United States Department of Labor
Employees' Compensation Appeals Board

W.H., Appellant	)	
and	)	**Docket No. 09-1389**
	)	**Issued: March 16, 2010**
DEPARTMENT OF THE ARMY, ANNISTON ARMY DEPOT, Anniston, AL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before**:**
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 5, 2009 appellant filed a timely appeal from the June 13, 2008 and January 8, 2009 merit decisions of the Office of Workers' Compensation Programs, denying his recurrence claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this appeal.

ISSUE

The issue is whether appellant met his burden of proof to establish that he sustained a recurrence of his medical condition on or subsequent to April 10, 2008 that was causally related to his accepted injury.

FACTUAL HISTORY

On July 30, 2007 appellant, a 54-year-old firefighter, filed a traumatic injury claim alleging that he strained his upper back and experienced pain in his right shoulder blade, down his upper spine on July 28, 2007, while lifting a 100-pound block. He did not stop working. Appellant's claim was administratively accepted but not fully developed by the Office.

Appellant was treated by Dr. David E. Wade, a chiropractor. The record contains Dr. Wade's physician's notes and appointment slips for the period August 2 through January 3, 2008. On September 4, 2007 appellant was released to return to work with no restrictions. On August 21, 2007 Dr. Wade noted right shoulder pain to the mid back when lifting.

The record contains an October 5, 2007 clinic pass, which reflected that appellant was treated for back pain related to a work injury that occurred on that date.

Appellant submitted a November 21, 2007 report from Dr. Thomas A.S. Wilson, Jr., a Board-certified neurological surgeon, who stated that appellant had sustained a series of injuries to his thoracic and lumbar spine over the previous 18 months. Noting that his original injury occurred on July 7, 2007, Dr. Wilson indicated that appellant had experienced an acute "tearing" of his mid back on October 16, 2007 while picking up a 100-pound basket. Dr. Wilson reported the results of a magnetic resonance imaging (MRI) scan performed prior to appellant's "most recent injury." The MRI scan revealed disc protrusion at T11-12; degenerative changes at L5, with questionable slight listhesis at L4/5 and evidence of rotary scoliosis.

Appellant submitted a January 3, 2008 report from Dr. Pete McManus, a chiropractor, reflecting the results of computerized mechanical isometric muscle testing with torque curves. Testing included arm, floor and leg lifts, representing critical job tasks. Based upon the results of the testing, Dr. McManus recommended that appellant be limited to lifting 20 pounds occasionally and 5 pounds continuously and that he be permitted to alternate between sitting and standing. The record contains a February 26, 2008 report of a computerized tomography scan of the thoracic spine reflecting a T11-12 left-sided disc bulge into the foramen.

On March 5, 2008 Dr. Wilson discussed the results of appellant's thoracic study, which revealed diffuse degenerative changes, but no significant disc herniation or nerve root encroachment. He stated that he did not see anything further that could be done for appellant's thoracic disease, "as it represente[d] a strain in the setting of diffuse degenerative arthritis." Dr. Wilson recommended trying some facet joint blocks with respect to appellant's lumbar disease.

On April 28, 2008 appellant submitted a notice of recurrence (Form CA-2a) as of April 10, 2008 requesting medical treatment only. He stated that he had never completely recovered from his original July 28, 2007 injury and that his current symptoms were identical to those he experienced at that time.

In a statement dated April 10, 2008, appellant indicated that he had been experiencing pain in his neck, back and shoulder on April 9, 2008. While working with his hands and arms on April 10, 2008, he felt a sharp pain, starting at the base of his neck, going up behind his head and down to the right shoulder. Appellant stated that his mid back continued to hurt and throb. In an undated statement, he indicated that working in an uncomfortable chair for 10 to 12 hours per day, six days per week, aggravated his back condition.

In addition to previously submitted medical notes, appellant submitted notes dated July 30, 2007 from Dr. Wade, who stated that appellant had sustained an injury at work on

July 28, 2007 while lifting boxes in an awkward position. Dr. Wade noted that appellant had shoulder and mid-back pain, as well as decreased range of motion. He diagnosed cervical strain.

In an April 22, 2008 report, Dr. Wade indicated that appellant wanted to reopen his claim to have his back "looked at." Appellant reported right-sided pain, tingling and numbness. Dr. Wade reported decreased range of motion in the right shoulder, neck and upper back. In a separate report of the same date, he provided a history of injury, stating that appellant felt a strain in his right shoulder, mid back and neck on July 28, 2007 while lifting an object at work. Dr. Wade indicated that appellant's neck, shoulder and arm pain had progressively increased since the July 28, 2007 incident. On examination, he found "spasm from segmental fraction (motion asymmetry), palpable tenderness along the right cervical thoracic region." Dr. Wade diagnosed cervical subluxation, mechanical and right shoulder spasm, indicating by placing a checkmark in the "yes" box that the diagnosed condition was caused by employment activity. He noted a disc herniation a T12, diagnosed by MRI scan, which had occurred at work in May 2006. Dr. Wade stated that he had released appellant from treatment related to his original July 28, 2007 injury on November 28, 2007. On the date of examination, he was experiencing pain, which was exacerbated by shoulder and arm movements.

The record contains a report of a July 30, 2007 radiograph of the cervical spine reflecting rotational malposition and an August 21, 2007 electromyogram report.

In a letter dated May 7, 2008, the Office informed appellant that the evidence submitted was insufficient to establish that he had experienced a traumatic injury on July 28, 2007 and that even if the Office accepted that he experienced a compensable injury, the evidence was insufficient to establish that his current condition was causally related to that injury. It advised him to submit a physician's narrative report with a diagnosis, test results and a rationalized opinion explaining how his current condition was related to the July 28, 2007 incident.[1] Appellant was specifically asked whether he had sustained any intervening injuries to his mid back since July 28, 2007; whether he sustained a new back injury on October 16, 2007 and why he was seen in the base clinic on January 3, 2008.

In an undated statement, appellant indicated that he had no intervening injuries since July 28, 2007; that no medical physician had told him that the October 16, 2007 injury was related to his current condition; that he was unaware of any injury or new claim on January 3, 2008 and that he was enduring the same symptoms he experienced following the July 28, 2007 injury.

By decision dated June 13, 2008, the Office denied appellant's claim on the grounds that the medical evidence was insufficient to show that his claimed medical condition was due to the established work-related event. It stated that the medical evidence did not contain an x-ray with a diagnosed spinal subluxation.

[1] The Office informed appellant that, at the time his initial claim was received, it appeared to be a minor injury, with no time lost and, therefore, payment of a minimal amount of medical expenses was approved. Since a recurrence claim had been submitted, the Office planned to develop the claim to determine whether appellant had experienced a work-related injury on July 28, 2007.

The record contains a January 3, 2008 clinic pass reflecting that appellant was seen in the clinic for back pain due to a job-related injury, which allegedly occurred on that date. The record also contains appointment slips from Dr. Wade from September 17 through December 18, 2007 and chiropractic notes from May 17, 2004 through April 21, 2008.

In a May 13, 2008 report, Dr. Wade provided a history of appellant's back condition, stating that he had experienced continuing back pain since May 19, 2006 "while swinging a hammer and causing a strain injury while at work." In November 2006, appellant reinjured his back while straining to rise from a low chair, resulting in radiating symptoms into the groin, with anterior thigh pain. He injured his upper back, neck on the job on July 27, 2007, causing vertebral subluxation. An October 4, 2007 MRI scan revealed a small herniation at T12, which Dr. Wade opined was due to the May 19, 2006 injury. He opined that appellant's symptoms of stiffness and various pains related to the T11-12 disc region and the original injury and were complicated by the progressive, degenerative condition of his spine. On April 22, 2008 appellant reported that he sustained an aggravation of his upper back subluxation injury while bending over at his workstation. Dr. Wade opined that the degenerative nature of appellant's spine, coupled with the disc damage from the May 19, 2006 injury, caused antalgic changes in motion and progressive stiffness, with resulting further decreases in motion.

On July 11, 2008 appellant requested an oral hearing, which was later converted to a review of the written record.

Appellant submitted a September 30, 2008 report from Dr. Tamara Ann McIntosh, a Board-certified family practitioner, who noted that she had been appellant's primary care physician since September 2002. Dr. McIntosh related the history of injury, as reported by appellant. On May 18, 2006 appellant felt a sudden sharp pain in his mid back while swinging a sledgehammer at work. On November 16, 2006 he experienced a sudden pain in his low back when he strained to get out of a chair. A myelogram of the thoracic spine dated February 26, 2008 showed a T11-12 left-sided disc bulge into the foramen and multiple level osteophytes. An October 4, 2007 MRI scan revealed moderate to severe facet degenerative changes and mild degenerative bulging discs in his lumbar spine. Dr. McIntosh opined that the May 16 and November 16, 2006 injuries directly caused the T11-12 disc herniation and exacerbation of degenerative disc disease in both the thoracic and lumbar spine. Due to appellant's current condition, he would be unable to perform the duties of his position. Dr. McIntosh noted that appellant had never complained to her about his back until well after the injury and she had no notations of back pain in her records until October 9, 2007, when she received copies of lumbar and thoracic spine MRI scan performed by his chiropractor.

On October 31, 2008 Dr. McIntosh reported that in July 2007 appellant injured his upper back, neck and shoulder while picking up a heavy breechblock, noting that he was standing in an awkward position when trying to move it. Later, when he went home, he had pain in his neck and shoulders over the next several days. Dr. McIntosh stated that, according to his neurosurgeon, Dr. Wilson, appellant had diffuse degenerative arthritis in his neck, which was "likely aggravated by the injury noted above." She indicated that he also had work-related injuries and pain due to a T11-12 disc herniation, with exacerbation of degenerative disc disease in both the thoracic and lumbar spine.

In an October 27, 2008 report, Dr. Wilson stated that appellant was experiencing neck and back pain due to a July 2007 work injury. He noted that a cervical MRI scan revealed diffuse degenerative arthritis, but no significant disc herniation or spinal cord depression. A thoracic study demonstrated similar diffuse nonsurgical degenerative changes.

By decision dated January 8, 2009, an Office hearing representative affirmed in part and reversed in part, the Office's June 13, 2008 decision. The representative found that the medical evidence established that appellant had sustained a traumatic injury in the performance of duty and that his claim should be accepted for cervical subluxation, resolved no later than November 28, 2007, when he was discharged by Dr. Wade. The hearing representative denied appellant's recurrence claim, on the grounds that the evidence failed to establish that his ongoing spine condition was causally related to the accepted incident.

LEGAL PRECEDENT

Appellant has the burden of establishing that he sustained a recurrence of a medical condition[2] that is causally related to his accepted employment injury. To meet his burden, he must furnish 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 supports that conclusion with sound medical rationale.[3] Where no such rationale is present, the medical evidence is of diminished probative value.[4]

Office regulations define a recurrence of medical condition as the documented need for further medical treatment after release from treatment of the accepted condition when there is no work stoppage. Continued treatment for the original condition is not considered a renewed need for medical care, nor is examination without treatment.[5]

The Office's procedure manual provides that, after 90 days of release from medical care (based on the physician's statement or instruction to return PRN (as needed) or computed by the claims examiner from the date of last examination), a claimant is responsible for submitting an attending physician's report which contains a description of the objective findings and supports causal relationship between the claimant's current condition and the previously accepted work injury.[6]

[2] "Recurrence of medical condition" means a documented need for further medical treatment after release from treatment for the accepted condition or injury when there is no accompanying work stoppage. Continuous treatment for the original condition or injury is not considered a need for further medical treatment after release from treatment, nor is an examination without treatment. 20 C.F.R. § 10.5(y) (2002).

[3] *Ronald A. Eldridge*, 53 ECAB 218 (2001).

[4] *Mary A. Ceglia*, 55 ECAB 626 (2004); *Albert C. Brown*, 52 ECAB 152 (2000).

[5] 20 C.F.R. § 10.5(y).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Recurrences*, Chapter 2.1500.5(b) (September 2003).

ANALYSIS

Appellant has not met his burden of proof to establish that he sustained a recurrence of a medical condition on or subsequent to April 10, 2008. The Office hearing representative directed the Office to accept appellant's July 30, 2007 traumatic injury claim for cervical subluxation, which it determined had resolved by November 28, 2007. Appellant has alleged that, on April 10, 2008, he felt a sharp pain, starting at the base of his neck, going up behind his head and down to the right shoulder. He asserted that he never completely recovered from his original July 28, 2007 injury and that his current symptoms were identical to those he experienced at that time. However, appellant has failed to produce any rationalized medical opinion evidence establishing that he required further medical treatment for a continuing employment-related condition.

The record reflects that Dr. Wade discharged appellant from treatment related to his original July 28, 2007 injury on November 28, 2007. There is no evidence of record that appellant was treated for the accepted cervical subluxation after November 28, 2007. Although appellant was treated for other diagnosed neck, shoulder and spinal conditions subsequent to his discharge by Dr. Wade, he has failed to establish that these conditions were causally related to the July 28, 2007 incident.[7] He had the burden of submitting sufficient medical evidence to document the need for further medical treatment.[8] Appellant did not submit the evidence required and thus failed to establish a need for continuing medical treatment.[9]

Dr. Wade's reports do not establish that appellant's current spinal and shoulder conditions were causally related to the accepted employment injury. On April 22, 2008 he reported decreased range of motion in the right shoulder, neck and upper back. Dr. Wade provided a history of injury, stating that appellant felt a strain in his right shoulder, mid back and neck on July 28, 2007 while lifting an object at work. On examination, he found "spasm from segmental fraction (motion asymmetry), palpable tenderness along the right cervical thoracic region." Dr. Wade diagnosed cervical subluxation, mechanical and right shoulder spasm and noted a disc herniation at T12, diagnosed by MRI scan, which had occurred at work in May 2006. He stated that he had released appellant from treatment related to her original July 28, 2007 injury on November 28, 2007. On the date of Dr. Wade's examination, appellant was experiencing pain, which Dr. Wade stated was exacerbated by shoulder and arm movements. He indicated by placing a checkmark in the "yes" box that the diagnosed condition was caused by employment activity. The Board has found that a report that addresses causal relationship with a checkmark, without a medical rationale, is of diminished probative value and is insufficient to establish causal relationship.[10] Dr. Wade did not explain how or why appellant would be experiencing pain and spasms related to his July 28, 2007 injury, particularly, since he had been discharged from treatment four months earlier. Moreover, it is unclear whether Dr. Wade's diagnosis of cervical subluxation was current or whether it referred to the original

[7] *Id*.

[8] *Supra* note 5.

[9] *See J.F.*, 58 ECAB 124 (2006).

[10] *See Calvin E. King, Jr.*, 51 ECAB 394 (2000); *see also Frederick E. Howard, Jr.*, 41 ECAB 843 (1990).

diagnosis, prior to his discharge. The Board notes that the term "physician" under the Federal Employees' Compensation Act includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.[11] Although the Office correctly accepted Dr. Wade as a "physician" under the Act for the purpose of diagnosing and treating a subluxation, his opinion regarding the diagnosis or cause of any other conditions is of limited probative value.

On May 13, 2008 Dr. Wade stated that appellant had experienced continuing back pain since May 19, 2006 while swinging a hammer and causing a herniated disc. He noted that appellant had reinjured his back in November 2006 and July 27, 2007, causing vertebral subluxation. Dr. Wade opined that the degenerative nature of appellant's spine, coupled with the disc damage from the May 19, 2006 injury, caused antalgic changes in motion and progressive stiffness, with resulting further decreases in motion. As he did not relate appellant's current condition to the July 28, 2007 injury or the accepted cervical subluxation, his report does not support appellant's claim.

Dr. Wilson's reports are insufficient to establish a causal relationship between the accepted injury and appellant's current condition. On November 21, 2007 he stated that appellant had sustained a series of injuries to his thoracic and lumbar spine over the previous 18 months. Noting that appellant's original injury occurred on July 7, 2007, Dr. Wilson indicated that appellant had experienced an acute "tearing" of his mid back on October 16, 2007 while picking up a 100-pound basket. Dr. Wilson reported that an MRI scan revealed disc protrusion at T11-12; degenerative changes at L5, with questionable slight listhesis at L4/5 and evidence of rotary scoliosis. On March 5, 2008 he discussed the results of appellant's thoracic study, which revealed diffuse degenerative changes, but no significant disc herniation or nerve root encroachment. Dr. Wilson stated that he did not see anything further that could be done for appellant's thoracic disease, "as it represente[d] a strain in the setting of diffuse degenerative arthritis." As neither report contains an opinion as to the cause of appellant's condition, they are of limited probative value.[12] On October 27, 2008 Dr. Wilson stated that appellant was experiencing neck and back pain due to a July 2007 work injury. He noted that a cervical MRI scan revealed diffuse degenerative arthritis, but no significant disc herniation or spinal cord depression. A thoracic study demonstrated similar diffuse nonsurgical degenerative changes. Although Dr. Wilson stated that appellant's neck and back pain was due to "a July 2007 work injury," he did not provide a history of injury or explain how the accepted incident could be responsible for his current condition. Moreover, he did not offer a diagnosis, which he

[11] A medical report may not be considered as probative medical evidence if there is no indication that the person completing the report qualifies as a physician under section 8101(2) of the Act, which provides: "(2) 'physician' includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. The term 'physician' includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist and subject to regulation by the secretary." *See Merton J. Sills*, 39 ECAB 572 (1988).

[12] The Board has long held that medical evidence which does not offer an opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship. *A.D.*, 58 ECAB 149 (2006); *Michael E. Smith*, 50 ECAB 313 (1999).

definitively relates to the accepted injury, rather than to a previous or intervening injury.[13] Accordingly, Dr. Wilson's reports are of diminished probative value.

Dr. McManus' reports lack probative value on several counts. Neither report contains examination findings; nor is there any indication that he ever examined appellant's neck or spine. In fact, he acknowledged that he was unaware of his back condition until October 9, 2007, when she received copies of lumbar and thoracic spine MRI scans. Dr. McManus' opinion that appellant's degenerative arthritis was "likely aggravated" by the July 2007 injury is speculative at best and is unsupported by rationalized medical evidence explaining the nature of the relationship between appellant's spine and shoulder conditions and the accepted injury.[14]

The remaining medical of evidence, which includes reports of MRI scans, x-rays and other reports, which do not contain an opinion as to the cause of appellant's condition, are of diminished probative value and are insufficient to establish his claim.[15]

On appeal, appellant contends that the Office confused the issues and medical evidence to the point that it lost track of his injuries. The Board finds his contentions to be unsubstantiated and, for the reasons stated, affirms the Office's January 8, 2009 decision.

The Board finds that the evidence submitted was insufficient to establish that appellant sustained a recurrence of a medical condition, as it failed to establish that his current spine and shoulder conditions were causally related to the accepted July 28, 2007 incident.[16]

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he sustained a recurrence of a medical condition that was causally related to his accepted injury.

[13] The Board notes that the record is replete with evidence that appellant sustained intervening injuries between July 28, 2007 and April 10, 2008, any of which might be responsible for his current condition. For example, an October 5, 2007 clinic pass reflects that appellant was treated for back pain related to a work injury that occurred on that date. A January 3, 2008 clinic pass reflects that he was seen in the clinic for back pain due to a job-related injury, which allegedly occurred on that date. In his own statement, appellant indicated that, while working with his hands and arms on April 10, 2008, he felt a sharp pain, starting at the base of his neck, going up behind his head and down to the right shoulder. Dr. Wilson stated that appellant had experienced an acute "tearing" of his mid back on October 16, 2007 while picking up a 100-pound basket.

[14] While the medical opinion of a physician supporting causal relationship does not have to reduce the cause or etiology of a disease or condition to an absolute certainty, neither can such opinion be speculative or equivocal. The opinion of a physician supporting causal relationship must be one of reasonable medical certainty that the condition for which compensation is claimed is causally related to federal employment and such relationship must be supported with affirmative evidence, explained by medical rationale and be based upon a complete and accurate medical and factual background of the claimant. *See Thomas A. Faber*, 50 ECAB 566 (1999); *Samuel Senkow*, 50 ECAB 370 (1999).

[15] *See Mary E. Marshall*, 56 ECAB 420 (2005).

[16] The Board notes that the Office hearing representative addressed the issue of a recurrence of disability, rather than a recurrence of a medical condition. However, appellant's CA-2a form clearly states that he was seeking medical treatment only.

ORDER

IT IS HEREBY ORDERED THAT the January 8, 2009 and June 13, 2008 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: March 16, 2010
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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