United States Department of Labor
Employees' Compensation Appeals Board

J.H., Appellant	)	
and	)	**Docket No. 14-786**
	)	**Issued: July 7, 2014**
DEPARTMENT OF AGRICULTURE, U.S. FOREST SERVICE, Dillon, MT, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Acting Chief Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 25, 2014 appellant timely appealed the December 4, 2013 nonmerit decision of the Office of Workers' Compensation Programs (OWCP) denying reconsideration. The latest merit decision was issued on August 1, 2013, which is more than 180 days prior to the filing of the current appeal. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board's jurisdiction is limited to the December 4, 2013 nonmerit decision.[2]

ISSUE

The issue is whether OWCP properly denied merit review pursuant to 5 U.S.C. § 8128(a).

[1] 5 U.S.C. §§ 8101-8193 (2006).

[2] Had appellant filed his appeal on or before January 28, 2014, the Board would have had jurisdiction over the August 1, 2013 merit decision.

FACTUAL HISTORY

On May 14, 1990 appellant, then a 37-year-old archeology technician, filed a traumatic injury claim (Form CA-1) for lower back strain. On May 7, 1990 he slipped while walking up a north facing slope, which was icy and very steep. At the time, he worked at Beaverhead-Deerlodge National Forest. The incident occurred on a hillside in Goodrich Gulch. Appellant stopped work on May 8, 1990 and returned to work on May 14, 1990. The claim form indicated that he first received medical care on May 8, 1990.

OWCP received appellant's claim more than two decades after the May 7, 1990 employment incident. By letter dated February 20, 2013, OWCP acknowledged receipt of the claim and explained the five basic elements to establishing entitlement under FECA. Additionally, it advised appellant that it had not received any medical evidence regarding his claimed injury. OWCP afforded him 30 days to provide a narrative medical report from a qualified physician.

In a February 22, 2013 statement, appellant indicated that he was initially treated by Dr. Scott Bentley, a chiropractor, and Dr. Jacob M. Taverna, a Board-certified internist, who reportedly diagnosed severe muscle strain. Following the May 7, 1990 incident, appellant stated that he was off work for one to two weeks and received chiropractic treatment for several weeks. He also stated that he continued to receive chiropractic treatment off and on until 2004 when he underwent the first of several lumbar-related surgeries. Appellant believed that the May 7, 1990 lumbar injury was the precursor to his other spinal issues. He claimed that he had no issues with his spine until May 7, 1990.

Appellant noted that many health care providers destroyed their records after 7 to 10 years, and therefore, he was unable to obtain treatment records contemporaneous to the May 7, 1990 employment incident.[3] Of the evidence submitted, the earliest medical records regarding his lumbar spine appear to be chiropractic treatment records from May 2001. At the time, the treatment notes referenced lumbar subluxations, osteophyte formations and wedging disc. The chiropractic treatment notes also referenced a February 13, 2002 lumbar x-ray that reportedly revealed disc space narrowing at L2-3 and L3-4, and osteoarthritic spur formations at L3-4.

On January 16, 2003 appellant was evaluated for a cervical condition he attributed to a 1973 motor vehicle accident (MVA).[4] However, the examining neurologist also noted a prior history of "'bulging disc'" in the lumbar spine. Appellant reported occasional bilateral lower extremity symptoms he called "sciatica," which was well managed with chiropractic care.

Appellant was involved in another MVA on October 28, 2003. He swerved to avoid a large rock in the road and lost control of his vehicle, hitting a large boulder. Lumbar x-rays from November 2003 revealed disc space narrowing at L2-3 and L3-4, neuroforaminal encroachment at L3-4 and osteoarthritic spur formations at L3 and L4.

[3] Both Dr. Taverna and Dr. Bentley no longer retained copies of appellant's treatment records.

[4] On February 28, 2003 appellant underwent an anterior cervical discectomy and fusion at C5-6 and C6-7.

On February 13, 2004 Dr. Kenneth C. Brewington II, a Board-certified neurosurgeon, examined appellant for complaints of increasing left leg weakness. He noted that appellant was involved in an MVA during hunting season in late October 2003. At the time, appellant had a little bit of buttock and posterior thigh pain, as well as significant mechanical back pain. This responded to conservative therapy, but subsequently he occasionally noticed a left foot drag, which was sporadic and also associated with buttock pain. Dr. Brewington indicated that appellant currently still had some buttock pain, but most of his pain was in the lower lumbar spine. He recommended obtaining a lumbar magnetic resonance imaging (MRI) scan. Dr. Brewington's initial lumbar-related diagnoses included left L5 radiculopathy and mechanical back pain.

Appellant's February 13, 2004 lumbar MRI scan revealed degenerative disc disease and facet disease at L5-S1. There was also evidence of severe degenerative disc disease at L3-4 and disc desiccation at L4-5, with mild disc space narrowing and a broad-based disc bulge.

During a February 23, 2004 follow-up examination, Dr. Brewington reviewed appellant's recent lumbar MRI scan and diagnosed L5 radiculopathy, mechanical back pain, left L4-5 severe foraminal stenosis and L4-5 subarticular recess stenosis. He recommended lumbar surgery.

On February 26, 2004 Dr. Brewington performed a left L4 laminectomy and left L4 and L5 foraminotomies. Over an eight-year period, appellant underwent at least four additional lumbar-related surgeries involving L4-5, L5 and L5-S1. As recently as January 18, 2012, appellant underwent a left L5-S1 far lateral foraminotomy and lateral foraminal decompression with limited discectomy. Following the January 18, 2012 surgery, appellant received a series (3) of lumbar epidural steroid injections, culminating on August 10, 2012.

In a May 14, 2013 report, Dr. Bill S. Rosen, a Board-certified physiatrist, indicated that appellant developed an acute onset of low back pain as a consequence of a May 5, 1990 employment-related fall.[5] The pain was localized at the L4-5 level and worse on the left side. Dr. Rosen noted that appellant apparently had ongoing back pain since the May 1990 incident. Appellant reported that his back pain never fully resolved. Dr. Rosen indicated that appellant aggravated his back pain when he was driving and hit a fairly good-sized rock in the road. Appellant subsequently noted weakness in his back and left leg, including his left foot. Dr. Rosen also described appellant's several lumbar surgeries, including his most recent L5 foraminal decompression, which according to appellant provided the most relief.

Dr. Rosen further explained that, prior to hitting the rock in the road, appellant occasionally had pain-free or near pain-free days, especially following chiropractic treatment. Appellant would occasionally have five to seven days of relief with chiropractic treatment, but he never experienced complete remission of pain. He believed that the October 2003 MVA aggravated his back pain, after which he developed leg symptoms. The location of appellant's back pain (L4-5) did not change following the latest MVA. Over the past three years, the pain radiated down into the sacroiliac joint. Appellant also reported weakness in the left lower extremity following a recent epidural injection. Based on the reported history and his own physical examination findings, Dr. Rosen provided the following impression: A 60-year-old left-

[5] Dr. Rosen reported that appellant slipped and fell while hiking up a snowy hill.

handed male with a long history of back pain dating back to May 5, 1990 with progressive deterioration ultimately resulting in what appears to be primarily S1 radiculopathy, but also to at least some degree an L5 radiculopathy. He also stated that it would appear that "at least from a temporal standpoint, [appellant's] back problems can be associated with the original injury of May 5, 1990."

In an August 1, 2013 decision, OWCP denied appellant's traumatic injury claim because the record did not establish a medical diagnosis in connection with the May 7, 1990 employment incident. It explained, *inter alia*, that Dr. Rosen's finding of "'pain'" was not considered a medical diagnosis under FECA.

On October 14, 2013 appellant requested reconsideration. He explained that the inability to provide contemporaneous medical records was due to the employing establishment's delay in processing his claim, coupled with the medical providers' 7- to 10-year record retention policy.

In a September 11, 2013 report, Dr. Rosen stated that appellant's current low back pain and associated weakness can be directly attributed to his May 7, 1990 work-related injury. He noted that appellant suffered an acute injury while hiking up a snowy hill. Appellant developed acute onset of low back pain, which eventually became radicular in nature. Dr. Rosen indicated that the progressive weakness appellant noted stemmed originally from the May 7, 1990 injury, and currently he was left with permanent neurologic deficits of the left leg. He further explained that, if not for the May 7, 1990 injury, appellant may never have gone on to develop the weakness and pain syndrome he is plagued with. Dr. Rosen's current residual weakness was a natural progression of the original 1990 injury. He found that all impairments and subsequent disability with regard to appellant's lumbar spine could be traced to the specific event in May 1990.

By decision dated December 4, 2013, OWCP denied appellant's request for reconsideration. It considered Dr. Rosen's latest report cumulative, and thus, insufficient to warrant further merit review.

LEGAL PRECEDENT

OWCP has the discretion to reopen a case for review on the merits.[6] An application for reconsideration, including all supporting documents, must set forth arguments and contain evidence that either: (i) shows that OWCP erroneously applied or interpreted a specific point of law; (ii) advances a relevant legal argument not previously considered by OWCP; or (iii) constitutes relevant and pertinent new evidence not previously considered by OWCP.[7] When an application for reconsideration does not meet at least one of the above-noted requirements, OWCP will deny the request for reconsideration without reopening the case for a review on the merits.[8]

[6] 5 U.S.C. § 8128(a).

[7] 20 C.F.R. § 10.606(b)(2).

[8] *Id.* at § 10.608(b).

ANALYSIS

Appellant's October 14, 2013 request for reconsideration neither alleged nor demonstrated that OWCP erroneously applied or interpreted a specific point of law. He also did not advance a relevant legal argument not previously considered by OWCP. The issue on reconsideration was whether there was a specific medical diagnosis attributable to the May 7, 1990 employment incident. This is a question regarding the quality of the medical evidence. OWCP was already aware of the reasons for appellant's inability to submit medical evidence contemporaneous to the May 7, 1990 incident. As noted, the issue on reconsideration pertained to the sufficiency of the medical evidence, not why appellant had difficulty providing evidence to support the claim. Therefore, appellant is not entitled to a review of the merits based on the first and second requirements under section 10.606(b)(2).[9]

Appellant also failed to submit any "relevant and pertinent new evidence" with his October 14, 2013 request for reconsideration. OWCP determined that merit review was unwarranted because the newly submitted evidence was cumulative. Providing additional evidence that repeats or duplicates information already in the record does not constitute a basis for reopening a claim.[10] While Dr. Rosen traced appellant's current lumbar-related lower extremity complaints to the May 7, 1990 employment incident, he still failed to provide a specific diagnosis that purportedly arose on that date, be it a lumbar sprain, disc herniation, subluxation or aggravation of some underlying degenerative process. As OWCP previously explained, acute low back pain is not an acceptable medical diagnosis under FECA. Dr. Rosen's May 14 and September 11, 2013 reports are essentially duplicative. Because appellant did not provide any new evidence that might arguably impact the prior decision, he is not entitled to a review of the merits based on the third requirement under section 10.606(b)(2).[11] Accordingly, OWCP properly declined to reopen appellant's case under 5 U.S.C. § 8128(a).

CONCLUSION

The Board finds that OWCP properly denied further merit review with respect to appellant's October 14, 2013 request for reconsideration.

[9] 20 C.F.R. § 10.606(b)(2)(i) and (ii).

[10] *James W. Scott*, 55 ECAB 606, 608 n.4 (2004).

[11] 20 C.F.R. § 10.606(b)(2)(iii).

ORDER

IT IS HEREBY ORDERED THAT the December 4, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 7, 2014
Washington, DC

Patricia Howard Fitzgerald, Acting Chief Judge
Employees' Compensation Appeals Board

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

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