**United States Department of Labor**
**Employees' Compensation Appeals Board**

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| **R.B., Appellant** | ) | |
| **and** | ) | **Docket No. 21-0044** |
| | ) | **Issued: November 4, 2022** |
| **DEPARTMENT OF VETERANS AFFAIRS, CONNECTICUT HEALTHCARE SYSTEM, West Haven, CT, Employer** | ) | |

*Appearances:*
*John L. DeGeneres*, *Jr.*, *Esq.*, for the appellant[1]
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

# DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

## ***JURISDICTION***

On October 13, 2020 appellant, through counsel, filed a timely appeal from a September 2, 2020 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.

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[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.*

## ***ISSUES***

The issues are: (1) whether appellant has met his burden of proof to expand the acceptance of his claim to include additional left shoulder conditions as causally related to his accepted October 25, 2016 employment injury; and (2) whether OWCP abused its discretion by denying authorization for left shoulder surgeries.

## ***FACTUAL HISTORY***

On November 1, 2016 appellant, then a 71-year-old motor vehicle operator, filed a traumatic injury claim (Form CA-1) alleging that on October 25, 2016 he developed a shoulder bone spur when he felt his shoulder pop when pushing a walker into a van while in the performance of duty. OWCP accepted the claim for left shoulder rotator cuff strain.

In progress notes dated November 7, 2016, Dr. Rafael Y. Lefkowitz, a Board-certified internist and preventive medicine specialist, provided an accurate injury history and diagnosed left rotator cuff strain, rule out rotator cuff tear.

In reports dated December 13, 2016 and April 18, 2017, Dr. Norman R. Kaplan, a Board-certified orthopedic surgeon, noted an October 25, 2016 injury date and described examination findings, which included limited left shoulder range of motion and rotator cuff weakness with no glenohumeral instability. Diagnoses included left shoulder impingement syndrome and left rotator cuff tear.

On February 16, 2017 appellant underwent left shoulder open Neer acromioplasty, Mumford distal claviculectomy, excision of coracoacromial ligament with inspection, and rotator cuff debridement. The preoperative and postoperative diagnoses were massive left shoulder rotator cuff tear with acromioclavicular joint arthritis and impingement.

Dr. Kaplan, in a March 21, 2017 report, described the October 25, 2016 injury, provided examination findings following left shoulder surgery, and diagnosed left shoulder impingement syndrome. He explained that, on the surgery date, he found an old severe impingement with a nonoperable huge rotator cuff tear. Prior to the October 2016 employment injury, Dr. Kaplan noted that appellant had no symptoms. He opined that the October 25, 2016 employment injury was the predominant reason for appellant's left shoulder problems and need for surgery, and that, while there were preexisting left shoulder problems, appellant was asymptomatic until the work injury. Dr. Kaplan opined that October 25, 2015 employment injury caused the current left shoulder conditions.

In progress notes dated May 16, 2017, Dr. Kaplan provided examination findings and diagnosed left shoulder rotator cuff tear of unspecified tear extent and work-related injury. Since the last visit, he noted that appellant ruptured his biceps tendon and developed mid-biceps ecchymosis.

By decision dated July 19, 2017, OWCP denied expansion of the acceptance of appellant's claim to include left shoulder rotator cuff tear and left shoulder impingement syndrome.

Subsequent to the July 19, 2017 decision, OWCP received progress notes dated April 18, 2017 from Dr. Kaplan noting that appellant was status post acromioplasty surgery. Dr. Kaplan reported that appellant's rotator cuff had been debrided, but not fixed as it was too torn. Physical examination findings were described, which included reduced shoulder range of motion and rotator cuff weakness. Dr. Kaplan diagnosed a work-related injury and left rotator cuff tear of unspecified tear extent.

An August 3, 2017 report from Dr. Kaplan was repetitive of his March 21, 2017 report.

On August 16, 2017 appellant requested review of the written record by a representative of OWCP's Branch of Hearings and Review.

In progress notes dated October 26, 2017, Dr. Kaplan reiterated diagnoses and physical examination findings from prior reports. He advised that appellant required reverse total shoulder replacement surgery.

By decision dated December 5, 2017, OWCP's hearing representative found the evidence of record sufficient to warrant further development of the record. On remand, she instructed OWCP to refer appellant for a second opinion evaluation as to whether his preexisting left shoulder had been aggravated by the accepted employment injury and whether any aggravation was temporary or permanent. OWCP's hearing representative also instructed OWCP on remand to have the referral physician address whether the February 16, 2017 surgery was medically necessary and causally related to the accepted October 25, 2016 employment injury.

Subsequent to the December 5, 2017 decision, OWCP received progress notes covering the period November 29, 2016 through January 15, 2018 from Dr. Kaplan, which were unchanged from his prior reports. It also received progress notes dated September 8 and October 10, 2016, from the diagnosing left shoulder impingement syndrome, which predated the October 25, 2016 employment injury.

Dr. Kaplan, in a work capacity evaluation form (Form OWCP-5c) dated January 15, 2018, diagnosed left shoulder rotator cuff strain and severe tear. He found appellant totally disabled due to severe left shoulder pain, decreased range of motion, and strength. Dr. Kaplan recommended left shoulder replacement surgery.

In a January 23, 2018 report, Dr. John P. Daigneault, a Board-certified orthopedic surgeon, detailed appellant's injury and medical history, reviewed diagnostic tests, and provided examination findings. Physical examination findings included reduced range of motion, biceps muscle deformity consistent with long tendon rupture, prominent anterior humeral head consistent with anterior superior subluxation, well-healed horizontal incision along the left anterior clavicle and acromion, positive drop arm, and negative belly press test. Dr. Daigneault diagnosed left rotator cuff tear, work-related injury, left shoulder joint crepitus, and left shoulder osteoarthritis. He reported that appellant had limited left shoulder range of motion, weakness, and pain following his work injury. Despite subsequent cuff tear arthropathy with anterior superior escape surgery and physical therapy, Dr. Daigneault reported that appellant continued to have limited range of motion, pain, and weakness in his left shoulder. Due to appellant's poor function and severe pain, he recommended reverse shoulder arthroplasty. In a work status report of even date,

Dr. Daigneault noted an injury date of October 25, 2016 and diagnosis of "left shoulder." He indicated that the condition was work related and appellant was to continue with work restrictions.

A February 1, 2018 magnetic resonance imaging (MRI) scan revealed left shoulder degenerative change with chronic rotator cuff tear with retraction and atrophy.

On February 15, 2018 appellant requested authorization to perform left reverse shoulder arthroplasty.

Dr. Kaplan, in progress notes dated February 20, 2018, noted that at the end of March appellant was scheduled to undergo reverse total right shoulder replacement surgery, which appellant described as a necessity. Examination findings were detailed and unchanged from prior reports. Dr. Kaplan diagnosed nontraumatic shoulder rotator cuff tear.[3]

On March 2, 2018 OWCP referred appellant, together with a statement of accepted facts (SOAF), list of questions, and medical record, to Dr. Edward Staub, a Board-certified orthopedic surgeon, to serve as a second opinion specialist. It requested that Dr. Staub provide an opinion on whether the requested left shoulder surgery should be authorized and whether the acceptance of appellant's claim should be expanded to include additional left shoulder conditions. The appointment was scheduled for March 23, 2018. Appellant did not attend the scheduled appointment.

Dr. Daigneault, in progress notes dated March 14, 2018, diagnosed left shoulder primary osteoarthritis, left shoulder joint contracture, left shoulder joint crepitus, left biceps tear, and subsequent strain of left biceps long head muscle, fascia, and tendon. Appellant continued to experience left shoulder limited range of motion, weakness and significant pain. Physical examination findings were unchanged.

On March 22, 2018 appellant underwent left reverse total shoulder arthroplasty.

In an April 4, 2018 notice of proposed suspension, OWCP found that appellant had neither appeared for the schedule March 23, 2018 second opinion appointment, nor did he provide any reason for his failure to attend the scheduled appointment.

In an April 11, 2018 report, Dr. Daigneault summarized a history of the employment injury and medical treatment. He described the surgeries performed and diagnosed rotator cuff tear arthropathy with extensive supraspinatus and infraspinatus tendons tearing and retraction to the glenoid level.

In a letter dated April 25, 2018, appellant stated he did not attend the schedule March 23, 2018 second opinion evaluation due to left shoulder surgery on March 22, 2018.

On May 3, 2018 OWCP forwarded appellant's medical record and a SOAF to a district medical adviser (DMA) in order to determine whether appellant's requested left reverse total

[3] The Board notes that Dr. Kaplan refers to right shoulder at the beginning of the report and at the end of the report refers to left shoulder problem. The reference to a right shoulder at the beginning of the report appears to be a typographical error.

shoulder arthroplasty was medically necessary. In a report dated May 9, 2018, Dr. David H. Garelick, a Board-certified orthopedic surgeon serving as a DMA, reviewed the evidence to determine whether appellant required left reverse total shoulder arthroplasty causally related to appellant's employment injury. He advised that appellant had preexisting massive rotator cuff tear and was symptomatic prior to the employment injury and would have required surgery in the absence of appellant's employment injury. Dr. Garelick recommended against surgical authorizations for both the debridement surgery and reverse shoulder replacement surgery.

On June 7, 2018 OWCP referred appellant to Dr. Dennis M. Rodin, a Board-certified orthopedic surgeon, as an impartial medical examiner (IME), to resolve the conflict in the medical opinion evidence between Drs. Daigneault and Kaplan, appellant's treating physicians, and the DMA, on whether left reverse total shoulder arthroplasty performed on March 22, 2018 was causally related to the accepted medical conditions and medically necessary.

In a report dated July 6, 2018, Dr. Rodin agreed with the DMA's conclusion that the left reverse total shoulder arthroplasty surgery was not causally related to the accepted October 25, 2016 employment injury and would have been required in the absence of the employment injury. He noted that it was unclear as to what treatment appellant received prior to the September 8, 2016 office visit and how long his symptoms existed prior to the employment injury. Based on his review of Dr. Kaplan's progress notes dated September 8 and October 10, 2016, appellant had a preexisting left shoulder condition and received treatment for left shoulder pain.

By decision dated May 1, 2019, OWCP denied expansion of the acceptance of appellant's claim to include left shoulder rotator cuff tear and left shoulder impingement syndrome. It also denied authorization for his two surgeries as OWCP found that they were not medically necessary to treat the accepted left shoulder rotator cuff strain. In reaching these conclusions, OWCP accorded Dr. Rodin's opinion the special weight of the medical opinion evidence entitled as the IME.

On May 21, 2019 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A telephonic hearing was held on October 2, 2019.[4]

Subsequent to the May 1, 2019 decision, OWCP received an October 27, 2016 report from Dr. Kaplan noting that over the past year he has seen appellant for left shoulder impingement syndrome and that cortisone helped after two shots. Appellant had been improving, but developed left shoulder subacromial pain after pushing someone into a van who was on a walker. Physical examination findings included limited left shoulder range of motion, no glenohumeral instability, and lateral and posterior soreness on palpation of the subacromial space. A review of x-ray interpretations showed a huge acromioclavicular joint spur narrowing the subacromial space by 50 percent and no glenohumeral arthritis.

Dr. Kaplan, in a report dated November 15, 2019, noted while appellant had symptoms of his chronic left rotator cuff tendinitis prior to his October 2016 injury, appellant was able to work full time as the symptoms were manageable and surgery was not considered. He noted that x-rays taken prior to October 2016 showed significant subacromial narrowing due to acromioclavicular

[4] On September 27, 2019 appellant requested a telephonic hearing in lieu of an oral hearing.

joint arthritis and spurs and that an MRI scan take following the injury showed full-thickness supraspinatus and infraspinatus tendon tear. Surgery was performed based on appellant doing poorly following the employment injury. The surgery revealed a huge rotator cuff tear, which was unrepairable, but a Neer acromioplasty and Mumford distal claviculectomy was conducted to totally decompress the subacromial space. According to Dr. Kaplan, appellant's condition worsened requiring reverse total shoulder replacement surgery. He agreed with the DMA and Dr. Rodin that appellant had left shoulder symptoms prior to the accepted October 25, 2016 employment injury, but found the symptoms insignificant and surgery was not warranted. It was only after the accepted October 25, 2016 employment injury that appellant's symptoms worsened to the point that surgery was considered. Dr. Kaplan explained that, while appellant had preexisting rotator cuff pathology and some tearing, he opined that appellant's weakened rotator cuff tear was aggravated by the October 25, 2016 employment injury such that it was not repairable. He further opined that surgery would not have been required, but for the accepted October 25, 2016 employment injury.

By decision dated November 25, 2019, OWCP's hearing representative affirmed the denial of authorization for left shoulder surgery finding Dr. Rodin's opinion was entitled to the special weight of the medical opinion evidence. He further found that the subsequent reports from Dr. Kaplan were insufficient to create a new conflict in the medical opinion evidence.

On February 20, 2020 appellant, through counsel, requested reconsideration and submitted an August 22, 2016 report from Dr. Kaplan in support of his request. Dr. Kaplan, in his August 22, 2016 report, noted that appellant continued to have constant left acromial aching. A review of an x-ray interpretation revealed huge acromioclavicular joint spurs and narrowed subacromial space with no upward humeral head migration against the acromion.

By decision dated July 14, 2020, OWCP denied modification finding the evidence insufficient to warrant expansion of the acceptance of appellant's claim or to authorize the requested left shoulder surgeries.

On August 19, 2020 appellant, through counsel, requested reconsideration and submitted a July 30, 2020 report from Dr. Bryon V. Hartunian, an orthopedic surgeon, in support of his request. Dr. Hartunian, based on a review of medical records, injury history, and medical history and physical examination, diagnosed status post left shoulder arthroplasty with residual loss of motion. Based on his review of the medical records prior to the October 25, 2016 employment injury, he noted that no need or suggestion of complete left rotator cuff tear surgery nor any need for radical surgery. Dr. Hartunian explained that the usual cause for a massive rotator cuff tear, which was the diagnosis subsequent to appellant's October 25, 2016 employment injury, are almost always the cause of trauma especially when the description includes "popping" and immediate onset of symptoms. Additionally, he explained that appellant's symptoms prior to the October 2016 injury were not supportive of a diagnosis of massive rotator cuff tear or need for total shoulder replacement surgery. Appellant's symptoms prior to his injury supported a diagnosis of possible partial rotator cuff tear rotator cuff inflammation. He disagreed with the conclusions of both the DMA and Dr. Rodin as neither physicians' opinion was well-rationalized or based on a complete medical history, nor did they consider whether the accepted October 25, 2016 employment injury aggravated appellant's preexisting left shoulder condition. Dr. Hartunian opined that the October 25, 2016 employment injury caused the full-thickness left rotator tear as

well as causing a complete tearing of a possible preexisting partial left rotator cuff tear and need for left reverse total shoulder replacement.

By decision dated September 2, 2020, OWCP denied modification of the July 14, 2020 decision.

## ***LEGAL PRECEDENT -- ISSUE 1***

When an employee claims that, a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.[5]

To establish causal relationship, the employee must submit rationalized medical opinion evidence.[6] The opinion of the physician must be based on a complete factual and medical background of the claimant, 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 accepted employment injury.[7] The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[8]

## ***ANALYSIS -- ISSUE 1***

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

Appellant submitted medical evidence from Dr. Kaplan diagnosing left shoulder rotator cuff tear and left shoulder impingement syndrome. By decision dated July 19, 2017, OWCP denied expansion of the acceptance of his claim to include left shoulder rotator cuff tear and left shoulder impingement syndrome. In a decision dated December 5, 2017, an OWCP hearing representative set aside the July 19, 2017 decision finding that further development of the evidence as to whether the accepted October 25, 2016 employment injury caused or aggravated any additional left shoulder conditions. She instructed OWCP to refer appellant for a second opinion evaluation as to whether his preexisting left shoulder condition had been aggravated by the accepted employment injury and whether any aggravation was temporary or permanent. OWCP's hearing representative also instructed OWCP to have the referral physician address whether the February 16, 2017 surgery was medically necessary and causally related to the accepted October 25, 2016 employment injury. On March 2, 2018 OWCP referred appellant, to Dr. Staub, for a second opinion evaluation and opinion as to whether the requested left shoulder surgery

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[5] *See W.C.*, Docket No. 19-1740 (issued June 4, 2020); *T.F.*, Docket No. 17-0645 (issued August 15, 2018); *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[6] *E.M.*, Docket No. 18-1599 (issued March 7, 2019); *Robert G. Morris*, 48 ECAB 238 (1996).

[7] *D.S.*, Docket No. 20-0146 (issued June 11, 2020); *M.V.*, Docket No. 18-0884 (issued December 28, 2018); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[8] *Id*.

should be authorized and whether appellant's claim should be expanded to include additional left shoulder conditions. The appointment was scheduled for March 23, 2018.

Appellant did not attend the scheduled March 23, 2018 appointment because he underwent left reverse total shoulder arthroplasty on March 22, 2018. While OWCP referred the case record to the DMA, Dr. Garelick, on May 3, 2018 to determine whether appellant's left shoulder surgery should be authorized, it did not specifically request that the DMA address the hearing representative's remand instructions to obtain another physical evaluation to determine whether appellant's preexisting left shoulder conditions had been aggravated by the accepted employment injury and whether any aggravation was temporary or permanent. Therefore, the DMA's May 9, 2018 report only focused on the necessity of the surgical procedure and did not address whether the accepted employment injury aggravated appellant's preexisting left shoulder condition.

OWCP thereafter determined that a conflict existed between appellant's treating physicians, Drs. Daigneault and Kaplan, and the DMA regarding the medical necessity of the requested surgery. However, it again did not specifically request that the IME, Dr. Rodin, address the underlying issue noted by the hearing representative in the December 5, 2017 remand order, that is whether appellant's preexisting left shoulder conditions were aggravated by the accepted employment injury.

It is well established that proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[9] While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[10] Once OWCP undertakes development of the record, it must procure medical evidence that will resolve the relevant issues in the case.[11] As OWCP undertook development of the issue of whether appellant's accepted employment injury aggravated his preexisting left shoulder conditions, by referring appellant to Dr. Staub, but did not resolve the issue, the Board finds that further medical development is necessitated prior to OWCP resolving the issue of whether it properly denied appellant authorization for left shoulder surgeries.

On remand, OWCP shall reschedule appellant for a medical evaluation with Dr. Staub for an opinion as to whether appellant's accepted employment injury aggravated his preexisting left shoulder conditions. If Dr. Staub is not available, OWCP shall refer appellant to a physician in the appropriate field of medicine to resolve this outstanding issue. Once the issue of aggravation is resolved, OWCP shall then request an opinion on the underlying issue of whether the acceptance of appellant's claim should be expanded to include additional left shoulder conditions and whether the left shoulder surgeries were causally related to the accepted October 25, 2016 employment injury and medically warranted. Following this and other such further development as OWCP deems necessary, it shall issue a *de novo* decision.

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[9] *See D.T.*, Docket No. 20-0234 (issued January 8, 2021); *F.K.*, Docket No. 19-1804 (issued April 27, 2020); *B.W.*, Docket No. 19-0965 (issued December 3, 2019).

[10] *Id.*

[11] *Id.*

## ***CONCLUSION***

The Board finds that this case is not in posture for a decision.[12]

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the September 2, 2020 decision of the Office of Workers' Compensation Programs is set aside and the case and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: November 4, 2022
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board

[12] In view of the Board's disposition of Issue 1, Issue 2 is rendered moot.