United States Department of Labor
Employees' Compensation Appeals Board

D.G., Appellant	)	
and	)	**Docket No. 18-0043**
	)	**Issued: May 7, 2019**
DEPARTMENT OF THE ARMY, MEDICAL COMMAND, Fort Bliss, TX, 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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On October 6, 2017 appellant filed a timely appeal from a July 12, 2017 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]

ISSUE

The issue is whether appellant has met her burden of proof to establish total disability commencing June 23, 2016 causally related to the accepted August 23, 2012 employment injury.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the July 12, 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*.

FACTUAL HISTORY

On September 19, 2012 appellant, then a 58-year-old practical nurse, filed a traumatic injury claim (Form CA-1) alleging that, on August 23, 2012, she sustained pain and limited range of motion to her left arm and shoulder when a door that was closing hit her on the left arm and shoulder while in the performance of duty. OWCP paid continuation of pay (COP) until October 13, 2012.

OWCP accepted appellant's claim for left shoulder rotator cuff sprain and tear and disorder of bursae and tendons of the left shoulder.

On November 12, 2012 appellant underwent authorized left shoulder surgery. She stopped work and received wage-loss compensation benefits. OWCP placed appellant on the periodic rolls, effective December 16, 2012.

On April 15, 2013 appellant returned to part-time limited-duty work, for four hours per day. She worked limited duty for six hours per day beginning April 24, 2013. OWCP paid wage-loss compensation for part-time disability on the supplemental rolls.

On June 21, 2013 appellant returned to full-time limited-duty work and she continued to receive wage-loss compensation on the supplemental rolls for attendance at medical appointments.

On September 6, 2013 appellant resigned from federal employment. In 2015 she indicated that she wanted to return to work.

On March 9, 2015 OWCP referred appellant, along with a statement of accepted facts (SOAF) and a copy of the record, to Dr. Sofia M. Weigel, a Board-certified physiatrist, for a second opinion examination to determine whether appellant was capable of returning to full duty. In a July 7, 2015 report, Dr. Weigel reviewed appellant's history and noted that she reviewed the SOAF. Upon physical examination of appellant's left shoulder, she observed mild pain over the acromioclavicular (AC) joint and moderate pain over the bicipital tendon. Dr. Weigel also noted decreased range of motion and mild impingement sign. Drop arm test was negative. Dr. Weigel opined that appellant was able to work full time with restrictions. She indicated that appellant's disability was causally related to the August 23, 2012 employment injury. Dr. Weigel provided a work capacity evaluation form, which recommended that appellant work full time with restrictions of no reaching above the shoulder and no lifting.

In a June 15, 2016 report, Ryann Putman, a nurse practitioner, related that appellant was seen for a follow-up visit before her scheduled left rotator cuff repair surgery on June 23, 2016. She reviewed appellant's history and noted that she was currently working regular duty. Upon physical examination of appellant's left shoulder, Ms. Putman observed tenderness of the AC joint and tenderness of the supraspinatus and the subacromial bursa. Hawkin's and Neer's tests were positive. Ms. Putman diagnosed left shoulder full-thickness rotator cuff tear, left shoulder arthritis of the AC joint, left shoulder bursitis, and left shoulder pain. She concluded that appellant had symptomatic rotator cuff tear with impingement syndrome and needed an acromioplasty and mini-open rotator cuff repair of the left shoulder.

On June 23, 2016 appellant underwent authorized left shoulder recurrent rotator cuff tear repair surgery.

On June 15, 2016 appellant filed a claim for wage-loss compensation (Form CA-7) for the period June 23 through August 4, 2016. On July 15, 2016 she filed a separate Form CA-7 seeking wage-loss compensation for the period June 23 to July 9, 2016. She indicated that she had been employed as a nurse by Landsun Homes Long Term Care in Carlsbad, New Mexico from April 8 to June 22, 2016. Appellant subsequently filed Form CA-7 claims for compensation for subsequent periods of disability.

In a development letter dated July 27, 2016, OWCP informed appellant that it had received her claim for wage-loss compensation beginning June 23, 2016. It requested additional evidence to establish that she was unable to work during the claimed period as a result of her accepted August 23, 2012 employment injury. OWCP afforded appellant 30 days to submit the requested evidence.

In an August 3, 2016 letter, OWCP requested additional information from appellant regarding her current work at Landsun Homes Long Term Care and all work activities she performed since she had returned to work in 2013. In a separate letter of the same date, it also requested that she respond to an attached questionnaire in order to substantiate that her accepted injury had worsened to the extent that she was no longer able to work. OWCP also requested that appellant submit medical evidence to establish a recurrence of disability due to her August 23, 2012 employment injury. It afforded her 30 days to submit the requested evidence.

OWCP received appellant's response to its development letter on August 16, 2016. Appellant included a handwritten notation that she had not returned to work and instructed OWCP to review her medical notes that she had previously submitted. She also submitted additional medical evidence along with her response.

Appellant provided an August 9, 2016 work status note by Dr. Omar Osmani, an orthopedic surgeon. Dr. Osmani checked a box indicating "No work until further notice." In another work status note of even date, Dr. Osmani checked a box indicating "No work until further notice from June 23, 2016."

On August 18, 2016 OWCP received a statement dated August 17, 2016 from appellant. Appellant described the August 23, 2012 employment injury and indicated that because it had been 2½ years since her November 2012 left shoulder surgery and she still experienced left shoulder pain, she sought medical treatment from Dr. Weigel. She related that she had told the physician that her left shoulder pain had increased and her left shoulder was hanging lower than her right shoulder. Appellant reported that an x-ray scan was taken, which showed that the screw in her left shoulder was moving freely. She explained that her muscles had atrophied and weakened because she had not utilized her shoulder due to pain. Appellant submitted a series of physical therapy treatment notes.

By decision dated September 26, 2016, OWCP denied appellant claim for wage-loss compensation beginning June 23, 2016. It found that the medical evidence submitted was

insufficient to establish total disability from work due to a change or worsening of her August 23, 2012 employment injury.

On October 12, 2016 appellant requested reconsideration. She related that the only accident to her left shoulder rotator cuff was on August 23, 2012 at work. Appellant explained that in March 2016, her left arm started to hurt worse and her shoulder was drooping. She noted that no trauma or accident had occurred. Appellant reported that the hardware inserted in the original surgery had come apart and opened up her rotator cuff. She indicated that the muscle below the rotator cuff was atrophied to the second degree and alleged that it was a worsening of the original injury. Appellant submitted medical evidence in support of her claim.

OWCP received appellant's June 23, 2016 operative report. Appellant included a handwritten notation that the operation showed the original hardware from her first surgery had come apart.

In an August 16, 2016 report, Dr. Osmani noted that he treated appellant for follow-up of left shoulder bursitis, pain, impingement syndrome, full thickness rotator cuff tear, and arthritis of the AC joint. He related appellant's complaints of increased pain in her shoulder and limited range of motion. Dr. Osmani reviewed appellant's history and conducted an examination of appellant's left shoulder. He reported no swelling, tenderness, or warmth. Range of motion was limited. Dr. Osmani diagnosed postoperative rotator cuff repair with acute bursitis, left shoulder impingement syndrome, left shoulder AC joint arthritis, and bilateral shoulder pain.

OWCP provided a December 1, 2016 OWCP memorandum where a claims examiner noted that appellant had resigned from federal employment on September 6, 2013, but there was no evidence of continued private sector employment. The examiner indicated that appellant worked briefly from April through June 2016.

By decision dated December 1, 2016, OWCP denied modification of the September 26, 2016 decision. It found that appellant had not provided details about the work she performed between 2013 and 2016. OWCP also determined that the medical evidence submitted was insufficient to establish that appellant was totally disabled from work due to her accepted August 23, 2012 employment injury.

On February 24, 2017 appellant again requested reconsideration.

OWCP received additional medical evidence from Dr. Osmani. In reports dated November 8 and December 9, 2016, Dr. Osmani indicated that appellant was postoperative left rotator cuff tear, but still complained of pain and weakness in her left shoulder. Upon physical examination of appellant's left shoulder, he observed no swelling, tenderness, or warmth and appropriate range of motion. Dr. Osmani diagnosed left shoulder rotator cuff tear, left shoulder impingement syndrome, left shoulder bursitis, left shoulder AC joint arthritis, and bilateral shoulder pain. He indicated that appellant could return to work.

Appellant underwent a left shoulder x-ray examination on December 2, 2016 by Dr. Matthew Stalker, a Board-certified diagnostic radiologist, who noted no shoulder subluxation or dislocation and no focal bony defect or fracture.

OWCP also received a December 2, 2016 report by Dr. Eric Sides, a Board-certified orthopedic surgeon. Dr. Sides noted that appellant was status post left shoulder rotator cuff tear repair. He reported that appellant had a left shoulder rotator cuff tear repair surgery in November 2012 and now had lost the ability to lift her arm completely. Dr. Sides reviewed appellant's history and conducted an examination. He reported that her left shoulder had no significant motion arising from the glenohumeral joint and minimal motion from the scapulothoracic joint. Dr. Sides noted profound weakness of the rotator cuff and pain with palpation of the greater tuberosity. He diagnosed complete rotator cuff tear or rupture of the left shoulder.

In an unsigned January 18, 2017 left shoulder magnetic resonance imaging (MRI) arthrogram, an unknown provider noted a large, full-thickness supraspinatus tendon rotator cuff tear with tendon retraction and muscle atrophy.

Appellant submitted a January 27, 2017 letter by G.E. Booth, a physician assistant. He indicated that appellant had been under pain management since December 2013 due to the late effects of her left shoulder injury which appellant injured on August 23, 2012.

In a February 3, 2017 report, Dr. Daniel W. Vande Lune, a Board-certified orthopedic surgeon, began to treat appellant and indicated that she was status post left shoulder rotator cuff tear repair. Dr. Vande Lune related that appellant had a second surgery in June 2016 for her rotator cuff tear and had lost the ability to lift her arm completely. Upon physical examination, he observed no significant motion from the glenohumeral joint of appellant's left shoulder and minimal motion from the scapulothoracic joint. Dr. Vande Lune noted profound weakness of the rotator cuff and pain with palpation of the greater tuberosity. He indicated that appellant had a rotator cuff tear that was retracted to the level of the glenoid with supraspinatus and infraspinatus fatty infiltration consistent with atrophy. Dr. Vande Lune diagnosed left shoulder complete rotator cuff tear or rupture. He noted that appellant had failed, for a second time at rotator cuff repair. Dr. Vande Lune opined: "all of these incidences relate to the problem, which took her to the operating room initially in 2012." He explained that appellant had a rotator cuff tear that was repaired and without further injury progressed to tearing again. Dr. Vande Lune related that appellant's left shoulder MRI scan showed a tear that was really not repairable given the fatty atrophy and retraction.

OWCP received a February 3, 2017 work status note by Dr. Osmani. Dr. Osmani noted: "when original injury occurred muscle was torn, after surgery muscle did not heal which caused a retear of the muscle."

In a February 17, 2017 letter, Dr. Sides reported that appellant initially had a left shoulder injury at work with a subsequent rotator cuff tear which required arthroscopic repair. He noted that the date of injury was August 23, 2012 and that appellant's first surgery was in November 2012. Dr. Sides related that appellant continued to experience pain and difficulties with her arm due to a failure of her rotator cuff repair. He indicated that appellant underwent a repeat repair in June 2016, but still experienced persistent pain and loss of function in her left arm. Dr. Sides noted that a left shoulder MRI scan showed a recurrent tear and supraspinatus atrophy. He opined: "the recurrent tear in June was most likely because of a failure of her initial repair." Dr. Sides noted that the second repair also failed. He reported that both the initial and second

surgical repair were "within reasonable medical probability" and would be related to her original injury.

On February 24, 2017 OWCP received a statement from appellant. Appellant indicated that she did not ask to see Dr. Weigel for a second opinion examination and noted that she had not seen her since May 1, 2015. She explained that she began to see Dr. Osmani for treatment because her left shoulder pain had increased and her left shoulder was lower than the right shoulder. Appellant asserted that the fact that her muscle atrophied in her left shoulder proved that she was not using her left shoulder and was working within her limitations. She alleged that she obtained a well-reasoned medical opinion from Dr. Osmani on how the retear in her left shoulder was attributable to the original August 23, 2012 work injury. Appellant explained that the left shoulder retear was caused because the original surgery in November 2012 had not healed. She related that she worked for Landsun Homes Long Term Care from April to June 2016. Appellant listed her duties as pouring medications into a red cup, taking it to a patient, and returning to a cart to give another patient his or her medicine. She noted that she repeated this activity until all the medications were passed.

By decision dated July 12, 2017, OWCP denied modification of the December 1, 2016 decision. It found that the medical evidence submitted was insufficient to establish that she was unable to work beginning June 23, 2016 due to the August 23, 2012 employment injury.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] has the burden of proof to establish the essential elements of his or her claim, including that any disability for which compensation is claimed is causally related to the employment injury.[4] The term disability is defined as the incapacity because of an employment injury to earn the wages the employee was receiving at the time of the injury.[5]

Whether a particular injury causes an employee to be disabled from employment and the duration of that disability are medical issues which must be proven by a preponderance of the reliable, probative, and substantial medical evidence.[6] Findings on examination are generally needed to support a physician's opinion that an employee is disabled from work.[7] When the physician's statements regarding an employee's ability to work consist only of repetition of the employee's complaints that he or she was in too much pain to work, without objective findings or

[3] *Supra* note 1.

[4] *Kathryn Haggerty*, 45 ECAB 383 (1994); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[5] 20 C.F.R. § 10.5(f); *see, e.g., Cheryl L. Decavitch*, 50 ECAB 397 (1999).

[6] *Amelia S. Jefferson*, 57 ECAB 183 (2005); *William A. Archer*, 55 ECAB 674 (2004).

[7] *Dean E. Pierce*, 40 ECAB 1249 (1989).

disability being shown, the physician has not presented a medical opinion, supported by medical rationale, on the issue of disability or a basis for payment of compensation.[8]

The Board will not require OWCP to pay compensation for disability in the absence of any medical evidence addressing the specific dates of disability for which compensation is claimed. To do so would essentially allow an employee to self-certify his or her disability and entitlement to compensation.[9]

ANALYSIS

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

In support of her wage-loss compensation claim, appellant submitted various reports by Dr. Osmani dated August 9, 2016 to February 3, 2017. In an August 9, 2016 work status note, he checked a box indicating "No work" from June 23, 2016. Dr. Osmani further related in reports dated August 16 to December 9, 2016 that appellant complained of increased pain and weakness in her left shoulder and limited range of motion after her November 12, 2012 surgery. He provided examination findings and diagnosed postoperative rotator cuff repair with acute bursitis, left shoulder impingement syndrome, left shoulder rotator cuff tear, left shoulder AC joint arthritis, and bilateral shoulder pain. In a February 3, 2017 work status note, Dr. Osmani reported that when the original injury occurred the muscle was torn, it did not heal after surgery, and this caused a retear of the muscle.

The Board finds that, while the reports from Dr. Osmani are not completely rationalized, they are consistent in indicating that appellant sustained a retear of her left shoulder rotator cuff tear which caused her to be disabled from work, and his reports are not contradicted by any substantial medical or factual evidence of record.[10] Although the reports are insufficient to meet appellant's burden of proof to establish the claim, they raise an uncontroverted inference between appellant's current condition and resultant inability to work and the accepted August 23, 2012 employment injury, and thus, they are sufficient to require OWCP to further develop the medical evidence.[11]

The Board notes that although the reports of Dr. Osmani do not provide medical rationale explaining how the accepted employment incident caused or contributed to appellant's current left shoulder condition and inability to work, they strongly suggest and support a relationship between the accepted August 23, 2012 injury and appellant's current left shoulder condition and resultant disability from work.

[8] *See Fereidoon Kharabi*, 52 ECAB 291 (2001).

[9] *Amelia S. Jefferson, supra* note 6.

[10] *See E.J.*, Docket No. 09-1481 (issued February 19, 2010).

[11] *Richard E. Simpson*, 55 ECAB 490, 500 (2004); *John J. Carlone*, 41 ECAB 354, 360 (1989).

It is well-established that proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter.[12] While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence and to see that justice is done.[13] Thus, the Board will remand the case to OWCP for further development to obtain a rationalized medical opinion as to whether appellant's inability to work beginning June 23, 2016 is causally related to the August 23, 2012 employment injury and issue a *de novo* decision on whether she was totally disabled beginning June 23, 2016 causally related to the August 23, 2012 employment injury.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the July 12, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with the above opinion.

Issued: May 7, 2019
Washington, DC

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

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

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

[12] *See Vanessa Young*, 56 ECAB 575 (2004).

[13] *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *Jimmy A. Hammons*, 51 ECAB 219 (1999); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).