United States Department of Labor
Employees' Compensation Appeals Board

D.B., Appellant	)	
and	)	**Docket No. 17-0214**
	)	**Issued: August 3, 2017**
U.S. POSTAL SERVICE, MICHIGAN METROPLEX PROCESSING & DELIVERY CENTER, Pontiac, MI, 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 November 4, 2016 appellant filed a timely appeal from a May 13, 2016 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 this case.

ISSUES

The issues are: (1) whether appellant met his burden of proof to establish a recurrence of disability on November 7, 2014; and (2) whether appellant met his burden of proof to expand acceptance of his claim to include a herniated disc at C6-7 with radiculopathy.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On March 11, 2014 appellant, then a 47-year-old mail processing clerk, filed a traumatic injury claim (Form CA-1) alleging that he sustained injury to his right shoulder while pushing a bulk mail carrier on that date. Appellant continued to work with restrictions of no pushing or pulling over five pounds and no reaching above his shoulders. However, on June 18, 2014 appellant stopped work as there was no work available within his restrictions. OWCP accepted appellant's claim for disorder of bursae and tendons in right shoulder region; sprain of neck; sprain of shoulder, upper arm, and right rotator cuff; and sprain of shoulder and upper arm, right supraspinatus.

OWCP subsequently referred appellant to Dr. Emmanuel N. Obianwu, a Board-certified orthopedic surgeon, for a second opinion as to appellant's disability status. In a report dated August 29, 2014, Dr. Obianwu listed appellant's diagnoses as resolved right shoulder strain and sprain; mild impingement, right shoulder, with rotator cuff tendinitis; temporary aggravation of cervical spondylosis; and rule out C7 cervical radiculopathy. He opined that all of the accepted conditions had fully resolved, noting that appellant no longer had a sprain of the right shoulder and upper arm, and that the sprain of the rotator cuff and supraspinatus had improved. However, Dr. Obianwu noted that the accepted findings did not take into consideration that appellant had a temporary aggravation of his cervical spondylosis. He noted that shortly after the March 11, 2014 incident appellant had presented to Concentra Clinic and that his clinical presentation at that time suggested that the main pathology was cervical spondylosis. Dr. Obianwu noted that appellant's symptoms persisted for five months after the injury date because that particular condition had not been addressed. He did not believe that the severe pathology seen at C6-7 was wholly related to the employment incident, noting that a 2009 magnetic resonance imaging (MRI) scan revealed similar changes in appellant's cervical spine. Dr. Obianwu noted that it had been five years since the original pathology was identified and that further progression of these degenerative changes would have been expected. He concluded that the onset of symptoms with specific activity suggested a relationship of current symptoms with that activity and that the diagnosis would be a temporary aggravation of the underlying pathology. Dr. Obianwu explained, however, that he could not establish direct causal relationship between the diagnosed C6-7 disc herniation and the work incident of March 11, 2014. He opined that the disc herniation at C6-7 definitely occurred slowly in a progressive manner over the past five years, but that the incident at work resulted in manifestation of radicular pain, which was not unusual for such pathology. Dr. Obianwu noted that clinically appellant did not have C6 radiculopathy, but may have C7 radiculopathy. He recommended that electrodiagnostic studies be approved. Dr. Obianwu concluded that appellant could not perform his date-of-injury position, but could work with restrictions.

Based on the report of Dr. Obianwu, appellant's claim was expanded to include temporary aggravation of preexisting cervical spondylosis without myelopathy.

In a report dated October 2, 2014, Dr. Peter Biglin, appellant's treating Board-certified physiatrist, diagnosed right C7 radiculopathy due to C6-7 disc herniation, elbow flexion weakness on examination due to right C7 radiculopathy and resulting from the C6-7 disc herniation, normal electromyogram (EMG) study with the exception of questionable denervation of the biceps, and labral tearing in the right shoulder as a secondary finding, possibly incidental.

Dr. Biglin recommended that appellant continue with physical therapy, medication, and cervical injections. Dr. Biglin noted that appellant could work light duty at that time, with lifting restricted to five pounds.

On October 2, 2014 appellant accepted an offer from the employing establishment to return to work as a limited-duty mail processing clerk, with limitations of no lifting over five pounds, no prolonged standing over 10 minutes per hour, no pushing/pulling over 10 pounds, and no reaching above shoulder with his right arm.

In a November 7, 2014 report, Dr. Biglin listed appellant's date of injury as March 11, 2014. He noted the diagnosis as shoulder tenosynovitis and related that appellant's physical examination was unchanged. However, Dr. Biglin noted that appellant reported increased pain in his neck radiating down the right arm with numbness and tingling in digits 4 and 5, that appellant had cervical range of motion limited in all directions, Spurling's causes right shoulder pain, and no focal neurologic deficits. He noted that a cervical spine MRI scan indicated a small disc herniation at C6-7, but that the right upper extremity EMG was normal. Dr. Biglin listed impressions as right C6 radiculopathy due to C6-7 disc herniation, cerviogenic headaches, and failure to respond to conservative treatment. He noted that appellant's pain level was 8 out of 10 and getting worse. Dr. Biglin indicated that appellant should be off work and that he would see him in four weeks after evaluation by a neurosurgeon.

On November 25, 2014 appellant filed a claim for a recurrence of disability (Form CA-2a) alleging that he suffered a recurrence of the March 11, 2014 injury on November 7, 2014. He noted that he had returned to work with limitations, but that his condition had not improved since he returned to work. Appellant noted that his pain worsened and his numbness had increased.

In a November 21, 2014 initial surgical evaluation, Dr. Mark L. Goldberger, a Board-certified neurosurgeon, noted that appellant was referred to him by Dr. Biglin. He described appellant's employment injury of March 11, 2014, conducted a neurological examination, and listed his impressions as cervicalgia, cervical radiculitis in the right upper extremity, cervical herniated disc at C6-7, and intractable prior shoulder pathology. Dr. Goldberger noted that appellant had failed physical therapy and conservative management. He advised appellant to consider an anterior cervical discectomy with fusion at the C6-7 level.

By letter dated December 10, 2014, OWCP requested that appellant submit information, including rationalized medical opinion evidence, in support of his claim. Appellant was afforded 30 days to submit the necessary evidence. In response, appellant resubmitted the October 2, 2014 report by Dr. Biglin, an August 29, 2014 report by Dr. Obianwu, and physical therapy notes from September 12 through October 23, 2014. Appellant also submitted an April 21, 2014 MRI scan of the cervical spine which noted an increase in size of the posterior disc protrusion at C6-7, with borderline central canal narrowing, and increased bilateral neural foraminal stenosis in conjunction with facet/uncovertebral arthropathy.

In a January 23, 2015 report, Dr. Goldberger responded to queries from OWCP. He noted that on March 11, 2014, appellant was pushing a bulk mail carrier and felt a sharp pain in his right shoulder, upper trapezius, and neck. Dr. Goldberger noted that the pain radiated down

around the scapula and triceps location with a dull ache in his forearm. He summarized appellant's medical treatment. Dr. Goldberger noted that appellant had cervicalgia with radiculitis into the right upper extremity correlating with MRI scan imaging. He noted objective findings upon examination included positive nerve compression testing on the right side and that it correlated with appellant's level of pathology. With regard to his work duties, Dr. Goldbeger noted that appellant's work duties were not fully known to him, but noted that appellant was unable to adequately maneuver his right upper extremity due to neck pain and right upper extremity discomfort. With regard to causal relationship, he indicated that appellant did sustain an injury while pushing an extremely heavy object which was likely the source of this disc herniation. Dr. Goldberger noted that beyond that there was medically and physically no way to determine whether the disc herniation was directly related to the work injury other than based on appellant's description, the MRI scan findings, and the correlation of the MRI scan findings to appellant's symptoms. He reiterated that appellant was to be scheduled for surgical intervention.

By decision dated February 27, 2015, OWCP denied appellant's claim for recurrence of disability, finding that the evidence submitted was insufficient to establish total disability due to a material change/worsening of the accepted work-related conditions.

In reports dated February 24 through November 19, 2015, Dr. Biglin indicated that appellant could perform no work activity. In February 24 and March 19, 2015 reports, he again noted right C6 radiculopathy due to C6-7 disc herniation, cervicogenic headaches, and that appellant had failed to respond to conservative treatment. On March 30, 2015 Dr. Biglin gave appellant a cervical epidural steroid injection at C7-T1. On May 7, 2015 he listed impressions of right C6 radiculopathy, cervicogenic headaches, and right shoulder bursitis due to impingement findings on examination. Dr. Biglin also noted no electrodiagnostic evidence for right cervical radiculopathy. He noted that, clinically, appellant's symptoms were consistent with cervical radiculitis, but that he was unable to prove it with testing/axon loss. In a July 23, 2015 note, Dr. Biglin indicated that appellant should follow up for surgical decompression as soon as possible. In a September 17, 2015 note, he indicated that appellant had a positive MRI scan.

In a Form CA-2a signed on January 9, 2015, appellant related that he claimed a recurrence on November 7, 2014, because his condition was worsening. He noted increased weakness in his hand, arm, and neck, and related that his headaches had worsened. Appellant explained that since returning to work he was assigned to manually handle mail. He was constantly moving his head around to put mail in slots. Appellant noted no new injury, but related that he returned to the doctor on November 7, 2014. He indicated that his conditions were present continuously, with weakness in his arm, hand, and neck.

An October 14, 2015 MRI scan report conducted by Dr. Brian Sabb, a Board-certified radiologist, found acquired cervical spondylosis most pronounced at C6-7 where there was mild central canal stenosis with effacement of the ventral surface of the spinal cord, similar to the prior examination. He also noted that at this level there was pronounced left worse than right neural foraminal narrowing, and that the neural foraminal narrowing on the right had worsened compared to the prior examination. Dr. Sabb noted that the remainder of the spondylosis appeared very similar to the prior exam. He further found redemonstration of slight retrolisthesis at C6-7 and altered signal intensity in the central aspect of the spinal cord.

In a November 6, 2015 follow-up appointment, Dr. Goldberg indicated that appellant's last MRI scan showed that a disc herniation was present and appeared to be slightly worse, and that there was new evidence of a mass effect upon the cervical cord. He noted that it was eccentric slightly to the right side which correlated with the patient's symptoms. He noted that appellant still required anterior cervical discectomy and fusion at C6-7.

In a January 26, 2016 report, Dr. Biglin stated that surgical intervention was required for appellant's C6 radiculopathy due to right C6-7 disc herniation. He noted that appellant had not responded to conservative treatment.

By letter dated February 2, 2016 and received by OWCP on February 17, 2016, appellant requested reconsideration of the February 27, 2015 decision.

Appellant continued to submit monthly progress reports by Dr. Biglin. These reports reflected Dr. Biglin's continued belief that surgical intervention was needed for appellant's C6 radiculopathy due to right C6-7 herniation as appellant was not responding to conservative treatment.

By decision dated May 13, 2016, OWCP denied modification of its February 27, 2015 decision finding that appellant failed to establish his work-related medical condition objectively worsened to the point he was no longer medically capable of performing his work duties as of November 7, 2014.

LEGAL PRECEDENT -- ISSUE 1

A recurrence of disability means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition resulting from a previous injury or illness without an intervening cause or a new exposure to the work environment that caused the illness. It can also mean an inability to work that takes place when a light-duty assignment made specifically to accommodate an employee's physical limitations due to his or her work-related injury or illness is withdrawn or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations.[2]

When an employee who is disabled from the job he or she held when injured on account of employment-related residuals returns to a limited-duty position or the medical evidence of record establishes that he or she can perform the limited-duty position, the employee has the burden of proof to establish, by the weight of the reliable, probative, and substantial evidence, a recurrence of total disability and an inability to perform such limited-duty work. As part of its burden, the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the limited-duty job requirements.[3] To show a change in the degree of the work-related injury or condition, the claimant must submit rationalized medical

[2] *J.F.*, 58 ECAB 124 (2006). A recurrence of disability does not apply when a light-duty assignment is withdrawn for reasons of misconduct, nonperformance of job duties, or other downsizing. 20 C.F.R. § 10.5(x). *See also Richard A. Neidert*, 57 ECAB 474 (2006).

[3] *M.C*, Docket No. 15-1762 (issued August 26, 2016).

evidence documenting such change and explaining how or why the accepted injury or condition disabled the claimant from work on and after the date of the alleged recurrence of disability.[4]

OWCP procedures recognize that if an alleged recurrence occurs less than 90 days after a return to light or full duty, the claimant is not required to produce the same evidence as for a recurrence claimed long after apparent recovery and return to work. Therefore, in cases where recurring disability from work is claimed within 90 days or less from the first return to duty, the focus is on disability rather than causal relationship.[5] The attending physician should describe the duties which the employee cannot perform and the demonstrated objective medical findings that form the basis for the renewed disability from work.[6]

ANALYSIS -- ISSUE 1

OWCP accepted appellant's claim for disorder of bursae and tendons in the right shoulder region; sprain of neck; sprain of shoulder and upper arm, right rotator cuff; sprain of shoulder an upper arm, right supraspinatus; and temporary aggravation of preexisting cervical spondylosis without myelopathy.

Appellant returned to work on October 2, 2014 as a limited-duty mail processing clerk, with limitations on lifting, prolonged standing, pushing/pulling, and reaching above his shoulder with his right arm. He stopped work and alleged a recurrence of disability on November 7, 2014 causally related to his March 11, 2014 accepted employment injury.

The Board finds that appellant has not met his burden of proof to establish a recurrence beginning November 7, 2014. There is no evidence that appellant's light-duty assignment was withdrawn or that the physical requirements of such an assignment were altered so as to exceed appellant's established physical limitations as set by Dr. Obianwu.[7] Therefore, the issue under consideration is whether on November 7, 2014 appellant had a spontaneous change in his accepted medical condition resulting from the previous injury or illness without a new exposure to the work environment that caused the illness.

OWCP procedures provide if a claim for recurrence of disability is made within 90 days or less following the first return to duty, the focus is on disability rather than causal relationship.[8] The Board finds that there is no objective rationalized medical evidence of record establishing a recurrence of disability on November 7, 2014.[9]

[4] *James H. Botts*, 50 ECAB 265 (1999).

[5] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Recurrences*, Chapter 2.1500.5(a) (June 2013). *See also J.S.*, Docket No. 16-0922 (issued September 22, 2016).

[6] *D.K.*, Docket No. 15-665 (issued August 10, 2015).

[7] *Supra* note 2.

[8] *Supra* note 5.

[9] *Supra* note 7.

Appellant saw Dr. Biglin on October 2, 2014, at which time he noted that appellant had continued symptoms, but could work light duty. In Dr. Biglin's November 7, 2014 report, he noted that appellant's physical examination was unchanged. He also noted increased symptoms and indicated that appellant should be off work. Dr. Biglin did not provide a well-rationalized explanation for this discrepancy. As such, Dr. Biglin did not provide the rationalized objective medical evidence necessary to establish total disability.[10]

Dr. Goldberger first saw appellant on November 21, 2014. He did not find a spontaneous change in appellant's medical condition starting November 7, 2014, nor did he explain why appellant could not perform his specific job duties. Although Dr. Goldberger did note some restrictions such as indicating that appellant could not adequately maneuver his right extremities, he did not indicate why appellant could not perform his limited-duty assignment.[11] Furthermore, most of his concerns regard appellant's cervical condition. However, the Board notes that although appellant's claim was accepted for cervical spondylosis without myelopathy, OWCP never accepted appellant's claim for C6-7 herniated disc with radiculopathy.

Dr. Sabb interpreted appellant's October 14, 2015 MRI scan, but did not provide an opinion on appellant's ability to work, and therefore his opinion is of limited probative value.[12] Accordingly, the Board finds that there is no objective medical evidence of record to establish a recurrence of total disability on November 7, 2014.

LEGAL PRECEDENT -- ISSUE 2

When an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.[13]

Causal relationship is a medical issue and the evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is evidence which includes a physician's opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background, 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 the claimant.[14]

[10] *Id*.

[11] *Supra* note 5.

[12] *See G.M.*, Docket No. 14-2057 (issued May 12, 2015).

[13] *Jaja K. Asaramo,* 55 ECAB 200 (2004); *see also M.R.*, Docket No. 15-1181 (issued January 29, 2016).

[14] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams,* 41 ECAB 345, 352 (1989).

ANALYSIS -- ISSUE 2

The Board finds that appellant has not met his burden of proof to establish that his C6-7 disc herniation was causally related to the accepted March 11, 2014 employment injury. Dr. Obianwu compared the MRI scan in 2009 with the April 21, 2014 MRI scan. He noted that he could not establish a direct causal relationship between the diagnosed C6-7 disc herniation and the work incident of March 11, 2014.

Dr. Biglin did refer to a cervical spine MRI scan showing a left-sided herniated disc, but failed to provide a rationalized explanation as to how the work injury of March 11, 2014 caused this herniated disc. Dr. Goldberger indicated that pushing the heavy object was likely the source of the disc herniation, but that there was no way to indicate whether the disc herniation was directly related to the work injury other than appellant's description, the MRI scan findings, and the correlation of the MRI scan findings to appellant's symptoms. The mere fact that a condition manifests itself during a period of employment does not raise an inference that there is causal relationship between the two.[15] Moreover, opinions which are speculative are of diminished value.[16] Accordingly, Dr. Goldberger's opinions are insufficient to establish causal relationship between the accepted employment incident and the C6-7 disc herniation.

Accordingly, the Board finds that appellant has failed to submit a rationalized medical opinion establishing that his herniated disc at C6-7 is causally related to the accepted employment incident of March 11, 2014.

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 his burden of proof to establish a recurrence of disability on November 7, 2014. Furthermore, appellant did not meet his burden of proof to expand his claim to include an accepted herniated disc at C6-7 with radiculopathy.

[15] *S.C.*, Docket No. 16-1572 (issued January 24, 2017).

[16] *See S.E.*, Docket No. 15-1759 issued January 8, 2016) (finding that opinions such as the condition is probably related, most likely related, or could be related are speculative and diminish the probative value of the medical opinion.) *Cecilia M. Corley*, 56 EAB 662 (2005) (finding that medical opinions which are speculative or equivocal are of diminished probative value.).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 13, 2016 is affirmed.

Issued: August 3, 2017
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