

FACTUAL HISTORY

OWCP accepted that on October 10, 2006 appellant, then a 38-year-old part-time flexible clerk, sustained employment-related left ulnar neuropathy and tenosynovitis of the left wrist in the performance of duty. Following these injuries, she returned to limited-duty work on August 13, 2007.

On October 27, 2007 appellant filed a claim for wage-loss compensation (Form CA-7) for the period October 14 through 15, 2007 as she attended medical examinations. On November 1, 2007 she filed a Form CA-7 for the period October 24 through 26, 2007 for medical treatment.

On October 22, 2007 appellant filed a claim (Form CA-2a) alleging that she sustained a recurrence of disability commencing September 11, 2007 causally related to her October 10, 2006 employment injuries. She stated that she was performing light-duty work. A January 25, 2007 operative report indicated that appellant underwent left elbow anterior submuscular ulnar nerve transposition with flexor pronator lengthening.

Medical reports dated December 13, 2006 through September 10, 2007 from Dr. David G. Kuntz, Jr., a Board-certified orthopedic surgeon, advised that appellant had neck pain, cervical radiculopathy, right cubital tunnel syndrome and the accepted left elbow ulnar neuropathy. In a September 10, 2007 report, Dr. Kuntz explained how the C8 nerve went into the same sensory distribution as the ulnar nerve which was a totally separate area of nerve compression. He advised that appellant's ulnar nerve had returned to normal electrical function after her left elbow surgery. This was very good news as the ulnar nerve had recovered electrically and ulnar nerve damage had been reversed. Dr. Kuntz advised that the cervical radiculopathy was not related to appellant's work duties, but instead it was related to a degenerative spine process that occurred typically in humans that age. Since he was not a cervical spine expert, he recommended that appellant undergo evaluation by a neurosurgeon.

In diagnostic test reports dated April 23 and June 23, 2007, Dr. Tony T. Ton-That, a Board-certified physiatrist, and Dr. Maurice C. Perry, a Board-certified radiologist, respectively, indicated that a cervical magnetic resonance imaging (MRI) scan and electromyogram/nerve conduction study (EMG/NCS) revealed left C8 radiculopathy, degenerative disc disease at C5-C6 and C6-7 which had progressed at the C5-C6 level since a prior MRI scan and diffuse posterior disc osteophyte complex at this level associated with mild narrowing of the spinal canal which had increased slightly in degree in the interval. In a June 22, 2007 narrative report, Dr. Ton-That reviewed a history of the October 10, 2006 employment injuries and appellant's medical treatment. He listed his findings on physical examination of the neck and left upper extremity. Dr. Ton-That ordered an EMG to rule out peripheral neuropathy versus cervical radiculopathy.

In a June 5, 2007 report, Dr. Perry J. Argires, a Board-certified neurologist, obtained a history of the October 10, 2006 employment injuries and appellant's medical treatment, family and social background. He listed findings on physical, neurological and diagnostic examination. Dr. Argires advised that appellant had left ulnar neuropathy and neck pain related to a C5-6 herniated disc. He further advised that her current neurologic deficits and measurable findings

were not related to her C5-6 herniated disc. Appellant's neck pain was related to that segment. In a July 13, 2007 report, Dr. Argires discussed a treatment plan for appellant's cervical radiculopathy and cervical disc herniations at C5-6 and C6-7. In a September 11, 2007 report, he placed her on light-duty work.

By letter dated November 16, 2007, OWCP requested that appellant submit factual and medical evidence in support of her claim. It indicated that Dr. Kuntz released her to return to full-duty work on September 17, 2007. OWCP stated that, based on the medical evidence submitted, appellant appeared to be claiming that she sustained a cervical condition causally related to the October 10, 2006 employment injury.

Hospital records indicated that appellant underwent left-sided C7-T1 interlaminar epidural steroid injections under fluoroscopic guidance on October 24 and November 14 and 28, 2007 to treat her disc herniations at C5-C6 and C6-C7 with left upper extremity radicular pain.

In an October 2, 2007 report, Dr. Michael A. Weaver, a Board-certified anesthesiologist, listed his findings on physical and neurological examination. He diagnosed herniated intervertebral discs at C5-C6 and C6-C7.

In a December 21, 2007 decision, OWCP found that appellant did not sustain a recurrence of disability commencing September 11, 2007. The medical evidence established that she no longer had any residuals of her accepted October 10, 2006 employment injuries. Appellant failed to submit any medical evidence to support her time lost from work on October 14 and 15, 2007. Her lost time from work from October 24 through 26, 2007 was due to her nonemployment-related cervical condition.

By letter dated January 14, 2008, appellant, through her attorney, requested an oral hearing before an OWCP hearing representative and submitted additional evidence.

In a June 13, 2007 report, a physical therapist addressed the treatment of appellant's pain and numbness in the left upper extremity.

In a June 22, 2007 report, Dr. Ton-That compared the results of an EMG/NCS performed on that date and on November 8, 2006. He found electrodiagnostic evidence of left C8 radiculopathy. There was no electrodiagnostic evidence suggestive of left median and ulnar motor and sensory neuropathy.²

A February 5, 2008 report signed by Denise Wechter, a certified registered nurse in Dr. Argires' office, noted the October 10, 2006 employment injury and stated that appellant developed neck and left upper extremity radicular pain. Ms. Wechter also had numbness in the left upper extremity. She advised that appellant had disc herniations at C5-C6 and C6-C7 that were causally related to her October 10, 2006 employment injuries.

² The November 8, 2006 EMG/NCS revealed electrodiagnostic evidence suggestive of moderately severe left ulnar motor neuropathy with evidence of nerve compression across the elbow and no evidence of severe axonal loss. There was no electrodiagnostic evidence suggestive of left cervical radiculopathy, bilateral median motor and sensory neuropathy or right ulnar motor and sensory neuropathy.

In a partial report dated February 21, 2008, Dr. Robert W. Macht, a surgeon, listed findings on physical and objective examination. He advised that appellant had ulnar nerve entrapment at the left elbow and traumatic injury to her neck with disc injury. Dr. Macht further advised that she did not have any radiculopathy. He concluded that appellant's neck condition was due to her October 10, 2006 employment injuries.

In a March 13, 2008 disability certificate, Dr. Argires noted that appellant underwent cervical surgery on March 12, 2008. It was undetermined as to when she could return to work.

In an August 22, 2008 decision, an OWCP hearing representative set aside the December 21, 2007 decision. The hearing representative found that, although the medical evidence did not establish that appellant sustained a recurrence of disability causally related to her October 10, 2006 employment injuries, it suggested a causal relationship between her cervical symptoms and the accepted work injuries. The case was remanded for referral to an appropriate medical specialist for a second opinion examination to determine whether appellant's herniated discs at C5-6 and C6-7 and neck pain were caused by her accepted employment injuries. The hearing representative stated that the medical specialist should also determine whether the March 12, 2008 neck surgery was warranted and necessary as a result of the accepted work injuries and January 2007 left elbow surgery. Lastly, the hearing representative stated that the medical specialist should determine the extent and duration of any disability.

On September 9, 2008 OWCP referred appellant, together with a statement of accepted facts and the medical record, to Dr. Robert F. Draper, Jr., a Board-certified orthopedic surgeon. In a September 30, 2008 report, Dr. Draper obtained a history of the October 10, 2006 employment injuries and appellant's medical treatment, social, educational and family background. He listed his findings on physical examination of the cervical spine and bilateral upper extremities. Dr. Draper diagnosed left cubital tunnel syndrome (ulnar nerve entrapment of the left elbow) and degenerative cervical disc disease at C5-C6 and C6-C7. He indicated that appellant was status post a January 2007 anterior transposition of the ulnar nerve and anterior cervical discectomy and fusion at C5-6 and C6-7. Dr. Draper opined that the ulnar nerve entrapment condition was causally related to the October 10, 2006 employment injuries. He noted that an EMG/NCS revealed that the accepted condition had resolved. Dr. Draper further noted that appellant's neck pain existed prior to the accepted employment injury and worsened following her January 2007 surgery and required physical therapy. He advised that the onset of her neck pain was not caused by physical therapy or the surgery. Dr. Draper opined that appellant's neck pain was causally related to preexisting degenerative disc disease at the stated multiple levels. The neck surgery appeared to be warranted and necessary, but not causally related to her work duties or the accepted conditions. Dr. Draper advised that appellant continued to have residuals of the accepted left elbow condition, noting that her elbow had limited range of motion and her left hand had weakness. He concluded that she would not reach maximum medical improvement until January 3, 2009. Dr. Draper further concluded that appellant could only perform light work with restrictions.

In a November 24, 2008 decision, OWCP denied appellant's recurrence claim, finding that her cervical condition and resultant surgery were not causally related to her October 10, 2006 employment injuries based on Dr. Draper's medical opinion. It also found that the

diagnostic evidence established that her employment-related left nerve entrapment condition was no longer present.

On December 16, 2008 appellant, through her attorney, requested a telephone hearing.

In a March 2, 2009 report, Dr. James P. Argires, a Board-certified neurosurgeon, noted appellant's difficulty with her left forearm and hand. He advised that she had a cervical disc osteophyte complex occurring as a result of her October 10, 2006 accepted conditions. Appellant had preexisting degenerative changes that were aggravated by the accepted employment injury. Dr. Argires concluded that the disc osteophyte formation was a result of that aggravation. In an April 3, 2009 report, he advised that a March 31, 2009 EMG/NCS revealed an ulnar nerve injury with axonal loss which was consistent with appellant's history of injury. There was nothing to suggest any injury to this nerve in the cervical region. In a May 4, 2009 report, Dr. Argires noted that appellant continued to have left upper extremity painful sensations. Appellant could not work more than six hours a day. In a June 1, 2009 report, Dr. Argires noted her left hand and forearm symptoms. He stated that nothing had changed. Dr. Argires concluded that appellant's condition may be permanent.

In a June 29, 2009 decision, an OWCP hearing representative set aside the November 24, 2008 decision. The hearing representative found a conflict in the medical opinion evidence between Dr. Draper, Dr. Macht and Dr. James P. Argires regarding whether the October 10, 2006 employment injuries caused appellant's cervical condition and surgery. The case was remanded to OWCP for referral to an appropriate impartial medical specialist to resolve the conflict. The hearing representative stated that the impartial medical specialist should address the changes in diagnostic testing and the extent and duration of any work-related disability.

On August 6, 2009 OWCP referred appellant, together with a statement of accepted facts and the medical record, to Dr. Thomas J. Green, a Board-certified orthopedic surgeon, for an impartial medical examination. It asked him to provide whether there was a causal relationship between appellant's cervical condition and resultant surgery and the accepted October 10, 2006 injuries. OWCP also asked him to provide whether she had any residuals of the cervical condition. Lastly, Dr. Green was asked to describe the extent and duration of any employment-related disability.

Dr. Green submitted an August 20, 2009 report in which he obtained a history of the October 10, 2006 employment injuries and appellant's medical treatment. On physical examination, he noted that appellant overcame her distress and was able to cooperate fully with the study. Upon standing from the sitting position, there was no evidence of impairment. Appellant's station and gait appeared to be normal. She was able to walk forward and backward with equal ability without a limp. There was no asymmetry of the muscles of the legs. Appellant was able to do a deep knee bend, single leg stance and toe and heel rises with equal power, muscle tone and facility. She did show a bit of anxiety when asked to bend over as if to pick up something from the floor. Appellant stated that doing so reproduced symptoms in her neck and left upper extremity. Upon sitting on the examining table, her deep tendon reflexes in the ankles and knees were symmetrical and normal. The deep tendon reflexes in the elbows and wrists were all symmetrical and normal. Range of motion of the neck was normal in flexor, extension, rotation and side bending. However, appellant experienced stiffness and wincing with

pain on rotation at the extremes of motion right and left and bending side to side right and left. The neck muscles showed no asymmetry or spasm. Range of motion in the shoulders was normal. However, upon placing the hand in extension behind the back and pushing against Dr. Green's resistance, there was weakness and pain behavior on the left that was not present on the right. There was also pain with the extremes of left shoulder motion, but it was very functional and in the normal range. The drop sign was negative. There was no deltoid atrophy or asymmetry. Rotation in the abducted position did not result in a significant clicking, crepitus or pain. There was major tenderness of the epicondylar region of the left elbow along the course of the transposed ulnar nerve. The scar and the cubital tunnel area were nontender. There was some tenderness of the neurovascular bundle in the axilla and in the upper arm halfway down toward the elbow. There was some mild tenderness proximally in the area of the anterior scalene muscles. There was no adenopathy. There was a well-healed nontender scar in the neck from the cervical procedure. Power grip and pinch and range of motion in the elbow were normal. Wrists and fingers had normal range of motion. There was no evidence of static or dynamic instability in the hands or wrists. There was no clawing or other neurologic manifestation of muscle imbalance in the hand. The adductor muscle used for key pinch was present and normal to palpation. Power grip was only slightly decreased in the left compared to the right, but without significant atrophy of the forearm flexor muscles.

Dr. Green diagnosed chronic pain syndrome with anxiety, probable ulnar intraneural fibrosis with residual impairment from the October 10, 2006 work-related injuries and mild rotator cuff arthropathy. He stated that appellant was status post two-level cervical discectomy and fusion. Dr. Green advised that her shoulder and cervical complaints were not causally related to the accepted conditions. He noted the finding of Dr. Kuntz that appellant had a progression of her cervical disc disease based on his comparison of MRI scans performed on April 23, 2007 and in March 2001. Dr. Green stated that the findings of cervical spondylosis with progression, over a six-year period was most compatible with a natural history of the disease and not compatible with a work-related injury. There was no direct correlation, causal, aggravation or precipitation of appellant's cervical spine condition and the accepted conditions. The accepted condition was ulnar neuropathy at the left elbow. The cervical spine condition was an unrelated degenerative disease that had progressed and may in all probability contributed to a double crush syndrome. Dr. Green agreed with Dr. Draper's opinion that the cervical spine pathology was entirely different and separate from appellant's workers' compensation claim and, therefore, it could not be a part of her claim. He advised that she continued to suffer from residuals of her work-related condition and subsequent failure of the surgery despite that being an appropriate treatment modality. The objective findings for power pinch and power grasp were minimally inhibited, however, appellant continued to have difficulty with weakness in her hand and persistent numbness in the ring and little finger which prevented her from lifting more than 10 pounds. Dr. Green stated that the prognosis for her complete recovery was poor. He did not think that she would ever return to her normal preinjury status and, thus, she would not be able to return to her previous job if it involved lifting 10- to 15-pound totes that were used in mail sorting. Dr. Green expected that, if appellant continued to improve, then she would be able to work up to eight hours per day as a mail sorter. He advised that her disability was primarily due to her work-related injuries. Dr. Green noted that appellant's nonwork-related cervical degenerative disc disease and subsequent surgery would appear to have helped and may continue to improve her physical limitations.

In reports dated October 16 and 23, 2009, Dr. Randy A. Cohen, an osteopath, obtained a history of the October 10, 2006 employment injuries and appellant's medical treatment. He noted her complaints of neck and left upper extremity pain and impairment. Dr. Cohen listed his findings on physical examination and reviewed the results of the March 31, 2009 EMG/NCS. He diagnosed probable ulnar intraneural fibrosis with residual impairment from the accepted work injuries and muscle disorder. Dr. Cohen advised that appellant was status post two-level cervical discectomy and fusion.

In a November 19, 2009 decision, OWCP found that appellant did not sustain a recurrence of disability commencing September 11, 2007 or a cervical condition that required surgical intervention due to her October 10, 2006 employment injuries. It found that Dr. Green's opinion constituted the special weight of the medical evidence.

By letter dated November 30, 2009, appellant, through counsel, requested a hearing.

In reports dated December 10, 2009 through March 9, 2010, Dr. Cohen noted appellant's continuing cervical and left elbow mild range of motion limitations and diffuse muscle tenderness. He, however, stated that the neurological examination was nonfocal. Dr. Cohen placed appellant off work until her sedation due to medication could be better controlled. He later advised that appellant could not return to her regular work duties, but she might be able to perform sedentary work if she were able to stay alert given her pain medication. Dr. Cohen concluded that, for all intents and purposes, appellant was permanently and totally disabled for work. In an April 6, 2010 report, he indicated that appellant wished to perform sedentary work. On April 13 and May 4, 2010 Dr. Cohen advised that she could return to part-time light-duty work with restrictions.

In a June 1, 2010 decision, an OWCP hearing representative affirmed the November 19, 2009 decision. The hearing representative found that the report of Dr. Green was entitled to special weight and established that appellant did not sustain a recurrence of disability commencing September 11, 2007 or a cervical condition causally related to her October 10, 2006 employment injuries.³

On June 11, 2010 appellant, through counsel, requested reconsideration.

In a July 15, 2010 decision, OWCP denied modification of the June 1, 2010 decision. It found that the medical evidence submitted by appellant was insufficient to outweigh the special weight accorded to Dr. Green's impartial medical opinion.

LEGAL PRECEDENT -- ISSUE 1

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

³ By decision dated June 9, 2010, OWCP denied appellant's claim for compensation for the period March 13 through April 14, 2010. As appellant is not appealing from this decision, the Board will not address it. See 20 C.F.R. § 501.3(a).

that caused the illness.⁴ This 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.⁵

When an employee who is disabled from the job she held when injured on account of employment-related residuals returns to a limited-duty position or the medical evidence of record establishes that she can perform the limited-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 to show that she cannot perform such limited-duty work. 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 limited-duty job requirements.⁶

To show a change in the degree of the work-related injury or condition, the claimant must submit rationalized medical evidence documenting such change and explaining how and why the accepted injury or condition disabled the claimant for work on and after the date of the alleged recurrence of disability.⁷

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 (known as a referee physician or impartial medical specialist) who shall make an examination.⁸ In cases where OWCP has referred appellant to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.⁹

ANALYSIS -- ISSUE 1

The Board finds that the case is not in posture for decision as to whether appellant sustained a recurrence of disability, in that there exists an unresolved conflict in medical opinion. OWCP found that appellant did not sustain a recurrence of total disability commencing September 11, 2007 due to a worsening of her accepted employment-related left elbow ulnar neuropathy and tenosynovitis of the left wrist based on the medical opinion of Dr. Green, an impartial medical specialist.

⁴ 20 C.F.R. § 10.5(x).

⁵ *Id.*

⁶ *Albert C. Brown*, 52 ECAB 152, 154-155 (2000); *Barry C. Petterson*, 52 ECAB 120 (2000); *Terry R. Hedman*, 38 ECAB 222, 227 (1986).

⁷ *James H. Botts*, 50 ECAB 265 (1999).

⁸ 5 U.S.C. § 8123(a); *see S.T.*, Docket No. 08-1675 (issued May 4, 2009).

⁹ *Gloria J. Godfrey*, 52 ECAB 486 (2001); *B.P.*, Docket No. 08-1457 (issued February 2, 2009).

OWCP determined that a conflict existed between appellant's attending physicians, Dr. Macht and Dr. James P. Argires and Dr. Draper, an OWCP referral physician, as to whether appellant's cervical condition and need for surgery were caused by the accepted October 10, 2006. In order to resolve the conflict, it referred appellant to Dr. Green, for an impartial medical examination. In an August 20, 2009 report, Dr. Green listed his findings on physical examination and diagnosed chronic pain syndrome with anxiety, probable ulnar intraneural fibrosis with residual impairment due the October 10, 2006 employment injuries and mild rotator cuff arthropathy. He stated that appellant was status post two-level cervical discectomy and fusion. Dr. Green found that she continued to have residuals of her accepted conditions. He stated that appellant could not return to her date-of-injury position, but related that, if her condition continued to improve, then she could work up to eight hours per day with restrictions as a mail sorter. Dr. Green found that her cervical spondylosis, which had progressed over a six-year period, was not work related as it was compatible with a natural history of the disease. He concluded that appellant's disability was primarily work related. The Board finds that OWCP'S reliance on Dr. Green's opinion in denying appellant's recurrence of disability claim was misplaced given his opinion that appellant's ongoing disability was employment related. Further, although Dr. Green concluded that appellant's disability was employment related, he did not furnish sufficient rationale to support his opinion on causal relation. He did not explain why her current disability was due to the accepted injuries. Moreover, Dr. Green did not describe the extent and duration of any employment-related disability as instructed by OWCP. For these reasons, the Board finds that Dr. Green's report is of diminished probative value.

In a situation where OWCP secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from such specialist requires clarification or elaboration, OWCP may not regard the opinion as of no particular significance, particularly where it is favorable to the claimant. Under such circumstances, it has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in his original report.¹⁰

The case will be remanded for OWCP to obtain clarification of Dr. Green's opinion on the causal relationship between appellant's September 11, 2007 recurrence of disability and the accepted employment injuries. If it is unable to obtain such clarification, then appellant should be referred to another Board-certified specialist for an examination and an opinion on the issue of whether the September 11, 2007 recurrence of disability was causally related to her accepted employment injuries.¹¹ After such further development of the case record as OWCP deems necessary, it should issue a *de novo* decision on appellant's recurrence claim.

LEGAL PRECEDENT -- ISSUE 2

It is an accepted principle of workers' compensation law that, when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that

¹⁰ See *Richard L. West*, 30 ECAB 691 (1979); *April Ann Erickson*, 28 ECAB 336 (1977).

¹¹ See *James P. Roberts*, 31 ECAB 1010 (1980); *Harold Travis*, 30 ECAB 1071 (1979).

flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause which is attributable to the employee's own intentional conduct.¹² Regarding the range of compensable consequences of an employment-related injury, Larson notes that, when the question is whether compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury, the rules that come into play are essentially based upon the concepts of direct and natural results and of the claimant's own conduct as an independent intervening cause. 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. Thus, once the work-connected character of any condition is established, the subsequent progression of that condition remains compensable so long as the worsening is not shown to have been produced by an independent nonindustrial cause.¹³

A claimant bears the burden of proof to establish a claim for a consequential injury.¹⁴ As part of this burden, he or she must present rationalized medical opinion evidence, based on a complete factual and medical background, showing causal relationship. Rationalized medical evidence is evidence, which relates a work incident or factors of employment to a claimant's condition, with stated reasons of a physician. The opinion must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship of the diagnosed condition and the specific employment factors or employment injury.¹⁵

ANALYSIS -- ISSUE 2

The Board finds that the case is not in posture for decision as to whether appellant sustained a cervical condition that warranted surgery due to her accepted employment injuries. As noted, OWCP referred appellant to Dr. Green to resolve the conflict in the medical opinion evidence between her attending physicians and the OWCP referral physician as to whether her diagnosed cervical condition and resultant surgery were causally related to the October 10, 2006 employment injuries.

Dr. Green opined that appellant had not developed cervical spondylosis as a consequence of her accepted injuries. He stated that the diagnosed condition had progressed over a six-year period and was compatible with a natural history of the disease based on Dr. Kuntz's comparison of the April 23, 2007 and March 2001 MRI scan findings. Dr. Green advised that there was no direct correlation, causal, aggravation or precipitation of appellant's cervical spine condition and the accepted conditions. He noted that the accepted condition was ulnar neuropathy at the left elbow while the diagnosed cervical spine condition was an unrelated degenerative disease that had progressed and may in all probability contributed to a double crush syndrome. Dr. Green agreed with the opinion of Dr. Draper, the OWCP referral physician, that the cervical spine pathology was entirely different and separate from appellant's workers' compensation claim and,

¹² *Albert F. Ranieri*, 55 ECAB 598 (2004).

¹³ A. Larson, *The Law of Workers' Compensation* § 10.01 (November 2000).

¹⁴ *J.J.*, Docket No. 09-27 (issued February 10, 2009).

¹⁵ *Charles W. Downey*, 54 ECAB 421 (2003).

thus, it could not be a part of her claim. The Board finds that Dr. Green did not provide sufficient rationale to support his opinion that appellant's cervical spondylosis was not caused by her accepted injuries. He failed to explain how the diagnostic test results supported his opinion that her cervical condition was part of a degenerative process rather than a result of the accepted injuries. Dr. Green did not address whether appellant's March 12, 2008 cervical surgery was medically warranted due to the accepted conditions.

The Board finds that Dr. Green's report is insufficiently rationalized to resolve the conflict in medical opinion as to whether appellant developed cervical spondylosis that warranted surgery as a consequence of her accepted injuries.¹⁶ Therefore, the case shall be remanded to OWCP for a supplemental opinion, which provides clarification and elaboration.¹⁷ If Dr. Green is unwilling or unable to clarify and elaborate on his opinion, the case should be referred to another appropriate specialist.¹⁸ After such further development as OWCP deems necessary, an appropriate decision should be issued regarding this matter.

CONCLUSION

The Board finds that the case is not in posture for a decision as to whether appellant sustained a recurrence of disability commencing September 11, 2007 causally related to her October 10, 2006 employment injuries or as to whether she developed a cervical condition that warranted surgery as a consequence of her accepted injuries.

¹⁶ *Willa M. Frazier*, 55 ECAB 379 (2004) (the Board has held that medical conclusions unsupported by rationale are of little probative value).

¹⁷ See cases cited, *supra* note 10.

¹⁸ See cases cited, *supra* note 11.

ORDER

IT IS HEREBY ORDERED THAT the July 15 and June 1, 2010 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further development of the medical evidence in accordance with this decision.

Issued: September 28, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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