United States Department of Labor
Employees' Compensation Appeals Board

C.B., Appellant	)	
and	)	**Docket No. 09-923**
	)	**Issued: January 4, 2010**
DEPARTMENT OF VETERANS AFFAIRS, NORTH TEXAS HEALTH CLINIC SYSTEM, Dallas, TX, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On February 25, 2009 appellant, through her attorney, filed a timely appeal from the June 13, 2008 and January 9, 2009 merit decisions of the Office of Workers' Compensation Programs denying her recurrence of disability claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this appeal.

ISSUE

The issue is whether appellant sustained a recurrence of disability commencing September 3, 2007 causally related to her May 25, 2007 injury.

FACTUAL HISTORY

On January 23, 2008 appellant, then a 40-year-old medical support assistant, filed a claim alleging injury to her back on May 25, 2007 when she attempted to sit on a chair and slipped, falling to the floor on her buttocks. She did not stop work. The record indicates that, on May 29, 2007, appellant was treated at the employing establishment health unit and lumbosacral x-rays

were obtained. The staff radiologist interpreted the studies as normal with no evidence of fracture or dislocation and normal vertebral spacing and alignment. Appellant subsequently stopped work on September 3, 2007.[1] By letter dated March 12, 2008, the Office accepted her claim for brachial, thoracic and lumbosacral neuritis and radiculitis.

On March 13, 2008 appellant filed a claim for wage-loss compensation (Form CA-7) for the period commencing September 3, 2007. In disability certificates dated September 10, 17 and October 29, 2007, Dr. Pierre Herding, a Board-certified neurologist, stated that appellant experienced neck and shoulder pain. He indicated that she was totally disabled from September 10 to November 5, 2007. In disability certificates dated November 5 and 19, 2007, Dr. Herding noted that it was undetermined when appellant could return to work.

The record reflects that appellant came under the treatment of Dr. Ronnie D. Shade, a Board-certified orthopedic surgeon. On January 17, 2008 Dr. Shade obtained a magnetic imaging resonance (MRI) scan of the lumbar spine that revealed a small central disc extrusion at L5-S1 with a possible minimal compression on the bilateral S1 nerve root. His treatment records advised that appellant sustained a lumbar disc extrusion at L5-S1 and chronic lumbar strain with bilateral lower extremity radiculopathy. Dr. Shade stated that she was totally disabled for work. He recommended that the Office accept appellant's claim for lumbar disc extrusion at L5-S1.

Appellant was referred by Dr. Shade to Dr. Stephen J. Becker, Board-certified in physical medicine and rehabilitation. In a February 8, 2008 report, Dr. Becker noted that appellant had "a long history of both upper and lower extremity symptoms of pain and radiating numbness. This subsequently worsened after falling to her buttocks on May 25, 2007 from a rolling chair." Dr. Becker advised that appellant complained of cervical pain radiating into her left upper extremity and lumbar pain radiating into both lower extremities. He reviewed electrodiagnostic testing of the left upper and lower extremities, finding cervical and lumbar radiculopathy.

In a letter dated May 7, 2008, the Office addressed the factual and medical evidence appellant needed to submit to establish her recurrence of disability claim. In a May 8, 2008 response, appellant stated that she worked following the May 25, 2007 employment injury but was unable to continue working by September 2007. She submitted a September 6, 2007 treatment note from the employing establishment health clinic that listed treatment for cervical and shoulder pain.

In an April 21, 2008 report, Jesse C. Ingram, Ph.D., a clinical psychologist, reviewed a history of appellant's May 25, 2007 injury and medical treatment. After listing his findings on psychological examination, he diagnosed pain disorder associated with both psychological factors and chronic general medical condition on Axis I, severe depressive disorder on Axis II, lumbar disc extrusion at L5-S1 and chronic lumbar strain with bilateral lower extremity radiculopathy on Axis III, severe family and employment stressors on Axis IV and a global assessment functioning (GAF) score of 48 on Axis V.

[1] The Office denied appellant's claim for continuation of pay, noting that her claim was not filed within 30 days of the date of injury.

In an April 18, 2008 report, Dr. Aaron T. Lloyd, a Board-certified anesthesiologist, reviewed the history of injury and medical treatment. On examination, he noted essentially normal findings with significant spasm of the lumbar paraspinal muscles, limited extension secondary to spasm and pain radiating down the legs with forward flexion and on positive straight leg raising. An MRI scan of the cervical spine revealed a C5-6 disc protrusion. An MRI scan of the lumbar spine showed a two millimeter disc herniation at L5-S1. Electromyogram and nerve conduction velocity studies (EMG/NCV) were consistent with C6 and L5 radiculitis. Dr. Lloyd opined that appellant sustained a work-related injury with radicular symptoms. On May 12, 2008 appellant underwent a lumbar epidural steroid injection at L5-S1 under fluoroscopy.

A May 13, 2008 report from Michele Steffek, a physician's assistant, addressed appellant's accepted employment-related conditions. She stated that Cymbalta was medically necessary for the treatment of pain.

In a May 27, 2008 report, Dr. Leeroy McCurley, a family practitioner, stated that appellant's back, neck and ankle pain were treated with medication and physical therapy.

By decision dated June 13, 2008, the Office denied appellant's recurrence of disability claim. It found that the medical evidence was insufficient to establish that she was totally disabled commencing September 3, 2007 due to her May 25, 2007 injury.

In a July 11, 2008 letter, appellant, through counsel, requested a telephonic hearing before an Office hearing representative. She submitted a May 23, 2008 report from Dr. Lloyd who noted that her employment-related conditions had not significantly improved following epidural steroid injection. Dr. Lloyd reiterated that appellant had lumbar and cervical herniated discs. On June 25, 2008 he stated that appellant underwent a left nerve root block at C6-7. In a November 11, 2008 letter, Dr. Lloyd stated that, at the time of his last examination on July 16, 2008, appellant had definitive findings of disc protrusion and right C6 radiculopathy.

On July 9, 2008 Dr. Shade reviewed appellant's medical treatment. On physical examination he noted spasms in the left trapezial and parascapular region secondary to the June 25, 2008 injection. Dr. Shade advised that, since the injection, appellant was unable to return to work and was totally disabled until further evaluation. His subsequent treatment records reiterated that she remained totally disabled. Dr. Shade diagnosed appellant as having carpal and cubital tunnel syndrome, enthesopathy of the elbow, impingement syndrome, shoulder tendinitis, myofasciitis -- para scapula, medial and lateral meniscus tear, chondromalacia of the patella, Achilles tendinitis, ankle sprain/strain and joint pain with arthralgia.

A July 9, 2008 report from Gwen Brown, a registered nurse, noted that appellant had a history of cervical and lumbar disc herniation with radicular symptoms. In a December 3, 2008 report, Ms. Brown stated that appellant suffered from worsening left upper extremity pain, numbness and weakness with known cervical disc herniation.

In a July 18, 2008 report, Dr. Ingram advised that appellant could not work through at least September 15, 2008 due to her participation in a pain management program. In subsequent reports he restated his diagnoses and addressed her pain management treatment. On August 21,

2008 Dr. Ingram noted that appellant experienced decreased pain coping skills and sleep disturbance, increased chronic pain, anxiety and severe depression related to her injury and family stressors. This disabled her from work.

In a July 22, 2008 report, Dr. Charles E. Willis, II, a Board-certified anesthesiologist, provided essentially normal findings on physical examination with decreased range of motion of the cervical and lumbar spines, decreased sensation in the left upper and lower extremities and decreased motor function of the left upper extremity. He diagnosed chronic neck and low back pain, cervical disc displacement and radiculopathy and lumbar radiculopathy. On August 12, 2008 Dr. Willis related that appellant had poor tolerance to certain pain medications.

In reports dated July 21 to August 21, 2008, Dr. Santiago, a chiropractor, stated that appellant was not physically active due to persistent pain. Appellant made some progress since participating in a pain management program.

In a December 3, 2008 report, Dr. Herding stated that appellant experienced persistent left upper extremity pain of unknown etiology.

In a December 15, 2008 report, Dr. Ronald J. Washington, a Board-certified internist, reviewed the history of appellant's May 25, 2007 employment injury and medical treatment. Appellant complained of pain in her neck, shoulders, right arm and ankle. Dr. Washington diagnosed cervical/lumbar injuries and left shoulder enthesopathy with disability due to painful impairment in strength, endurance and flexibility. He opined that she was totally disabled.

During a November 3, 2008 telephonic hearing, appellant testified that following her injury on May 25, 2007 she returned to regular work duty on May 28, 2007. She was off work intermittently in July and August 2007 due to pain she experienced while working. On August 21, 2007 appellant was sent home by a physician's assistant at the employing establishment health unit.

By decision dated January 9, 2009, an Office hearing representative affirmed the June 13, 2008 decision. He found that the medical evidence was insufficient to establish that appellant's disability commencing September 3, 2007 was due to her accepted injury.

LEGAL PRECEDENT

A recurrence of disability is the inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition, which had resulted from a previous injury or illness without an intervening injury or new exposure to the work environment, which caused the illness. The term also means an inability to work that takes place when a light-duty assignment made specifically to accommodate an employee's physical limitations due to his or her work-related injury or illness is withdrawn (except when such withdrawal occurs for reasons of misconduct, nonperformance of job duties or a reduction-in-force) or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations.[2]

[2] 20 C.F.R. § 10.5(x).

A person who claims a recurrence of disability has the burden of establishing by the weight of the substantial, reliable and probative evidence that the disability, for which she claims compensation is causally related to the accepted employment injury.[3] Appellant has the burden of establishing by the weight of the substantial, reliable and probative evidence a causal relationship between her recurrence of disability and her employment injury.[4] This burden includes the necessity of furnishing evidence from a qualified physician who, on the basis of a complete and accurate factual and medical history, concludes that the condition is causally related to the employment injury.[5] Moreover, the physician's conclusion must be supported by sound medical reasoning.[6]

The medical evidence must demonstrate that the claimed recurrence was caused, precipitated, accelerated or aggravated by the accepted injury.[7] In this regard, medical evidence of bridging symptoms between the recurrence and the accepted injury must support the physician's conclusion of a causal relationship.[8] While the opinion of a physician supporting causal relationship need not be one of absolute medical certainty, the opinion must not be speculative or equivocal. The opinion should be expressed in terms of a reasonable degree of medical certainty.[9]

ANALYSIS

The Office accepted that appellant sustained brachial, thoracic and lumbosacral neuritis and radiculitis in the May 25, 2007 injury. She returned to her regular duties as of May 28, 2007. Appellant subsequently stopped work on September 3, 2007 and claimed total disability for work due to her accepted claim. The Board finds that she failed to submit sufficient medical evidence to establish that her disability commencing that date is attributable to her accepted conditions.

The Board notes that appellant did not stop work contemporaneous to the May 25, 2007 injury. The evidence reflects that she worked at her regular duties until she stopped work on September 3, 2007. The medical evidence of record lacks a well-reasoned medical report from any of appellant's attending physicians addressing how her disability for work is due to the accepted injury. Such medical explanation is crucial to her claim, as the medical evidence reflects that she had a "long history" of upper and lower extremity complaints preexisting the

[3] *Kenneth R. Love*, 50 ECAB 193, 199 (1998).

[4] *Carmen Gould*, 50 ECAB 504 (1999); *Lourdes Davila*, 45 ECAB 139 (1993).

[5] *Ricky S. Storms*, 52 ECAB 349 (2001); *see also* 20 C.F.R. § 10.104(a)-(b).

[6] *Alfredo Rodriguez*, 47 ECAB 437 (1996); *Louise G. Malloy*, 45 ECAB 613 (1994).

[7] *See Ricky S. Storms*, *supra* note 5; *see also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.2 (June 1995).

[8] For the importance of bridging information in establishing a claim for a recurrence of disability, *see Richard McBride*, 37 ECAB 748 at 753 (1986).

[9] *See Ricky S. Storms*, *supra* note 5; *Morris Scanlon*, 11 ECAB 384, 385 (1960).

injury at work. This is an aspect of her case that has not been adequately addressed in the records submitted.

Dr. Herding submitted disability certificates dated September 10 to November 19, 2007, noting that appellant had neck and shoulder pain and was totally disabled. On December 3, 2008 he noted that appellant's left upper extremity symptoms were of unknown etiology. Similarly, Dr. Lloyd provided disability certificates in 2008 advising that appellant underwent epidural steroid injections without significant improvement and had a C6-7 nerve root block. He advised that she was totally disabled. Dr. Lloyd subsequently advised that diagnostic studies revealed a C5-6 disc protrusion and a disc herniation at L5-S1. He provided lumbar epidural injections in treatment of appellant's radicular symptoms. However, neither physician provided any explanation of how appellant's disability in September 2007 or in 2008 was caused or contributed to by the accepted radiculitis or neuritis conditions. The reports fail to provide a full history of appellant's upper or lower extremity conditions or address whether any preexisting conditions were aggravated by the fall she sustained at work. A mere medical conclusion without rationale for the opinion reached is of diminished probative value.[10] Dr. Lloyd failed to address whether the disc herniations found in early 2008 preexisted the employment injury or whether they were first diagnosed after appellant's fall at work.[11] The evidence from Dr. Herding and Dr. Lloyd is insufficient to establish appellant's claim.

Appellant was treated by Dr. Shade who noted that a January 17, 2008 MRI scan revealed a small central disc herniation at L5-S1 and that she experienced bilateral lower extremity radiculopathy for which she was disabled. In July 2008, Dr. Shade noted muscle spasms in the region secondary to the June 25, 2008 steroid injection. He also diagnosed several conditions not accepted by the Office as related to the May 25, 2007 injury, including carpal and cubital tunnel syndrome, enthesopathy of the elbows, medial and lateral meniscus tears and Achilles tendinitis. As noted, Dr. Becker obtained a "long history" of upper and lower extremity symptoms and complaints. The reports submitted by Dr. Shade do not provide any further detail as to appellant's medical treatment prior to the accepted injury such that they do not provide a full or accurate history.[12] He did not adequately address how appellant's disability as of September 3, 2007 or medical treatment related to those conditions accepted by the Office, rather than the other physical conditions he diagnosed. The Board has held that rationalized medical evidence is an opinion from a physician which is based on a complete and accurate factual and medical background of the claimant, findings on physical examination and diagnostic testing and one of reasonable medical certainty in explaining how the accepted incident or employment factor caused disability for work.[13] The reports of Dr. Shade are of reduced probative value as they are based on an incomplete medical history and do not explain how she was able to continue in her employment from May 29 until September 3, 2007. He does not adequately address any

[10] *See Beverly A. Spencer*, 55 ECAB 501 (2004).

[11] The delay in diagnostic testing raises a question as to whether the conditions found are attributable to the accepted employment injury. *See Mary A. Ceglia*, 55 ECAB 626 (2004).

[12] *See John W. Montoya*, 54 ECAB 306 (2003). Medical reports based on an incomplete or inaccurate history are of reduced probative value.

[13] *See Betty J. Smith*, 54 ECAB 174 (2002).

bridging symptoms between the accepted injury and her medical treatment or disability on or after the date she stopped work.[14] This renders Dr. Shade's opinion on causal relationship of limited probative value.

Dr. Ingram, a clinical psychologist, treated appellant in April 2008 and made findings on psychological examination. He diagnosed pain disorder associated with psychological factors and a chronic medical condition and noted severe family and employment stressors. Dr. Ingram advised that appellant was disabled due to her condition, noting that she was attending a pain management program. His reports share the same deficiencies as noted with Dr. Shade. They lack a detailed history of appellant's upper or lower extremity conditions or any explanation of how appellant's accepted injury resulted in her disability on September 3, 2003 or the emotional condition for which Dr. Ingram first treated her in 2008. Appellant has the burden of establishing that her fall of May 25, 2007 caused or contributed to the emotional condition for which Dr. Ingram provided treatment as it is not a condition accepted by the Office in this case.[15] The family and work stressor referenced by Dr. Ingram are not well explained in his reports. This further reduces the probative value of his opinion on appellant's capacity for work and disability for the period claimed.

The remainder of the medical evidence submitted is also insufficient to establish that appellant sustained a recurrence of disability. Dr. Washington reviewed a history of appellant's May 25, 2007 injury and diagnosed cervical and lumbar conditions and left shoulder enthesopathy for which she was disabled. Dr. Willis found essentially normal findings on physical examination and diagnosed chronic neck and low back pain, cervical disc displacement and radiculopathy and lumbar radiculopathy. Dr. McCurley noted only that appellant was treated for her symptoms with medication and physical therapy. None of these physicians addressed the issue of how her disability for work on September 3, 2007 related to her accepted claim. The Board has held that the weight of medical opinion is not supported by the number of physicians of record. Rather, it is based on the opportunity for and thoroughness of the medical examination, the accuracy and completeness of the physician's knowledge of the facts and medical history and the care brought to the analysis in medical rationale expressed in support of the opinion on causal relationship.[16] Applying this standard, the medical reports of these attending physicians must be found of reduced probative value.

The evidence from Ms. Steffek, a physician's assistant, and Ms. Brown, a registered nurse, is of no probative value in establishing appellant's claim. Neither a physician's assistant[17] nor a nurse[18] is a "physician" as defined under the Federal Employees' Compensation Act. Moreover, the term "physician" under 8101(2) includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to

[14] *See Ricky S. Storms*, *supra* note 5.

[15] *See Jaya K. Asaramo*, 55 ECAB 200 (2004).

[16] *See John D. Jackson*, 55 ECAB 465 (2004).

[17] 5 U.S.C. § 8101(2); *Roy L. Humphrey*, 57 ECAB 238, 242 (2005).

[18] 5 U.S.C. § 8101(2); *G.G.*, 58 ECAB ___ (Docket No. 06-1564, issued February 27, 2007).

correct a subluxation as demonstrated by x-ray to exist.[19] As Dr. Santiago did not diagnose a spinal subluxation based on x-ray, he is not a physician as defined and his reports are not probative on the issue of appellant's disability commencing September 3, 2007.[20]

Appellant has failed to submit rationalized medical evidence establishing that her disability commencing September 3, 2007 resulted from the accepted injury.

CONCLUSION

The Board finds that appellant failed to establish that she sustained a recurrence of disability commencing September 3, 2007 causally related to her May 25, 2007 injury.

ORDER

IT IS HEREBY ORDERED THAT the January 9, 2009 and June 13, 2008 decisions of the Office of Workers' Compensation Programs be affirmed.

Issued: January 4, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

[19] 5 U.S.C. § 8101(2); *see Paul Foster*, 56 ECAB 208 (2004).

[20] *See Michelle Salazar*, 54 ECAB 523 (2003).