United States Department of Labor
Employees' Compensation Appeals Board

D.T., Appellant	)	
and	)	**Docket No. 15-1114**
	)	**Issued: February 1, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Rainier, OR, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On April 20, 2015 appellant filed a timely appeal from an April 10, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant met her burden of proof to establish a recurrence of her medical conditions causally related to her March 9, 2002 employment injury.

FACTUAL HISTORY

On March 11, 2002 appellant, then a 48-year-old rural carrier associate, filed an occupational disease claim (Form CA-2) indicating that her arm, back, and leg had been bothering her for some time and that on March 9, 2002 her condition worsened after she heard a

[1] 5 U.S.C. § 8101 *et seq.*

"pop." OWCP accepted the claim for left gluteus muscle strain.[2] The record indicates that appellant stopped work on July 3, 2002, returned to light duty on April 3, 2003, and returned to full duty on July 8, 2003.

Appellant filed a recurrence of disability on May 14, 2004 alleging that on May 12, 2004 she again stopped work due to the March 9, 2002 employment injury. By decision dated July 21, 2004, OWCP expanded her claim to include lumbar strain and lumbar herniated nucleus pulposus and accepted that she had sustained disability as of May 12, 2004. Additional conditions of sprain of lumbosacral (joint)/(ligament) and displacement of lumbar intervertebral disc without myelopathy were also accepted. The record substantiates that appellant received wage-loss benefits on the short-term rolls from May 12, 2004 until June 3, 2005. OWCP terminated appellant's wage-loss compensation regarding this claim by decision dated June 3, 2005.

On March 2, 2015 appellant filed a claim for a recurrence of disability (Form CA-2a) for medical treatment of the accepted injury-related back conditions. She claimed her back condition has not resolved. Appellant stated that her doctor treated her injuries under both the current claim and claim number xxxxxx974, which was accepted for bilateral carpal tunnel syndrome, but failed to submit bills to OWCP when she was treated for her back injury. She stated that her work-related back injury remained static until recently. Appellant indicated that her treating doctor retired and her accepted claim for back conditions had been closed, but that she now needed a new doctor and additional medical treatment. The employing establishment noted on the claim form that appellant was on OWCP periodic compensation rolls under claim number xxxxxx974. No medical evidence was submitted with her recurrence claim.

In a February 13, 2015 letter, appellant explained that she saw the same doctor for her back and carpal tunnel syndrome conditions. She alleged that the doctor mistakenly thought she needed reports for her carpal tunnel claim and had focused on her wrist injury, which she indicated had caused pain for the past years and for which she receives compensation. Appellant stated that every three or four months, she saw her doctor for her back injury, but the doctor's office failed to bill under the correct claim number. She subsequently learned that OWCP was not paying the bills for medical treatment of her back.

In a March 4, 2015 letter, OWCP noted that there was limited evidence of medical treatment for appellant's accepted back conditions since April 24, 2007. It requested that she provide additional factual evidence along with copies of all medical records for the work-related lumbar condition and a comprehensive, narrative medical report from her treating physician, which contained an opinion supported by medical rationale as to the relationship between her current medical conditions and the accepted injury. Appellant was afforded 30 days to submit the requested evidence.

In response, OWCP received correspondence from appellant and OWCP regarding her authorized representatives; correspondence pertaining to a request for extension of time;

[2] Appellant also has an accepted claim for bilateral/lateral epicondylitis, with a date of injury of June 14, 2002 under OWCP File No. xxxxxx943, and an accepted claim for bilateral carpal tunnel syndrome under OWCP File No. xxxxxx974.

correspondence regarding bill payment issues; appellant's supplemental statements of April 3, 6, and 9, 2015 and copies of diagnostic testing from 2014.

Authorization requests and treatment reports from different physicians covering the period February 25, 2010 through March 26, 2015 were submitted.[3]

Medical reports from Dr. Donald S. Orr, a Board-certified neurologist, from 2010 through 2014 were received. The majority of the reports pertained to appellant's upper extremity conditions and occasionally mentioned low back pain syndrome. In treatment notes dated April 22, 2013 through September 16, 2014, Dr. Orr mentioned a low back condition, back pain, and lumbar-related conditions. In a July 17, 2014 report, he reported that appellant had significant low back pain, right upper extremity pain, and fully resolved left wrist pain. With respect to the back, Dr. Orr diagnosed low back pain syndrome. He noted that he was suspicious of an underlying discogenic lumbar pain component and noted results from an April 30, 2003 magnetic resonance imaging (MRI) scan of the lumbar spine. In a September 16, 2014 report, Dr. Orr reported that appellant recognized, over the past week, a pain in her left groin and beginning today, a pronounced discomfort at her left hemipelvic area when she placed weight onto her left lower extremity. An assessment of lumbar disc herniation without myelopathy, sacroiliac pain, and low back pain syndrome was provided. Appellant received left-sided S1 joint injection. Dr. Orr noted that he was suspicious that appellant's low back generator was that of a damaged intervertebral disc with an internal annual tear. He suspected that she has developed, secondarily due to mechanical stresses, subluxation of her left sacroiliac joint, which manifested as left groin pain and gait difficulty.

In a January 2, 2015 report, Dr. Orr summarized that on November 6, 2014 appellant was found to have a fracture in her left hip at the femoral neck. Appellant recalled in retrospect that in late August or early September she tripped going up steps at home and went back down about five of those steps while somehow maintaining an upright position as she landed hard on her feet. Dr. Orr noted that it now seemed that appellant very likely sustained the fracture at that time. After appellant was seen in mid-September her left hip pain intensified and her primary care physician took a radiograph of her left hip, which was read as normal. Dr. Daniel Nicholson, a Board-certified orthopedic surgeon, had appellant undergo a left hip MRI scan, which showed the fracture. Appellant was to undergo a bone density study. Dr. Orr advised that the bone density scan showed osteopenia at her femoral heads, just past borderline osteoporosis in her lumbar spine. He noted that Dr. Daniel Kingloff, a Board-certified orthopedic surgeon, had indicated that appellant would not require surgery for the nondisplaced fracture of the left femoral head. Dr. Orr related that appellant understood that her hip injury/fracture lay outside the purview of workers' compensation. No assessment/diagnosis was provided regarding appellant's back condition.

Reports from Dr. Daniel A. Nicholson, a Board-certified orthopedic surgeon, were received and contained handwritten comments. In an October 15, 2014 report, he noted that appellant reported an onset of left hip pain/groin pain three weeks previously, but that there was no injury that caused the onset of the pain. The pain worsened approximately one week prior,

[3] Medical reports received for the period February 25, 2010 to March 19, 2013 pertained to treatment of appellant's carpal tunnel and upper extremity conditions.

after she stumbled and fell, landing on her left leg.[4] Dr. Nicholson found that appellant had a herniated lumbar disc, but no other back issues. Appellant had no previous history of injury to the hip and had not had any treatment. Dr. Nicholson noted that at this point in time the etiology of appellant's pain was unclear. There were no radiographic signs of acetabular impingement or significant degenerative joint disease. Dr. Nicholson advised appellant's known lumbar pathology may be playing a role in her complex of symptoms. However, he noted the majority of the pain appeared to be in the left groin. Additional diagnostic testing was recommended.

In an October 27, 2014 report, Dr. Nicholson reported that appellant had a fractured hip.

In an October 30, 2014 report, Dr. Nicholson diagnosed a closed fracture at the base of the neck of the femur, along with joint pain involving the pelvic region and thigh. Appellant was scheduled for surgery on November 3, 2014 for left hip percutaneous pinning.

In a January 28, 2015 report, Dr. Kevin Sheahan, a Board-certified anesthesiologist and certified pain specialist, noted that appellant was seen for upper extremity pain. An assessment of reflex sympathetic dystrophy (RSD) upper extremity, lumbar spondylosis without myelo/facet arthrophy, and carpal tunnel syndrome was provided.

In a March 13, 2015 report, Dr. Damon Kimes, a Board-certified family practitioner, reported that appellant was a new patient. He reported that appellant had seen another physician for her chronic lower back and left hip pain for over seven years, but the physician had retired and closed his office. Appellant reported a history of a work-related back strain in 2002 followed by disc disease. She reported a left hip fracture in September, which a prior MRI scan showed was a fractured femoral head. Dr. Kimes noted his review of appellant's records from Southeastern Interventional Pain Associates, including Dr. Orr's notes, and provided examination findings. The following assessments were provided: encounter for long-term (current) use of other medications; lumbago; facet arthropathy lumbar and cervical; carpal tunnel syndrome; chronic pain syndrome; pain hip; sacroiliitis; lumbosacral radiculopathy; and cervical radiculopathy. Follow-up reports from Dr. Kimes dated March 26, 2015 contained the same assessments.

By decision dated April 10, 2015, OWCP denied the recurrence claim and found that medical treatment was not authorized because the medical evidence was insufficient to establish a recurrence of appellant's accepted conditions causally related to the March 9, 2002 accepted back conditions.

LEGAL PRECEDENT

A recurrence of a medical condition is defined as a documented need for further medical treatment after release from treatment for the accepted condition or injury.[5] Continuous treatment for the original condition or injury is not considered a recurrence of a medical

[4] A handwritten note on the report stated, "never told him I fell … told him about when @ park with/ kids, when I hit that tree root hard & Tim had to help me back to the car."

[5] 20 C.F.R. § 10.5(y).

treatment nor is an examination without treatment.[6] As distinguished from a recurrence of disability, a recurrence of a medical condition does not involve an accompanying work stoppage.[7]

It is the employee's burden to establish that the claimed recurrence is causally related to the original injury.[8] Causal relationship is a medical issue that can generally be resolved only by rationalized medical opinion evidence.[9] This requires furnishing medical evidence from a 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 and who supports that conclusion with sound medical reasoning.[10] Where no such rationale is present, medical evidence is of diminished probative value.[11]

In order to establish that a claimant's alleged recurrence of the condition was caused by the accepted injury, medical evidence of bridging symptoms between her present condition and the accepted injury must support the physician's conclusion of a causal relationship.[12]

ANALYSIS

OWCP accepted that appellant's March 9, 2002 employment injury resulted in left gluteus muscle strain, sprain of back, lumbar region, sprain of lumbosacral (joint)/(ligament), and displacement of lumbar intervertebral disc without myelopathy. Appellant returned to work. She was eventually totally disabled as a result of conditions in other accepted claims and placed on the periodic compensation rolls. On March 2, 2015 OWCP received appellant's Form CA-2a claim for a recurrence due to her March 9, 2002 employment injury.

Appellant submitted authorization requests and treatment reports from different physicians covering the period February 25, 2010 through March 26, 2015. The medical records from February 25, 2010 to March 19, 2013 do not mention a back condition. Rather, they are treatment notes for carpal tunnel and upper extremity problems. In treatment notes for the period April 22, 2013 through September 16, 2014, Dr. Orr mentioned a low back condition, back pain and lumbar-related conditions, but provided no opinion with medical rationale as to how the diagnoses were due to, caused by, or related to the original injury. Medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[13] Although Dr. Orr did not formally discharge

[6] *Id.*

[7] *Id.* at § 10.5(x).

[8] *Id.* at § 10.104. *See also Mary A. Ceglia*, 55 ECAB 626, 629 (2004).

[9] *See Jennifer Atkerson*, 55 ECAB 317 (2004).

[10] *Dennis E. Twardzik*, 34 ECAB 536 (1983); *Max Grossman*, 8 ECAB 508 (1956).

[11] *Michael Stockert*, 39 ECAB 1186, 1187-88 (1988); *see Ronald C. Hand*, 49 ECAB 113 (1957).

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

[13] *Jaja K. Asaramo*, 55 ECAB 200 (2004).

appellant from treatment for her back conditions, a sufficiently lengthy gap in treatment has the same effect as a formal discharge.[14] Appellant has the burden of proof to establish that her need for medical treatment beginning April 22, 2013 through September 16, 2014 was causally related to her March 9, 2002 employment injury.

In September 2014 appellant reported left groin pain and discomfort in her left hemipelvic area, which was later diagnosed as left hip fracture at the femoral neck. In his September 16, 2014 report, Dr. Orr reported that appellant recognized, over the past week, a pain in her left groin and beginning today, a pronounced discomfort at her left hemipelvic area when she placed weight onto her left lower extremity. An assessment of lumbar disc herniation without myelopathy, sacroiliac pain, and low back pain syndrome was provided. Dr. Orr subsequently related in his January 2, 2015 report that appellant was found to have a fracture in her left hip at the femoral neck. He noted that appellant recalled in retrospect that in late August or early September she tripped while walking up steps at home and fell back down approximately five of those steps while somehow maintaining an upright position as she landed hard on her feet onto the landing. Dr. Orr noted that she very likely sustained fracture at that time. While he previously suspected a damaged intervertebral disc with an annual tear, and subluxation of her left sacroiliac joint secondarily due to mechanical stresses, which manifested as left groin pain and gait difficulty, it is not possible to verify that appellant's current condition is causally related to the original injury due to the void of ongoing treatment records or any medical evidence bridging the gap of treatment. Furthermore, the history of injury reflects that appellant either tripped going up steps or stumbled over a tree root and fell.

The October 15, 2014 treatment note from Dr. Nicholson provided a history that appellant stumbled and fell landing on her left leg. The handwritten note on the report alleged that "never told him I fell … told him about when @ park with/ kids, when I hit that tree root hard & Tim had to help me back to the car." This exposure over stumbling over a tree root and falling and/or tripping while walking up steps are incidents which break the chain of causation to establish a recurrence of disability. Additionally, the medical histories provided to Dr. Orr and Dr. Nicholson are inconsistent and cast doubt on the validity of the claim.

Appellant also submitted reports dated January 28, 2015 from Dr. Sheahan, and March 13, 2015 from Dr. Kimes. While these physicians provided diagnoses of appellant's conditions, they did not offer any opinion regarding the cause of the diagnosed conditions or whether they required further medical treatment. The other medical reports submitted fail to provide a rational medical opinion with an accurate factual and medical history causally relating appellant's current condition to the March 9, 2002 injury.

The Board finds that the evidence submitted by appellant lacks adequate rationale to establish a causal connection between the alleged recurrence of her medical conditions and the accepted employment injury. Appellant had the burden of submitting sufficient medical evidence to document the need for further medical treatment. She did not submit such evidence as required and failed to establish a need for continuing medical treatment.[15]

[14] *See Kent W. Rasmusen*, Docket No. 04-1137 (issued August 4, 2004).

[15] *See P.Q.*, Docket No. 14-1905 (issued May 26, 2015); *J.F.*, 58 ECAB 331 (2006).

On appeal appellant notes her frustration with an OWCP claims examiner and her desire to reopen her claim. In a separate letter, she also expressed her belief that her former physician, Dr. Orr, engaged in improper billing practices and that this gave the appearance that she stopped treatment for her back. As noted, appellant's recurrence claim was denied as the medical evidence lacked adequate rationale to establish a causal connection between the alleged recurrence of her medical condition and the accepted employment injury. She did not submit such evidence as required and failed to establish a need for continuing medical treatment.

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

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish a recurrence of her medical conditions causally related to her March 9, 2002 employment injury.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated April 10, 2015 is affirmed.

Issued: February 1, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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