United States Department of Labor
Employees' Compensation Appeals Board

P.F., Appellant	)	
and	)	**Docket No. 14-1881**
	)	**Issued: April 24, 2015**
DEPARTMENT OF VETERANS AFFAIRS, LEXINGTON VETERANS ADMINISTRATION MEDICAL CENTER, Lexington, KY, Employer	)	

Appearances:
Allan J. Shapiro, Esq., for the appellant
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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 26, 2014 appellant, through counsel, filed a timely appeal from a July 30, 2014 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 that she sustained a recurrence of disability on June 3, 2013 causally related to the accepted employment injury of May 28, 2009.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On May 28, 2009 appellant then a 43-year-old nurse, injured her left arm when a patient grabbed her. OWCP accepted her claim for sprain of the left shoulder and upper arm and expanded her claim to include other affections of the left shoulder region not elsewhere classified, left causalgia of the upper left limb, and sprain of the left shoulder, upper arm, and rotator cuff. It authorized a July 18, 2012 left shoulder arthroscopic debridement, capsular release, and subacromial decompression performed by Dr. W. Ben Kibler, a Board-certified orthopedist. After surgery appellant returned to work in a full-time light-duty position on August 20, 2012.

After appellant claimed a schedule award, on April 16, 2013, OWCP referred her to Dr. E. Gregory Fisher, a Board-certified orthopedist, for a second opinion regarding permanent impairment and her work status.[2] In a May 7, 2013 report, Dr. Fisher noted no obvious muscle atrophy of the deltoid or left shoulder girdle, no winging of the left scapula, intact sensation over the left shoulder, intact muscle strength, negative impingement sign, and decreased range of motion in abduction and forward flexion of the left shoulder. He opined that the sprains of the shoulder and upper arm, other specified sites on the left, sprains of the shoulder and upper arm, rotator cuff healed in a matter of months and she reached maximum medical improvement by August 1, 2009. With regard to the other affections of the left shoulder region, appellant underwent surgery on July 18, 2012 and was released from care on February 28, 2013. Dr. Fisher noted that the sprain of the shoulder and upper arm, other specified sites on the left, sprains of the shoulder, and upper arm, rotator cuff resolved. He advised, with regard to the other affections of the left shoulder region, appellant continued to have residuals of decreased motion of the left shoulder. Dr. Fisher opined that she sustained a 10 percent impairment of the left arm.[3] He diagnosed postoperative status arthroscopy of the left shoulder with debridement, acromioplasty for the left shoulder impingement syndrome. In a work capacity evaluation of May 6, 2013, Dr. Fisher noted that appellant could return to work full time with permanent restrictions on pushing, pulling, and lifting more than 10 pounds occasionally and 5 pounds frequently.

On July 5, 2013 appellant filed a Form CA-2a, notice of recurrence of disability, asserting that she had a recurrence of disability for which she stopped work commencing June 3, 2013. She noted that the date of her original injury was May 28, 2009 and she worked full-time light duty since August 20, 2012. Appellant stated that her condition never completely healed. The employing establishment noted that she was placed in a limited-duty assignment within her work restrictions after her injury and that her work duties had remained within her restrictions.

Appellant submitted reports from Dr. Kibler dated July 5, 2013, who noted that she presented with soreness, tenderness, and fibromyalgia-type symptoms in the upper trapezius with soreness around the right shoulder with impingement. Dr. Kibler noted trigger points in the

[2] Matters pertaining to permanent impairment are not before the Board on the present appeal.

[3] On May 14, 2013 OWCP issued appellant a schedule award for 10 percent permanent impairment of the left arm.

trapezius, latissimus, and pectoralis minor. Appellant reported that her job caused her symptoms to increase and she requested to be off work for a while. Dr. Kibler noted that he gave her an "off work" slip until she could get into a pain management clinic. In workers' compensation visit reports dated a July 5 and August 5, 2013, he noted that appellant was unable to return to work until she could see a pain management physician for Botox injections for multiple trigger points and fibromyalgia. In a work status report dated July 23, 2013, Dr. Kibler noted that she was unable to work pending an appointment with a pain management physician. On August 5, 2013 he noted that appellant underwent injections, which relieved her muscle spasm, but she reported limiting pain and soreness in the upper trapezius, biceps, and triceps. Dr. Kibler noted that her pain prevented her from doing normal work activities. In another August 5, 2013 report, he recommended that appellant not work until he saw the results of the Botox injections. Dr. Kibler diagnosed impingement with centrally mediated pain response and muscle spasms. He opined that the prognosis was guarded about a return to work because of the extreme limitations due to pain. Appellant submitted a July 31, 2013 report from Dr. William O. Witt, a Board-certified anesthesiologist to whom she was referred by Dr. Kibler, diagnosed muscle spasm, myalgia and myositis, and thoracic spine pain. Dr. Witt noted administering Myobloc injections.

In an August 15, 2013 letter, OWCP advised appellant of the type evidence needed to establish her recurrence of disability claim. It particularly requested a physician's reasoned opinion addressing the relationship of her claimed condition and specific employment factors.

Appellant provided an August 5, 2013 work status note from Dr. Kibler who indicated that she was unable to work while the Botox was in effect. In a September 5, 2013 report, Dr. Kibler noted that injections reduced her spasms, but she had arm weakness. In a September 5, 2013 workers' compensation visit report, he noted that appellant could return to modified duty on September 9, 2013 with the prior restrictions. On September 23, 2013 Dr. Kibler noted that she reported fibromyalgia-type pain in her upper trapezius, medial scapular border, biceps, and triceps. He noted mild impingement and diagnosed reflex sympathetic dystrophy. Dr. Kibler indicated that he did not have much to offer appellant, but recommended pain management and Botox injections.

On September 9, 2013 appellant accepted the employing establishment's limited-duty position offer in patient care service subject to her physician's restrictions.

In a September 9, 2013 letter, appellant noted that she returned to restricted duty after her 2012 surgery. She reported that the muscle spasms, pain, and swelling never stopped and she was treated continuously since May 28, 2009. Appellant noted that her work activities were restricted since returning to work and the exacerbation of muscle spasms, pain, and swelling in her left shoulder, scapula, and neck was a chronic issue that limited her ability to do anything work related. She noted that her disability was due to her May 28, 2009 work injury. Appellant advised that Dr. Kibler placed her off work from July 5, 2013. She stated that he released her to work on September 9, 2013 with restrictions for four to six hours per day as tolerated.

In an October 11, 2013 decision, OWCP found that the medical evidence submitted did not establish that appellant sustained a recurrence of disability.

On October 22, 2013 appellant requested an oral hearing. She submitted an October 17, 2013 report from Dr. Kibler who noted that she was stable and no further treatment was anticipated. In a workers' compensation visit report dated October 17, 2013, Dr. Kibler noted that appellant could continue modified duty with the same restrictions. Appellant submitted reports from Dr. June Abadilla, a family practitioner, dated September 30 and October 14, 2013, who treated appellant for worsening shoulder pains radiating into her hands with numbness. Dr. Abadilla noted a history of injury and treatment and diagnosed hypothyroidism, restless leg syndrome, hyperlipidemia, peripheral vertigo, bilateral joint shoulder pain, and cervical radiculopathy. She noted that appellant continued to work in a clerical job. On September 30, 2013 Dr. Abadilla took appellant off work for two weeks. On October 14, 2013 she noted that appellant could return to work on January 14, 2014.

Appellant filed a Form CA-7, claim for compensation, asserting that she was totally disabled for the period August 19 to December 20, 2013. In a letter dated December 31, 2013, OWCP requested that she submit medical evidence establishing total disability from work on August 19, 2013.

In an undated report, Dr. Abadilla noted that appellant had chronic shoulder, arm pain, and weakness since a work incident on May 8, 2009. She noted a magnetic resonance imaging (MRI) scan of the left shoulder revealed lateral and medial impingement of the left shoulder with capsular tear. Dr. Abadilla indicated that studies revealed significant cervical disc disease with muscle spasm which was "likely aggravated by prior trauma at work." She noted that appellant was not able to perform the type of work that she used to do and opined that she was disabled from her usual work. Dr. Abadilla noted that, prior to appellant's injury, she never had issues with her shoulders or arms, and she opined that the trauma she sustained at work "may have" caused her current symptoms. In a January 14, 2014 work capacity evaluation, she noted that appellant was disabled from work due to shoulder pain.

Appellant also submitted reports from Dr. Michael Harned, Board-certified in pain medicine. In a December 12, 2013 reports, Dr. Harned noted that her left shoulder pain and discussed performing a ganglion block. On January 29, 2014 he administered a cervical epidural steroid injection and diagnosed cervical radiculitis.

In a February 11, 2014 decision, OWCP denied appellant's claim for compensation for the period August 19 to December 20, 2013, on the grounds that the evidence did not establish that her total disability was due to her accepted work injury.[4]

A telephonic hearing was held on April 21, 2014 with regard to the denial of appellant's claim for a recurrence of disability. Appellant testified that she returned to light-duty work after her 2012 surgery and that she continued receiving treatment for her injury as her symptoms never resolved. She indicated that she stopped work on June 3, 2013 due to her increased symptoms.

[4] Appellant also filed a CA-7 form, claim for compensation, for the period December 21, 2013 to June 5, 2014. In a decision dated July 29, 2014, OWCP denied that claim. Appellant did not appeal that decision and that matter is not presently before the Board.

Appellant submitted additional medical evidence. In reports dated January 14 to July 11, 2014, Dr. Abadilla treated appellant for worsening neck and shoulder pain from the May 28, 2009 work injury. She opined that appellant was disabled from work. Dr. Abadilla diagnosed cervicalgia, depression, diabetes, hypothyroidism, degeneration of cervical intervertebral disc, and osteoarthritis of the acromioclavicular joint. She treated appellant on June 25, 2013 for worsening bilateral shoulder pain. Dr. Abadilla noted tenderness to palpation of the bilateral upper extremities with pain with joint motion. Diagnoses included paresthesias of the left leg, restless leg syndrome, and bilateral shoulder joint pain. Dr. Abadilla noted that appellant was off work. In reports dated October 7 to November 1, 2013, she treated appellant for arm and neck pain and noted diagnoses. Dr. Abadilla indicated that appellant had arm and neck pain and that a MRI scan revealed C4-6 spinal stenosis.

Appellant also provided February 28 and April 19, 2013, reports from Dr. Kibler who diagnosed a flare-up of fibromyalgia with pain around the trapezius and performed injections. Dr. Kibler continued her work restrictions. Reports from Dr. Harned dated February 27 to July 10, 2014, diagnosed arthralgia of the shoulder, neuropathic pain, and muscle spasm. On March 10, May 19 and June 2, 2014, he performed a stellate ganglion block at left C6 and diagnosed pain in the limb. Appellant was treated on December 3, 2013 by Dr. Phillip A. Tibbs, a Board-certified neurosurgeon, who noted a history of injury on May 28, 2009 and subsequent treatment. Dr. Tibbs noted that a cervical spine MRI scan revealed a minor bulge at C4-6 with no cord compression.[5] He diagnosed complex regional pain syndrome and recommended stellate ganglion blocks.

Appellant was treated by Dr. Kaveh R. Sajadi, a Board-certified orthopedist, on April 10, 2014 for left shoulder pain. She reported a work injury in 2009 and surgery in 2011 without relief from her symptoms. Dr. Sajadi related that appellant noted "continued litigation regarding this work-related injury." He noted that her MRI scan was normal and opined that her symptoms were not consistent with recurrence of impingement, rather, he opined that her symptoms were consistent with complex regional pain syndrome especially in the shoulder.

In a decision dated July 30, 2014, an OWCP hearing representative affirmed the October 11, 2013 decision denying appellant's claim for a recurrence of disability beginning June 3, 2013.

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 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

[5] An MRI scan of the cervical spine dated October 15, 2013 showed broad-based disc bulges at C4-5 and C5-6 causing central spinal stenosis.

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.[6]

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 this 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.[7] To establish a change in the nature and extent of the injury-related condition, there must be a probative medical opinion, based on a complete and accurate factual and medical history as well as supported by sound medical reasoning, that the disabling condition is causally related to employment factors.[8] In the absence of rationale, the medical evidence is of diminished probative value.[9] While the opinion of a physician supporting causal relationship need not be one of absolute medical certainty, it must not be speculative or equivocal. The opinion should be expressed in terms of a reasonable degree of medical certainty.[10]

ANALYSIS

OWCP accepted that appellant sustained sprain of the left shoulder and upper arm and expanded her claim to include other affections of the left shoulder region, causalgia of the upper left limb, and sprain of the rotator cuff. It authorized a left shoulder subacromial decompression that was performed on July 18, 2012. Appellant returned to a full-time light-duty position on August 20, 2012 and continued to work until June 3, 2013 when she stopped work. On July 5, 2013 she filed a claim for a recurrence of disability.[11] The Board finds that the existing medical record lacks a well-reasoned narrative from appellant's physicians relating her claimed recurrent disability to her accepted employment injury. Furthermore, appellant has not presented evidence that the employing establishment either withdrew her light-duty job or changed her duties so as to require her to exceed her physical restrictions.

Appellant submitted a July 5, 2013 report from Dr. Kibler, who noted that she had soreness, tenderness, and fibromyalgia-type symptoms in the arms with impingement. She reported that her job caused increased symptoms and she requested to be off work. Dr. Kibler

[6] *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).

[7] *A.M.*, Docket No. 09-1895 (issued April 23, 2010); *Terry R. Hedman*, 38 ECAB 222 (1986).

[8] *Mary A. Ceglia*, 55 ECAB 626, 629 (2004).

[9] *Id.*; *Robert H. St. Onge*, 43 ECAB 1169 (1992).

[10] *Ricky S. Storms*, 52 ECAB 349 (2001).

[11] Appellant returned to a part-time light-duty position on September 9, 2013 and worked intermittently thereafter.

noted giving appellant an "off work" slip until she could see a pain management physician. In July 5 and August 5, 2013 reports, he noted that she could not work until she could see a pain management physician. In the August 5, 2013 reports, Dr. Kibler noted that appellant had injections that relieved her muscle spasm, but she reported limiting pain and soreness in the upper trapezius. He diagnosed impingement with centrally-mediated pain response and muscle spasms. Dr. Kibler noted that appellant was unable to work while the Botox injections were in effect. None these reports most contemporaneous with the claimed recurrence noted a specific date of a recurrence of disability, nor did he note a particular change in the nature of her physical condition, arising from the work injury, which prevented her from performing her light-duty position.[12] Additionally, the Board notes that there is no "bridging evidence" which would relate the fibromyalgia condition to the accepted employment injury.[13] That is, Dr. Kibler does not explain, how the accepted left shoulder and arm conditions were exacerbated by appellant's work factors to result in fibromyalgia. OWCP has not accepted that she developed fibromyalgia as a result of his May 28, 2009 work injury and there is no medical evidence to support such a conclusion.[14] Other reports from Dr. Kibler either predate the claimed period of recurrent disability or do not specifically address how appellant had a spontaneous change in her accepted conditions that caused her recurrent disability.

Appellant was also treated by Dr. Abadilla. In an undated report, Dr. Abadilla noted that appellant had chronic shoulder, arm pain, and weakness since a May 8, 2009 work incident. She advised that appellant had significant cervical disc disease with muscle spasm, which was "likely aggravated by prior trauma at work." Dr. Abadilla noted that appellant's condition was worsening and she was disabled. She noted that, before appellant's work injury, she never had issues with her shoulders or arms and she believed that the work trauma "may have" caused her current symptoms. This report is of limited probative value as Dr. Abadilla did not specifically address whether appellant had a recurrence of disability on June 3, 2013 causally related to the accepted employment condition. She did not otherwise provide medical reasoning explaining why any current condition or disability was due to the accepted May 28, 2009 work injury. Rather, Dr. Abadilla opined that appellant's condition was "likely aggravated by prior trauma at work" and the trauma she sustained at work "may have" caused her current symptoms. At best, this provides only speculative support for causal relationship.[15] Therefore, this report is insufficient to meet appellant's burden of proof. Other reports from Dr. Abadilla are also deficient as they do not specifically address how appellant's disability beginning June 3, 2013 was due to a spontaneous change in her accepted conditions.

[12] *See Katherine A. Williamson*, 33 ECAB 1696 (1982); *Arthur N. Meyers*, 23 ECAB 111 (1971) (where the Board has consistently held that contemporaneous evidence is entitled to greater probative value than later evidence).

[13] For the importance of bridging evidence in establishing a claim of continuing disability see *Robert H. St. Onge*, 43 ECAB 1169, 1175 (1992).

[14] *See Jaja K. Asaramo*, 55 ECAB 200 (2004) (for conditions not accepted by OWCP as due to a work injury, the claimant bears the burden of proof to establish that the condition is causally related to the work injury).

[15] Medical opinions that are speculative or equivocal in character are of diminished probative value. *D.D.*, 57 ECAB 734 (2006).

On April 10, 2014 appellant was treated by Dr. Sajadi who related that she noted "continued litigation regarding this work-related injury." However, Dr. Sajadi advised that her MRI scan was normal and opined that her symptoms were not consistent with recurrence of impingement but, rather, were consistent with complex regional pain syndrome in the shoulder. Thus, this report does support a recurrence of disability, but rather indicates that appellant's symptoms were due to a nonaccepted condition. As Dr. Sajadi did not explain how complex regional pain syndrome would have been caused or aggravated by her accepted conditions, his report is insufficient to establish the recurrence claim.

Appellant also submitted provided reports from Drs. Witt, Tibbs, and Harned. While these physicians noted their treatment of her, they are insufficient to establish her claim for a recurrence of disability beginning June 3, 2013, as none of these physicians explained how there was a spontaneous change in her accepted condition beginning that date nor did they otherwise explain how any diagnosed condition and associated disability are causally related to the accepted work injury.

The Board further notes that Dr. Fisher, an OWCP referral physician, in a May 6, 2013 work capacity evaluation and May 7, 2013 report, indicated that appellant could work full-time within restrictions that were consistent with her limited-duty job. Appellant did not otherwise submit medical evidence supporting that she sustained a recurrence of disability beginning June 3, 2013, causally related to her May 28, 2009 work injury.

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 has not met her burden of proof in establishing that she sustained a recurrence of disability on June 3, 2013 causally related to the accepted employment injury of May 28, 2009.

ORDER

IT IS HEREBY ORDERED THAT the July 30, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 24, 2015
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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