

U. S. DEPARTMENT OF LABO

Employees' Compensation Appeals Board

In the Matter of BOBBY S. WINES and DEPARTMENT OF VETERANS AFFAIRS,
VETERANS ADMINISTRATION MEDICAL CENTER, Murfreesboro, TN

*Docket No. 97-1668; Submitted on the Record;
Issued September 8, 1999*

DECISION and ORDER

Before DAVID S. GERSON, BRADLEY T. KNOTT,
A. PETER KANJORSKI

The issues are: (1) whether appellant has established that he sustained a recurrence of disability commencing January 27, 1995, causally related to his September 17, 1993 accepted L5-S1 herniated nucleus pulposus; and (2) whether the Office of Workers' Compensation Programs abused its discretion by denying appellant's request for L5-S1 herniated disc surgery.

On September 17, 1993 appellant, then a 23-year-old nursing assistant, experienced back pain which became progressively more severe, when his partner in a team lift dropped her side of the patient, causing the patient's weight to fall totally on appellant. A magnetic resonance imaging (MRI) scan of the lumbar spine performed on November 12, 1993 was reported as demonstrating "a [six] mm [millimeter] central L5-S1 disc bulge/herniation" and "minor bilateral neural foraminal narrowing at L5-S1." Electromyographic (EMG) testing on November 23, 1993 was reported as demonstrating "soft evidence of mild chronic left sciatic neuropathy." The Office accepted that appellant sustained a herniated nucleus pulposus at L5-S1.

By letter to the Office dated December 10, 1993, Dr. Cully A. Cobb, Jr., a Board-certified neurosurgeon, commented on appellant's case, noting: "Despite the appearance of a large disc herniation I felt that continuing [appellant's] physical therapy and medications would be appropriate and that there is a reasonable chance that he will make a satisfactory recovery without surgery." On December 20, 1993 he opined that appellant could return to light sedentary duty part time.

Appellant returned to light sedentary duty for four hours per day on December 27, 1993.

However, on January 10, 1994 Dr. Cobb examined appellant, noted continuing pain, weakness and hypalgesia, opined that this was "certainly not a very satisfactory level of recovery," and referred appellant to Dr. Hester for consideration of possible surgery.

By report dated January 11, 1994, Dr. Ray W. Hester, a Board-certified neurosurgeon, noted that appellant had a disc rupture with associated irritation of the nerve root, that at that point they were trying to avoid surgery, but that if the situation did not improve over the next 6 to 12 months, and if appellant developed increasing weakness or something of that sort, then an operation would be mandatory. He recommended continued restricted activity.

Appellant continued on restricted duty, increasing his hours from 25 to 32 hours per week on April 24, 1994 and continued to have pain and difficulties.

By medical progress note dated July 14, 1994, Dr. Hester noted that appellant was continuing to have problems with pain, trouble when walking any distance, his leg feeling like it was giving out, a pinching sensation going into both calves and positive straight leg raising at 80 to 90 degrees. A July 21, 1994 note indicated that a repeat MRI scan showed "a moderate to severe broad based disc herniation protrusion at the L5-S1 area that goes over to both sides causing bilateral-lateral recess stenosis at the present." Dr. Hester opined that since this had not changed since appellant's 1993 MRI, this was a situation that was deserving of an operation since appellant had failed to improve sufficiently to return to work on a full-time basis. He opined that postoperatively appellant had about an 85 to 90 percent chance of getting enough resolution to enable him to return to work on a full-time basis.

By report dated July 26, 1994, Dr. Hester advised that he had treated appellant "with restricted activities and medication and therapy, all to no avail over the past year. He does have an underlying ruptured disc which we feel would benefit from operative intervention with the idea of improving him so that he could work full time and not require therapy or medication in the future. We have recommended this to [appellant] and would like approval from [the Office] as far as payment is concerned so that he might be able to afford to proceed with proper medical care."

By report dated September 13, 1994, Dr. Hester noted that appellant continued to have problems with his back and leg pain, that he had a disc protrusion at the lower interspace with a repeat MRI scan showing the disc to still be present and protruding and that appellant was a candidate for an operation which would proceed when approval was granted, or sooner if he should develop any emergency situations. By medical progress note dated October 27, 1994, Dr. Hester noted that appellant was still having pain in his back and into his legs, that he continued to work 32 hours per week, and that work hurt and caused him problems. Dr. Hester advised appellant that he could either continue with his present regimen and wait until the Office made a decision on whether to authorize surgery, or he could go ahead with surgery using his regular insurance and then seek reimbursement after an Office decision was made.

On November 16, 1994 the employing establishment noted appellant's increasing use of sick leave and unscheduled annual leave and recommended, since this sick leave was due to his back, that he seek further medical treatment and obtain medical verification that he could continue to work 10-hour shifts.

On February 1, 1995 appellant filed a claim for recurrence of disability commencing January 27, 1995. In explanation appellant stated that since his 1993 herniated disc injury, he had attempted to work light duty and part time, but that his condition had not improved.

Appellant claimed that the herniated disc had worsened to the point that his physician released him from duty and that he was unable to fight his crippling pain any longer.

In support of the recurrence claim appellant submitted a February 7, 1995 report from his Board-certified treating osteopathic family practitioner, Dr. David G. Florence, which reviewed appellant's history of injury and treatment, noted that a recent MRI clearly showed that his condition, regardless of physical therapy and medications, continued to be very much still present, opined that appellant required the requested surgery, "now so more than ever due to the continued suffering and deterioration in his condition." Dr. Florence diagnosed "degenerative effects of an L5-S1 disc protrusion combined with the disabling complications involving the previously stated mild chronic left sciatic neuropathy," and noted that he continued to suffer from sharp pains and numbness in his lower extremities which all appeared to coincide with his original September 17, 1993 injury. Dr. Florence noted that he provided a recommendation to the employing establishment dated January 27, 1995 stating that appellant was to remain off duty for four to six weeks, during which he would undergo physical therapy in the hopes that that combined with rest would allow him to suffer as little as possible.¹ Dr. Florence agreed with Dr. Hester that surgery was required and he opined that until pressure could be relieved off the nerve and some repair can be surgically made, appellant's condition would continue to worsen. He indicated that physical therapy and medications only alleviated appellant's symptoms, and would not be a means for a cure and indicated that appellant's current state only reinforced that fact. Dr. Florence opined that appellant's recurrence was definitely a result of his original injury of September 17, 1993. He noted that from the date of injury appellant had been unable to perform his regular job, that he had been given light duty, but that, in accordance with his recommendation of January 27, 1995, he felt it was in appellant's best interest to remain off duty and continue with rest and physical therapy, due to the severity of his pain and also because of the weakness, numbness and sharp pains in his lower extremities. Dr. Florence opined that appellant was an excellent candidate for surgery and that such surgery would enable him to return to his regular duties and his life.

The Office referred appellant's record to an Office medical adviser, who by response dated February 14, 1995 opined "no" to the question of whether the proposed surgery was indicated. The Office medical adviser commented: "[Appellant's] medical records show no evidence of radiculopathy. Dr. Cully Cobb on November 7, 1993 said the same and noted 'surgery is not immediately indicated.'"

By report dated May 30, 1995, Dr. Hester noted that appellant still had the same problems and he opined that surgery was the "most appropriate approach to [appellant's] situation after this long period of time." He noted that appellant continued "to have significant amounts of pain in his back and associated numbness an[d] so forth going into his legs working 32 hours a week on restricted activities." Dr. Hester noted appellant's continued working restrictions as determined in October 1994, that he had had some increase in his pain, and that he had "stopped work beginning in January of 1995." He opined that "[appellant] would benefit

¹ A copy of the January 27, 1995 recommendation to the employing establishment was also submitted which noted that on that day appellant's back pain was so severe that he had to leave work and seek medical treatment. Dr. Florence opined that appellant needed to have his back problem repaired surgically.

from an operation and removal of the disc protrusion at the present time and that he would then be able to return to work” with reduced work restrictions. Dr. Hester opined that at that time appellant was unable to work without being on pain medication and that that was not an acceptable alternative at that point and that he either needed to stay off from work so that he would take less pain medication or he needed to go ahead with an operation so that he could return to work.

A second report that date from Dr. Hester advised appellant’s family practitioner that he continued to have problems and difficulty with pain in his back and legs, that he had a problem with a protruding L5-S1 disc, that appellant had been a candidate for an operation for these months, and that he had continued to get, if anything, somewhat worse. Dr. Hester opined that appellant still was a candidate for surgery, and that because of his deterioration, he was unable to work at the present time.

The Office then referred appellant to Dr. John C. McInnis, a Board-certified orthopedic surgeon, for a second opinion.

By report dated June 6, 1995, Dr. McInnis examined appellant and noted:

“[T]here was some mildly objective evidence to support a radiculopathy on [appellant]. That is, the minor neural foramen narrowing by the central disc herniation. His straight leg raising, however, was normal. I continue to feel that surgery may alleviate [appellant’s] left leg pain but may not ‘dramatically improve his back pain.’ With successful surgery, it is possible that his lifting restrictions may improve, but I would feel that he would always have some restrictions as far as heavy lifting and avoiding repetitive bending and stooping.”

By reports dated July 25, 1995, Dr. Hester noted that appellant still had protrusion of the L5-S1 disc out into the foramen on either side, that he continued to have pain in both legs, that straight leg raising to 80 degrees caused pain to the calves bilaterally, and that he was a candidate for decompression surgery at L5 bilaterally with foramenotomies. He noted that appellant was scheduled for surgery using his own insurance and that he needed to continue to be off work for another month.

By decision dated July 31, 1995, the Office rejected appellant’s claim for a recurrence of disability commencing January 27, 1995 and rejected his request for corrective surgery. The Office found that surgery could not be authorized because the weight of the medical evidence lay with the Office medical adviser and Dr. McInnis who both opined that surgery would be of little benefit. The Office stated that Drs. Cobb and McInnis found only mild radiculopathy and that Dr. Cobb felt surgery was inappropriate in 1993, the Office medical adviser felt it was inappropriate in 1994 and Dr. McInnis felt it was inappropriate in 1995. The Office further found that the medical evidence of record did not support that appellant sustained a recurrence of total disability on January 27, 1995. The Office found that Dr. Florence did not provide objective evidence that appellant’s condition had worsened or medical rationale as to why.

By letter to the Office dated August 1, 1995, the employing establishment noted that appellant had been off work since January 27, 1995, that appellant had been offered light duty

within the October 1994 work restrictions but had declined the job, that Dr. Hester had indicated appellant's work restrictions and yet that he opined that appellant should remain off work. The employing establishment opined that "It appears that [appellant] is and has been physically capable of performing light duty similar to that he was performing at the time of alleged recurrence, as well as duties offered in May 1995."

On September 1, 1995 appellant requested a hearing, which was denied by decision dated December 13, 1995 on the grounds that it was untimely requested and that appellant could request reconsideration and submit new evidence or argument in support.

Thereafter appellant underwent the recommended surgery using his private insurance.

On July 31, 1996 appellant requested reconsideration and resubmitted medical evidence previously of record. He also submitted an April 11, 1995 copy of Dr. McInnis's second opinion evaluation which diagnosed central disc herniation at L5-S1, which noted positive straight leg raising test results at 45 degrees, and which opined:

"It would appear that [appellant] has had good conservative treatment with failure to improve. I told him, however, that the surgery would most likely improve his leg pain, [but] may do very little as far as improving his back pain. I have no other suggestions as far as treatment is concerned *other than surgery. I think surgery for removal of the central disc herniation at L5-S1 is reasonable*, although I doubt we will improve all of [appellant's] back problems." (Emphasis added.)

Additionally submitted was an attending physician's report dated May 17, 1995 signed by Dr. Florence which noted that appellant had a recurrence of disability commencing January 24, 1995, and noted that appellant's condition at that time was a degeneration of his initial injury. The report noted that the injury warranted either a discectomy or a laminectomy, and indicated that appellant was totally disabled from January 27 through June 17, 1995.

Appellant also submitted medical reports from his postoperative period. Of record were medical progress reports dated October 24 and November 28, 1995 from Dr. Hester which noted that postoperatively appellant was markedly improved and was gradually increasing his activities and feeling much better. Less severe activity restrictions were prescribed. In January 1996 Dr. Hester opined that appellant could return to work as of January 2, 1996.

By report dated July 30, 1996, Dr. Hester noted that following the recommended surgery, appellant "made a marked improvement" and "w[as] then able to go back to a more full-time type of activity." He noted that at surgery it was determined that appellant had degenerative joint disease, disc protrusion, stenosis and compression of the nerve roots, causing pain and numbness going into his legs.

Appellant also offered the argument that the Office's second opinion specialist was an orthopedist and not a neurosurgeon, and that the nature of appellant's problem and the surgery requested was neurosurgical, such that orthopedists were not experts on neurosurgical problems and therefore their opinions on the need for neurosurgery were of diminished probative value.

By decision dated April 2, 1997, the Office denied modification of the prior decision finding that the evidence submitted was insufficient to warrant modification. The Office contended that Drs. Cobb and McInnis and the Office medical adviser were the weight of the medical evidence, and it quoted its discretion in authorizing such requested surgery.

The Board finds that the Office abused its discretion in denying surgical authorization.

With regard to prospective surgical authorization, section 8103(a) of the Federal Employees' Compensation Act provides for furnishing to an injured employee "the services, appliances and supplies prescribed by a qualified physician" which the Office "considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation."² The Board has found that the Office has great discretion in determining whether a particular type of treatment is likely to cure or give relief.³

Further, in order to be entitled to reimbursement of medical expenses, appellant must establish that the expenditures were incurred for treatment of the effects of an employment-related injury. Proof of causal relation in a case such as this must include supporting rationalized medical evidence.⁴

The medical opinions upon which the Office relied in denying surgical authorization did not contain the statements with which the Office attributed them. The Office claimed that Dr. Cobb's 1993 report stated that surgery was inappropriate, which he did not so state, as he opined only that surgery was not immediately necessary and that conservative treatment would be tried first. Further, the Office, in its denial decision, overlooked Dr. Cobb's subsequent, and more recent January 10, 1994 report which stated that the recommended conservative treatment yielded "certainly not a very satisfactory level of recovery," and the fact that he then explained that he was referring appellant to Dr. Hester for consideration of possible surgery.

The Office should not have relied on the report of the Office medical adviser, as the Office medical adviser omitted any consideration of Dr. Cobb's January 10, 1994 change in therapeutic direction toward evaluation for surgery, which followed an unsuccessful period of his recommend conservative treatment. The Office medical adviser merely quoted Dr. Cobb's initial opinion as stating that surgery was not immediately necessary at that time, and ignored his subsequent opinion. Further, the Board notes that the Office medical adviser incorrectly stated that appellant's record showed no evidence of radiculopathy, as November 23, 1993 EMG testing demonstrated a left sciatic neuropathy,⁵ and as Dr. Hester reported multiple symptoms of radiculopathy. Further, the Office medical adviser's short opinion is contradicted by the Office's

² 5 U.S.C. § 8103(a).

³ *James E. Archie*, 43 ECAB 180 (1991); *Daniel J. Perea*, 42 ECAB 214 (1990); *William F. Gay*, 38 ECAB 599 (1987).

⁴ *Bertha L. Arnold*, 38 ECAB 282 (1986); *Delores May Pearson*, 34 ECAB 995 (1983); *Zane H. Cassell*, 32 ECAB 1537 (1981); *John R. Benton*, 15 ECAB 48 (1963).

⁵ The Board notes that a radiculopathy is a subcategory or type of neuropathy; see DORLAND'S ILLUSTRATED *Medical Dictionary*, 27th Edition, p.1131, (1988).

second opinion physician, who reported the presence of radiculopathy on June 6, 1995, along with the identification of mechanical neural foramen narrowing by the disc herniation. As the Office medical adviser's opinion was not based upon a complete review of the record, overlooking Dr. Cobb's January 10, 1994 opinion and EMG testing results, and as it was contradicted by the Office's own second opinion physician's findings, the Office should not have relied on this opinion.

Moreover, contrary to the Office's finding that Dr. McInnis found that surgery was inappropriate in 1995, he did not. Most of Dr. McInnis's statements were couched in equivocal and speculative terms and avoided any semblance of definitive or certain opinion. Further, Dr. McInnis supported the appropriateness of surgery stating that he felt that surgery might alleviate appellant's leg symptoms, that he had no recommendation for further treatment except surgery, and that he felt that surgery for removal for the central; disc herniation at L5-S1 was reasonable. These opinions do not support the Office's characterization that Dr. McInnis felt that surgery was inappropriate. The Board notes that Dr. McInnis also stated that with successful surgery it was *possible* that appellant's lifting restrictions *might* improve, but that it "*might* not dramatically improve" his back pain, or that surgery "*might* do little" for appellant's back, but these speculative statements were unrationalized and, balanced against his supportive statements, do not provide significant or sufficient support for the Office's finding that the requested surgery would not "cure, give relief, reduce the degree of disability or aid in lessening the amount of compensation." In fact, the Board notes that Dr. McInnis does support that surgery would give relief and reduce the degree of disability with respect to appellant's leg symptomatology.

As the totality of other medical evidence of record supports that mechanical repair of the central disc herniation which caused bilateral recess stenosis and obstructed the neural foramina, would reduce if not alleviate appellant's disabling symptomatology, and as postoperative reports demonstrated that, in fact, that was exactly what happened as a result of surgery, appellant has met his burden of proof to be entitled to reimbursement of medical expenses, as postoperative reports establish that the expenditures were incurred for treatment of the effects of his employment-related injury.

The Board further finds that the case is not in posture for decision on the issue of appellant's January 27, 1995 recurrence of disability claim.

An employee returning to light duty, or whose medical evidence shows the ability to perform light duty, has the burden of proof to establish a recurrence of temporary total disability by the weight of reliable, probative and substantial evidence and to show that he cannot perform the light duty.⁶ As part of his burden, the employee must show a change in the nature and extent of the injury-related conditions or a change in the nature and extent of the light-duty requirements.⁷

⁶ *Terry R. Hedman*, 38 ECA 222, 227 (1986).

⁷ *Id.*

In this case, appellant alleged a change in the nature and extent of his herniated disc injury by deterioration in his condition and increasingly disabling pain, and he has submitted supportive medical evidence.

Proceedings under the Act are not adversary in nature, nor is the Office a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence to see that justice is done.⁸ This holds true in recurrence claims as well as in initial traumatic and occupational claims. In the instant case, although none of appellant's treating physicians' reports contain rationale sufficient to completely discharge appellant's burden of proving by the weight of reliable, substantial and probative evidence that he sustained a recurrence of total disability, causally related to his September 17, 1993 injury, they constitute substantial, uncontradicted evidence in support of appellant's claim and raise an uncontroverted inference of causal relationship between his allegedly disabling complaints and period of disability and his original traumatic injury, that is sufficient to require further development of the case record by the Office.⁹ Additionally, there is no opposing medical evidence in the record.

The case must therefore be remanded to the Office for the completion of a corrected statement of accepted facts,¹⁰ and for referral of appellant, together with the complete case record augmented by medical evidence regarding appellant's September 1995 surgery, and the specific questions to be answered, to a Board-certified neurosurgeon, for a rationalized opinion of whether appellant sustained a recurrence of disability commencing January 27, 1995, causally related to his accepted herniated disc injury.

⁸ *William J. Cantrell*, 34 ECAB 1223 (1983).

⁹ *John J. Carlone*, 41 ECAB 354 (1989); *Horace Langhorne*, 29 ECAB 820 (1978); see also *Cheryl A. Monnell*, 40 ECAB 545 (1989); *Bobby W. Hornbuckle*, 38 ECAB 626 (1987) (if medical evidence establishes that residuals of an employment-related impairment are such that they prevent an employee from continuing in the employment, he is entitled to compensation for any loss of wage-earning capacity resulting from such incapacity).

¹⁰ The Board notes that several of the statements of accepted facts of record contain inaccurate information.

Consequently, the decision of the Office of Workers' Compensation Programs dated April 2, 1997 is hereby reversed in part, set aside in part, and remanded for further development in accordance with this decision and order of the Board.

Dated, Washington, D.C.
September 8, 1999

David S. Gerson
Member

Bradley T. Knott
Alternate Member

A. Peter Kanjorski
Alternate Member