

ISSUES

The issues are: (1) whether appellant has met his burden of proof to expand the acceptance of his claim to include left elbow tendinosis and left shoulder tear, as causally related to, or consequential to, the accepted October 1, 2019 employment injury; and (2) whether OWCP properly denied authorization for left shoulder surgery.

FACTUAL HISTORY

On October 1, 2019, appellant, then a 35-year-old registered nurse, filed a traumatic injury claim (Form CA-1) alleging that he injured his left arm, left shoulder, left wrist, neck and back when trying to secure a patient who was suffering from a seizure while in the performance of duty. He stopped work on October 2, 2019. OWCP accepted the claim for left hamstring strain. It paid appellant wage-loss compensation on the supplemental rolls commencing November 10, 2019, and on the periodic rolls commencing February 2, 2020. Appellant returned to full-time modified duty on November 15, 2020.

In a report dated October 2, 2019, Dr. William J. Lackey, a Board-certified orthopedic surgeon, related appellant's history of injury and noted that appellant had previously undergone two left shoulder arthroscopic procedures. In a November 6, 2019 report, Dr. Lackey noted that appellant underwent a magnetic resonance imaging (MRI) scan of the left shoulder. He assessed left shoulder posterior labral tear, and left elbow internal derangement.

In a November 21, 2019 report, Dr. Abraham M. Glasman, a Board-certified neurologist, opined that the acceptance of the claim should be expanded to include cervical and lumbar spine, shoulder, wrist, and head as causally related to the accepted employment injury.

OWCP referred appellant, along with a November 12, 2019 statement of accepted facts (SOAF), medical record, and series of questions, to Dr. Leon Sultan, a Board-certified orthopedic surgeon, and Dr. Steven Ender, an osteopath and Board-certified neurologist, for second opinion evaluations regarding the status of appellant's accepted conditions and to determine whether the acceptance of the claim should be expanded to include additional conditions as causally related to the employment injury.

Both Dr. Sultan and Dr. Ender reviewed appellant's history of injury, the medical record, and the SOAF. In a December 31, 2019 report, Dr. Sultan observed that physical examinations of appellant's left shoulder and left elbow revealed normal findings. He also opined that appellant was no longer suffering from disabling residuals of the accepted condition.

On May 18, 2020, OWCP expanded the acceptance of the claim to include cervical strain, lumbar strain, temporary aggravation of lumbar degenerative disease, and temporary aggravation of cervical degenerative disease.

Dr. Sultan opined in a June 26, 2020 addendum report that appellant had a negative left shoulder evaluation. He concluded that there was no correlation between appellant's current left shoulder findings and the findings from the October 3, 2019 MRI scan. Dr. Sultan related that appellant did not require left shoulder arthroscopy.

On March 30, 2021 OWCP determined that a conflict in medical opinion existed between the treating physicians and the second opinion physicians regarding appellant's additional conditions. It referred him along with the case record, a SOAF, and a series of questions to Dr. Barry C. Kleeman, a Board-certified orthopedic surgeon, to serve as an impartial medical examiner (IME) to resolve the conflict.

In a May 17, 2021 report, Dr. Kleeman noted appellant's two prior surgeries to the left shoulder, including a recent 2019 left shoulder arthroscopy decompression. He found no objective findings on examination consistent with appellant's complaints of left shoulder pain. Dr. Kleeman related that appellant had no evidence of left shoulder muscle atrophy, and he had normal range of motion of the left shoulder. He opined that the employment injury could have resulted in a posterolateral deltoid muscle contusion or strain; however, his current objective findings did not correlate with his symptoms. Dr. Kleeman related that an MRI arthrogram of the left shoulder may be warranted to evaluate the labrum. He asserted that left shoulder surgery was not warranted unless the MRI arthrogram demonstrated a surgically correctable shoulder pathology. Dr. Kleeman also noted that appellant's left elbow examination was normal.

A November 1, 2021 MRI arthrogram report of appellant's left shoulder revealed high-grade partial-thickness articular-sided tear involving the anterior and mid supraspinatus tendon insertion, mild subacromial/subdeltoid bursitis, tear of the posterior and posteroinferior labrum with multiloculated para labral cyst formation arising from the posterior labrum.

In a November 24, 2021 report, Dr. Lackey assessed left shoulder tear of the posterior and posterior inferior labrum with associated parameniscal cyst and a high-grade partial thickness tear involving the supraspinatus with associated impingement. He opined that appellant's left shoulder conditions and symptoms were a direct result of the October 1, 2019 employment injury, noting that, prior to this injury, appellant had fully recovered from previous shoulder issues with full functionality. Dr. Lackey also found left elbow internal derangement, rule out lateral epicondylitis.

On July 28, 2022, OWCP expanded the acceptance of the claim to include strain/contusion of left shoulder and sprain of left wrist.

By separate decision dated July 28, 2022, OWCP denied expansion of the claim to include additional conditions. It accorded the special weight of the medical evidence to Dr. Kleeman, the IME.

On August 2, 2022, appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on December 7, 2022.

OWCP subsequently received progress reports dated October 27 and November 30, 2022 and January 5, 2023, wherein Dr. Lackey provided appellant's physical examination findings, including restricted range of motion of the left shoulder. Dr. Lackey diagnosed pain in the left shoulder associated with shoulder impingement, subacromial bursitis, shoulder sprain, bicipital tendinitis, rotator cuff tendinitis, rotator cuff tear, superior glenoid labrum lesion, and shoulder arthritis. He also noted appellant's left elbow pain.

By decision dated January 27, 2023, the OWCP hearing representative set aside the July 28, 2022 decision and remanded the case for further development of the evidence. On remand, he instructed OWCP to update the SOAF and refer the medical record to Dr. Kleeman for a supplemental opinion on whether the October 1, 2019 employment injury contributed to the left shoulder pathologies revealed on the November 1, 2021 MRI arthrogram, whether left shoulder surgery was warranted, or whether additional diagnostic evidence was needed. The hearing representative also instructed OWCP to ask Dr. Kleeman to address whether the October 1, 2019 employment injury contributed to appellant's left elbow condition.

On February 6, 2023, OWCP prepared an updated SOAF which included the newly-expanded conditions and requested a supplemental report from Dr. Kleeman; however, Dr. Kleeman did not respond.

On September 22, 2023, OWCP referred appellant, along with the February 6, 2023 SOAF, the medical record, and a series of questions, to Dr. Frank J. Corrigan, a Board-certified orthopedic surgeon, for an impartial medical evaluation.

In a report dated November 16, 2023, Dr. Corrigan reviewed appellant's medical record, diagnostic data, and the SOAF. He stated that he could not comment on the causality of the left shoulder posterior labral tear, noting that since appellant had prior injuries and two arthroscopic surgeries to the left shoulder, additional information as to what pathology was present prior to the October 1, 2019 employment injury was necessary. Dr. Corrigan additionally indicated that while there had been an alleged injury to the lateral epicondylitis, lateral epicondylitis was more commonly due to chronic and repetitive work rather than an acute injury or trauma. He advised that as there were no diagnostic imaging studies involving the left elbow, he could not render an opinion on causation. Dr. Corrigan indicated that he would provide an addendum to his report if further information regarding appellant's prior left shoulder injuries and surgeries, and diagnostic studies of the left elbow were made available.

In a letter dated November 30, 2023, OWCP informed appellant of the deficiencies of his claim for expansion. It advised him of the type of medical evidence necessary to establish his claim and afforded him 30 days to submit the necessary evidence.

By *de novo* decision dated January 10, 2024, OWCP denied appellant's request to expand the acceptance of his claim to include left elbow tendinosis and left shoulder conditions.

On January 18, 2024, appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

Following a preliminary review, by decision dated March 7, 2024, OWCP's hearing representative set aside the January 10, 2024 decision and remanded the case for further development. The hearing representative instructed OWCP to obtain all medical records related to treatment involving appellant's left shoulder prior to October 1, 2019, including operative reports or details of such, and any diagnostic testing performed for the left elbow. The hearing representative further instructed OWCP to prepare a corrected medical conflict statement regarding expansion and the need for left shoulder surgery. Additionally, the hearing representative instructed OWCP to prepare appropriate questions and request a supplemental

report from Dr. Corrigan to provide medical rationale as to whether each specific diagnosis requested for expansion was related to the October 1, 2019 mechanism of injury by causation, aggravation, acceleration or precipitation, by any degree, followed by a *de novo* decision.

On April 12, 2024, OWCP notified appellant that his claim was accepted for strain of the muscle, fascia and tendon of the posterior muscle group at the thigh level; sprain of ligaments of the cervical and lumbar spine; other intervertebral disc degeneration of the lumbar and cervical regions; strain of other muscles, fascia and tendons at shoulder and upper arm level, left arm; sprain of unspecified part of left wrist and hand; resolved cervical radiculopathy; and resolved lumbar radiculopathy.

On April 12, 2024, OWCP referred appellant, along with the case record, and a series of questions, to Dr. Corrigan for a supplemental opinion to resolve the conflict in the medical opinion evidence between Drs. Glasman and Lackey, appellant's treating physicians, and Dr. Sultan, the second opinion physician, regarding appellant's left shoulder pathologies, left shoulder surgery, and his left elbow condition.

An April 9, 2024 MRI scan of appellant's left elbow related an impression of mild common extensor origin tendinosis, with partial-thickness undersurface tear at the tendon origin not excluded. Significant retraction was not evident.

As OWCP did not receive a response from Dr. Corrigan, on August 6, 2024, it referred appellant, along with the medical record, the February 6, 2023 SOAF, and a series of questions to Dr. Howard Pecker, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the outstanding conflict in the medical opinion evidence between Drs. Glasman and Lackey, appellant's treating physicians, and Dr. Sultan, OWCP's second opinion physician, regarding appellant's left shoulder pathologies, left shoulder surgery, and left elbow condition.

In a September 3, 2024 report, Dr. Pecker noted the accepted conditions in the case, the October 1, 2019 employment injury, and his review of the medical record. He provided appellant's physical examination findings and opined that appellant did not have a left elbow or left shoulder condition causally related to the October 1, 2019 employment injury. Dr. Pecker further opined that the accepted conditions of contusion and sprain of the left shoulder had resolved. With regard to the left shoulder pathology revealed on the November 1, 2021 MRI arthrogram, he found there was no mechanism of injury to produce circumferential labral tears. Dr. Pecker explained that the labral tears seen were typically from repetitive microtrauma or frank dislocations, neither of which was present. He indicated that rotator cuff tear, especially partial-thickness tears, occurred from repetitive microtrauma more likely secondary to weightlifting as a hobby. Dr. Pecker noted that while acute rotator cuff tears can occur for eccentric loading, such a mechanism was not present. He further opined that surgery for the anterior and posterior tears was not warranted as there was no instability on examination. Dr. Pecker indicated that the partial-thickness rotator cuff tear noted on the November 21, 2021 MRI arthrogram was not present on the MRI scan two days post-accident, which showed an intact rotator cuff. He explained that this was evidence that the partial-thickness rotator cuff tear occurred in the interval between the October 1, 2019 employment injury and a subsequent scan approximately two years later, indicative of a finding likely secondary to weightlifting as a hobby, or general exercise. Dr. Pecker further opined that appellant's left extensor tendinosis was brought on by repetitive microtrauma of over gripping. He indicated that

there was no evidence of the diagnosis being trauma related and such a diagnosis was commonly seen in appellant's age group.

By *de novo* decision dated November 12, 2024, OWCP denied expansion of the acceptance of the claim to include left elbow tendinosis, left shoulder tear, finding that the medical evidence of record was insufficient to establish causal relationship between these additional conditions and the accepted employment injury. It also denied authorization for left shoulder surgery, finding that the medical evidence of record was insufficient to establish that the requested surgery was medically necessary and causally related to the accepted employment injury.

On November 19, 2024, appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on February 19, 2025.

On December 10, 2024, OWCP issued an updated SOAF containing the newly accepted conditions.

By decision dated February 27, 2025, OWCP's hearing representative set aside the November 12, 2024 decision and remanded the case for further development on the issue of expansion. It instructed OWCP to send Dr. Pecker an updated SOAF and request an addendum report as to whether the new evidence changed his opinion that appellant's left shoulder and left elbow conditions were not contributed to in any way by the October 1, 2019 employment injury. Following receipt and review of the supplemental report and any further development as deemed necessary, OWCP was to issue a *de novo* decision.

By *de novo* decision dated March 3, 2025, OWCP found the accepted conditions in the case remained as determined in the April 12, 2024 decision.

On March 3, 2025, OWCP also requested that Dr. Pecker review the updated SOAF and all medical documentation received since August 1, 2024 and provide a supplemental report clarifying whether the new evidence changed his opinion that appellant's left shoulder and left elbow conditions were not contributed to in any way by the October 1, 2019 employment injury.

On March 13, 2025, OWCP received an undated report from Dr. Pecker. Dr. Pecker noted he reviewed an "August 6, 2024" SOAF and the medical documentation received since August 1, 2024. He concluded that his opinion was unchanged. Dr. Pecker again explained, that at the time of his examination, appellant had no functional deficits of the left elbow. Regarding appellant's left shoulder, he related that there was no evidence of aggravation or acceleration of appellant's preexisting degenerative changes, and there was no rotator cuff tear.

By *de novo* decision dated March 13, 2025, OWCP denied expansion of the acceptance of the claim to include left elbow tendinosis and left shoulder tear. It also denied authorization for left shoulder surgery. OWCP accorded the special weight of the medical evidence to Dr. Pecker's opinion.

On April 1, 2025, appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

Following a preliminary review, by decision dated July 8, 2025, OWCP's hearing representative set aside the March 13, 2025 decision and remanded the case for further development. On remand, the hearing representative instructed OWCP to provide Dr. Pecker with the December 10, 2024 updated SOAF and obtain a supplemental report which addressed whether the evidence established a causal relationship between appellant's left elbow and/or left shoulder conditions, and whether the proposed left shoulder surgery was medically indicated and necessary secondary to the employment injury.

On July 9 and 25, 2025, OWCP requested an additional supplemental report from Dr. Pecker.

In an August 5, 2025 report, Dr. Pecker opined that the case should not be expanded to include the left elbow, left shoulder conditions, and left shoulder surgery. He stated that lateral epicondylitis is a condition resulting from repetitive microtrauma, not from a single traumatic event. Dr. Pecker explained that repetitive microtrauma were typically seen when no complete tendon rupture is found. He stated that appellant's October 3, 2019 MRI scan of the left elbow had no findings of repetitive microtrauma and there was no evidence of lateral epicondylitis at the time of his physical examination. Dr. Pecker provided left elbow examination findings and explained how none of the symptoms were indicative of lateral epicondylitis. He further explained that in addition to no objective evidence on examination, lateral epicondylitis typically resolved spontaneously, typically within nine months' time from the date of onset. Dr. Pecker also indicated that as the left elbow MRI scan noted "mild common extensor origin tendinosis, with partial-thickness undersurface tear at the tendon origin not excluded, this meant it was not definitively seen." He stated that this finding was consistent with mild tendinopathy, which was not active at the time of his examination or the MRI scan report. Dr. Pecker further opined that if tendinopathy was aggravated at the time of the incident, then the aggravation had ceased, and the condition resolved, at the time of his examination. He, however, opined that if the findings were secondary to an acute incident, then he would have expected to see a total rupture of the muscle tendon unit or evidence of a prior tear that had scarred, which he did not see. Dr. Pecker concluded that the medical evidence revealed that the employment injury did not contribute in any way, by either direct causation, aggravation, acceleration, or precipitation, to appellant's left elbow condition.

With regard to a request for claim expansion to include rotator cuff tear, Dr. Pecker stated that, as previously noted, the MRI scan of the left shoulder that was taken days after the incident showed no evidence of rotator cuff tear, such as hemorrhage or a defect in the rotator cuff or osteochondral injury to suggest any type of displacement of the humeral head inside the glenoid. He noted that at the time of his examination, appellant had excellent development of the deltoid and normal strength in various maneuvers that test the rotator cuff including horn blower's, empty can, belly press, and external rotation, with no evidence of abnormality. Dr. Pecker concluded that the medical evidence revealed that the employment injury did not contribute in any way by either direct causation, aggravation, acceleration, or precipitation, to appellant's current condition.

Dr. Pecker also opined that the October 1, 2019 employment injury did not cause or contribute in any way to the posterior labral tear. He noted that the presence of circumferential labral tears was consistent with appellant having sustained labral tears unrelated to his single incident. Dr. Pecker opined that extreme trauma did not occur as such a trauma that would cause

an acute labral tear or acute aggravation of a preexisting tear in one direction which would, by virtue of its subsequent pain, temporarily disable appellant from using the arm. In addition, the MRI scan performed days after the incident did not show any signs of subluxation or dislocation, which are the associated traumatic findings for an acute labral tear or acute exacerbation of the tear, and there was no hemorrhage and no osteochondral injury to suggest subluxation of the humeral head or the glenoid that might have caused a labral tear or aggravated a previous labral tear. Dr. Pecker related that the March 30, 2011 MRI scan showed a probable tear of the posterior labral margin, noting that there were significant differences in the left shoulder MRIs regarding the labrum. He noted the October 3, 2019 MRI scan was interpreted as “likely” reflecting a tear and the November 1, 2021 MRI scan showed a loculated ganglion cyst at the posterior inferior labrum, which was consistent with appellant having some subsequent degeneration or injury of the left shoulder superimposed on his March 30, 2011 history of preexisting degeneration. Dr. Pecker further noted that while it was not impossible for someone to have aggravation of labral tear from restraining a patient, appellant’s MRI scan performed days after the incident showed no evidence of acute trauma to that area and the March 30, 2011 MRI scan findings and appearance described were essentially the same on the October 3, 2019 MRI report, where no definite tear was found. Additionally, the October 3, 2019 MRI report found no reported bone marrow edema of the glenoid or humeral head, which he explained was a finding that occurred with bruising and microfracture of the humeral head coming over the lip of the glenoid, the causative mechanism of an acute labral tear. Dr. Pecker further indicated that appellant’s examination findings at the time of his examination was not consistent with a symptomatic labral tear, internal derangement of the shoulder or a labral tear. Thus, he concluded that the October 1, 2019 employment injury did not contribute by direct causation, aggravation, acceleration, or precipitation to appellant’s condition.

Dr. Pecker further opined that the recommendation that appellant undergo left shoulder arthroscopy for a superior labrum from anterior to posterior (SLAP) tear should not be accepted as there was no medical evidence to suggest that the October 1, 2019 employment injury had contributed by either direct causation, aggravation, acceleration or precipitation, as previously discussed, to any of the positive shoulder conditions seen on the November 1, 2021 MRI arthrogram. He noted that while the November 1, 2021 MRI arthrogram was positive for 50 percent thickness tear of the anterior mid rotator cuff tendon, it did not identify which tendon had the partial tear. While it is presumed to be the supraspinatus tendon, as the other three tendons were unremarkable, Dr. Pecker stated that a tear of the posterior inferior labrum was typically found with degenerative change in the glenoid. Likewise, an anterior superior labrum consistent with a sub-labral recess or possible anterior superior tear was not likely to represent a traumatic tear of the anterior superior labrum. Dr. Pecker opined that the November 1, 2021 MRI arthrogram indicated that the partial rotator cuff tear should be repaired; however, he indicated that this was likely a sub-labral recess, a natural finding, which should not be repaired. He further opined that any surgery would be elective and not likely to have a positive effect on appellant’s shoulder function.

By *de novo* decision dated September 4, 2025, OWCP denied expansion of the acceptance of the claim to include a left shoulder tear and left elbow tendinosis. It also denied authorization for left shoulder surgery. OWCP accorded the special weight of the medical evidence to Dr. Pecker’s August 5, 2025 supplemental report.

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.³

To establish causal relationship between a condition and the employment event or incident, the employee must submit rationalized medical opinion evidence based on a complete factual and medical background, supporting such a causal relationship.⁴ The opinion of the physician must be one of reasonable certainty, and must explain the nature of the relationship between the diagnosed condition and the accepted employment injury.⁵

In discussing the range of compensable consequences, once the primary injury is causally connected with the employment, the question is whether compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury. The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.⁶

Section 8123(a) of FECA provides 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.⁷ 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. In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an IME for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well-rationalized and based upon a proper factual background, must be given special weight.⁸

³ *S.P.*, Docket No. 25-0669 (issued November 25, 2025); *S.L.*, Docket No. 24-0220 (issued May 15, 2024); *N.U.*, Docket No. 22-1329 (issued April 18, 2023); *J.R.*, Docket No. 20-0292 (issued June 26, 2020); *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004).

⁴ *S.L.*, *id.*; *B.W.*, Docket No. 21-0536 (issued March 6, 2023); *D.E.*, Docket No. 20-0936 (issued June 24, 2021); *S.L.*, Docket No. 19-0603 (issued January 28, 2020).

⁵ *Id.*

⁶ *See L.M.*, Docket No. 23-0605 (issued December 5, 2023); *D.L.*, Docket No. 21-0047 (issued February 22, 2023); *D.H.*, Docket Nos. 20-0041 & 20-0261 (issued February 5, 2021).

⁷ 5 U.S.C. § 8123(a). *See D.M.*, Docket No. 25-0317 (issued April 15, 2025); *R.C.*, Docket No. 18-0463 (issued February 7, 2020); *see also G.B.*, Docket No. 16-0996 (issued September 14, 2016).

⁸ 20 C.F.R. § 10.321. *See also D.M.*, *id.*; *J.H.*, Docket No. 22-0981 (issued October 30, 2023); *N.D.*, Docket No. 21-1134 (issued July 13, 2022); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001); *James P. Roberts*, 31 ECAB 1010 (1980).

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met his burden of proof to expand the acceptance of his claim to include left elbow tendinosis and left shoulder conditions as causally related to, or consequential to, the accepted October 1, 2019 employment injury.

OWCP determined that there was a conflict in the medical opinion evidence between appellant's treating physicians, and Dr. Sultan, OWCP's second opinion examiner, regarding whether appellant's left elbow tendinosis and left shoulder conditions were causally related to, or consequential to, the October 1, 2019 employment injury

In a September 3, 2024 report, Dr. Pecker concluded that appellant's left elbow and left shoulder conditions did not occur from a single traumatic event and, thus, those conditions were not causally related to the October 1, 2019 employment injury. He explained that appellant's left extensor tendinosis was brought on by repetitive microtrauma of over gripping. Dr. Pecker concluded that there was no evidence of the diagnosis being trauma related and such a diagnosis was commonly seen in appellant's age group. Regarding appellant's left shoulder, he indicated that the partial-thickness rotator cuff tear noted on the November 21, 2021 MRI arthrogram was not present on the MRI scan two days post-accident. Dr. Pecker explained that this was evidence that the partial-thickness rotator cuff tear occurred in the interval between the October 1, 2019 employment injury and the subsequent scan. He noted that this finding was likely secondary to appellant's weight-lifting hobby, or general exercise.

Following his review of the updated December 10, 2024 SOAF, Dr. Pecker, in his August 5, 2025 supplemental report, stated that lateral epicondylitis was a condition resulting from repetitive microtrauma, not from a single traumatic event. He explained that appellant's left elbow MRI scan noted mild common extensor origin tendinosis, with partial-thickness undersurface tear at the tendon origin not excluded; however, this meant that it was not definitively seen. Dr. Pecker further explained that if the findings were secondary to an acute incident, then he would have expected to see a total rupture of the muscle tendon unit or evidence of a prior tear that had scarred, which he did not see.

Regarding appellant's left shoulder injury, Dr. Pecker indicated that the MRI scan of the left shoulder taken days after the October 1, 2019 employment injury showed no evidence of a rotator cuff tear or osteochondral injury. He also related that there was no supporting evidence of a hemorrhage or a defect in the rotator cuff or osteochondral injury to suggest any type of displacement of the humeral head inside the glenoid. Dr. Pecker explained that while the November 1, 2021 MRI arthrogram was positive for 50 percent thickness tear of the anterior mid rotator cuff tendon, it did not identify which tendon had the partial tear, though it was presumed to be the supraspinatus tendon, as the other three tendons were unremarkable. In addition, he stated that a tear of the posterior inferior labrum was typically found with degenerative change in the glenoid. An anterior superior labrum consistent with a sub-labral recess or possible anterior superior tear was also not likely to represent a traumatic tear of the anterior superior labrum.

Dr. Pecker based his opinion on the updated SOAF, a proper factual and medical history, physical examination findings and the diagnostic testing of record. He performed a thorough clinical examination and provided detailed findings. Dr. Pecker provided rationale for opinion as

to why appellant's left elbow condition and left shoulder conditions were not causally related to, or consequential to, the accepted October 1, 2019 employment injury. The Board therefore finds that Dr. Pecker's opinion is entitled to the special weight accorded to an IME and establishes that appellant has not met his burden of proof to expand the acceptance of his claim to include additional left elbow and left shoulder conditions as causally related to, or consequential to, his accepted employment injury.⁹

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

LEGAL PRECEDENT -- ISSUE 2

Section 8103(a) of FECA¹⁰ 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 by 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.¹¹

In interpreting this section of FECA, the Board has recognized that OWCP has broad discretion in determining whether a particular type of treatment is likely to cure or give relief.¹² The only limitation on OWCP's authority is that of reasonableness.¹³

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 could be construed to produce a contrary factual conclusion.¹⁴

While OWCP is obligated to pay for treatment of employment-related conditions, appellant has the burden of proof to establish that the expenditures were incurred for treatment of the effects of an employment-related injury or condition.¹⁵ Proof of causal relationship in a case such as this

⁹ See *O.R.*, Docket No. 25-0070 (issued January 13, 2025); *A.P.*, Docket No. 24-0170 (issued March 26, 2024); *M.G.*, Docket No. 23-0674 (issued October 3, 2023); *F.A.*, Docket No. 20-1652 (issued May 21, 2021).

¹⁰ 5 U.S.C. § 8103(a).

¹¹ *Id.*; see *J.K.*, Docket No. 20-1313 (issued May 17, 2021); *Thomas W. Stevens*, 50 ECAB 288 (1999).

¹² *R.C.*, Docket No. 18-0612 (issued October 19, 2018); *W.T.*, Docket No. 08-812 (issued April 3, 2009).

¹³ See *V.F.*, Docket No. 25-0548 (issued September 5, 2025); *S.Y.*, Docket No. 24-0443 (issued May 28, 2024); see *D.C.*, Docket No. 20-0854 (issued July 19, 2021); *C.L.*, Docket No. 17-0230 (issued April 24, 2018); *D.K.*, 59 ECAB 141 (2007).

¹⁴ See *E.F.*, Docket No. 20-1680 (issued November 10, 2021); *J.L.*, Docket No. 18-0503 (issued October 16, 2018); *Daniel J. Perea*, 42 ECAB 214, 221 (1990).

¹⁵ *R.M.*, Docket No. 19-1319 (issued December 10, 2019); *J.T.*, Docket No. 18-0503 (issued October 16, 2018); *Debra S. King*, 44 ECAB 203, 209 (1992); *Zane H. Cassell*, 32 ECAB 1537, 1540-41 (1981).

must include supporting rationalized medical evidence.¹⁶ In order for a procedure to be authorized, appellant must establish that the procedure was for a condition causally related to the employment injury and that the procedure was medically warranted.¹⁷ Both of these criteria must be met in order for OWCP to authorize payment.¹⁸

Section 8123(a) of FECA provides 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.¹⁹ 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. In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an IME for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well-rationalized and based upon a proper factual background, must be given special weight.²⁰

ANALYSIS -- ISSUE 2

The Board finds that OWCP properly denied authorization for left shoulder surgery.

As explained above, OWCP properly found a conflict and referred appellant to Dr. Pecker for an impartial medical examination. Dr. Pecker, in his August 5, 2025 supplemental report, opined that the recommendation that appellant undergo left shoulder arthroscopy for a SLAP tear should not be accepted as there was no medical evidence to suggest that the October 1, 2019 employment injury had contributed by either direct causation, aggravation, acceleration or precipitation, as previously discussed, to any of the shoulder conditions seen on the November 1, 2021 MRI arthrogram. He noted that while the November 1, 2021 MRI arthrogram was positive for a 50 percent thickness tear of the anterior mid rotator cuff tendon, it did not identify which tendon had the partial tear. While it is presumed to be the supraspinatus tendon, Dr. Pecker stated that a tear of the posterior inferior labrum was typically found with degenerative change in the glenoid, and a sub-labral recess or possible anterior superior tear was not likely to represent a traumatic tear of the anterior superior labrum. Dr. Pecker further explained that the partial rotator cuff tear identified on the MRI arthrogram was likely a sub-labral recess, a natural finding, which should not be repaired. He opined that any surgery would be elective and not likely to have a positive effect on appellant's shoulder function.

As Dr. Pecker explained, with supporting medical rationale, that the procedure requested was not related to the accepted conditions, it was not likely to cure, give relief, reduce the degree

¹⁶ *K.W.*, Docket No. 18-1523 (issued May 22, 2019); *C.L.*, Docket No. 17-0230 (issued April 24, 2018); *M.B.*, 58 ECAB 588 (2007); *Bertha L. Arnold*, 38 ECAB 282 (1986).

¹⁷ *T.A.*, Docket No 19-1030 (issued November 22, 2019); *John E. Benton*, 15 ECAB 48, 49 (1963).

¹⁸ *J.L.*, Docket No. 18-0990 (issued March 5, 2019); *R.C.*, 58 ECAB 238 (2006); *Cathy B. Millin*, 51 ECAB 331, 333 (2000).

¹⁹ *Supra* note 7

²⁰ *Supra* note 8.

or the period of any disability, or aid in lessening the amount of any monthly compensation.²¹ Thus, the Board finds that OWCP did not abuse its discretion in denying appellant's request for surgical authorization of the left partial rotator cuff tear repair.

CONCLUSION

The Board finds that appellant has not met his burden of proof to expand the acceptance of his claim to include additional left elbow and left shoulder conditions as causally related to, or consequential to, the accepted October 1, 2019 employment injury. The Board further finds that OWCP properly denied authorization for left shoulder surgery.

ORDER

IT IS HEREBY ORDERED THAT the September 4, 2025 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 11, 2026
Washington, DC

Alec J. Koromilas, 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

²¹ 5 U.S.C. § 8103(a); *see D.O.*, Docket No. 25-0722 (issued January 5, 2026); *P.M.*, Docket No. 18-0287 (issued October 11, 2018); *B.L.*, Docket No. 15-1452 (issued September 20, 2016); *L.D.*, 59 ECAB 648 (2008).