United States Department of Labor
Employees' Compensation Appeals Board

G.M., Appellant	)	
and	)	**Docket No. 17-1004**
	)	**Issued: March 28, 2018**
DEPARTMENT OF LABOR, WAGE & HOUR DIVISION, Chicago, IL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 7, 2017 appellant, through counsel, filed a timely appeal from a January 20, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant established a recurrence of total disability beginning April 13, 2015 causally related to her November 20, 2014 employment injury.

[1] 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.

[2] 5 U.S.C. § 8101 *et seq.*

On appeal counsel asserts that the January 20, 2017 decision is contrary to fact and law.

FACTUAL HISTORY

On November 25, 2014 appellant, then a 45-year-old wage and hour investigator, filed a traumatic injury claim (Form CA-1) alleging that on November 20, 2014 she injured her left knee and right ankle at work when she fell from a stool while getting files from a cabinet. She stopped work on the date of injury. OWCP adjudicated this claim under File No. xxxxxx390.

Appellant was seen in an emergency room on the date of injury. Dr. Paul Weygandt, an emergency medicine physician, diagnosed mechanical fall. A brain computerized tomography (CT) scan demonstrated no evidence of acute intracranial abnormality. A CT scan of the cervical spine revealed no acute fracture or subluxation and multilevel degenerative changes within the cervical spine with moderate canal stenosis and mild neural foraminal stenosis. X-ray of the lumbar spine, sacrum, and coccyx showed no fracture or malalignment with mild degenerative disease at L3-4 and L4-5.

In November 24, 2014 reports, Dr. Kaihua Kevin Lai, a Board-certified internist, noted that appellant fell from a two-foot stool at work. Following examination, he diagnosed ankle sprain, back strain, contusion of buttock, knee sprain, and neck sprain. Dr. Lai advised that appellant was totally disabled and should follow up with an orthopedist.

Dr. Michael J. Hejna, a Board-certified orthopedic surgeon, began treating appellant on December 2, 2014 at which time he described the employment injury and appellant's complaints of generalized pain, most significant in her neck and low back. He described physical examination findings and diagnosed mild left knee and right ankle sprains, and cervical and lumbar sprains. Dr. Hejna advised that appellant not work.

On January 14, 2015 OWCP accepted right ankle sprain, contusion of buttock, left knee sprain, and neck and lumbar sprains. Appellant received continuation of pay (COP) through January 4, 2015 and wage-loss compensation beginning January 5, 2015.

A February 5, 2015 cervical spine magnetic resonance imaging (MRI) scan showed mild spondylotic changes, particularly from C3-4 through C6-7 with no cervical fracture or subluxation. On February 11, 2015 Dr. Hejna noted his review of the MRI scan. He advised that the fall likely aggravated appellant's cervical spondylosis, and indicated that she could return to sedentary work. On March 3, 2015 Dr. Hejna reiterated his recommendation that appellant could return to sedentary work.

On February 23, 2015 Dr. Lai noted appellant's continued complaints of neck, back, knee, ankle, and bilateral shoulder pain. He reviewed the cervical MRI scan and indicated that appellant could not ambulate due to pain, unsteady gait, and obesity. Examination demonstrated joint pain, but no musculoskeletal symptoms. Dr. Lai additionally diagnosed morbid obesity, unsteady gait, osteoarthritis at multiple sites, and cervical facet syndrome. He advised that he did not have much to offer appellant and recommended orthopedic care.

On March 6, 2015 the employing establishment offered appellant a limited-duty assignment as a wage and hour investigator. The job offer noted that, based on the information

provided by her physician, she could perform all the duties identified in her position description. Physical requirements of the modified position were no lifting, pushing, or pulling greater than 10 pounds; no repeated bending or twisting; no climbing or working at heights; no kneeling or squatting; no over the shoulder work or play; may stand/walk 15 minutes per hour; and seated work/play only. There were no restrictions of right or left hand use or on driving. The record also includes a position description for appellant's regular job as a wage and hour investigator indicating that the work was primarily sedentary with some bending, stretching, and light lifting.

In reports dated March 10 and 11, 2015, Dr. Reem Bitar, Board-certified in anesthesiology and pain medicine, related that appellant had an epidural steroid injection in May 2014, and that she continued to complain of cervical spine pain on and off until she fell at work on November 20, 2014, which resulted in multi-joint pain and headaches with occasional numbness in hands and feet. He noted that she was using a walker. Examination demonstrated limited cervical spine range of motion and intact sensory examination of the upper extremities. Straight leg raising was negative. Dr. Bitar diagnosed accidental fall, ankle sprain, back strain, cervical facet syndrome, contusion of buttock, knee sprain, morbid obesity, neck strain, osteoarthritis at multiple sites, and unsteady gait. He found appellant totally disabled.

On March 26, 2015 Dr. Sean A. Salehi, a Board-certified neurosurgeon, noted the history of injury and appellant's complaints of knee, ankle, neck, and low back pain, and bladder and bowel incontinence. He found tenderness and decreased range of motion on cervical and lumbar spine examination. Dr. Salehi reviewed the cervical spine MRI scan and diagnosed cervical spondylosis and low back pain. He advised that appellant's neck pain was a result of aggravation of the preexisting cervical spondylosis and that, due to bladder and bowel complaints, she needed a lumbar spine MRI scan.

After first refusing the offered position, appellant later accepted the job on March 26, 2016. She returned to part-time modified duty on March 30, 2015 and began full-time work on April 1, 2015. On April 29, 2015 appellant filed a claim for intermittent compensation (Form CA-7) for the period April 5 to 18, 2015, which included eight hours of leave without pay on April 13, 2015 for a swollen knee. From April 14 to May 16, 2015, she received intermittent wage-loss compensation for medical and therapy appointments. Appellant received no wage-loss compensation under this claim after May 16, 2015. She began four hours of modified duty on May 20, 2015 and took sick and annual leave for the remaining four hours daily. Appellant continued to file claims for compensation.[3]

In a partial report dated April 14, 2015, Dr. Hejna advised that, due to ongoing pain in various locations, most significantly in the right shoulder and left knee, he suggested that appellant's work hours be reduced to four hours daily. On April 30, 2015 Dr. Hejna advised that appellant could not work on April 13, 14, and 24, 2015 due to pain and swelling of the left knee.

In a May 12, 2015 report, Dr. Salehi noted his review of the diagnostic studies.[4] He reiterated his diagnoses and commented that appellant's mechanical low back pain could be due

[3] In May 8, 2015 letters, OWCP informed appellant of the evidence needed to establish her compensation claims.

[4] An April 16, 2015 thoracic and lumbar spine MRI scan showed no evidence of acute fracture and mild degenerative changes, primarily in the lower lumbar spine.

to facet arthropathy, but there was no significant pathology to warrant surgery, noting no cord compression or cauda equina to explain her incontinence. Dr. Salehi noted that she was at maximum medical improvement (MMI) with regard to spinal issues and needed no further spine treatment. He referred her back to Dr. Hejna due to her orthopedic complaints.

In a May 12, 2015 treatment note, Dr. Hejna noted his review of appellant's right shoulder and left knee MRI scans.[5] He reported that he advised appellant that, based on these findings, her ongoing symptoms were not related to the employment injury. Dr. Hejna opined that appellant was at MMI with respect to the employment injury and could return to modified duty.

On May 27, 2015 appellant filed a notice of recurrence (Form CA-2a). She indicated that the recurrence occurred on May 21, 2015, relating that she could not kneel or squat and could not file items from cabinets above or below the waist line, and could not lift anything over eight pounds. Appellant indicated that she had constant neck, shoulder, and back pain, and arm, hand, and leg weakness. She also maintained that she had not been furnished approved ergonomic assistance. The employing establishment indicated that an ergonomic assessment of appellant's workstation was done on April 2, 2015 that included eight recommendations on how she could improve her work area, none of which she had done.

Appellant submitted evidence from Dr. Lai that included May 22, 2015 reports, noting her complaint that her work duties aggravated her neck, back, and shoulders, caused by the November 20, 2014 employment injury. Dr. Lai noted that appellant's work was quite sedentary for several hours daily and that she would like to get compensation because she felt she was unable to work due to significant knee, back, and neck pain, and morbid obesity. Dr. Lai reiterated findings and diagnosed back and neck pain, muscle spasm, and osteoarthritis of the knee, and cervical and lumbar spine. He recommended pain management and orthopedic evaluation. On June 19, 2015 Dr. Lai reviewed the MRI scans. He advised that appellant's complaints of chronic neck and back pain, unsteady gait with morbid obesity were primarily related to her degenerative joint disease. Dr. Lai opined that he was not sure that her pain was related to the work injury, indicating that she had no clear evidence of injury, but that the pain was aggravated by her work. He advised that appellant could not sit, stand, or walk for very long and had limitations of no repetitive bending, stooping, squatting, pushing, or pulling, with a weight limitation of 10 pounds. Dr. Lai recommended a physical performance test, pain medication, and an orthopedic evaluation of her right shoulder. In an undated handwritten note, received on June 26, 2015, he advised that appellant should work four hours of light duty daily without kneeling, squatting, climbing, walking on heights, or repetitive bending, and should be able to use a cane. Dr. Lai indicated that this was due to morbid obesity, arthritis, and muscle spasm aggravated by her work.

In July 2015, appellant filed two additional traumatic injury claims. In a claim adjudicated by OWCP under File No. xxxxxx039, she alleged that on July 15, 2015 she injured her left shoulder, both hands, and both feet. In a claim adjudicated under File No. xxxxxx524, appellant

[5] An April 30, 2015 right shoulder MRI scan was suspicious for a right acromioclavicular (AC) joint injury with capsular strain or possible tear, and moderate tendinosis. No fracture was seen, and x-rays were recommended. A May 4, 2015 MRI scan of the left knee was negative for internal derangement. Mild nonspecific knee joint effusion and a small Baker's cyst were seen.

alleged that on July 29, 2015 she suffered chest pains at work.[6] She stopped work on July 29, 2015 and did not return.

On August 5, 2015 Dr. Lai noted that appellant had recently visited an emergency room for stress. Appellant also complained of severe pain. Dr. Lai found her totally disabled until she saw a spine specialist and psychiatrist. In an August 17, 2015 attending physician's report (Form CA-20), he referenced OWCP File No. xxxxxx039 and advised that appellant was totally disabled until further notice and referred her to a psychiatrist.

In an August 17, 2015 report, Dr. Kern Singh, a Board-certified orthopedist, noted that on November 20, 2014 appellant fell off a stool at work. He described her subsequent pain and treatment and reported that she had a history of axial neck complaints since 2013. Dr. Singh reviewed cervical, thoracic, and lumbar spine MRI scans and provided examination findings. He diagnosed cervical muscular strain, lumbar muscular strain, and L3 to L5 lumbar stenosis. Dr. Singh advised that appellant could return to work without restrictions and was at MMI with regard to her cervical and lumbar spines.

On August 17, 2015 Dr. Nikhil Verma, Board-certified in orthopedic surgery and sports medicine, noted seeing appellant for right shoulder and left knee complaints. He reviewed left knee and left shoulder MRI scans. Following physical examination, Dr. Verma diagnosed right shoulder AC separation/arthrosis and left knee osteoarthritis and injected the right AC joint and left knee. On August 24, 2015 his office called OWCP regarding appellant's right shoulder condition and was told that it had not been accepted. On September 9, 2015 Dr. Verma opined that appellant had AC joint pain with secondary impingement and discussed surgery.

On August 31, 2015 Dr. Lai advised that appellant should be off work due to multiple joint pain, arthritis, and an unsteady gait. He indicated that she could return to modified duty on December 1, 2015. On September 21, 2015 Dr. Lai cleared appellant for right shoulder arthroscopic surgery.

On September 28, 2015 Dr. Verma noted that appellant's surgery was not authorized. After examining her left knee, he advised that underlying knee arthritis did not necessarily warrant arthroplastic surgery and that her restrictions were unchanged.

A telephone memorandum dated October 14, 2015 indicated that appellant called OWCP and requested that the CA-7 claims for compensation she submitted under File Nos. xxxxxx524 and xxxxxx039 be transferred to the instant, accepted claim, File No. xxxxxx390.

On October 27, 2015 appellant informed OWCP that she worked four hours daily from May 22 to July 29, 2015 when she stopped and did not return. On October 27, 2015 OWCP also received information including a statement about the July 29, 2015 chest pain claim, one page of a notice of recurrence (Form CA-2a) dated June 8, 2015, which indicated that the original injury

[6] Appellant filed appeals with the Board from OWCP decisions in both File No. xxxxxx039 and File No. xxxxxx524. These have been assigned Docket Nos. 17-1469 and 17-1738 respectively, and shall adjudicate separately.

occurred on October 28, 2013,[7] and e-mail correspondence regarding appellant's requests for assistive devices. An amended limited-duty assignment dated May 11, 2015 indicated that appellant would do her regularly assigned duties and other duties within her physician's restrictions. It included physical limitations on filing, advised that she use a cane while ambulating, and indicated that she was limited to four hours of work daily.

In an October 5, 2015 report, Dr. Asokumar Buvanendran, Board-certified in anesthesiology and pain medicine, described the November 20, 2014 work injury. He evaluated appellant for neck and arm pain and advised that she was also undergoing evaluation for bariatric surgery. Following examination, Dr. Buvanendran diagnosed cervical radiculopathy, cervical spondylitis with radiculitis, and paresthesias and pain of both arms.

On October 29, 2015 appellant requested that her claim be expanded. The correspondence, however, did not include a list of specific additional conditions. Rather, it included a diary beginning on April 14, 2015. Appellant reported that on that date the medical management nurse assigned to her case evaluated her workstation. She then indicated that on May 21, 2015 she worked eight hours, but was in tremendous pain. Appellant described her subsequent medical appointments.

Appellant also forwarded an April 6, 2015 ergonomic assessment of her workstation, which indicated that adjustments were made. It included suggestions for appellant and noted that the employing establishment should provide her a new keyboard and headset for telephone use. Appellant also forwarded April 16 and May 21, 2015 e-mails and February 6, 2015 correspondence regarding a November 3, 2014 reasonable accommodation request she made.[8] The correspondence indicated that, upon her return to work, she would be allowed additional breaks, and that her request for ergonomic equipment had been forwarded to the appropriate office. A request to telework for no more than one day per week up to March 30, 2015 was granted by the employing establishment.

Appellant also submitted a May 14, 2014 treatment note from Dr. Bitar, which predated the November 20, 2014 work injury. Dr. Bitar noted appellant's complaints of cervical and bilateral shoulder pain. Diagnoses included AC joint arthritis, a bulging disc at C6-7, radiculopathy, right shoulder pain, and cervical spine facet arthritis.

In June 12 and August 5, 2014 treatment notes, Dr. Shing Yen, a Board-certified orthopedist, discussed appellant's neck and shoulder pain. On August 5, 2014 he advised that appellant should stay off work.

Dr. Buvanendran performed cervical epidural steroid injections on November 4 and December 2, 2015, and January 6, 2016. On December 22, 2015 he noted appellant's complaints of neck, bilateral shoulder, and bilateral knee pain. Dr. Buvanendran diagnosed cervical radicular

[7] There is no record that appellant filed a claim with OWCP for an October 28, 2013 employment injury.

[8] The specific condition necessitating accommodation was not identified and the correspondence did not indicate that it was work related.

pain. In a partial report dated January 8, 2016, he noted her complaint of low back pain radiating into both legs.

In a January 11, 2016 treatment note, Dr. Verma noted appellant's complaints of right arm weakness and difficulty raising her arm. He described examination findings of AC joint and biceps tendon tenderness and diagnosed right shoulder AC joint separation and arthritis. Dr. Verma noted that surgery was scheduled for January 19, 2016.[9]

On January 14, 2016 Dr. Lai reported appellant's complaints of neck, back, and buttock pain. He observed that appellant ambulated with difficulty and her joints were arthritic without effusion. Dr. Lai diagnosed history of contusion of buttock, cervical facet syndrome, accidental fall, back strain, knee sprain, low back pain, and osteoarthritis, multiple sites. He advised that appellant had reached MMI and discharged her from his care.

On January 28, 2016 Dr. Buvanendran noted appellant's complaints of neck and low back pain. He diagnosed paresthesia and pain of both upper extremities, cervical spondylitis with radiculitis, and cervical radiculopathy. On February 10, 2016 Dr. Buvanendran performed lumbar epidural steroid injection.

In a February 5, 2016 report, Patricia Merriman, Ph.D., a clinical psychologist, noted complaints of anxiety and distress caused by neck, right arm, and low back pain that followed a November 2014 fall at work. She diagnosed panic disorder, without agoraphobia, and major depressive disorder, single episode, moderate. Dr. Merriman recommended medication and therapy. On February 19, 2016 she noted that appellant continued to struggle with anxiety and distress resulting from pain and related stressors.

On February 15, 2016 Dr. Craig McAsey, a Board-certified orthopedic surgeon, noted appellant's complaints of diffuse, generalized body pain. He noted generalized tenderness of examination of the knees and hips. Dr. McAsey diagnosed bilateral hip trochanteric bursitis and generalized knee pain without mechanical symptoms.

On March 4, 2016 Dr. Buvanendran noted appellant's continued complaints of pain. He additionally diagnosed panic disorder without agoraphobia and major depressive disorder. Dr. Buvanendran performed lumbar steroid injection on March 9, 2016.

On March 9, 2016 Dr. Verma noted that appellant was status post right shoulder arthroscopy with distal clavicle excision. He advised that her recovery was good.

By decision dated March 31, 2016, OWCP found that appellant was entitled to wage-loss compensation for a total of 28 hours for April 6 to 10, 14, and 16, 2015, for which she was paid on May 15, 2015.

By decision dated April 1, 2016, OWCP found that appellant had not established a recurrence of disability beginning April 13, 2015 because the medical evidence of record was insufficient to establish that she was totally disabled due to a material change or worsening in the

[9] On January 13, 2016 appellant requested that OWCP authorize right shoulder and left knee surgery.

accepted conditions of contusion of buttock, and sprains of right ankle, left knee, neck, and lumbar region.

On April 5, 2016 counsel requested a hearing with OWCP's Branch of Hearings and Review from the March 31, 2016 decision. On April 11, 2016 he requested a hearing from the April 1, 2016 decision. Evidence submitted included a January 13, 2015 report from Dr. Mitchell J. Weiss, a chiropractor, who noted appellant's complaints of continued head, neck, arm, leg, and ear pain since the November 20, 2014 work injury. Dr. Weiss recommended a cervical MRI scan and electrodiagnostic study.

In an April 20, 2016 report, Dr. Verma noted that appellant was doing well following her right shoulder surgery. He noted her complaints of left shoulder and left knee pain. Examination findings included a positive left shoulder impingement sign with left overhead elevation, and a mall effusion of the left knee with limited knee range of motion due to pain. Dr. Verma recommended left shoulder and left knee MRI scans. An April 27, 2016 left shoulder MRI scan revealed partial-thickness undersurface tears of the supraspinatus, subscapularis and supraspinatus tendinosis, moderate AC joint osteoarthritis, tendinosis of the intra-articular portion of the biceps tendon, and capsulitis at the rotator cuff interval. Dr. Verma reviewed the left shoulder MRI scan that day. He also indicated that a left knee MRI scan showed small effusion with patellar chondromalacia and possible medial meniscal tear.[10] Dr. Verma noted that appellant would proceed to left shoulder arthroscopic surgery and left knee injection.

In progress notes dated March 4 to July 15, 2016, Dr. Buvanendran reiterated his findings and conclusions. He performed a lumbar epidural steroid injection on May 9, 2016 and cervical epidural injections on June 10, August 24, and September 14, 2016. On September 16, 2016 Dr. Buvanendran reported that, although appellant continued to have radiating cervical pain, she felt she was ready to return to work. He noted that right-sided hip pain had worsened over the last three months. Dr. Buvanendran diagnosed cervical radiculopathy, cervical spondylitis with radiculitis, and paresthesia and pain in both upper extremities.

Dr. Merriman submitted March 11 to September 16, 2016 treatment notes in which she saw appellant in follow up for pain management and counseling. She reiterated her diagnoses.[11]

A hearing was held on held on November 8, 2016 regarding the April 1, 2016 decision denying appellant's claim that she sustained a recurrence of disability beginning April 13, 2016. Appellant testified that she had trouble with her neck prior to the November 20, 2014 employment injury. She indicated that, following her return to full duty, at the advice of Dr. Hejna, she began part-time work on April 14, 2015 due to constant neck, lower back, and knee pain. Appellant

[10] A copy of a 2016 left knee MRI scan is not found in the record before the Board. The Board also notes that Dr. David Weiss, a Board-certified physiatrist, noted on March 23, 2016 that he had seen appellant that day for an electrodiagnostic study. A copy of that study is also not found in the record before the Board.

[11] On February 18, 2016 appellant claimed a schedule award (Form CA-7). On May 11, 2016 Dr. Neil Allen, Board-certified in internal medicine and neurology, advised that, under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, appellant had eight percent left arm impairment, one percent right arm impairment, nine percent left knee impairment, and one percent right ankle impairment. The schedule award issue remains under development by OWCP.

stated that her neck continued to hurt too much to work full time. She indicated that she was working part time at the time of the hearing and described her current medical care. The hearing representative advised appellant of the type of evidence needed to support her total disability claim.[12]

Appellant subsequently submitted a September 16, 2016 report from Dr. Buvanendran which discussed her claimed July 17, 2015 and July 29, 2015 work injuries. Dr. Buvanendran diagnosed accidental fall, neck sprain, back strain, cervical facet syndrome, history of contusion of buttock, ankle sprain, shoulder sprain, knee pain, unsteady gait, low back pain, right knee contusion, knee sprain, right wrist sprain, right elbow tendinitis, bilateral trochanteric bursitis, anxiety as acute reaction to exceptional stress, and work-related stress. He provided work restrictions and recommended ergonomic accommodations and telework. In progress notes dated November 11 and December 30, 2016, Dr. Buvanendran noted seeing appellant for complaints of neck, shoulder, and low back pain. He described physical examination findings and reiterated his diagnoses.

In progress notes dated November 1 to December 6, 2016, Dr. Herriman noted that appellant had returned to part-time work for four hours daily.[13] She described appellant's complaint of anxiety and depression related to her work situation and limitations, her counselling sessions, and reiterated her diagnoses.[14]

By decision dated January 20, 2017, an OWCP hearing representative affirmed the April 1, 2016 decision that denied appellant's claim for a recurrence of disability beginning April 13, 2015 as the medical evidence of record did not establish that appellant was no longer able to perform her full-time limited-duty position.[15]

LEGAL PRECEDENT

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 which had resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness.[16] This term also means an inability to work when a light-duty assignment made specifically to accommodate an employee's physical limitations due to the work-related injury or illness is withdrawn (except when such withdrawal occurs for reasons of misconduct,

[12] A hearing from the March 31, 2016 decision, denying compensation for specific dates in April 2015, was held on November 21, 2016.

[13] The record in this claim does not indicate the exact date appellant returned to work, although she filed a claim for intermittent compensation beginning October 3, 2016.

[14] OWCP received a recurrence claim, signed by appellant on December 2, 2016 and indicating an October 28, 2013 original injury. *See supra* note 7. Appellant indicated that a recurrence occurred on November 18, 2016 when she had acute neck, lower back, and bilateral shoulder pain while reading at her desk.

[15] A February 3, 2017 decision issued by OWCP's Branch of Hearings and Review from the March 31, 2016 decision has not been appealed to the Board.

[16] 20 C.F.R. § 10.5(x); *see Theresa L. Andrews*, 55 ECAB 719 (2004).

nonperformance of job duties, or a reduction-in-force), or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations.[17]

When an employee, who is disabled from the job he or she held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence establishes that light duty can be performed, the employee has the burden to establish by the weight of reliable, probative, and substantial evidence a recurrence of total disability. As part of this burden of proof, the employee must show either a change in the nature and extent of the injury-related condition, or a change in the nature and extent of the light-duty requirements.[18]

An individual who claims a recurrence of disability resulting from an accepted employment injury has the burden of establishing that the disability is related to the accepted injury. This burden requires furnishing medical evidence from a physician who, on the basis of a complete and accurate factual and medical history, concludes that the disabling condition is causally related to the employment injury and supports that conclusion with sound medical reasoning.[19]

ANALYSIS

The Board finds that appellant did not establish a recurrence of disability on or after April 13, 2015 causally related to the accepted conditions of contusion of buttock, right ankle and left knee sprains, and cervical and lumbar sprains caused by a November 20, 2014 work injury. Appellant did not establish that the nature and extent of these injury-related conditions changed so as to prevent her from continuing to perform her sedentary modified assignment.

A partially disabled claimant who returns to a light-duty job has the burden of proving that he or she cannot perform the light duty, if a recurrence of total disability is claimed.[20] The issue of whether the claimant has disability from performing a modified position is primarily a medical question and must be resolved by probative medical evidence.[21] Appellant's burden includes submitting rationalized medical opinion supporting that the disabling condition is causally related to the employment injury.[22] Where no such rationale is present, the medical evidence is of diminished probative value.[23] Medical evidence submitted by appellant to support her recurrence claim should reflect a correct history and should offer a medically sound explanation by a physician of how the modified duties she was performing on and April 13, 2015 physiologically

[17] *Id.*

[18] *Shelly A. Paolinetti*, 52 ECAB 391 (2001); *Robert Kirby*, 51 ECAB 474 (2000); *Terry R. Hedman*, 38 ECAB 222 (1986).

[19] *S.S.*, 59 ECAB 315 (2008).

[20] *See William M. Bailey*, 51 ECAB 197 (1999).

[21] *Cecelia M. Corley*, 56 ECAB 662 (2005).

[22] *Supra* note 19.

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

caused or aggravated the accepted conditions such that she had increased disability.[24] Appellant submitted no such evidence in this case.

After the November 20, 2014 work injury, appellant received appropriate COP and wage-loss compensation. On February 11, 2015 Dr. Hejna advised that she could return to sedentary work. On February 23, 2015 Dr. Lai advised that he did not have much to offer appellant and recommended orthopedic care. Dr. Hejna reiterated his conclusion that appellant could return to work on March 3, 2015. On March 30, 2015 appellant returned to a modified, sedentary position. Lifting, pushing, and pulling were limited to 10 pounds with no repeated bending, twisting, climbing, working at heights, kneeling, squatting, or over the shoulder work. Appellant filed claims for compensation for intermittent periods of disability thereafter, including eight hours missed on April 13, 2015. Her regular position as a wage and hour investigator is sedentary in nature. Beginning on May 18, 2015, other than working a few full-time days, she worked approximately four hours daily. Appellant received intermittent wage-loss compensation through May 16, 2015 for medical and therapy appointments. She stopped work on July 29, 2015 and did not return until October 2016.

The record also supports that appellant had preexisting cervical and shoulder conditions. In a May 14, 2014 treatment note that predated the employment injury, Dr. Bitar noted appellant's complaints of cervical and bilateral shoulder pain and diagnosed AC joint arthritis, a bulging disc at C6-7, radiculopathy, right shoulder pain, and facet arthritis of the cervical spine. In June 12 and August 5, 2014 treatment notes, Dr. Yen also discussed appellant's neck and shoulder pain. In March 2015 reports, Dr. Bitar noted treating appellant the previous year for cervical spine pain. On March 26, 2015 Dr. Salehi advised that appellant's neck pain was caused by an aggravation of preexisting cervical spondylosis. Neither Dr. Bitar nor Dr. Salehi, however, commented on appellant's ability to work at that time. Likewise, Dr. McAsey did not comment on appellant's ability to work.[25] The Board has long held that medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[26]

In a partial report dated April 14, 2015, Dr. Hejna advised that, due to ongoing pain in various locations, most significantly in the right shoulder and left knee, appellant should only work four hours daily. On April 30, 2015 he advised that appellant could not work on April 13, 14, and 24, 2015 due to pain and swelling of the left knee. Pain is a symptom, not a compensable medical diagnosis.[27] 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 no such

[24] *S.S.*, *supra* note 19.

[25] Dr. Mitchell J. Weiss also did not comment regarding appellant's work capabilities. Moreover, under section 8101(2) of FECA, 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. 5 U.S.C. § 8101(2); *see D.S.*, Docket No. 09-0860 (issued November 2, 2009). Dr. Weiss did not diagnose a subluxation by x-ray.

[26] *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

[27] *C.B.*, Docket No. 09-2027 (issued May 12, 2010).

rationale is present, the medical opinion is of diminished probative value.[28] Dr. Hejna, who had advised as early as February 11, 2015 that appellant could return to sedentary work, and reiterated this opinion on March 3, 2015. While in the partial report dated April 14, 2014 he indicated that appellant should reduce her work hours, he did not explain how or why this was caused by the accepted conditions. This brief and incomplete opinion is insufficient to meet appellant's burden of proof that she could only work four hours a day. Moreover, on May 12, 2015 Dr. Hejna advised that appellant's ongoing symptoms were not related to the November 20, 2014 employment injury, and opined that she was at MMI with respect to the work injury and could return to modified duty. Thus, Dr. Hejna's opinion is clearly unsupportive of appellant's claimed disability after that date.

In a May 12, 2015 report, Dr. Salehi reviewed diagnostic studies and commented that appellant's mechanical low back pain could be due to facet arthropathy, but there was no significant pathology to warrant surgery. He indicated that appellant needed no further spine treatment. As he did not clearly relate any increased disability to the accepted conditions, Dr. Salehi's opinion is of limited probative value and insufficient to establish appellant's claim. Likewise, on August 17, 2015 Dr. Singh advised that appellant could return to work without restrictions with regard to her cervical and lumbar spine. He did not comment on the accepted buttock contusion or right ankle and left knee sprains.[29]

In an undated, handwritten note, received by OWCP on June 5, 2015, Dr. Lai advised that appellant should work four hours of restricted duty daily and indicated that this was due to morbid obesity, arthritis, and muscle spasm aggravated by her work. On May 22, 2015 he reported appellant's complaint that her duties at work aggravated her neck, back, and shoulders, caused by the November 20, 2014 employment injury. Dr.Lai, however, advised that appellant's work was quite sedentary and that she felt she should get compensation because she was unable to work due to significant knee, back, and neck pain, and morbid obesity. On June 19, 2015 he opined that he was not sure that appellant's pain was related to the employment injury, indicating that she had no clear evidence of injury, but that the pain was aggravated by her work. Other reports from Dr. Lai did not specifically address causal relationship for the period of disability at issue.

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.[30] When considered as a whole, Dr. Lai's reports are inconsistent. While he noted that appellant's position is sedentary, he exhibited no knowledge of her exact work duties and offered no consistent explanation as to why she is totally or partially disabled due to the November 20, 2014 employment injury. Dr. Lai did not provide medical rationale explaining how her sedentary work duties aggravated her conditions resulting in

[28] *T.M.*, Docket No. 08-0975 (issued February 6, 2009).

[29] *See supra* note 26.

[30] *Patricia J. Glenn*, 53 ECAB 159 (2001).

increased disability on or after April 13, 2015. His opinion is, therefore, insufficient to meet appellant's burden of proof.

Dr. Verma began treating appellant in August 2015, nine months after the November 20, 2014 employment injury. He mainly treated appellant for shoulder conditions which have not been accepted under this claim. Although Dr. Verma advised that appellant had left knee osteoarthritis, this has not been accepted,[31] and he did not advise that an accepted condition caused increased disability. While Dr. Verma reported on April 27, 2016 that a left knee MRI scan demonstrated a possible meniscal tear, the report of this study is not found in the record before the Board and he did not explain how this was related to the November 20, 2014 employment injury.[32] Thus, the evidence does not support that the November 20, 2014 work injury, accepted for left knee strain, caused additional left knee conditions.

Other medical reports are of limited probative value as they do not contain a physician's opinion relating appellant's disability beginning April 13, 2015 to the accepted conditions.[33]

When an employee returns to light-duty work, he or she has the burden to establish a recurrence of disability due to the employment-related conditions, and that he or she cannot perform such light duty.[34] The employee must show a change in the nature of the accepted condition or a change in the light-duty job requirements.[35] Appellant submitted no such evidence in this case. Where, as here, a claimant stops work for reasons unrelated to the accepted employment injury, there is no disability within the meaning of FECA.[36]

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 failed to establish a recurrence of total disability beginning April 13, 2015 caused by a November 20, 2014 employment injury

[31] *See supra* note 28 (where a claimant claims that a condition not accepted or approved by OWCP was due to an employment injury, the claimant bears the burden of proof to establish that the condition is causally related to the employment injury through the submission of rationalized medical evidence).

[32] Furthermore, a May 4, 2015 MRI scan of the left knee was negative for derangement.

[33] *S.E., supra* note 26.

[34] *William D. Bailey, supra* note 20.

[35] *K.C.*, Docket No. 09-1666 (issued August 25, 2010).

[36] *See A.M.*, Docket No. 09-1895 (issued April 23, 2010).

ORDER

IT IS HEREBY ORDERED THAT the January 20, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 28, 2018
Washington, DC

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

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

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