United States Department of Labor
Employees' Compensation Appeals Board

T.H., Appellant	)	
and	)	**Docket No. 12-903**
	)	**Issued: December 12, 2012**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Marion, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge

JURISDICTION

On March 15, 2012 appellant filed a timely appeal from a February 13, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant met her burden of proof to establish a recurrence of disability commencing June 21, 2010 causally related to her accepted employment condition.

FACTUAL HISTORY

On January 8, 2009 appellant, then a 46-year-old histotechnologist clerk, filed an occupational disease claim for a right elbow condition as a result of performing repetitive duties.

[1] 5 U.S.C. §§ 8101-8193.

OWCP accepted the claim for right lateral epicondylitis. Appellant worked intermittently thereafter. On June 21, 2010 she returned to work full time, without restrictions. Appellant again stopped work on June 30, 2010.

Appellant was initially treated for right elbow pain and returned to restricted work. She was treated by Dr. Robert J. Golz, a Board-certified orthopedist, from March 20 to June 24, 2009, who diagnosed lateral epicondylitis and recommended cortisone injections and an orthotic brace. Dr. Golz returned appellant to restricted duties. A June 8, 2009 magnetic resonance imaging (MRI) scan of the right elbow revealed no abnormalities. Thereafter, appellant was treated by Dr. Scott G. Kaar, a Board-certified orthopedist, from August 12, 2009 to February 17, 2010 for right arm pain. Dr. Kaar diagnosed right arm and forearm pain and right lateral epicondylitis. He opined that appellant's symptoms were out of proportion or exaggerated for what he was able to find clinically and radiographically but advised that she was totally disabled. A December 24, 2009 x-ray of the right forearm, elbow and wrist revealed no acute osseous abnormality and minimal degenerative changes.

In a May 5, 2010 report, Dr. Kaar diagnosed right lateral epicondylitis that was not improving and was inoperative. In a June 23, 2010 report, he diagnosed symptomatic lateral epicondylitis and noted appellant recently returned to work full time without restrictions. Dr. Kaar noted that the right elbow was neurovascularly intact with lateral epicondylar tenderness over the elbow. He opined that appellant's elbow lateral epicondylitis was stable and that she was at maximum medical improvement and could work full time without restrictions.

On June 17, 2010 appellant was treated by Dr. Gregory A. Merrell, a Board-certified orthopedist, who noted a work history and medical treatment for right lateral epicondylitis. Dr. Merrell noted no evidence of right arm atrophy, no skin changes or temperature changes and a significant lack of effort on grip testing. He noted that the limited examination findings seemed to be out of proportion with the history and injury. Dr. Merrell noted that there was no objective evidence based on the examination that was reliable enough to support a particular diagnosis or treatment given the inconsistencies on the history and examination. He opined that appellant could work without restrictions. In a June 17, 2010 status report, Dr. Merrell also returned appellant to work without restrictions.

In a June 21, 2010 compensation termination worksheet, OWCP noted that appellant returned to work on June 21, 2010.

In a letter dated June 27, 2010, appellant indicated that Dr. Merrell returned her to work without restrictions; however, he did not have her complete medical records. She noted returning to work on June 21, 2010 for five hours and on June 22, 24 and 25, 2010 for eight hours per day. Appellant indicated that she did not work on June 23, 2010 because she had an appointment with Dr. Kaar. She further indicated that upon return to work she was assigned to continuing education classes on the computer and required to perform repetitive typing eight hours a day which caused arm pain and numbness. Appellant submitted notes dated June 27 and 28, 2010 from a physician's assistant noting that she returned to work but had right arm numbness due to computer work. She was taken off work. A June 30, 2010 attending physician's report prepared from a physician's assistant report was also provided. In a June 30, 2010 note, Dr. Kurt Martin, a Board-certified orthopedist, noted that appellant was currently

under his care and would be disabled from work for one week and return to work on July 9, 2010. Also submitted was an x-ray of the right wrist which revealed no acute fracture with possible soft tissue swelling dorsally.

On July 1, 2010 appellant filed a recurrence of disability claim, noting that she had a recurrence on June 21, 2010 causally related to her work injury. She noted returning to work on June 21, 2010 without restrictions and stopping on June 30, 2010.

In a July 16, 2010 letter, OWCP advised appellant of the type of evidence needed to establish her claim. It particularly requesting that she submit a physician's reasoned opinion addressing the relationship of her disability due to her accepted condition.

Appellant submitted a July 7, 2010 report from Dr. Kaar who diagnosed right elbow lateral epicondylitis, shoulder rotator cuff pain and wrist pain and opined that the etiology of the symptoms was unclear. Dr. Kaar returned her to work without restrictions. A work status note from a physician's assistant noted that appellant was disabled due to cervicalgia and right arm, elbow and wrist pain. An August 9, 2010 work capacity evaluation from Dr. Mohammad Azam, an internist, diagnosed right lateral epicondylitis and noted that appellant could not return to work but needed to regain range of motion. He noted that restrictions would apply for six weeks. On August 23, 2010 Dr. Azam advised that appellant would be disabled until further notice. On October 6, 2010 appellant was treated by Dr. David M. Deisher, a Board-certified orthopedist, who noted a history of injury and treatment and indicated that based on the degree of pain experienced appellant may have a ruptured extensor tendon or radial collateral ligament. He recommended an MRI scan.

In a decision dated November 8, 2010, OWCP denied appellant's claim for a recurrence of disability commencing June 21, 2010.

Appellant requested an oral hearing which was held on April 12, 2011. She submitted a July 13, 2010 report from Dr. Ana Migone, a Board-certified internist, who treated her for neck pain that began one month prior and arm pain that began eight months earlier. Dr. Migone diagnosed cervicalgia and forearm joint pain and recommended a hand splint. On November 11, 2010 Dr. Azam diagnosed right forearm lateral epicondylitis and rupture of the tendon. Appellant was treated by Dr. Sonjay J. Fonn, an osteopath, from November 24, 2010 to April 13, 2011, for cervical disc degeneration and cervical radiculopathy. She reported working as a histotechnologist for 18 years that involved fine dexterous motions of her hand and arm and repetitive motion in her neck. Appellant developed neck pain radiating into her right finger. In return to work slips, Dr. Fonn diagnosed cervical disc degeneration, cervical radiculopathy, cervical stenosis and cervical spondylosis. He noted that appellant was disabled and needed surgery. Appellant was treated by Dr. Kaar from December 8, 2010 to April 20, 2011, for right lateral epicondylitis and right wrist pain. In a December 8, 2010 work capacity evaluation, Dr. Kaar diagnosed right elbow/wrist pain of unclear etiology and lateral epicondylitis. He noted that appellant could work without restrictions. An electromyogram (EMG) dated December 17, 2010 revealed mild bilateral carpal tunnel syndrome, mild right ulnar neuropathy at the elbow and no evidence of cervical radiculopathy. A January 20, 2011 cervical spine MRI scan revealed multilevel osteoarthritic degenerative changes at C5-6 and C6-7 and C4-5 with no acute fracture. On May 25, 2011 appellant was treated by Dr. Dirk H. Alander, a Board-certified orthopedist,

for neck pain and degenerative disc disease that began one year prior. Dr. Alander opined that he could not determine if appellant's cervical pain was work related. An April 14, 2011 MRI scan of the right elbow revealed mild tendinosis.

In a June 28, 2011 decision, an OWCP hearing representative affirmed the November 18, 2010 decision.

Appellant requested reconsideration and submitted a July 8, 2010 report from Dr. Mack McCain, an orthopedist, who treated her for right radial wrist pain and that she thought was related to her chronic epicondylitis that worsened when she returned to work. Dr. McCain diagnosed pain in the limb and cervicalgia. Dr. Azam treated appellant from October 11, 2010 to October 20, 2011, and diagnosed right forearm lateral epicondylitis and rupture of the tendon. In an October 11, 2010 work capacity evaluation, Dr. Azam diagnosed right lateral epicondylitis and noted that appellant could not work until evaluated by an orthopedist. Other reports from Dr. Kaar from March 23 to November 23, 2011 diagnosed right elbow pain and right wrist pain with unclear etiology, possibly related to a degenerative tear of the triangular fibrocartilage complex in the right wrist. He noted that there was no evidence of lateral epicondylitis in the elbow and returned appellant to work with restrictions. In a July 28, 2011 work capacity evaluation, Dr. Kaar noted that appellant was totally disabled. Reports from Dr. Fonn, from July 7, 2011 to January 18, 2012, noted treating a cervical condition. He opined that the repetitive motions performed while working in pathology and histology could cause the degenerative changes in her cervical spine and result in her symptoms and need for surgery. In work status notes dated July 7, 2011 to January 18, 2012, Dr. Fonn noted that appellant was off work indefinitely. In November 8 and December 1, 2011 attending physician's reports, he diagnosed cervical pain, cervical radiculopathy and spondylosis and checked a box "yes" that appellant's condition was caused by repetitive motions as a histotechnician. On July 27, 2011 Dr. Alander diagnosed neck pain and degenerative disc disease. He could not definitely state that her current condition was work related. July 28, 2011 reports from Dr. Mary Elizabeth Rashid, a Board-certified surgeon, diagnosed right-sided small triangular fibrocartilage complex tear. Dr. Rashid returned appellant to work with restrictions.

An October 4, 2011 statement from Dr. Cornelio Katubig, a pathologist who was appellant's supervisor, noted that appellant performed many repetitive tasks at work, including carrying and lifting heavy articles, slides and chemicals as well as patients during autopsies. Also submitted was an October 6, 2011 statement from Dr. Mina Gabrawy, a retired pathologist, who worked with appellant and noted that she performed repetitive motions and heavy lifting and developed an occupational disease in her neck and right arm due to repetitive motions and lifting in her job. Also provided were October 20 and December 15, 2011 x-rays of the right elbow and shoulder that showed mild osteoarthritis of the right acromioclavicular joint, and right glenohumeral joint and a well-corticated ossific fragment at the ulnar trochlear articulation of the elbow compatible with a remote injury.

The employing establishment submitted a statement from Dr. Hugh Lancaster, a pathologist and appellant's supervisor, who disputed appellant's claim noting that his duties were not excessive. Dr. Lancaster noted that Drs. Katubig and Gabrawy both worked part time with Dr. Katubig retiring in 2006 and Dr. Gabrawy being terminated in 2010.

In a decision dated February 13, 2012, OWCP denied modification of the prior decision.

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 resulted from a previous injury or illness without an intervening injury or a new exposure to the work environment.[2]

When an employee claims a recurrence of disability causally related to an accepted employment injury, he or she has the burden of establishing by the weight of the reliable, probative and substantial medical evidence that the claimed recurrence of disability is causally related to the accepted injury.[3] This burden includes the necessity of 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.[4] An award of compensation may not be made on the basis of surmise, conjecture or speculation or on an appellant's unsupported belief of causal relation.[5]

ANALYSIS

OWCP accepted that appellant developed right lateral epicondylitis. She returned to regular duty on June 21, 2010. On July 1, 2010 appellant claimed a recurrence on June 21, 2010 for which she stopped work on June 30, 2010. On appeal, she reasserts contentions made before OWCP on reconsideration. The Board finds that the medical record lacks a well-reasoned medical report relating the claimed recurrent disability to the accepted condition.

A June 17, 2010 report from Dr. Merrell noted an essentially normal physical examination and advised that appellant's limitations on examination seemed to be out of proportion with the history and injury. Dr. Merrell noted that there was no objective evidence on examination that supported a particular diagnoses or treatment given the inconsistencies on the history and examination. He returned appellant to work without restrictions. In a June 23, 2010 report, Dr. Kaar diagnosed symptomatic lateral epicondylitis and noted that appellant recently returned to work full time without restrictions. He opined that her elbow lateral epicondylitis was stable and that she could return to work full time without restrictions. On July 7, 2010 Dr. Kaar noted an essentially normal examination and diagnosed right elbow lateral epicondylitis, shoulder rotator cuff pain and wrist pain and opined that the etiology of the symptoms was unclear. He returned appellant to work without restrictions. None of the medical records submitted most contemporaneous with the alleged recurrence of disability specifically mention that appellant had a recurrence of disability on June 30, 2010 causally related to the accepted condition. Drs. Merrell and Kaar both opined that the etiology of symptoms was unclear and appellant could work without restrictions.

[2] 20 C.F.R. § 10.5(x).

[3] *Alfredo Rodriguez,* 47 ECAB 437 (1996); *see Dominic M. DeScala*, 37 ECAB 369 (1986).

[4] *See Nicolea Bruso*, 33 ECAB 1138 (1982).

[5] *Ausberto Guzman*, 25 ECAB 362 (1974).

Other reports from Dr. Kaar including a December 8, 2010 work capacity evaluation, found right elbow/wrist pain of unclear etiology. He noted that appellant could work without restrictions. In reports dated March 23 to November 23, 2011, Dr. Kaar diagnosed right elbow pain and right wrist pain with unclear etiology and returned appellant to work with restrictions. In a July 28, 2011 work capacity evaluation, he noted that appellant was totally disabled from work but he did not specifically address whether she had disability beginning June 30, 2010 causally related to the accepted condition. Thus, these reports are insufficient to establish the claim.

Appellant submitted a June 30, 2010 note from Dr. Martin who advised that she was disabled from work for one week and could return on July 9, 2010. She submitted a July 13, 2010 report from Dr. Migone who treated her for neck pain which began one month prior and diagnosed cervicalgia and pain in forearm joint. Appellant submitted work capacity evaluations from Dr. Azam dated August 9 and October 10, 2010 who diagnosed right lateral epicondylitis and noted appellant could not return to work until seen by an orthopedist. Other reports from Dr. Azam dated August 23 and November 11, 2010 diagnosed right forearm lateral epicondylitis and rupture of the tendon. However, none of the medical records specifically mention that appellant had a recurrence on or after June 21, 2010 causally related to the accepted condition.

Reports from Dr. Fonn dated November 24, 2010 to January 18, 2012, noted appellant's treatment for cervical disc degeneration and cervical radiculopathy. He opined that the repetitive motions at work could cause the degenerative changes in her cervical spine and result in her symptoms and need for surgery. Dr. Fonn noted that appellant was disabled indefinitely and required surgery. However, he did not specifically address whether appellant had a recurrence beginning June 21, 2010 causally related to the accepted right lateral epicondylitis. Instead Dr. Fonn speculated that work duties could cause the diagnosed conditions, none of which were accepted by OWCP as employment related.[6] He did not provide a rationalized opinion explaining how appellant experienced a spontaneous change in her accepted condition.[7]

Other reports from Dr. Deisher and Dr. Alander specifically declined to offer an opinion on whether appellant's condition was employment related. In a July 8, 2010 report, Dr. McCain related that appellant felt that her condition was due to her accepted condition. To the extent that this history provided by appellant constitutes Dr. McCain's opinion, he did not provide any medical rationale in which he explained the reasons why any disability was due to a spontaneous change in the accepted right lateral epicondylitis.

Although appellant submitted October 2011 statements from Drs. Katubig and Gabrawy, both pathologists, supporting her claim, these statements were not rendered as treating physicians but as former coworkers and supervisors. Neither physician noted examining appellant and neither provided any medical reasoning explaining how her disability in June 2010 was due to a spontaneous change in her accepted condition.

[6] *See id. See also Jaja K. Asaramo*, 55 ECAB 200 (2004) (where 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).

[7] *See George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of little probative value).

Appellant submitted medical reports from 2008 and 2009 that predated the onset of the claimed recurrent disability. Thus, these reports are of no value in establishing the claim. The remainder of the medical evidence, including diagnostic test reports, is insufficient as it does not provide an opinion on the causal relationship between the claimed disability and appellant's accepted right lateral epicondylitis. Appellant also submitted evidence from a physician's assistant and a nurse practitioner. However, the Board has held that treatment notes signed by a nurse or physician's assistant are not considered medical evidence as these providers are not a physician under FECA.[8]

Appellant did not otherwise submit medical evidence supporting that she sustained a recurrence of disability causally related to her accepted condition. Therefore, she did not meet her burden of proof in establishing that she sustained a recurrence of disability.[9]

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.[10]

CONCLUSION

The Board finds that appellant has not met her burden of proof in establishing that she sustained a recurrence of disability causally related to her accepted condition.

[8] *See David P. Sawchuk*, 57 ECAB 316 (2006) (lay individuals such as physician's assistants, nurses and physical therapists are not competent to render a medical opinion under FECA); 5 U.S.C. § 8101(2) (this subsection defines a "physician" as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law).

[9] The case at hand can be distinguished from those cases wherein a claimant returned to light-duty work for a brief period and her disability was supported by a physician's opinion with no evidence that her disability was due to any factor other than her work-related condition. *See Janice F. Migut*, 50 ECAB 166 (1998). In this case, the reports most contemporaneous with the onset of the claimed disability, from Drs. Merrell and Kaar who treated appellant, noted complaints out of proportion to findings and both indicated that appellant could work without restriction.

[10] Appellant submitted new evidence on appeal. However, the Board may not consider such evidence for the first time on appeal. *See* 20 C.F.R. § 501.2(c).

ORDER

IT IS HEREBY ORDERED THAT the February 13, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 12, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board