United States Department of Labor
Employees' Compensation Appeals Board

D.M., Appellant	)	
and	)	**Docket No. 17-1563**
	)	**Issued: January 15, 2019**
DEPARTMENT OF VETERANS AFFAIRS, MANCHESTER VETERANS MEDICAL CENTER, Manchester, NH, Employer	)	

Appearances:
Bradley M. Lown, 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 July 10, 2017 appellant, through counsel, filed a timely appeal from a February 23, 2017 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.[3]

[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.*

[3] The Board notes that following the February 23, 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 improperly denied appellant's request for authorization for left shoulder surgery.

FACTUAL HISTORY

On April 29, 2010 appellant, a 50-year-old physician, filed an occupational disease claim (Form CA-2) alleging that he developed constant pain inside his right elbow, a burning sensation up his forearm, and numbness in his 4th and 5th digits due to his federal employment. OWCP initially accepted the claim for right medial epicondylitis and right ulnar neuritis. It authorized a right elbow common flexor pronator repair and anterior submuscular ulnar nerve transposition, which appellant underwent on November 29, 2010. OWCP later expanded the acceptance of appellant's claim to include bilateral medial epicondylitis, lesion of right ulnar nerve, bilateral carpal tunnel syndrome, adhesive capsulitis of bilateral shoulders, and right rotator cuff impingement syndrome. Appellant also has another occupational disease claim (date of injury October 8, 2010), which OWCP accepted for bilateral epicondylitis with ulnar neuritis (OWCP File No. xxxxxx080).

Appellant submitted reports dated April 1, 2, 14, and May 13, 2014 from Dr. Ira Moby Parsons,[4] a Board-certified orthopedic surgeon, who diagnosed left adhesive capsulitis of shoulder, left partial tear of biceps tendon, bilateral carpal tunnel syndrome, left lateral epicondylitis, bilateral recalcitrant medial epicondylitis with ulnar neuritis, and right, non-outlet shoulder impingement secondary to posterior shoulder capsulitis. In his April 14, 2014 report, Dr. Parsons opined that appellant had reached maximum medical improvement and had exhausted all forms of operative and nonoperative treatment that was likely to benefit him.

In the May 13, 2014 report, Dr. Parsons noted that appellant had been working at a car dealership which required significant repetitive motion in turning on ignition keys, opening windows and trunks, and all of this in an ergonomically unfavorable position reaching into the car. He opined that this caused significant exacerbation of appellant's symptoms to the point where both of his hands were numb. Appellant also had severe pain in both thenar eminences, elbows, palms, and his left shoulder was severely painful.

On May 20, 2014 appellant requested authorization for left shoulder surgery.

In a May 19, 2014 report, Dr. Parsons reiterated his diagnoses and advised that appellant was not capable of any repetitive activity on a day-to-day basis.

In a June 11, 2014 development letter, OWCP found that the medical evidence of record was insufficient to authorize the surgery because the requested treatment did not appear to be medically necessary for and/or causally related to appellant's accepted conditions. It requested a medical narrative from appellant's physician describing why the procedure was medically necessary and what future benefits he or she hoped to attain through the surgery. OWCP afforded appellant 30 days to submit additional evidence and respond to its inquiries.

[4] Dr. Ira M. Parsons also refers to himself and signs medical reports as Dr. Moby Parsons.

In response, appellant submitted a June 11, 2014 report from Dr. Parsons who indicated that appellant was experiencing a severe aggravation of upper extremity cumulative trauma disorders including carpal tunnel syndrome, cubital tunnel syndrome, medial epicondylitis, and left shoulder impingement. Dr. Parsons reiterated his opinion that appellant was unable to tolerate vocational rehabilitation either physically or due to the emotional toll that his daily pain was causing along with his sleep disturbance. He further indicated that the degree of driving and keyboarding required by even a sedentary job would only worsen his condition which already precluded such activity. Dr. Parsons advised that appellant remained totally disabled from work.

In a July 16, 2014 letter, OWCP found that the evidence submitted was insufficient to modify its previous authorization determination because appellant's physician had not provided a report discussing the requested procedure, describing the procedure, explaining why it was medically necessary as treatment for his accepted conditions, and noting what future benefits he hoped to attain through the requested procedure. It noted that this was not a final decision and if appellant wanted a formal decision regarding this matter, he should submit a written request.

Appellant subsequently submitted a June 16, 2014 report from Dr. Parsons who noted that he had been taking care of appellant for at least six years for bilateral repetitive overuse upper extremity disorders. Dr. Parsons reported that appellant had been through an extensive course of treatment, including multiple cortisone injections in the left shoulder. He opined that appellant "developed adhesive capsulitis and impingement syndrome as a consequence of his other upper extremity cumulative trauma disorders in compensation for the multiple functional deficits that he has distal to his shoulder." Dr. Parsons concluded that these additional conditions were causally related to his accepted employment injury.

On June 30, 2014 Dr. Parsons noted that appellant currently had recalcitrant impingement of his left shoulder as a result of adhesive capsulitis and explained that he had failed conservative measures. He reiterated his opinion that the resultant adhesive capsulitis was directly related to appellant's work-related injuries and should be covered under that claim.

In a July 18, 2014 report, Dr. Parsons indicated that appellant was still awaiting approval for his shoulder surgery.

A June 24, 2014 magnetic resonance imaging (MRI) scan of the left elbow revealed mild common extensor tendinosis, without discrete tear, unremarkable MRI scan appearance of the common flexor/pronator tendon complex, and trace joint effusion.

In a September 7, 2014 report, Dr. Parsons reviewed the June 24, 2014 MRI scan and found that it confirmed significant tendinosis of the common flexor pronator tendon. He opined that this was a degenerative tendon problem that was chronic and, given its duration, unlikely to heal. Dr. Parsons also found that appellant had a small reactive effusion in the joint beneath this area which was a bystander consequent of the ongoing tendon degeneration. He opined that this would indicate that the tendon had reached a relative stalemate in terms of its biological capacity for improvement and was likely to stay at a fixed state of degeneration with ongoing symptomatology.

On September 10, 2014 Dr. Parsons reported that appellant had been through extensive therapy, including multiple cortisone injections, occupational therapy, massage therapy, and acupuncture, all without appreciable long-term relief. He opined that given appellant's lack of response to conservative treatment, he recommended and proposed a left shoulder diagnostic

arthroscopy with indicated procedures to include subacromial decompression, capsular release, and repair of his biceps tendon through tenodesis. Dr. Parsons explained that indicated procedures meant that should other problems such as rotator cuff be encountered, these could be addressed concomitantly due to their association with ongoing pain. He further explained that an arthroscopic procedure was one in which small portals could be used to permit the insertion of a camera which allowed diagnostic and therapeutic procedures to be done in a minimally invasive fashion which should expedite recovery. Dr. Parsons explained that the outcome of the procedure was that appellant should have significant improvement in range of motion and reduction in pain. The recovery would depend on all that was done and should appellant require significant repair of tendinous structures, may require up to three to six months with rehabilitation to regain strength and range of motion.

In a December 7, 2014 report, Dr. David Krohn, a Board-certified internist and OWCP district medical adviser (DMA), reviewed the medical evidence of record and concluded that the proposed left shoulder surgery was neither warranted nor necessitated by any of appellant's work-related conditions. He noted that the only shoulder condition accepted by the statement of accepted facts (SOAF) was that of right rotator cuff impingement syndrome and that no left shoulder condition had been accepted by OWCP. Dr. Krohn further indicated that, even if a left shoulder condition was considered, it was his opinion that it was more likely to have resulted from appellant's underlying diabetes and avocational activities.

In reports dated November 7, 2014 and January 7, 2015, Dr. Parsons continued to diagnose adhesive capsulitis of the left shoulder.

By decision dated February 4, 2015, OWCP denied authorization for left shoulder surgery.

In reports dated February 11, 2015, Dr. Parsons opined that the fact that appellant's cortisone injections only provided short-term relief validated that further injection therapy and other conservative measures were unlikely to cure his left shoulder pain without surgical intervention. He further opined that the benefit of this surgery was that it had a high likelihood of curing his left shoulder pain, which seemed to be the most troublesome to him at this point in time and for which he required ongoing continuous medical care.

On February 24, 2015 Dr. Parsons opined that when diabetes affected a frozen shoulder, it resulted in a global adhesive capsulitis which appellant did not exhibit. He found that appellant had selective tightness of his posterior capsule, which resulted in an impingement-type process in the shoulder and was distinctly different from diabetic adhesive capsulitis. Dr. Parsons also noted that appellant's glycemic control had been excellent, which was further indication that it was less likely that his shoulder problems were a result of his diabetes as those most prone to frozen shoulder and other musculoskeletal complications of diabetes tended to be patients with long-standing poor glycemic control.

In a March 24, 2015 narrative statement, appellant indicated that OWCP had accepted adhesive capsulitis of both (bilateral) shoulders.

By decision dated April 3, 2015, OWCP denied modification of its prior decision denying authorization for surgery. It noted that appellant's claim had been accepted for adhesive capsulitis of bilateral shoulders, but denied authorization for left shoulder surgery because the medical evidence then of record was insufficient to establish that the proposed surgery was necessary.

In an April 22, 2015 report, Dr. Parsons reiterated his opinion that appellant had failed a host of conservative measures and remained disabled with limited tolerance for even simple daily activities.

On June 11, 2015 Dr. Parsons noted that appellant had recently been diagnosed with a complete tear of his common extensor tendon of the left elbow and that the etiology of the tear stemmed from the multiple cortisone injections he had to receive for pain management.

On April 1, 2016 counsel requested reconsideration.

In a March 16, 2016 report, Dr. Parsons indicated that appellant needed ongoing cortisone injection therapy, which was likely to cause further damage to the tendon and ultimately require surgical debridement and repair secondary to the dystrophic effects of cortisone on collagen-based tissues. He opined that surgical treatment was causally related to appellant's accepted conditions and necessary to definitely treat this rather than causing further damage.

OWCP referred appellant to Dr. Christopher B. Geary, a Board-certified orthopedic surgeon, for a second opinion examination, along with a SOAF which listed all of appellant's accepted conditions including bilateral adhesive capsulitis of the shoulder. In his June 6, 2016 report, Dr. Geary concluded that the proposed diagnostic left shoulder arthroscopy was not medically necessitated or causally related to appellant's accepted conditions. He opined that appellant's impingement or adhesive capsulitis was likely related to normal degenerative changes and his underlying metabolic conditions, including diabetes and smoking. Dr. Geary found no evidence that any of his work-related conditions would have put appellant at risk for frozen shoulder or impingement. Specifically, he found no evidence that his elbow or wrist conditions would put him at risk for impingement, which would necessitate shoulder arthroscopy.

In a June 24, 2016 addendum report, Dr. Geary continued to opine that the left shoulder arthroscopy was not medically necessary because he found that appellant's left shoulder condition was more degenerative in nature and not in any way related to his previous federal employment as a physician because it did not entail any heavy lifting or overhead work which might have caused or accelerated a shoulder condition.

By decision dated July 11, 2016, OWCP denied modification of its prior decision, relying on Dr. Geary's second opinion.

On September 26, 2016 counsel requested reconsideration.

In an August 12, 2016 report, Dr. Parsons commented on the second opinion report of Dr. Geary. He noted that appellant had always demonstrated a focal posterior capsulitis of his shoulder which would tend to be associated with a non-outlet impingement-type syndrome associated with cumulative trauma of the upper extremities as would lead to an impingement process. Dr. Parsons noted that this condition is marked by specific loss of internal rotation which causes obligate anterior superior translation of the humeral head against the coracoacromial arch putting excess pressure and abrasion on the rotator cuff. He explained that appellant's condition was distinctly different than a global frozen shoulder, which is what occurs in the setting of diabetes where there is glycosylation of the collagen molecules throughout the entire shoulder capsule leading to loss of range of motion in all planes, not specific to internal rotation. Dr. Parsons noted that appellant's current symptomology is consistent with his cumulative trauma

disorder of his upper extremities and not, as opined by Dr. Geary, a result of systemic endocrine abnormalities.

In a supplemental report dated September 30, 2016, Dr. Geary advised that appellant was unable to use his upper extremities in any capacity be it typing, lifting, writing, pushing, pulling, or anything else requiring the use of his upper extremities.

Appellant submitted reports dated October 17 and November 11, 2016 from Dr. Parsons indicating that he received cortisone injections for his medial epicondylitis.

By decision dated February 23, 2017, OWCP denied modification of its prior decision denying authorization for surgery.

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 the monthly compensation.[5] In interpreting this section of FECA, the Board has recognized that OWCP has broad discretion in approving services provided under FECA.[6] OWCP has the general objective of ensuring that an employee recovers from his or her injury to the fullest extent possible in the shortest amount of time. It therefore has broad administrative discretion in choosing means to achieve this goal. The only limitation on OWCP's authority is that of reasonableness.[7] 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.[8] It is not enough to merely show that the evidence could be construed so as to produce a contrary factual conclusion.[9] 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.[10] 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.[11]

When there are opposing reports of virtually equal weight and rationale, the case will be referred to an impartial medical specialist pursuant to section 8123(a) of FECA which provides

[5] 5 U.S.C. § 8103.

[6] *See J.B.*, Docket No. 11-1301 (issued March 22, 2012).

[7] *Id.*

[8] *Id.*

[9] *See Dale E. Jones*, 48 ECAB 648 (1997); *Daniel J. Perea*, 42 ECAB 214 (1990).

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

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

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 and resolve the conflict of medical evidence.[12] 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.[13]

In situations where there are opposing medical reports of virtually equal weight and rationale, and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[14]

ANALYSIS

The Board finds that this case is not in posture for decision.

OWCP initially accepted appellant's claim for right medial epicondylitis and right ulnar neuritis and authorized right elbow surgery. It later expanded acceptance of the claim to include bilateral medial epicondylitis, lesion of right ulnar nerve, bilateral carpal tunnel syndrome, adhesive capsulitis of bilateral shoulders, and right rotator cuff impingement syndrome.

In a report dated September 10, 2014, appellant's attending physician, Dr. Parsons, reported that appellant had undergone extensive therapy including multiple cortisone injections, occupational therapy, massage therapy, and acupuncture, all without any appreciable long-term relief. Given appellant's lack of response to conservative treatment, he recommended and proposed a left shoulder diagnostic arthroscopy, with indicated procedures to include subacromial decompression, capsular release, and repair of his biceps tendon through tenodesis. Dr. Parsons explained that an arthroscopic procedure was one in which small portals could be used to permit the insertion of a camera which allowed diagnostic and therapeutic procedures to be done in a minimally invasive fashion which should expedite recovery. He explained that the outcome of the procedure was that appellant should have significant improvement in range of motion and reduction in pain. The recovery would depend on all that was done and should appellant require significant repair of tendinous structures, may require up to three to six months with rehabilitation to regain strength and range of motion.

In his June 6, 2016 second opinion report, Dr. Geary concluded that the proposed diagnostic left shoulder arthroscopy was not medically necessitated or causally related to appellant's accepted conditions based on his opinion that appellant's adhesive capsulitis was likely related to normal degenerative changes and his underlying metabolic conditions, including diabetes. In his June 24, 2016 addendum report, he continued to opine that the left shoulder arthroscopy was not medically necessary.

Dr. Parsons opined, in reports dated February 24, 2015 and August 12, 2016, that when diabetes affects a frozen shoulder, it results in a global adhesive capsulitis which appellant did not exhibit. He found that appellant had selective tightness of his posterior capsule, which resulted in

[12] 5 U.S.C. §§ 8101-8193, 8123; *B.C.*, 58 ECAB 111 (2006); *M.S.*, 58 ECAB 328 (2007).

[13] *R.C.*, *supra* note 11.

[14] *Nathan L. Harrell*, 41 ECAB 401, 407 (1990).

an impingement-type process in the shoulder and was distinctly different from diabetic adhesive capsulitis. Dr. Parsons also noted that appellant's glycemic control had been excellent, which was further indication that it was less likely that his shoulder problems were a result of his diabetes as those most prone to frozen shoulder and other musculoskeletal complications of diabetes tended to be patients with long-standing poor glycemic control. He asserted that appellant had always demonstrated a focal posterior capsulitis of his shoulder which restricted internal rotation, but did not affect global range of motion, which was associated with a nonoutlet impingement-type syndrome associated with cumulative trauma of the upper extremities as would lead to an impingement-type process. Dr. Parsons explained that it was marked by specific loss of internal rotation which caused obligate anterior superior translation of the humeral head against the coracoacromial arch putting excess pressure and abrasion on the rotator cuff. He pointed out that this was distinctly different than a global frozen shoulder which occurred in the setting of diabetes where there was a glycosylation of the collagen molecules throughout the entire shoulder capsule leading to loss of range of motion in all planes, not specific to internal rotation. Dr. Parsons found, therefore, that given appellant's presentation of an isolated restriction of his posterior capsule, it was not fair to pin this on a diagnosis of diabetes which caused an entirely different clinical circumstance of global loss of range of motion. He concluded that appellant's current symptomatology was consistent with his cumulative trauma disorder of his upper extremities and not a result of his systemic endocrine abnormalities.

The Board finds that Dr. Geary's opinion conflicts with the SOAF. The SOAF made clear that OWCP had accepted appellant's claim for adhesive capsulitis of the right and left (bilateral) shoulders. OWCP procedures provide that, when an OWCP medical adviser, second opinion specialist, or referee physician renders a medical opinion based on a SOAF which is incomplete or inaccurate, or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.[15] In this case, Dr. Geary failed to follow the accepted conditions as set forth in the SOAF and therefore his opinion is insufficient as a basis to deny authorization for the requested surgery.

It is well established that proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done. As OWCP undertook development of the evidence by referring appellant to Dr. Geary, it had the duty to secure an appropriate report based on a proper factual and medical background, resolving the issue.[16]

For these reasons, the Board finds that this case is not in posture for decision and further development is required. After such other development as OWCP deems necessary, OWCP shall issue a *de novo* decision regarding appellant's claim for authorization of left shoulder surgery.

CONCLUSION

The Board finds that this case is not in posture for decision.

[15] *E.G.*, Docket No. 12-1011 (issued November 28, 2012).

[16] *See Phillip L. Barnes,* 55 ECAB 426 (2004); *see also Virginia Richard (Lionel F. Richard),* 53 ECAB 430 (2002); *William J. Cantrell,* 34 ECAB 1233 (1993); *Dorothy L. Sidwell,* 36 ECAB 699 (1985).

ORDER

IT IS HEREBY ORDERED THAT the February 23, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision of the Board.

Issued: January 15, 2019
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