United States Department of Labor
Employees' Compensation Appeals Board

E.L., Appellant	)	
and	)	**Docket No. 17-1445**
	)	**Issued: December 18, 2018**
DEPARTMENT OF THE NAVY, NAVY REGION SOUTHEAST, Jacksonville, FL, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 19, 2017 appellant filed a timely appeal from an April 4, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] 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.[3]

[1] Appellant timely requested oral argument pursuant to section 501.5(b) of the Board's *Rules of Procedure*. 20 C.F.R. § 501.5(b). By order dated November 17, 2017, the Board exercised its discretion and denied the request, finding that the arguments on appeal could adequately be addressed based on the case record. *Order Denying Request for Oral Argument*, Docket No. 17-1445 (issued November 17, 2017).

[2] 5 U.S.C. § 8101 *et seq*.

[3] The Board notes that following the April 24, 2017 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this evidence for the first time on appeal. *Id*.

ISSUE

The issue is whether OWCP abused its discretion by denying authorization for right shoulder surgery.

FACTUAL HISTORY

On September 13, 2011 appellant, then a 48-year-old electrical engineer, filed a traumatic injury claim (Form CA-1) alleging that, while in the performance of duty, he injured his right shoulder when a handicap seat fell into a bowl, causing him to fall forward and strike his right shoulder on a dispenser. He did not submit additional evidence.

OWCP denied the claim by decision dated October 26, 2011.

In a report dated July 7, 2011, Dr. Kieran Cody, a Board-certified orthopedic surgeon, noted that appellant had undergone two previous surgeries to his right shoulder.

Appellant requested an oral hearing before an OWCP hearing representative, postmarked November 14, 2011. The hearing representative reversed the October 26, 2011 decision on January 19, 2012. OWCP accepted appellant's claim for a right shoulder contusion on January 26, 2012, and on February 28, 2013 expanded the acceptance of the claim to include the additional condition of right rotator cuff tear.

On April 26, 2013 appellant underwent OWCP-approved surgeries with Dr. Cody including: a right shoulder arthroscopy with intra-articular labral debridement and lysis of adhesions; a rotator cuff repair; and a subacromial bursectomy with lysis of adhesions. The operations were completed without complications.

On March 19, 2014 appellant requested authorization for payment of physical and occupational therapy.

On March 24, 2014 OWCP referred appellant for evaluation with a second opinion physician in order to determine the nature and extent of his accepted injuries.

In a second opinion report dated April 25, 2014, Dr. Noubar Didizian, a Board-certified orthopedic surgeon, examined appellant, reviewed his medical file, and diagnosed status post right shoulder surgery. He noted that the fact that appellant had glenohumeral degenerative disease would probably necessitate shoulder joint replacement at some point and that appellant would never return to his preinjury level. Dr. Didizian noted that appellant was not disabled from performing his regular position as he only took three weeks off from work after surgery and continued to work in the same capacity. He noted that appellant did not require further physical therapy or chiropractic treatment.

By decision dated May 19, 2014, OWCP denied appellant's request for authorization for physical therapy and chiropractic treatment. It based its denial on Dr. Didizian's April 25, 2014 report.

On May 31, 2014 appellant requested an oral hearing before an OWCP hearing representative.

By letter dated September 10, 2014, Dr. Daniel Skubick, a Board-certified neurologist, expressed his disagreement with Dr. Didizian's findings. He noted that appellant retained active trigger points on physical examination and that appellant required treatment including additional injections. Dr. Skubick noted that appellant had an ongoing active pathology.

By decision dated December 3, 2014, the hearing representative set aside the May 19, 2014 decision and remanded the case to obtain additional medical evidence, to be followed by a *de novo* decision. The hearing representative noted that Dr. Skubick had not supported his opinion that appellant did not require further chiropractic or physical therapy with rationale, and also noted that his report was not forwarded to appellant's representative.

By letter dated December 11, 2014, OWCP requested that Dr. Didizian clarify his report of September 10, 2014. Dr. Didizian responded by letter dated December 12, 2014, explaining that appellant had advised him that he was no longer in physical therapy or chiropractic treatment. Appellant further advised Dr. Didizian that the only treatment he was receiving was myofascial treatment with Dr. Skubick. Dr. Didizian noted that appellant's healing process continued and that in the context of achieving full range of motion and a negative provocative test no further need for chiropractic or physical therapy was indicated.

By decision dated April 2, 2015, OWCP denied appellant's request for chiropractic treatment. It explained that it relied upon Dr. Didizian's December 11, 2014 letter in rendering its decision.

On July 29, 2015 appellant requested authorization for further injections of his right shoulder.

By letter dated September 17, 2015, OWCP referred appellant for evaluation with a second opinion physician in order to determine the necessity of additional injections.

On October 23, 2015 OWCP received appellant's request for right-sided rotator cuff repair and shoulder surgery.

In a second opinion report dated November 4, 2015, Dr. Robert F. Draper, a Board-certified orthopedic surgeon, examined appellant, reviewed his medical file, and diagnosed a history of a torn rotator cuff of the right shoulder. He noted that appellant had full range of motion of the right shoulder and all the usual signs for pathology are negative. Dr. Draper noted that under these circumstances appellant would have about a 50 percent chance of being improved by further right shoulder surgery. While he noted that he would not provide "an overwhelming recommendation for repeat arthroscopic surgery now," but also noted that he would "not strongly object to an arthroscopic surgery to the right shoulder since that is what he wants and has a surgeon willing to perform the surgery."

In a report dated October 12, 2015, Dr. James Gilbert, a Board-certified orthopedic surgeon, examined appellant and diagnosed a full-thickness rotator cuff tear. He noted that on

ultrasound appellant appeared to still have a full-thickness rotator cuff tear. Dr. Gilbert recommended magnetic resonance imaging (MRI) scan testing to corroborate this finding.

In a diagnostic report dated October 14, 2015, Dr. Alexander Mark, a Board-certified diagnostic radiologist, examined the results of a right shoulder MRI scan. He reported impressions of status post repair of the rotator cuff tear with scarring in the supraspinatus, but no evidence of a recurrent tear. Dr. Mark noted subtle glenohumeral joint arthrosis and fraying of the posterior labrum without definite chondral labral separation. He further noted mild thickening of the axillary sleeve, raising the possibility of adhesive capsulitus.

On October 20, 2015 Dr. Gilbert stated that the MRI scan had been performed and that he observed a rotator cuff tear which was full thickness, but not retracted, and with postoperative changes.

By letter dated November 24, 2015, OWCP notified appellant that it had authorized additional right shoulder injections, but that a repeat surgery had not been recommended by Dr. Draper.

On April 14, 2016 OWCP forwarded appellant's medical file and a statement of accepted facts (SOAF) to a district medical adviser (DMA) in order to determine whether appellant's requested arthroscopic surgery was medically necessary.

In a DMA's report dated April 19, 2016, Dr. David Garelick, a Board-certified orthopedic surgeon, reviewed appellant's medical records and the SOAF. He noted that physical examination revealed full right shoulder range of motion and strength and that diagnostic tests had not demonstrated any new rotator cuff tear. Dr. Garelick noted, "[Appellant] has ongoing symptoms of pain in his right shoulder, but a normal physical examination and relatively normal imaging studies. He has continued subjective complaints of pain despite three previous surgeries. Further, the examination is normal as are the imaging studies. For all these reasons, I also strongly recommend against additional surgery."

By decision dated May 10, 2016, OWCP denied appellant's request for authorization for additional shoulder surgery. It based its decision on Dr. Garelick's April 19, 2016 report, noting that Dr. Gilbert had not provided rationale for continued surgical intervention.

On May 19, 2016 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative. With the request appellant resubmitted the October 14, 2015 report of Dr. Mark and submitted a subsequent March 14, 2016 report of Dr. Mark.

In a report dated June 3, 2016, Dr. Gilbert examined appellant and diagnosed a full-thickness rotator cuff tear. He noted his medical opinion that the evidence justified further surgery on appellant's shoulder, as a right shoulder MRI scan demonstrated a full-thickness rotator cuff tear and because appellant's previous surgeries were "not performed in the open."

On June 9, 2015 Dr. Daniel performed an injection on appellant's right shoulder using ultrasound guidance. He observed subacromial subdeltoid bursitis and impingement with associated tendinosis of the supraspinatus tendon, with no significant tear.

By letter dated January 23, 2017, Dr. Uma Srikumaran, a Board-certified orthopedic surgeon, recommended that due to appellant's ongoing shoulder pain that he undergo right-sided arthroscopic debridement, decompression, biceps tenodesis, and rotator cuff debridement. Dr. Srikumaran contrasted rotator cuff debridement with rotator cuff repair-revision.

On January 27, 2017 appellant argued that Dr. Cody missed a diagnosed rotator cuff tear in his surgery of April 26, 2013, and that his current condition should be considered an existing condition rather than a retear.

The hearing was held on January 18, 2017. At the hearing, appellant testified that Dr. Gilbert and two other physicians had observed a tear in his right shoulder on ultrasound. He noted that there had been no intervening events between his shoulder surgery in 2013 and his current condition, except that the surgery on his shoulder had not been successful. Appellant further testified that he did not want to be operated on by Dr. Gilbert because he wanted a less invasive procedure performed. He stated that he had found another physician to perform shoulder surgery.

By decision dated April 4, 2017, the hearing representative affirmed OWCP's May 10, 2016 decision. The hearing representative explained that appellant had not submitted medical evidence explaining how the proposed surgery would improve appellant's condition and that Drs. Draper and Garelick had both expressed opinions that surgery was unlikely to improve appellant's condition. The hearing representative noted that there was some confusion on the part of appellant as to whether the surgery at issue was the same surgery requested by Dr. Gilbert, or another surgical procedure not yet requested for authorization.

LEGAL PRECEDENT

Section 8103 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, which OWCP considers likely to cure, give relief , reduce the degree, or the period of disability, or aid in lessening the amount of monthly compensation.[4] While OWCP is obligated to pay for treatment of employment-related conditions, the employee has the burden of establishing that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[5]

In interpreting section 8193 of FECA, the Board has recognized that OWCP has broad discretion in approving services provided, with the only limitation on OWCP's authority being that of reasonableness.[6] Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment, 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

[4] 5 U.S.C. § 8103; *see Thomas W. Stevens*, 50 ECAB 288 (1999).

[5] *Kennett O. Collins, Jr.*, 55 ECAB 648 (2004).

[6] *See D.K.*, 59 ECAB 141 (2007).

could be construed so as to produce a contrary factual conclusion.[7] To be entitled to reimbursement of medical expenses, a claimant has the burden of establishing that the expenditures were incurred for treatment of the effects of an employment-related injury or condition. Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[8] In order for a surgical procedure to be authorized, a claimant must submit evidence to show that the surgery is for a condition causally related to an employment injury and that it is medically warranted. Both of these criteria must be met in order for OWCP to authorize payment.[9]

ANALYSIS

The Board finds that OWCP did not abuse its discretion by denying authorization for right shoulder surgery.

OWCP accepted appellant's traumatic injury claim for right shoulder contusion and a right rotator cuff tear. In a diagnostic report dated October 14, 2015, Dr. Alexander Mark, a Board-certified diagnostic radiologist, examined the results of a right shoulder MRI scan. He noted impressions of status post repair of the rotator cuff tear with scarring in the supraspinatus, but no evidence of a recurrent tear. Dr. Mark also noted subtle glenohumeral joint arthrosis and fraying of the posterior labrum without definite chondral labral separation. He observed mild thickening of the axillary sleeve, raising the possibility of adhesive capsulitis.

In a DMA's report dated April 19, 2016, Dr. Garelick reviewed appellant's medical records and a SOAF. He noted that physical examination revealed full right shoulder range of motion and strength and that diagnostic tests had not demonstrated a new rotator cuff tear. Dr. Garelick noted that appellant had ongoing symptoms of pain in his right shoulder, with a normal physical examination and relatively normal imaging studies. He had continued subjective complaints of pain despite three previous surgeries. Dr. Garelick further noted that the examination was normal as were the imaging studies, and strongly recommended against further surgery.

On June 3, 2016 Dr. Gilbert examined appellant and diagnosed a full-thickness rotator cuff tear. He noted his medical opinion that the evidence justified further surgery on appellant's shoulder, as a right shoulder MRI scan demonstrated a full-thickness rotator cuff tear, and as appellant's previous surgeries were not performed in the open.

By letter dated January 23, 2017, Dr. Uma Srikumaran, a Board-certified orthopedic surgeon, recommended that due to appellant's ongoing shoulder pain, he undergo right arthroscopic debridement, decompression, biceps tenodesis, and rotator cuff debridement. She contrasted rotator cuff debridement with rotator cuff repair-revision.

The reports of Drs. Gilbert and Srikumaran do not include clear rationale discussing why the additional shoulder surgery would benefit appellant's condition given the objective medical evidence regarding appellant's range of motion and response to tests. Moreover, Dr. Gilbert's

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

[8] *M.B.*, 58 ECAB 588 (2007).

[9] *R.C.*, 58 ECAB 238 (2006).

reports do not accurately represent the results of diagnostic testing as he claims that appellant still had a rotator cuff tear which had explicitly been ruled out by the diagnostic report of October 14, 2015. Given the lack of rationale for the procedure and inaccurate representation of diagnostic evidence, these reports are of diminished probative value.

The Board finds that OWCP properly relied on the report of Dr. Garelick in its decision denying appellant's request for authorization for shoulder surgery. Dr. Garelick's opinion was well-rationalized and based upon a complete background, his review of the SOAF, the medical record, and examination findings. As such, Dr. Garelick's opinion that the requested procedure was not medically warranted for the accepted conditions represents the weight of the evidence.

The only limitation on OWCP's authority in approving or disapproving service under FECA is one of reasonableness.[10] In the instant case, appellant requested surgery. OWCP obtained a well-rationalized report from Dr. Garelick in which he opined that the requested surgery was not warranted for the accepted conditions. The remaining medical reports of record were of diminished probative value as previously explained. OWCP, therefore, had sufficient evidence upon which it made its decision to deny surgery and did not abuse its discretion.

CONCLUSION

The Board finds that OWCP did not abuse its discretion when it denied appellant authorization for right shoulder surgery.

[10] *Supra* note 5.

ORDER

IT IS HEREBY ORDERED THAT the April 4, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 18, 2018
Washington, DC

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

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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