United States Department of Labor
Employees' Compensation Appeals Board

D.M., Appellant	)	
and	)	**Docket No. 10-612**
	)	**Issued: November 30, 2010**
DEPARTMENT OF THE AIR FORCE, WRIGHT PATTERSON AIR FORCE BASE, Dayton, OH, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 4, 2010 appellant filed a timely appeal from July 7 and December 9, 2009 merit decisions of the Office of Workers' Compensation Programs denying his recurrence claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant established that he sustained a recurrence of disability on or after April 20, 2009.

FACTUAL HISTORY

On April 4, 2008 appellant, then a 54-year-old gardener, filed a traumatic injury claim alleging that he sustained a back injury in the performance of duty while lifting wet sod. The

Office accepted his claim for thoracic strain.[1] Appellant missed work due to the accepted injury from April 4 through 6, 2008. He returned to full, unrestricted duty on April 7, 2008 and began working in a full-time, limited-duty capacity in March 2009.

Appellant stopped work on April 20, 2009. He submitted a claim for wage-loss compensation alleging total disability commencing April 20, 2009 due to severe low back and radicular pain to his legs.

Appellant submitted a March 5, 2009 fitness examination report from Dr. Jon Jacobson, an employing establishment physician Board-certified in the field of occupational medicine. Dr. Jacobson noted that appellant would be off duty until April 20, 2009 due to upcoming carpal tunnel surgery, which was scheduled for March 10, 2009. Continued use of narcotics for lower back pain would continue to result in restrictions from driving and operating machinery.

In an April 15, 2009 report, Dr. Risa Spieldoch, a Board-certified family practitioner, noted that she had been treating appellant for several years for debilitating lower back and radicular pain associated with a 1992 military injury and a 1999 work injury. She stated that appellant's pain had become more severe since he underwent a physical therapy session two weeks' prior. Noting that appellant required sedation to address the pain, Dr. Spieldoch restricted him from driving and recommended that he be "off work" until evaluated by a workers' compensation physician.

On April 15, 2009 Dr. Paul Simon, a treating physician, diagnosed degenerative joint disease, with associated lower back pain. He recommended that appellant be restricted from lifting, pushing or pulling more than 10 pounds, or sitting or standing for more than two hours at a time.

On April 20, 2009 Dr. S.L. Patwa, an employing establishment physician, stated that appellant was "not cleared for duty" until evaluated by a workers' compensation physician. In an undated note, Shanthl Venkat, a physical therapist, advised that appellant had disc and facet changes with potentially significant encroachment of the left neural foramen at L5-S1. The record contains a report of a March 23, 2009 magnetic resonance imaging (MRI) scan.

In a letter dated May 12, 2009, the Office informed appellant that the evidence and information submitted was insufficient to establish his claim. Appellant was advised to submit a medical report with a diagnosis and opinion explaining how his claimed disabling condition was causally related to the accepted injury.

In a March 2, 2009 note, Dr. Spieldoch recommended continued light duty through April 27, 2009. In a March 5, 2009 return-to-duty report, Dr. Jacobson stated that appellant's April 1, 2008 injury was not work related and recommended restrictions regarding driving and the use of power tools.

[1] Appellant's claim was originally accepted administratively as "quick close case" and treated as a minor injury with no time lost from work. Conservative medical care and treatment was approved up to $1,500.00. The filing of appellant's claim for lost wages prompted formal adjudication of the claim.

Appellant submitted a June 9, 2009 report from Dr. Kedar Deshpande, a Board-certified physiatrist, who provided a history of the April 1, 2008 lifting injury and noted appellant's complaints of constant lower back pain. Examination of the lumbar spine revealed tenderness around the right L5 facet distribution and right S1 facet distribution. Extension was decreased and with pain; flexion was decreased and SLR was positive for leg pain on the right side. Deep tendon reflexes were symmetrical. Strength was normal. There were no focal sensory deficits. An MRI scan of the lumbar spine revealed potentially significant encroachment of the left neural foramen at L5-S1. Dr. Deshpande found that appellant had a combination of facetogenic pain and symptoms of radiculopathy. He opined that appellant's claim should be accepted for facet arthropathy. Dr. Deshpande stated:

> "[Appellant] did not have pain prior to his injury. In addition he also has symptoms of radiculopathy and this now goes beyond a simple sprain strain."

Appellant submitted reports from Dr. Ronald Lakatos, a Board-certified orthopedic surgeon, for the period May 4 through June 22, 2009. Dr. Lakatos stated that appellant's lower back pain was worsening with any kind of mechanical activities especially bending, lifting and twisting. He noted that appellant had recently been through physical therapy, which "if anything aggravated his symptoms and did not tend to improve it." Examination of the cervical spine revealed good range of motion, with no significant symptoms at endpoints. Tinel's examination was positive. Pain was present at the low lumbar and lumbosacral region, with no spasm. Forward flexion was around 40 to 45 degrees. There was no clonus noted and no lack of sensation. A March 23, 2009 MRI scan revealed normal lordotic position of the spine; some low grade facet arthropathy involving the lower levels; and some foraminal narrowing bilaterally, left greater than right at L5-S1 causing foraminal stenosis. The L5-Sl disc has loss of disc space height and some signal intensity. Dr. Lakatos diagnosed "chronic low back pain with what sounds like intermittent radicular symptoms, some foraminal stenosis bilaterally at L5-S1, also status post prior bypass operation with successful amount of weight loss and carpal tunnel symptoms as stated." In May 4 and 26, 2009 disability slips, Dr. Lakatos advised that appellant would be able to return to work on June 3, 2009.

On June 15, 2009 Dr. Lakatos reviewed the April 1, 2008 lifting injury as reported by appellant, noting that his lower back pain had worsened with mechanical activities. He reviewed appellant's position description, which included tasks such as stooping, bending, reaching and lifting up to 80 pounds, and noted appellant's feeling that he was unable to perform the duties of the job. Dr. Lakatos stated that restrictions were appropriate, as well as "possibly" consideration for part-time or off-duty status until symptoms improved. He opined that relative to the dates of total or partial disability, based on the information provided, this would extend from April 20, 2009 to the present. Dr. Lakatos stated:

> "It is my understanding that these symptoms are similar to the symptoms that began on April 2008, with a definite occurring on April 20, 2009. That is the same type of symptom pattern but more intense. It is well known that continued mechanical activities including bending, lifting, twisting can reaggravate the type of symptomatology which [appellant] had previously had and this is not uncommon with spinal conditions, which were seen on his MRI scan that is disc degeneration

and associated foraminal stenosis, and it is my opinion that is what has occurred with [appellant] and his current situation."

Dr. Lakatos concluded that, in addition to foraminal stenosis and disc degeneration at L5-S1, diagnoses of spinal stenosis with sciatica, lumbar disc degeneration and lumbosacral radiculitis were appropriate. In a June 22, 2009 letter, he reiterated that appellant had been totally disabled since April 20, 2009.

By decision dated June 7, 2009, the Office denied appellant's claim for wage-loss compensation beginning April 20, 2009. It found that he had not submitted sufficient medical evidence to establish a causal relationship between his current disability and the accepted April 1, 2008 injury.

On July 20, 2009 appellant requested a telephonic hearing.

Appellant submitted reports from Dr. Jacobson for the period May 5 through October 26, 2009. Dr. Jacobson related appellant's report of a herniated disc at L5-S1 and that he was not cleared to return to work until June 3, 2009. On July 27, 2009 he advised appellant that the Office would likely deny his claim because there was no medical evidence establishing a causal connection between his diagnosed herniated disc and degenerative joint disease and the April 1, 2008 injury. In August 28, September 25 and October 26, 2009 reports of follow-up visits, Dr. Jacobson indicated that appellant could continue to work with restrictions.

In a July 21, 2009 report, Dr. Spieldoch noted that she had been treating appellant for over 12 years for numerous conditions, including depression. Performing even simple tasks, such as mowing his yard, significantly worsened appellant's low back pain.

Appellant submitted additional reports from Dr. Deshpande. On July 9, 2009 Dr. Deshpande recommended that appellant's claim be accepted for lumbosacral spondylosis and lumbar degenerative disc disease. He opined that they were causally related to the April 1, 2008 injury. Physical examination revealed tenderness around the L5 and S1 facet distribution. Extension was decreased and with pain and flexion was decreased. A March 23, 2009 MRI scan revealed multiple levels of facet joint changes and disc changes. On July 29, 2009 Dr. Deshpande diagnosed a combination of facetogenic pain and symptoms of radiculopathy. Results of an EMG study revealed mild neurogenic changes in lower lumbar paraspinal muscles in the L5-S1 region. On July 31, 2009 Dr. Deshpande related appellant's continued complaints of low back pain radiating into his lower extremities. A July 9, 2009 EMG showed bilateral L5-S1 radiculopathy, which he opined was causally related to the accepted work injury. On August 26 and October 22, 2009 Dr. Deshpande administered bilateral facet joint injections.

Appellant provided back-to-work releases from Dr. Lakatos dated July 23, August 21 and September 24, 2009. On November 30, 2009 Dr. Lakatos reiterated his diagnosis of disc degeneration at L5-S1. Examination revealed tenderness to palpation in the lower lumbar spine, with some slight giveaway in the right leg on ratchety with knee extension. Dr. Lakatos recommended permanent restrictions.

Appellant submitted a July 6, 2009 report from Dr. Clay Baldwin, Board-certified in occupational medicine. Referring to the April 1, 2008 work injury, Dr. Baldwin stated that

appellant was not cleared for duty until July 31, 2009 and diagnosed lower back pain with radiculopathy. He noted, however, that the radicular symptoms were predominately on the right, which did not correspond with MRI scan findings. Dr. Baldwin opined that appellant's symptoms seemed out of proportion to results of testing.

On September 25, 2009 Michelle Bester, a certified nurse practitioner, diagnosed a combination of facetogenic pain with radiculopathy. The record contains an October 23, 2009 work excuse from the administrative coordinator for Dr. Deshpande.

In the October 6, 2009 telephonic hearing, appellant testified that he never healed after the April 1, 2008 injury, even though he returned to light duty. He stopped work on April 20, 2009 due to debilitating back pain.

By decision dated December 9, 2009, an Office hearing representative affirmed the July 7, 2009 decision. He found that the medical evidence was insufficient to establish a recurrence of disability causally related to appellant's accepted injury.

LEGAL PRECEDENT

A recurrence of disability means an 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 that caused the illness.[2]

Office procedures state that a recurrence of disability includes a work stoppage caused by a spontaneous material change, demonstrated by objective findings, in the medical condition that resulted from a previous injury or occupational illness without an intervening injury or new exposure to factors causing the original illness. It does not include a condition that results from a new injury, even if it involves the same part of the body previously injured.[3]

When an employee, who is disabled from the job he held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence of record establishes that he can perform the light-duty position, the employee has the burden to establish by the weight of the reliable, probative and substantial evidence a recurrence of total disability and show that he cannot perform such light duty. As part of this burden, the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the light-duty requirements.[4]

Appellant has the burden of establishing by the weight of the substantial, reliable and probative evidence a causal relationship between his recurrence of disability and his employment

[2] 20 C.F.R. § 10.5(x); *see S.F.*, 59 ECAB 525 (2008). *See* 20 C.F.R. § 10.5(y) (defines recurrence of a medical condition as a documented need for medical treatment after release from treatment for the accepted condition).

[3] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Recurrences*, Chapter 2.1500.3(b) (May 1997). *Kenneth R. Love*, 50 ECAB 193, 199 (1998).

[4] *Terry R. Hedman*, 38 ECAB 222 (1986).

injury.[5] 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.[6] The physician's conclusion must be supported by sound medical reasoning.[7]

ANALYSIS

The Office accepted that appellant sustained a thoracic strain on April 1, 2008 in the performance of duty. The record reflects that he returned to full-time work in April 7, 2008, and began working in a full-time, limited-duty capacity in March 2009. The issue is whether appellant has established that he sustained a recurrence of disability on or after April 20, 2009 causally related to his accepted injury.

The evidence of record fails to establish that appellant sustained a recurrence of disability. As noted, a recurrence of disability means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition resulting from a previous injury or illness without a new or intervening injury.[8] Appellant submitted no rationalized medical evidence supporting that he experienced a spontaneous change in his medical condition due to the accepted injury. Rather, he reported to the Office and to his physicians that his pain was exacerbated by a physical therapy session in early April 2009, immediately prior to his alleged date of disability. Dr. Lakatos opined that continued mechanical job activities, including bending, lifting, twisting, reaggravated appellant's spinal condition, resulting in disc degeneration and associated foraminal stenosis. The Board finds that appellant's claim does not meet the definition of a recurrence of disability.[9]

Appellant did not allege that his light-duty job requirements changed or that his position was withdrawn. Rather he contended that his accepted condition worsened such that he was unable to perform the duties of his position. The medical evidence of record, however, fails to establish that appellant's claimed disabling condition was causally related to the employment injury.[10]

On May 4, 2009 Dr. Lakatos provided examination findings and diagnosed chronic low back pain with intermittent radicular symptoms, foraminal stenosis bilaterally at L5-S1. He reviewed a report of a March 23, 2009 MRI scan, which revealed normal lordotic position of the spine; some low grade facet arthropathy involving the lower levels and some foraminal narrowing bilaterally, left greater than right at L5-S1 causing foraminal stenosis. Dr. Lakatos did not, however, express an opinion as to the cause of appellant's radicular condition. Medical

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

[6] *S.S.*, 59 ECAB 315 (2008).

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

[8] *Mary A. Ceglia*, 55 ECAB 626 (2004).

[9] *See Bryant F. Blackmon*, 56 ECAB 752 (2005).

[10] *S.S.*, *supra* note 6.

evidence which does not offer an opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[11] Dr. Lakatos did not address how the newly diagnosed facet arthropathy and foraminal stenosis conditions were causally related to the accepted thoracic strain. The medical record notes a history of low back and radicular symptoms back to 1992 associated with a military service injury. Dr. Lakatos did not address the relevance of appellant's preexisting low back condition to the 2008 injury.

On June 15, 2009 Dr. Lakatos noted a similarity between the symptoms appellant experienced following the April 1, 2008 injury and his current symptoms. In addition to foraminal stenosis and disc degeneration at L5-S1, he diagnosed spinal stenosis with sciatica, lumbar disc degeneration and lumbosacral radiculitis. Dr. Lakatos did not, however, explain how these conditions were related to the April 1, 2008 incident. Rather, he attributed them to continued mechanical activities including bending, lifting and twisting. Dr. Lakatos' opinion implicates that appellant's claimed disability was not a spontaneous occurrence, but was due to a new injury or occupational exposures.

On June 22, 2009 Dr. Lakatos stated that he had been totally disabled since April 20, 2009 and estimated that he would continue to be disabled through August 31, 2009. Reports through November 30, 2009 reflect his opinion that appellant was at least partially disabled due to his diagnosed back condition. None of these reports, however, contains an explanation as to how appellant's current condition was causally related to the accepted injury. Therefore, they are of limited probative value and insufficient to establish his claim.

On June 9, 2009 Dr. Deshpande provided a history of injury and treatment, as well as examination findings. He found that appellant had a combination of facetogenic pain and symptoms of radiculopathy and opined that his claim should be expanded to include an additional diagnosis of facet arthropathy on the grounds that he had no pain prior to his injury and his current symptoms of radiculopathy "now goes beyond a simple sprain strain." Dr. Deshpande's report, however, does not explain the development of appellant's current condition or how it is related to the accepted injury. The mere fact that the newly diagnosed conditions manifested themselves subsequent to appellant's return to work is insufficient to establish a causal relationship.[12] On July 31, 2009 Dr. Deshpande opined that appellant's bilateral L5-S1 radiculopathy was causally related to the accepted work injury. Neither this, nor any other report from him, contains medical reasoning explaining the relationship. Medical conclusions unsupported by rationale are of limited probative value.[13]

Dr. Spieldoch's reports were devoid of an opinion on the cause of appellant's current condition. Therefore, they are of limited probative value. Moreover, Dr. Spieldoch's April 15, 2009 report reflects that appellant's back pain increased significantly after undergoing a physical therapy session two weeks earlier, and that simple tasks, such as mowing his yard, significantly worsened his low back pain. Her conclusion that physical tasks worsened the back pain suggests

[11] *A.D.*, 58 ECAB 149 (2006); *Michael E. Smith*, 50 ECAB 313 (1999).

[12] *Dennis M. Mascarenas*, 49 ECAB 215, 218 (1997).

[13] *Willa M. Frazier*, 55 ECAB 379 (2004).

that appellant's current condition is due to an intervening, rather than to a spontaneous occurrence related to the April 1, 2008 incident.

Dr. Jacobson's reports, which reflect visits performed "for administrative purposes," do not support a causal relationship between appellant's current condition and the accepted injury. On March 5, 2009 he indicated that appellant's April 1, 2008 injury was not work related. On July 27, 2009 Dr. Jacobson advised appellant that the Office would likely deny his claim because there was no medical evidence establishing a causal connection between his diagnosed herniated disc and degenerative joint disease and the accepted injury. As none of his reports contain an opinion as to the cause of appellant's diagnosed conditions, they are of limited probative value.

The remaining medical evidence of record is insufficient to establish appellant's claim. Reports from Dr. Simon, Dr. Baldwin and Dr. Patwa lack an opinion on causal relationship. Therefore, they are of limited probative value. Appellant submitted reports signed by physical therapists, certified nurse practitioners and administrative coordinators. As these reports were not signed by individuals that qualify as physicians under the Act, the Board finds that they do not constitute probative medical evidence.[14] Reports of EMGs, MRI scans and other diagnostic test results which do not contain an opinion on causal relationship are also of limited probative value.

Appellant did not submit any medical reports from a physician who, on the basis of a complete and accurate factual and medical history, concluded that he was totally disabled as of April 20, 2009 due to residuals of his accepted injury. He has failed to establish by the weight of the reliable, probative and substantial evidence, a change in the nature and extent of the injury-related condition resulting in his inability to perform the duties of his modified employment. As appellant has not submitted any medical evidence showing that he sustained a recurrence of disability due to his accepted employment injury, the Board finds that he has not met his burden of proof.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish a recurrence of disability on or after April 20, 2009.

[14] A medical report may not be considered as probative medical evidence if there is no indication that the person completing the report qualifies as "physician" as defined in 5 U.S.C. § 8101(2). Section 8101(2) of the Act provides as follows: "(2) 'physician' includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law." *See Merton J. Sills*, 39 ECAB 572, 575 (1988).

ORDER

IT IS HEREBY ORDERED THAT the December 9 and July 7, 2009 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: November 30, 2010
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board