosis of partial left rotator cuff tear and that his current medical condition of left rotator cuff strain was an exacerbation of the original diagnosis. In addition, Dr. Taliaferro opined that appellant's rotator cuff strain was due to both the original injury and the later, exacerbating lifting injury as described. He concluded that the rotator cuff condition had materially worsened to the point that additional medical treatment was required.

In an October 27, 2015 report, a physical therapist noted that appellant had left shoulder pain, provided findings, and assesed moderate functional impairment due to incomplete tear of the rotator muscles in the shoulder. Assessments included mild range of motion limitation and subacromial impingement. The physical therapist recommended physical therapy.

In a January 7, 2016 letter, OWCP advised appellant that it had not received his Form CA-2a. It further advised him to file a traumatic injury claim (Form CA-1) if a new incident at work had caused his condition to recur or an occupational disease claim (Form CA-2) if work activities or factors occurring over more than one day caused his condition to recur. OWCP informed appellant that the evidence submitted was insufficient to establish the claimed cause of his condition and requested that he submit additional factual and medical evidence.

On January 11, 2016 appellant filed a Form CA-2a alleging that he had a recurrence of the need for medical treatment on October 13, 2015 due to his January 30, 2014 work injury. He indicated that he retired from the employing establishment after his accepted injury. Appellant related that on October 13, 2015 he experienced intense left shoulder pain when he placed a 25-pound golf bag into the back of his truck. He noted that he extended his arms away from his body which aggravated his existing shoulder problem. Appellant immediately applied ice to his

shoulder and rested as instructed by his physician. He indicated that his everyday activities were limited and he could not perform heavy lifting. Appellant maintained that his condition from March 10, 2015 to the date he aggravated his shoulder was good with minor soreness. In addition, his mobility was good as long as he continued with self-physical therapy. Appellant noted that he had similar symptoms before his claimed recurrence, but they were not as severe. He believed that his recurrence was related to his original injury because he never had any relief from the pain of his initial injury and a torn tendon could not be fixed without surgery.

Appellant submitted additional reports from Dr. Taliaferro. In his January 5 and 26 and March 8, 2016 reports, Dr. Taliaferro noted findings and appellant's complaint of left shoulder pain. He reiterated his prior assessment of partial left rotator cuff tear. Dr. Taliaferro indicated that on January 5, 2016 appellant received a left shoulder subacromial space injection.

By decision dated April 7, 2016, OWCP denied appellant's recurrence claim because the medical evidence of record did not establish that he required additional medical treatment due to a worsening of his accepted January 30, 2014 injury, without intervening cause.

OWCP received an April 19, 2016 report in which Dr. Taliaferro noted appellant's constant and worsening left shoulder pain and examination findings. He again assessed partial left rotator cuff tear.

On May 1, 2016 appellant requested an oral hearing before an OWCP hearing representative and submitted medical evidence. In an April 23, 2016 report, Dr. Taliaferro responded to OWCP's April 7, 2016 decision. He reviewed his prior reports, Dr. Patel's February 25, 2014 report, and diagnostic test reports.[4] Dr. Taliaferro maintained that his diagnosis of partial left rotator cuff tear (subscapularis tendon) was well-documented and based on his review of the March 12, 2014 MRI scan. He reported that the medical evidence showed a current need for medical treatment as a result of the original January 30, 2014 work injury. Dr. Taliaferro opined that, within a reasonable degree of probability, appellant's partial tear of his subscapularis tendon with subluxation of the biceps tendon was causally related to the January 30, 2014 work injury. He related that appellant's current need for medical treatment was the result of this injury, as the October 27, 2015 MRI scan study showed that the diagnosed condition had not healed and it was similar to the March 12, 2014 MRI scan. Dr. Taliaferro indicated that evidence of a worsening of the work-related condition, without intervening cause, could be found in his October 8, 2014 report which described "piercing and sharp pain," "limited to certain movements," "pain with resistance to abduction," "positive Neer sign," and in his March 10, 2015 report which described "episodic pain with certain lifting maneuvers." He referenced his October 20, 2015 report and noted that appellant's left shoulder condition was exacerbated (temporarily worsened) by lifting a golf bag. The bag weighed about 30 pounds and appellant lifted the bag with both arms in a forwardly elevated position with his arms extended. Dr. Taliaferro advised that this lifting position created a significant lever arm that required significant shoulder stabilizing (shear) force using the rotator cuff, specifically the partially torn subscapularis. Appellant immediately felt worsening pain.

[4] This included a March 12, 2014 a left shoulder x-ray which was reported to be normal by Dr. Verne F. Kemerer, Jr., a Board-certified radiologist.

Referencing his March 10, 2015 report, Dr. Taliaferro indicated that before the recent lifting incident, appellant had episodic pain with certain lifting maneuvers. He related that the January 30, 2014 work injury (partial tear of the subscapularis with subluxation of the biceps tendon) contributed to appellant's lifting injury because when he lifted the golf bag, the subscapularis muscle tendon unit fired to help stabilize the humeral head against the glenoid to allow forceful arm elevation in order to lift the 30-pound bag. Dr. Taliaferro further related that since this tendon was partially torn, it allowed for uncontrolled biceps subluxation with shear force across the partially torn subscapularis. He related that this was a rational explanation for the immediate pain that appellant described to him on his October 20, 2015 office visit. Dr. Taliaferro opined that, based on the evidence presented to him, appellant's current condition and need for medical treatment was related to the January 30, 2014 work injury and that reinjury caused by lifting the golf bag was a temporary exacerbation of the original work injury.

In a November 10, 2016 decision, an OWCP hearing representative affirmed the April 7, 2016 decision. She found that the medical evidence of record did not establish that appellant's need for additional medical treatment was due to a material worsening of his accepted condition, without intervening cause. The hearing representative determined that there was no rationalized medical evidence to establish that his medical condition or disability as of October 13, 2015 was causally related to the accepted January 30, 2014 work injury.

LEGAL PRECEDENT

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.[5]

Recurrence of medical condition means a documented need for further medical treatment after release from treatment for the accepted condition or injury when there is no accompanying work stoppage. Continuous treatment for the original condition or injury is not considered a need for further medical treatment after release from treatment, nor is an examination without treatment.[6]

If a claim for recurrence of medical condition is made more than 90 days after release from medical care, a claimant is responsible for submitting a medical report supporting a causal relationship between the employee's current condition and the original injury in order to meet his or her burden.[7]

An employee has the burden of proof to establish that he or she sustained a recurrence of a medical condition that is causally related to an accepted employment injury. To meet this

[5] 5 U.S.C. § 8103(a).

[6] 20 C.F.R. § 10.5(y).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Recurrences*, Chapter 2.1500.4(b) (June 2013); *see also J.M.*, Docket No. 09-2041 (issued May 6, 2010).

burden, the employee must submit medical evidence from a physician who, on the basis of a complete and accurate factual and medical history, supports that the condition is causally related and supports the conclusion with sound medical rationale.[8]

ANALYSIS

The Board finds that appellant has failed to establish a recurrence of a medical condition beginning October 13, 2015.

OWCP accepted that appellant sustained a left shoulder and upper arm rotator cuff sprain on January 30, 2014 in the performance of duty. On January 11, 2016 appellant filed a claim for recurrence of a medical condition, which OWCP denied as the medical evidence of record failed to establish that the requested treatment was due to the accepted injuries.

Appellant requested medical treatment for an incomplete tear of the left rotator cuff. While he submitted medical evidence, primarily reports from Dr. Taliaferro, an attending Board-certified orthopedic surgeon, none of the reports are sufficient to establish a need for medical treatment causally related to the accepted injuries.

In his reports dated October 20, 2015 to April 26, 2016, Dr. Taliaferro noted a history that appellant sustained a partial tear of the subscapularis with subluxation of the biceps tendon on January 30, 2014 when he slipped and fell on ice at work. He also noted a history that on October 13, 2015 appellant experienced increased left shoulder pain as a result of lifting a golf bag weighing 30 pounds. Dr. Taliaferro discussed his own history of treating appellant. He examined him and reviewed the findings of his medical partner, Dr. Patel, and MRI scan and x-ray findings. Dr. Taliaferro diagnosed an incomplete or partial tear of the left subscapularis tendon with subluxation of the biceps tendon and left rotator cuff strain. He opined that appellant's left shoulder conditions were causally related to the January 30, 2014 work-related fall. Dr. Taliaferro further opined that his left rotator cuff strain was exacerbated by the October 13, 2015 lifting incident. He explained why the lifting incident exacerbated appellant's left shoulder conditions. Dr. Taliaferro recommended physical therapy and possible left shoulder surgery and administered a subacromial cortisone injection to treat the diagnosed conditions.

The Board notes that OWCP has not accepted appellant's claim for either an incomplete or partial tear of the left subscapularis tendon with subluxation of the biceps tendon or left rotator cuff strain as causally related to the January 30, 2014 work injury. For conditions not accepted by OWCP as being employment related, it is the employee's burden of proof to provide rationalized medical evidence sufficient to establish causal relation, not OWCP's burden to disprove such relationship.[9] Dr. Taliaferro did not offer any medical rationale for his opinion that the work injury, left shoulder and upper arm rotator cuff sprain, caused appellant's current left shoulder conditions. Instead, he explained why appellant's left rotator cuff strain was exacerbated by the nonwork-related October 13, 2015 lifting incident. Dr. Taliaferro's opinion

[8] *See K.T.*, Docket No. 15-1758 (issued May 24, 2016).

[9] *T.M.*, Docket No. 16-1456 (issued January 10, 2017); *E.C.*, Docket No. 10-1554 (issued April 1, 2011); *Alice J. Tysinger*, 51 ECAB 638 (2000).

on causal relationship is of limited probative value as he did not provide adequate medical rationale in support of his conclusions.[10] Thus, the Board finds that Dr. Taliaferro's reports are insufficient to establish that appellant sustained a recurrence of his accepted medical conditions.[11]

The remaining medical evidence of record is also insufficient to establish that appellant sustained a recurrence of his accepted medical conditions. Dr. Kemerer's March 10, 2015 normal left shoulder x-ray report failed to provide a firm diagnosis of a particular medical condition.[12] Dr. Kowarski's October 27, 2015 MRI scan study offered no opinion regarding the cause of appellant's conditions. The Board has found that medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[13] Therefore, these diagnostic reports fail to establish causal relationship and appellant's recurrence claim.[14]

The October 27, 2015 report of a physical therapist, documenting treatment of appellant's left shoulder is also insufficient to establish his claim. Physical therapists are not considered physicians as defined under FECA, and their opinions are of no probative value.[15]

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 failed to meet his burden of proof to establish a recurrence of his medical condition on October 13, 2015 causally related to his accepted January 30, 2014 employment injuries.

[10] *T.M.*, *id.*

[11] *Id.*

[12] *See Deborah L. Beatty*, 54 ECAB 340 (2003) (where the Board found that in the absence of a medical report providing a diagnosed condition and a reasoned opinion on causal relationship with the employment incident, appellant did not meet her burden of proof).

[13] *See C.B.*, Docket No. 09-2027 (issued May 12, 2010); *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

[14] *K.H.*, Docket No. 16-0776 (issued October 19, 2016).

[15] 5 U.S.C. § 8102(2) of FECA provides as follows: (2) physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. *Gloria J. McPherson*, 51 ECAB 441 (2000); *F.G.*, Docket No. 16-1482 (issued January 25, 2017) (physical therapists); *Charley V.B. Harley*, 2 ECAB 208, 211 (1949) (a medical issue such as causal relationship can only be resolved through the submission of probative medical evidence from a physician).

ORDER

IT IS HEREBY ORDERED THAT the November 10, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 11, 2017
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board