

**United States Department of Labor  
Employees' Compensation Appeals Board**

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D.N., Appellant

and

U.S. POSTAL SERVICE, ASTRODOME  
STATION, Houston, TX, Employer

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**Docket No. 16-1439  
Issued: May 3, 2017**

*Appearances:*

*Alan J. Shapiro, Esq.*, for the appellant<sup>1</sup>  
*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  
VALERIE D. EVANS-HARRELL, Alternate Judge

**JURISDICTION**

On July 5, 2016 appellant, through counsel, filed a timely appeal from a February 12, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act<sup>2</sup> (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

**ISSUE**

The issue is whether appellant met her burden of proof to establish that she sustained bilateral brachial plexus impingement; reflex spasm in the neck, back, shoulder girdle, and

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<sup>1</sup> In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

<sup>2</sup> 5 U.S.C. § 8101 *et seq.*

buttocks; bilateral sciatic nerve impingement; deranged disc in the back, and bilateral L5-S1 impingement causally related to the accepted October 5, 2007 employment injury.

On appeal counsel asserts that the February 12, 2016 decision is contrary to fact and law.

### **FACTUAL HISTORY**

On October 5, 2007 appellant, then a 33-year-old letter carrier, injured her back on October 5, 2007 when she was pulling mail for her route. She began modified duty. On November 21, 2007 OWCP accepted sprain of back, thoracic region. The claim was subsequently expanded to include thoracic disc displacement.

In October 10 and 16, 2007 reports, Dr. Asaf R. Qadeer, Board-certified in family medicine, noted that on October 5, 2007 appellant injured her back between the shoulder blades while pulling mail. He diagnosed acute back sprain with muscle spasm. October 10, 2007 thoracic spine x-rays were normal.<sup>3</sup> Dr. Richard Francis, a Board-certified orthopedic surgeon, provided medical care commencing June 28, 2008.

In reports dated September 22, 2008, Dr. Ulysses W. Watkins Jr., a family physician, noted a history that appellant had been in a motor vehicle accident. Following physical examination, he diagnosed upper and lower back pain, headaches, chest pain, cervical pain, and left shoulder pain. A skull x-ray that day was negative.

Appellant stopped her modified-duty work on September 23, 2008 and filed a claim for compensation (Form CA-7). She received wage-loss compensation effective that date, and was placed on the periodic compensation rolls.

On September 29, 2008 appellant began pain management with Dr. Alan Moore, Board-certified in anesthesiology and pain medicine. Dr. Moore diagnosed displacement of thoracic intervertebral disc without myelopathy and scheduled steroid injections at T8-9.

Dr. M. Athari, a Board-certified neurologist, saw appellant on October 2, 2008 and diagnosed chronic back pain, post-traumatic myofascitis, possible thoracic herniated disc, and possible fibromyalgia. November 20, 2008 lower extremity electrodiagnostic testing showed evidence of T8-9 nerve root irritation on the left. On January 29, 2009 OWCP accepted displacement of the thoracic spine at T8-9.

Appellant continued treatment with Drs. Moore, Francis, and Athari. Dr. Moore additionally diagnosed thoracolumbar myofascial pain syndrome. In a March 19, 2009 report, Dr. Francis also noted appellant's report that she had a low back injury at work in 2001, but had recovered from this. An April 10, 2009 thoracic spine magnetic resonance imaging (MRI) scan, showed posterior bulging discs at T8-9 and T11-12.

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<sup>3</sup> The record also includes a June 1, 2007 x-ray of the thoracic spine that demonstrated minimal left lower thoracic scoliosis, and a lumbar x-ray that day demonstrated no abnormality.

On April 30, 2009 Dr. Stephen I. Esses, a Board-certified orthopedic surgeon, noted his review of the MRI scan revealed no spinal cord or nerve root compression.

OWCP referred appellant to Dr. Gary C. Freeman, a Board-certified orthopedist, for a second opinion evaluation. In a May 5, 2009 report, he related that on October 5, 2007 appellant, who was on light duty at the time, felt pain in her back after pulling a table, and now her entire back hurt. Dr. Freeman reviewed the medical record including MRI scans and performed physical examination. He advised that physical examination demonstrated symptom magnification, no positive findings, and that appellant had age-appropriate degenerative bulging at T8-9 and T10-11 and no displacement of thoracic intervertebral disc. Dr. Freeman found no indication of a herniated disc, fibromyalgia, or chronic myofasciitis, and diagnosed chronic mid-thoracic pain. He concluded that the October 5, 2007 employment injury had resolved without residuals and that appellant could return to her usual job duties.<sup>4</sup>

OWCP found that a conflict in medical opinion was created regarding appellant's work abilities, and in October 2009 referred her to Dr. Frank L. Barnes, a Board-certified orthopedic surgeon, for an impartial medical evaluation. In a November 19, 2009 report, Dr. Barnes noted his medical record review<sup>5</sup> and appellant's complaint of back pain. He noted the history of injury, the 2008 motor vehicle accident, and appellant's November 2008 lap-band procedure. Following examination and review of the MRI scans, Dr. Barnes diagnosed cervical, thoracic, and lumbar spine degenerative disc disease, and T8 nerve irritation. He opined that appellant had no objective findings of the work injury based on his examination, but that there was radiology evidence of a bulging T8-9 disc and electromyogram/nerve conduction velocity (EMG/NCV) evidence. Dr. Barnes concluded that appellant could perform modified duty for eight hours daily.<sup>6</sup>

In an April 5, 2010 addendum, Dr. Barnes acknowledged that appellant had a bulging thoracic T8-9 disc. He advised, however, that there was no evidence on examination of any

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<sup>4</sup> A May 5, 2009 cervical spine MRI scan showed mild disc protrusions at C4-5, C5-6, and C6-7 that mildly impressed the thecal sac. A lumbar MRI scan of the same date showed mild protrusion at L4-5 which mildly impressed the thecal sac, a mild bulge at L5-S1 that mildly impressed the thecal sac. Loss of lumbar lordosis, bilateral facet arthrosis, and mild bilateral neural foraminal narrowing was seen. A May 7, 2009 thoracic MRI scan showed moderate thoracic hyperkyphosis, a moderate protrusion at T8-9 that moderately impressed the thecal sac and appeared to contact the cord, and mild disc protrusions at T5-6 and T11-12 that mildly impressed the thecal sac. A June 25, 2009 FCE was invalid due to excessive magnified symptoms. On July 16, 2009 the employing establishment offered appellant a modified job that she declined.

<sup>5</sup> Dr. Barnes indicated that he could not review the OIG surveillance video as it was password-protected.

<sup>6</sup> On December 10, 2009 OWCP proposed to terminate appellant's compensation based on Dr. Barnes' impartial medical opinion. Appellant disagreed and asserted that Dr. Barnes did not properly review the medical record, that stress from her claim made her condition worse, and that the medical evidence established continuing disability. On January 12, 2010 OWCP terminated appellant's wage-loss and medical benefits, effective January 17, 2010. It found that the weight of the medical evidence rested with the opinion of Dr. Barnes. Appellant requested a hearing. In a March 16, 2010 decision, an OWCP hearing representative reversed the January 12, 2010 decision. She found that the opinion of Dr. Freeman, who performed the second opinion evaluation, was of no probative value as he did not base his medical conclusions on the statement of accepted facts. Appellant was returned to the periodic compensation rolls with retroactive compensation. In April 2010 the employing establishment offered appellant a modified letter carrier position which she declined.

neurologic loss of function that was consistent with a thoracic spine problem. Dr. Barnes specifically noted that appellant had four indicators of probable symptom magnification: lumbar pain with axial compression, inconsistent straight leg raising signs, pain with pelvic compression, and simulated rotation experienced in her lower back. He concluded that, although appellant had a bulging thoracic disc at T8-9 that could have occurred at the time of injury, this could not be demonstrated to be causing her pain which, she indicated was in her neck, shoulders, and upper thoracic spine, which were above the area of the bulging disc.

On April 26, 2010 Dr. John W. Ellis, a Board-certified family physician, reported the history of the October 5, 2007 work injury, and that appellant had been in motor vehicle accidents in 2005 and 2008. Current complaints included severe pain between her shoulders, the base of her neck, and buttocks as well as sacroiliac pain and headaches. Dr. Ellis noted review of medical evidence and described findings. He diagnosed work-related muscle tendon unit strain of the thoracic spine, deranged disc at T8-9, reflex spasm of the neck and shoulder girdles causing bilateral brachial plexus impingement and reflex spasm in the back causing tightness of the back, buttocks, and sacroiliac ligaments with bilateral sciatic nerve impingement.<sup>7</sup>

Appellant continued pain management with Dr. Moore. On May 12, 2010 he additionally diagnosed displacement of cervical and lumbar intervertebral disc without myelopathy, thoracic spinal pain, thoracic spondylosis without myelopathy, thoracolumbar myofascial pain syndrome, and lumbar radiculitis. Dr. Moore advised that her condition was worsening. A June 25, 2010 MRI scan of the lumbar spine demonstrated mild disc bulges at L3-4, L4-5, and L5-S1 mild impressing on the thecal sac.

On July 6, 2010 appellant began treatment with Dr. James D. Key, a Board-certified orthopedic surgeon. He noted a history that lifting cases of mail caused a thoracic herniated disc. Findings included decreased thoracic and lumbar spine range of motion, altered gait and balance secondary to low back pain, and tenderness on spinal examination. Dr. Key diagnosed brachial neuritis or radiculitis; lumbar neuritis/radiculitis/radiculopathy; lumbar herniated disc; status postlaminectomy syndrome; spinal instability L4 and L5-S1; failed back surgery syndrome; muscle spasm and myofascial pain syndrome of paraspinal musculature; muscle weakness, general, traumatic, antalgic; neck, thoracic spine, low back, sacroiliac joint, shoulder, elbow, wrist, hip, knee, and ankle/foot pain; nonallopathic lesion articular dysfunction/biomechanical lesion pelvic region (joint); internal derangement of knee; and chronic pain. He recommended MRI scans of both shoulders.

OWCP found that a conflict in the medical evidence was created between Dr. Barnes and Dr. Athari regarding appellant's work-related disability and referred her to Dr. Grant McKeever, a Board-certified orthopedic surgeon. In a July 23, 2010 report, Dr. McKeever diagnosed psychophysiologic spine pain and advised that the October 5, 2007 spine strain would have resolved within a few weeks of her injury. He opined that appellant could return to her usual letter carrier job. On September 15, 2010 OWCP proposed to terminate appellant's wage-loss compensation, based on Dr. McKeever's opinion. It finalized the termination on October 15, 2010, effective October 24, 2010. Counsel requested a hearing. In a December 9, 2010 report,

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<sup>7</sup> Dr. Ellis also assessed appellant's permanent impairment for schedule award purposes. Matters pertaining to a schedule award are not before the Board on the present appeal.

Dr. Ellis advised that appellant's condition had worsened since he last saw her on April 26, 2010. He advised that she had significant limitations and was permanently and totally disabled. In a second December 9, 2010 report, Dr. Ellis repeated the history of injury and appellant's current complaints that were in his April 26, 2010 report, and noted that she continued to receive pain management from Dr. Moore. He noted his review of medical evidence and provided examination findings, noting decreased sensation of the T7 and T8 nerve roots bilaterally, point tenderness of thoracic interspinous ligaments with palpable spasm of the paraspinal muscles in the mid and lower thoracic regions, mild spasm of the cervical and upper thoracic regions, and moderate spasm of the lumbar paraspinal muscles. Dr. Ellis further found tightness of the shoulder girdle muscles, tenderness over the iliolumbar and sacroiliac ligaments with diminished two-point discrimination and positive straight leg raising. He indicated that the accepted conditions were muscle tendon unit strain of the thoracic spine, derangement disc at T8-T9, and bilateral T8 and T9 spinal nerve root impingement. Dr. Ellis advised that additional conditions should be accepted: reflex spasm in the neck and shoulder girdles; bilateral brachial plexus impingement due to spasms of the shoulder girdle muscles; reflex spasm in the back and buttocks; bilateral sciatic nerve impingement; deranged discs in the back due to continued tightness of the back; and bilateral L5 and S1 spinal nerve impingement. He opined that these conditions were causally related to the work injury because appellant had an acute injury to the T8-9 thoracic disc which caused the paraspinal muscles in the thoracic and neck areas to become very tight and this caused brachial plexus impingement due to the tight muscles in the thoracic, cervical, and shoulder girdle area. Dr. Ellis maintained that continued pain in the spinal nerves caused the lower back to stay in spasm which caused tightness in the iliolumbar and sacroiliac ligaments and the buttocks muscles which led to bilateral sciatic nerve impingement, and that the continued tightness in her back caused increased pressure on the lumbar discs which caused the discs to impinge upon the bilateral L5 and S1 spinal nerve roots leading to impairment of the L5 and S1 spinal nerve roots bilaterally. He also provided an impairment evaluation.

Counsel requested a hearing before an OWCP hearing representative and submitted a May 3, 2010 note in which Dr. Ellis advised that appellant was totally disabled and needed further treatment. A hearing was held on February 9, 2011.

In a March 31, 2011 decision, a hearing representative reversed the termination of wage-loss compensation benefits.<sup>8</sup> He found the opinion of Dr. McKeever, the referee physician, insufficient to resolve the medical conflict because he did not address whether the accepted displaced disc at T8-9 had resolved or address appellant's cervical, shoulder, brachial plexus, and lower back conditions. On remand OWCP was also to determine whether additional conditions should be accepted. The hearing representative found that Dr. McKeever was a second opinion physician with respect to whether additional conditions should be accepted. OWCP reinstated benefits retroactive to the date of termination and appellant was returned to the periodic compensation rolls.

In a May 31, 2011 report, Dr. Dan K. Eidman, an attending Board-certified orthopedic surgeon, noted the history of injury and appellant's complaints of back pain, anxiety, depression,

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<sup>8</sup> See *id.*

and poor sleep. He noted tenderness in the cervical, thoracic, and lumbar spines with positive straight leg raise testing and decreased range of motion. Dr. Eidman diagnosed thoracic disc displacement, chronic pain syndrome, depressive disorder, and sleep disturbance.

On June 7, 2011 OWCP asked its medical adviser to comment on whether the conditions of reflex spasm in the neck and shoulder girdles, bilateral brachial plexus impingement due to spasms of the shoulder girdle muscles and ligaments, reflex spasm in the back, reflex spasm in the buttocks, bilateral sciatic nerve impingement, deranged discs in the back due to continued tightness of the back, and bilateral L5 and S1 spinal nerve impingement were consequential to the October 5, 2007 employment injury.

In a June 13, 2011 report, Dr. Michael M. Katz, a Board-certified orthopedic surgeon and OWCP medical adviser, described the history of injury. He listed the accepted conditions of sprain of back, thoracic region, and displacement of thoracic intervertebral disc without myelopathy and noted his review of the medical record, including Dr. Ellis' opinion. Dr. Katz advised that the mechanism for the consequential nature for additional conditions proposed by Dr. Ellis was unlikely and implausible given the accepted conditions, and the objective evidence available in the form of EMG/NCV testing. He further indicated that reports submitted by OWCP referral physicians Dr. Freeman and Dr. Sofia M. Weigel, a Board-certified physiatrist, did not support the physical findings reported by Dr. Ellis. Dr. Katz concluded that no additional conditions should be accepted. He also opined that the question of whether appellant could perform her regular job duties should be based on the opinion of examining physicians.

On August 4, 2011 Dr. Rafi Bidros, Board-certified in general and a plastic surgery, indicated that appellant had been treated for a medically necessary procedure on July 12, 2011 which rendered her temporarily totally disabled.<sup>9</sup>

In an August 18, 2011 decision, OWCP found that appellant did not establish that the additional claimed conditions were due to the October 5, 2007 employment injury. Appellant, through counsel, timely requested a hearing.

Appellant continued pain management with Dr. Moore. Dr. Moore described complaints, provided findings, and reiterated diagnoses.

In an October 28, 2011 decision, a hearing representative set aside the August 18, 2011 OWCP decision denying appellant's claim for additional employment-related conditions. The hearing representative remanded the case to obtain an additional report from Dr. McKeever to be followed by a *de novo* decision.

In a November 14, 2011 report, Dr. Ellis noted appellant's continued complaints and described examination findings. He reiterated his conclusions regarding the additional claimed conditions, noting that appellant did not think she had any residuals from the September 2008

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<sup>9</sup> On July 11, 2011 OWCP had referred appellant to Dr. McKeever for a repeat impartial evaluation. Appellant did not keep the appointment due to the unrelated plastic surgery procedure. OWCP recommended that, because appellant's condition had changed since the last second opinion evaluation, a new second opinion evaluation was appropriate.

motor vehicle accident. Dr. Ellis concluded that she had been totally disabled due to the employment injury from September 22, 2008 until October 20, 2010. He also provided lower extremity impairment evaluations.

On November 21, 2011 Dr. Key noted appellant's complaints of mid and low back pain and depression, described physical examination findings, and diagnosed thoracic disc displacement, chronic pain syndrome, depressive disorder, and sleep disturbance. A December 7, 2011 lower extremity EMG/NCV study was unremarkable for lumbar radiculopathy and/or peripheral entrapment syndromes.

In accordance with the October 28, 2011 hearing representative decision, OWCP notified appellant in December 2011 that a conflict in medical evidence was created regarding her work capabilities and again referred her to Dr. McKeever for an impairment evaluation. Dr. McKeever was also specifically asked to address whether the following conditions were caused or aggravated by the October 5, 2007 employment injury: reflex spasm in the neck and shoulder girdles, bilateral brachial plexus impingement due to spasm of the shoulder girdle, muscles, and ligaments, reflex spasm in the back, reflex spasm in the buttocks, bilateral sciatic nerve impingement, deranged discs in the back due to continued tightness of the back, and bilateral L5 and S1 nerve root impingement.

A January 27, 2012 MRI scan of the thoracic spine demonstrated a mild disc protrusions at T2-3 and T3-4 which mildly impressed the thecal sac, a mild central disc protrusion at T7-8 which mildly impressed the thecal sac and appeared to contact the cord, and a mild circumferential disc bulge at T10-11 which mildly impressed the thecal sac.

In a treatment note dated February 1, 2012, Dr. Moore noted appellant's complaint of radiating lumbar spine pain with additional complaints of muscle pain, spasms, spasticity, stiffness, weakness, and myalgias. He described physical examination findings, noting tenderness on palpation of the spine, full upper and lower strength, and normal bilateral passive straight leg raise. Dr. Moore diagnosed unspecified myalgia and myositis, unspecified lumbosacral neuritis, pain in the thoracic spine, thoracic disc displacement, cervical disc displacement, thoracic spondylosis, and lumbar disc displacement.

On February 6, 2012 appellant was evaluated by Dr. Yusuf Mosuro, Board-certified in anesthesiology and pain medicine. He described the work injury, appellant's complaint of mid and lower back pain, and physical examination findings. Dr. Mosuro diagnosed thoracic disc displacement and chronic pain syndrome, and recommended physical therapy and medication. On March 5, 2012 he advised that, because a lumbar spine MRI scan showed an L5-S1 disc protrusion, he asked that this be accepted.

In a March 12, 2012 report, Dr. McKeever noted his review of the statement of accepted facts, the medical record including diagnostic studies, and the history of injury. He noted that examination showed complaints of pain with very light pressure over the dorsal and lumbar spine and head. Dr. McKeever again diagnosed psychophysiologic spine pain with symptom magnification. He advised that appellant had no residuals of the accepted thoracic sprain and displaced intervertebral disc. Dr. McKeever noted that, per a functional capacity evaluation

(FCE), she was limited to sedentary work and recommended work hardening. A February 9, 2012 FCE, ordered by Dr. McKeever, showed that appellant functioned in a sedentary category.

A March 13, 2012 EMG/NCV study of the lower extremities demonstrated mild chronic and ongoing bilateral L5-S1 radiculopathy with no evidence of tibial or peroneal mononeuropathies. An April 5, 2012 cervical spine MRI scan demonstrated a subtle disc bulge at C5-6.

In an April 27, 2012 decision, OWCP found that appellant had not established that reflex spasm in the neck and shoulder girdles; bilateral brachial plexus impingement due to spasms of the shoulder girdle, muscles and ligaments; reflex spasm in the back; reflex spasm in the buttocks; bilateral sciatic nerve impingement; deranged discs in the back due to continued tightness of the back; and bilateral L5 and S1 nerve root impingement were consequential to the October 5, 2007 employment injury. Appellant, through counsel, timely requested a hearing.

Subsequently submitted medical evidence included an April 12, 2012 evaluation by Dr. Key who noted the history of injury. Physical examination demonstrated tenderness to palpation of the mid and lower back, decreased sensation and strength of the lower extremities, and a positive straight leg raising test bilaterally. Dr. Key diagnosed thoracic disc displacement and chronic pain. Dr. Moore and Dr. Key continued to submit monthly pain management reports.

On July 16, 2012 Dr. Suzanne M. Manzi, a Board-certified physiatrist and associate of Dr. Moore, noted seeing appellant for pain management. Findings included lumbar and thoracic spine tenderness to palpation with painful lumbar and thoracic range of motion. Sensory examination in the arms and legs was grossly intact. Dr. Manzi diagnosed unspecified lumbosacral neuritis; lumbar disc displacement; thoracic spine pain; cervical disc displacement; thoracic spondylosis; unspecified myalgia and myositis; and thoracic disc displacement.<sup>10</sup>

A hearing was held on August 7, 2012. Counsel noted that appellant continued to receive wage-loss compensation. Appellant testified that when she stopped work in September 2008 she was not restricted to a 40-hour workweek and was not working outside her restrictions. She stated that her condition worsened causing unbearable upper and lower back pain and migraine headaches.

Appellant thereafter submitted a May 15, 2012 report in which Dr. Key noted decreased sensation in both lower extremities with a positive straight leg raising test. Dr. Key advised that, following his evaluation and examination, and as evidenced by the May 5, 2009 lumbar MRI scan and March 13, 2012 EMG/NCV, appellant's work injury was not limited to thoracic disc displacement and chronic pain. He requested that her accepted conditions be upgraded to include lumbar disc displacement. In treatment notes dated August 13 and October 8, 2012, Dr. Manzi described appellant's pain management.

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<sup>10</sup> Dr. Moore's last treatment note was dated June 15, 2012. His associate Dr. Manzi thereafter provided pain management.



By decision dated October 15, 2012, an OWCP hearing representative found, while the medical evidence submitted was insufficient to establish the additional claimed conditions, OWCP had failed to completely develop the case prior to its denial. The hearing representative remanded the case to OWCP to seek an addendum report from Dr. McKeever, to be followed by a *de novo* decision on the claimed consequential conditions. He also indicated that OWCP should consider whether the allowed conditions remained symptomatic and disabling.

Dr. Manzi continued to submit monthly treatment notes in which she described appellant's pain management. On December 3, 2012 she reported that an EMG/NCV was done that day.<sup>11</sup> In reports dated November 26, 2012 and January 14, 2013, Dr. Mosuro described physical examination findings and diagnosed sprain thoracic region, thoracic disc displacement, and chronic pain syndrome. He advised that appellant could not work, indicating that she was retired.

In December 2012 OWCP again referred appellant to Dr. McKeever. In a February 4, 2013 report, Dr. McKeever noted reviewing the medical record including diagnostic studies and the history of injury. He described findings, noting appellant's complaint of neck pain that radiated down her left arm into the finger. Dr. McKeever found full range of motion of the right arm and intermittent motion on the left, with full range of motion of the elbows, hands, and wrists, and 5/5 strength in both shoulders. He noted spine tenderness at the bra strap level and in the lower lumbar musculature. Dr. McKeever diagnosed resolved acute dorsal muscular strain; resolved acute lumbosacral strain; and psychophysiologic left-sided body pain with symptom magnification. He advised that the conditions of reflex spasm in the neck and shoulder girdles, bilateral brachial plexus impingement due to spasm of the shoulder girdle, muscles, and ligaments, reflex spasm in the back, reflex spasm in the buttocks, bilateral sciatic nerve impingement, deranged discs in the back due to continued tightness of the back, and bilateral L5 and S1 nerve root impingement were not a result of the October 5, 2007 work injury. Dr. McKeever opined that the October 5, 2007 injury caused mild dorsal and lumbar muscular strains which would be expected to resolve in six to eight weeks from the injury date. He indicated that his opinion was supported by x-ray findings, Dr. Francis' June 2008 opinion that diagnosed chronic mid-thoracic spine pain, cervical, thoracic, and lumbar spine MRI scans which were consistent with chronic, long-standing degenerative spine disease not related to the October 5, 2007 work injury, an invalid June 2009 FCE, and Dr. Barnes November 19, 2009 evaluation which showed no evidence of work-related residuals and no objective finding to explain appellant's spine, arm, or leg pain. Dr. McKeever based his opinion on his clinical assessment, examination, and record documentation.

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<sup>11</sup> A report of the study is not found in the case record.

By decision dated March 4, 2013, OWCP denied appellant's claim for additional conditions causally related to the October 5, 2007 employment injury. Appellant, through counsel, timely requested a hearing from the March 4, 2013 decision.<sup>12</sup>

In January 29 through June 17, 2013 treatment notes, Dr. Manzi described examination findings and appellant's pain management regimen. She reiterated diagnoses of unspecified lumbosacral neuritis, lumbar disc displacement, thoracic spondylosis, thoracic disc displacement, cervical disc displacement, unspecified myalgia and myositis, and additionally diagnosed pain in thoracic spine, chronic pain syndrome, unspecified brachial neuritis, skin sensation disturbance, lumbosacral disc degeneration, cervicalgia, and gait abnormality. Dr. Manzi advised that, based on her review of the history, physical examination, and relevant imaging, appellant's complaints "may be" attributed in part to the listed diagnoses. A February 25, 2013 MRI scan of the lumbar spine demonstrated disc bulges at T11-12, L3-4, L4-5, and L5-S1 which mildly impressed the thecal sac. Dr. Manzi continued submitted status reports which reiterated her findings and conclusions.

At the hearing, held on July 12, 2013, appellant testified that she was not working due to severe back and leg pain which affected her activities of daily living. She stated that she had been in an automobile accident, but could not remember when. The hearing representative requested that she submit additional medical and factual information.<sup>13</sup>

In a September 25, 2013 decision, an OWCP hearing representative vacated the March 4, 2013 decision regarding appellant's claim for additional employment-related conditions. He found that Dr. McKeever did not discuss Dr. Ellis' December 9, 2010 report. The hearing representative remanded the case to OWCP to obtain a new second opinion evaluation on the issue of whether appellant developed additional medical conditions as a consequence of the October 5, 2007 employment injury.

In October 2013 OWCP referred appellant to Dr. Robert D. Harper, a Board-certified orthopedic surgeon, for a second opinion. The statement of accepted facts listed the accepted conditions of thoracic sprain, displacement of thoracic intervertebral disc without myelopathy, and chronic pain syndrome. Dr. Harper was asked to address whether the conditions specified as consequential injuries by Dr. Ellis were related to the October 5, 2007 work injury.

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<sup>12</sup> On June 13, 2013 OWCP proposed to terminate appellant's wage loss and medical benefits. It found that the special weight of the medical opinion evidence rested with Dr. McKeever, the referee physician, who submitted July 23, 2010, March 12, 2012, and February 4, 2013 reports and advised that the accepted conditions had resolved. Appellant disagreed with the proposed termination, maintaining that the medical evidence established continuing disability. Additional medical evidence submitted included unsigned emergency department discharge instructions dated November 28, 2012 which diagnosed cervical radiculopathy. On January 29 to May 20, 2013 questionnaires completed by appellant, she described her pain.

<sup>13</sup> In a July 26, 2013 decision, OWCP terminated appellant's wage-loss and medical benefits, effective July 28, 2013. It found that the weight of the medical evidence rested with Dr. McKeever. Counsel timely requested a hearing. In a December 12, 2013 decision, a hearing representative reversed the July 26, 2013 decision. He found that it was premature to terminate benefits until active development of appellant's claim for consequential conditions had been concluded. Appellant's medical and monetary benefits were restored, retroactive to the date of termination.

In an October 24, 2013 report, Dr. Harper noted the history of injury and his review of the medical record. He related her pain complaints throughout the back, neck, left leg, left foot/toe, left knee, left hip, left arm, and left buttock along with tingling, numbness, and burning. Activities made the pain worse. Appellant ambulated into the examination room with a slow, guarded and broad-based gait. On examination, she performed heel and toe walk without difficulty. Appellant was tender to palpation along the cervical, thoracic, and lumbar spines. No muscle spasms were noted. Rib compression tests were positive for mid thoracic pain. Sitting and supine straight leg raises were positive. Additional tests in the upper and lower extremities were negative. Dr. Harper also performed extensive sensation and muscle strength testing, finding normal results in all upper and lower extremities. He diagnosed thoracic sprain/strain and thoracic disc disorder. Dr. Harper noted his review of and disagreement with Dr. Ellis December 9, 2010 report, opining that the conclusions presented by Dr. Ellis had not previously been described in medical orthopedic literature, indicating that, while on the surface the mechanism of injury described by Dr. Ellis sounded plausible, it was simply not known to happen. Dr. Harper noted that commonly, muscle spasms are the result of spinal problems, and did not produce spinal problems as posited by Dr. Ellis. He advised that he found no reflex spasms in the neck, shoulder girdles, back, or buttocks, no bilateral brachial plexus impingement or sciatic nerve impingement in his examination, and he concluded that any muscle spasms were the result of the known underlying cervical and lumbar problems seen on MRI scans. Dr. Harper concluded that, after careful review of the record, none of the conditions found by Dr. Ellis were caused by the October 5, 2007 employment injury.

Dr. Manzi continued submitting monthly status reports from January 29 to August 13, 2014. She noted findings, reiterated diagnoses, and continued advising that appellant's complaints could be attributed to her diagnoses.

In October 2014, OWCP referred appellant, along with a statement of accepted facts, the medical record, and a set of questions to Dr. James Hood, Board-certified in orthopedic surgery, for a second opinion examination. Dr. Hood was asked to review Dr. Ellis' December 9, 2010 report and opine as to whether the following were causally related to the October 5, 2007 employment injury: reflex spasm in the neck and shoulder girdles; bilateral brachial plexus impingement due to spasm of the shoulder girdle, muscles, and ligaments; reflex spasm in the back; reflex spasm in the buttocks; bilateral sciatic nerve impingement; deranged discs in the back due to continued tightness of the back; and bilateral L5 and S1 nerve root impingement.

An October 28, 2014 upper and lower extremity EMG/NCV study was interpreted as normal by Dr. Goran A. Jezic, a Board-certified physiatrist. Dr. Jezic advised that there was no electrodiagnostic evidence of acute or chronic peripheral nerve or muscle pathology affecting the upper or lower extremities, specifically noting no evidence of radiculopathy, plexopathy, or focal peripheral neuropathy affecting any extremity. A November 5, 2014 lumbar MRI scan demonstrated disc bulges at L3-4, L4-5, and L5-S1 which mildly impressed the thecal sac with mild foraminal narrowing.

Dr. Hood provided an October 21, 2014 report in which he described the history of injury, reviewed the medical record including Dr. Ellis' December 9, 2010 report, and noted appellant's complaints. He related that appellant had been examined by numerous physicians and that, over the span of seven years, not one physician had noted any significant pathology that

would require any additional treatment and all indicated that as a result of the work event she had a thoracic sprain that in reasonable medical probability had resolved. Dr. Hood described findings from his October 21, 2014 examination, noting no palpable cervical spasm, no trigger points in the trapezial or rhomboid region, and normal arm reflexes and muscle strength bilaterally including deltoid, triceps, biceps, wrist extensors, thenar muscles and intrinsics. Lumbar examination demonstrated no palpable muscle spasm, no scoliosis, and normal lumbar lordosis but with limited range of motion. Lower extremity strength was normal in the hip flexors, quadriceps, hamstrings, and extensor hallucis longus with normal reflexes and no scapular winging. Dr. Hood noted the findings of the October 28, 2014 EMG/NCV examination. He opined that appellant's case should have been closed years earlier and, with regard to the October 5, 2007 injury, she could return to full duty without restrictions.

On February 22, 2015 OWCP forwarded Dr. Hood's report and the October 28, 2014 EMG/NCV study to Dr. Manzi for comment. In an April 1, 2015 treatment note, Dr. Manzi related appellant's complaint of worsening back pain. Physical examination demonstrated an antalgic gait and back pain with range of motion. Dr. Manzi diagnosed pain in the thoracic spine, unspecified myalgia and myositis, thoracic disc displacement, thoracic spondylosis, and chronic pain syndrome. She advised that, "based on careful review of the history, physical examination, and relevant imaging, I believe [appellant's] complaints may be attributed in part to the above listed diagnoses."

By decision dated April 27, 2015, OWCP denied appellant's claim for additional conditions due to the October 5, 2007 employment injury. Appellant, through counsel, timely requested a hearing.

Dr. Manzi continued to submit monthly pain management reports in which she reiterated her findings and conclusions.<sup>14</sup>

A hearing was held on December 16, 2015 regarding whether appellant had established consequential conditions. Counsel argued that the April 27, 2015 decision denying consequential conditions was premature, maintaining that it should have been held in abeyance until the issue of termination of accepted conditions was resolved. He suggested that the issues be combined with one referral physician rendering an opinion.

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<sup>14</sup> OWCP also continued to develop the issue of whether the accepted thoracic sprain, displacement of thoracic intervertebral disc without myelopathy, and chronic pain syndrome had resolved. It found that a conflict in medical evidence was created between Drs. Hood and Manzi regarding appellant's condition, work status, and treatment options related to the October 5, 2007 work injury. In June 2015, OWCP referred appellant to Dr. Larry L. Likover, a Board-certified orthopedic surgeon, for an impartial evaluation on the issue of whether the accepted conditions had resolved. In a June 25, 2015 report, Dr. Likover noted his review of the record and described examination findings. He reported that appellant was a very healthy-appearing 41-year-old female and opined that her case had been mismanaged from the very beginning. Dr. Likover advised that he was unable to identify any significant injury due to the October 5, 2007 work injury, opining that there was no justification for her to be managed and continue taking addictive narcotics. He found no sign of a surgical problem or evidence of permanent impairment. Dr. Likover concurred with Dr. Hood's assessment that appellant's work related conditions have resolved and that she required no further treatment, no further medication, and was capable of returning to work without restrictions. On November 17, 2015 OWCP proposed to terminate appellant's wage-loss and medical benefits, based on the opinion of Dr. Likover. Appellant disagreed with the proposed termination and continued to assert that she had additional injuries.

By decision dated December 22, 2015, OWCP terminated appellant's wage-loss compensation and medical benefits. It found that the weight of the medical evidence rested with the opinion of Dr. Likover who performed the impartial medical evaluation. Appellant, through counsel, timely requested a hearing from the December 22, 2015 termination decision.

A pain management treatment note from Dr. Manzi, dated November 3, 2015, was submitted on January 11, 2016 in which she reiterated her findings and conclusions.

By decision dated February 12, 2016, an OWCP hearing representative affirmed the April 27, 2015 decision regarding consequential conditions. She noted that OWCP had repeatedly addressed whether the conditions of reflex spasm of the neck and shoulder girdles, bilateral brachial plexus impingement, reflex spasm in the back, shoulder girdles, and buttocks, bilateral sciatic nerve impingement, deranged disc in the back, and bilateral L5-S1 impingement were consequential to the October 5, 2007 work injury. The hearing representative noted that only Dr. Ellis supported the relationship while OWCP's referral physicians did not support the relationship. She concluded that appellant did not meet her burden of proof to establish additional conditions causally related to the October 5, 2007 work injury.

### **LEGAL PRECEDENT**

In discussing the range of compensable consequences, once the primary injury is causally connected with the employment, 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 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.<sup>15</sup>

A claimant bears the burden of proof to establish a claim for a consequential injury. 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. 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.<sup>16</sup>

Causal relationship is a medical issue, and the medical evidence required to establish a causal relationship is rationalized medical evidence.<sup>17</sup> The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by

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<sup>15</sup> Lex K. Larson, *The Law of Workers' Compensation* § 3.05 (2014); see *Charles W. Downey*, 54 ECAB 421 (2003).

<sup>16</sup> *Charles W. Downey, id.*

<sup>17</sup> *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

the employee.<sup>18</sup> Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.<sup>19</sup>

### ANALYSIS

OWCP accepted that appellant sprained her back, thoracic region, on October 5, 2007 when she was pulling a table of mail. It later expanded the acceptance of the claim to include displacement of thoracic intervertebral disc without myelopathy and chronic pain syndrome. Dr. Ellis, an attending physician, opined that additional conditions of reflex spasm in the neck and shoulder girdles; bilateral brachial plexus impingement due to spasms of the shoulder girdle muscles; reflex spasm in the back and buttocks; bilateral sciatic nerve impingement; deranged discs in the back due to continued tightness of the back; and bilateral L5 and S1 spinal nerve impingement should be accepted. On February 12, 2016 an OWCP hearing representative affirmed an April 27, 2015 OWCP decision denying the claim for additional or consequential conditions. The Board finds that the record does not support that additional conditions should be accepted.

In April 26 and December 9, 2010, and November 14, 2011 reports, Dr. Ellis opined that the October 5, 2007 work injury caused consequential injuries. He noted the history of injury and also that appellant had been in motor vehicle accidents in 2005 and 2008. Dr. Ellis described current complaints and indicated that appellant's conditions worsened over time such that she was permanently and totally disabled. He maintained that appellant had an acute injury to the T8-9 thoracic disc on October 5, 2007, and this caused the paraspinous muscles in the thoracic and neck areas to become very tight which caused brachial plexus impingement due to the tight muscles in the thoracic, cervical, and shoulder girdle area; that continued pain in the spinal nerves caused the lower back to stay in spasm which caused tightness in the iliolumbar and sacroiliac ligaments, and in the buttocks muscles, and this led to bilateral sciatic nerve impingement. Dr. Ellis maintained that the continued tightness in her back caused increased pressure on the lumbar discs which caused the discs to impinge upon the bilateral L5 and S1 spinal nerve roots leading to impairment of the L5 and S1 spinal nerve roots bilaterally.

Dr. Ellis first saw appellant on April 26, 2010, two and a half years after the October 5, 2007 work injury. He did not discuss the impact of the 2008 motor vehicle accident that occurred shortly before appellant stopped work in September 2008 other than to say that appellant did not think she had any residuals of this accident. The record before the Board contains scant medical evidence regarding this accident, merely a brief note by Dr. Watkins dated September 22, 2008, the day before appellant stopped work. He noted that appellant had been in a motor vehicle accident and diagnosed upper and lower back pain, headaches, chest pain, cervical pain, and left shoulder pain.

The Board finds that Dr. Ellis' explanation of the mechanics of why the additional conditions should be accepted has insufficient rationale to meet appellant's burden of proof. He

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<sup>18</sup> *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

<sup>19</sup> *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

did not discuss the impact of disc protrusions found on a May 5, 2009 MRI scan of cervical spine, MRI scan findings of the lumbar spine demonstrating a mild disc protrusion at L4-5 and a mild disc bulge at L5-S1, or the December 7, 2011 lower extremity EMG/NCV that did not demonstrate lumbar radiculopathy and/or peripheral entrapment syndromes. While Dr. Ellis provided some explanation of why he believed the accepted thoracic conditions caused additional conditions, he exhibited limited knowledge of appellant's condition prior to the October 5, 2007 injury and did not explain with sufficient rationale how this work incident caused or aggravated additional conditions. As his reports did not contain sufficient rationale on causal relationship, they are of diminished probative value and are insufficient to meet appellant's burden of proof to establish additional conditions due to October 5, 2007 employment injury.<sup>20</sup>

Dr. Mosuro, a pain management specialist, treated appellant from February 6, 2012 to January 14, 2013. He advised on March 12, 2012 that, because a lumbar spine MRI scan demonstrated a disc protrusion at L5-S1 and he would ask that this be accepted. Similarly, on May 15, 2012, Dr. Key advised that, following his evaluation and examination, and as evidenced by the May 5, 2009 lumbar MRI scan and March 13, 2012 EMG/NCV, appellant's work injury was not limited to thoracic disc displacement and chronic pain. He requested that her accepted conditions include lumbar disc displacement. Neither Dr. Mosuro nor Dr. Key, however, provided an explanation of how the October 5, 2007 work injury caused the subsequent findings on the diagnostic studies. A physician's opinion on causal relationship between a claimant's disability and an employment injury is not conclusive simply because it is rendered by a physician. To be of probative value, the physician must provide rationale for the opinion reached. Where, as here, no such rationale is present, the medical opinion is of diminished probative value.<sup>21</sup>

Dr. Manzi began pain management in July 2012 and also diagnosed additional conditions of unspecified lumbosacral neuritis, lumbar and cervical disc displacement, unspecified myalgia and myositis, unspecified brachial neuritis, skin sensation disturbance, lumbosacral disc degeneration, cervicgia, and abnormality of gait. While she advised that based on her review of the history, physical examination, and relevant imaging, appellant's complaints "may be" attributed in part to her listed diagnoses, which included the accepted condition, she failed to explain how the October 5, 2007 employment injury caused the additional diagnoses. Moreover, the equivocal aspect of her opinion diminishes its probative value.<sup>22</sup>

Other medical evidence provided by appellant did not specifically address whether any additional diagnosed medical conditions were causally related to the October 5, 2007 work injury. Thus, this evidence is of limited probative value on the issue of causal relationship.<sup>23</sup> For example, reports from Dr. Athari, Dr. Moore, and Dr. Eidman did not specifically address how any additional conditions were causally related to the accepted work injury.

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<sup>20</sup> See *D.U.*, Docket No. 10-144 (issued July 27, 2010).

<sup>21</sup> *T.M.*, Docket No. 08-975 (issued February 6, 2009).

<sup>22</sup> See *D.D.*, 57 ECAB 734 (2006).

<sup>23</sup> *Willie M. Miller*, 53 ECAB 697 (2002).

Furthermore, the record contains reports from several OWCP physicians which do not support that any additional conditions were casually related to the October 5, 2007 work injury. Dr. Barnes, who provided an impartial medical evaluation regarding appellant's ability to work, opined on April 5, 2010 that appellant exhibited symptom magnification. On June 13, 2011 Dr. Katz, an OWCP medical adviser, opined that the mechanism for the consequential nature for additional conditions proposed by Dr. Ellis was unlikely and implausible given the accepted conditions and the objective evidence from diagnostic studies. OWCP's medical adviser referenced reports from other examining physicians that did not support the physical findings reported by Dr. Ellis.

In a February 4, 2013 report Dr. McKeever, an independent medical examining physician, described physical examination findings and diagnosed resolved acute dorsal muscular strain; resolved acute lumbosacral strain; and left-sided psychophysiological body pain with symptom magnification. Dr. McKeever specifically advised that the conditions of reflex spasm in the neck and shoulder girdles, bilateral brachial plexus impingement due to spasm of the shoulder girdle, muscles, and ligaments, reflex spasm in the back, reflex spasm in the buttocks, bilateral sciatic nerve impingement, deranged discs in the back due to continued tightness of the back, and bilateral L5 and S1 nerve root impingement were not due to the October 5, 2007 work injury. He opined that the October 5, 2007 injury caused mild dorsal and lumbar muscular strains which would have resolved within six to eight weeks after the injury. Dr. McKeever indicated that his opinion was supported by reports in the record as well as x-ray and MRI scan findings which were consistent with chronic, long-standing degenerative spine disease not related to the October 5, 2007 work injury.

In an October 24, 2013 report, Dr. Harper, an OWCP referral physician, reviewed the record, described examination findings and diagnosed thoracic sprain/strain and thoracic disc disorder. He disagreed with Dr. Ellis' December 9, 2010 report, opining that the conclusions presented by Dr. Ellis had not previously been described in medical orthopedic literature. Dr. Harper indicated that, while on the surface the mechanism of injury described by Dr. Ellis sounded plausible, it was simply not known to happen. He maintained that muscle spasms were commonly the result of spinal problems, but would not produce the spinal problems noted by Dr. Ellis. Dr. Harper advised that on examination, he found no reflex spasms in appellant's neck, shoulder girdles, back, or buttocks, and no bilateral brachial plexus impingement or sciatic nerve impingement. He concluded that any muscle spasms were the result of the known underlying cervical and lumbar problems seen on MRI scans. As such, none of the consequential conditions found by Dr. Ellis were due to the October 5, 2007 work injury.

Dr. Hood, also an OWCP referral physician, provided an October 21, 2014 report in which he related appellant's examination by numerous physicians had not indicated any significant pathology that would require any additional treatment. He described essentially normal examination findings and concluded that appellant's case should have been closed years earlier. Likewise, on June 25, 2015, Dr. Likover who examined appellant with regard to whether the accepted conditions had resolved, found no basis on which to attribute any continuing condition or impairment to the October 5, 2007 employment injury.



The Board finds that appellant has submitted insufficient rationalized medical evidence supporting causal relationship between any of the claimed additional conditions and the October 5, 2007 employment injury.

Appellant may submit new evidence or argument with a 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 did not meet her burden of proof to establish that she sustained bilateral brachial plexus impingement; reflex spasm in the neck, back, shoulder girdles, and buttocks, bilateral sciatic nerve impingement, deranged disc in the back, and bilateral L5-S1 impingement causally related to the October 5, 2007 employment injury.

**ORDER**

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated February 12, 2016 is affirmed.

Issued: May 3, 2017  
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge  
Employees' Compensation Appeals Board