United States Department of Labor
Employees' Compensation Appeals Board

L.G., Appellant	)	
and	)	**Docket No. 15-1790**
	)	**Issued: February 17, 2016**
DEPARTMENT OF VETERANS AFFAIRS, AUDIE L. MURPHY VETERANS ADMINISTRATION MEDICAL CENTER, San Antonio, TX, Employer	)	

Appearances:
Alan 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
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 28, 2015 appellant, through counsel, filed a timely appeal from an April 15, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met her burden of proof to establish a recurrence of disability on November 8, 2013 causally related to accepted employment injuries.

On appeal counsel asserts that the April 15, 2015 decision is contrary to fact and law.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On May 9, 2005 OWCP accepted that appellant, then a 47-year-old medical technologist, injured her lower back on August 13, 2004. The claim, adjudicated by OWCP under file number xxxxxx154, was accepted for lumbago, lumbar sprain, and thoracic or lumbosacral neuritis or radiculitis. On April 21, 2005 appellant again injured her back. OWCP adjudicated this claim under file number xxxxxx950 and accepted lumbar sprain. In decisions, under file number xxxxxx154, dated July 2 and August 8, 2007, OWCP denied appellant's claims for compensation for April 11, 2007 and continuing.

Appellant filed an additional claim for a May 16, 2010 injury, adjudicated by OWCP under file number xxxxxx028. OWCP accepted degeneration of lumbar or lumbosacral intervertebral disc, and displacement of lumbar intervertebral disc without myelopathy. Under file number xxxxxx028, in an August 25, 2011 decision, it denied appellant's claim for compensation for the period June 15 through 24, 2011. These claims were combined, with the xxxxxx154 claim becoming the master file.[2]

On January 3, 2014 appellant filed a recurrence claim, Form CA-2a, under file number xxxxxx154. She indicated that she had been working six hours of restricted duty daily. Appellant related that the recurrence occurred on November 8, 2013, and that she stopped work on December 13, 2013. She explained that, because she was scheduled for an epidural steroid injection she had to discontinue heart medication, and the day after the procedure she had shortness of breath, increased blood pressure and perspiration, and that her kidneys stopped functioning. Appellant related that the problems persisted.

The employing establishment indicated that appellant had been on restricted duty since the claims were accepted and was currently working six hours of restricted duty daily.[3] Appellant thereafter submitted claims for compensation (Form CA-7) for the period August 1, 2012 to August 15, 2015. The record indicates that she has preexisting lupus, coronary artery disease, and hypertension.

By letter dated March 24, 2014, OWCP advised appellant of the evidence needed to support her recurrence claim. Appellant was asked to provide all medical records related to her condition and include a narrative report from her physician that explained the relationship between the accepted conditions and any consequential condition and/or disability. She was to complete an attached questionnaire regarding the claimed condition/disability. In a separate March 24, 2014 letter, OWCP advised appellant that it would not address her CA-7 claims until the recurrence claim had been adjudicated.

Medical evidence submitted at that time, relevant to the claimed recurrence, included a number of reports from Dr. Yurii Borshch, Board-certified in anesthesiology and pain medicine. On September 20, 2013 Dr. Borshch reported seeing appellant for pain and medication management. He noted a past medical history of hypertension, anxiety disorder, heart disease,

[2] Appellant also has a number of additional claims that are not part of the present appeal.

[3] Appellant was restricted to 10 pounds lifting; one-half hour bending, stooping, and twisting; and one-quarter hour pulling and pushing.

lupus, depression, muscle spasms, heart attacks, heart stent, and incontinence, with active problems of anxiety, hypertension, brachial neuritis, chronic pain syndrome, enthesopathy of hip, lumbosacral spondylosis, long medication use, and lumbosacral neuritis radiculitis. Dr. Borshch advised that she would have an epidural steroid injection on her next visit and, in preparation she would stop Coumadin, an anticoagulant, and use injection therapy with Lovenox, also an anticoagulant. On October 17, 2013 he advised that appellant had a lumbar epidural steroid injection that day. Dr. Borshch described the procedure, advised that no complications were noted, and that appellant was discharged home with a designated driver.[4]

In reports dated October 23, 2013, Dr. Rodrigo David Cantu, Board-certified in family medicine, found that appellant could work no more than six hours daily due to chronic pain. On November 6, 2013 Dr. Shaun Jackson, Board-certified in physiatry and pain medicine, advised that appellant was seen for an electrodiagnostic study.[5]

On November 7, 2013 Dr. Borshch advised that appellant was seen to evaluate the outcome of the epidural steroid injection and that she reported that she was doing much better with pain control. He provided examination findings, noting no apparent cardiopulmonary distress. Dr. Borshch diagnosed lumbosacral neuritis, radiculitis, and chronic pain syndrome. On November 15, 2013 Dr. Cantu wrote that appellant should be excused from work from November 1 to 3, 2013 because she had a complication from treatment for her work-related injury.[6] On November 22, 2013 he reported that appellant's blood pressure was elevated since her last steroid injection and that she had an appointment with a cardiologist the following week. Dr. Cantu advised that her high blood pressure was not related to her injection and not work related.

On November 26, 2013 Dr. Jackie D. Stephenson, a Board-certified urologist, reported that anal sphincter testing revealed S1 radiculopathy with reduced anal sphincter response which was strongly suggestive that appellant's neurological injury was the cause of her urinary incontinence. She recommended a urodynamic study.

On December 24, 2013 Dr. Cantu noted that appellant was hospitalized due to complications including hypertension after an epidural steroid injection, had been out of work since December 13, 2013, and was totally disabled at that time. In reports dated January 3, 2014, he advised that appellant was under the care of a cardiologist, noting that she initially had severe hypertension, an electrocardiogram showed no acute change, and that after treatment was initiated she became hypotensive and required hospitalization. Dr. Cantu advised that she could not return to work because she felt fatigued and rundown. He diagnosed lumbar disc disease, herniated disc, and hypotension secondary to steroid injection for herniated disc.

On January 14, 2014 Dr. Robert M. Saad, Board-certified in internal medicine and cardiology, reported that he followed appellant for coronary artery disease with a history of stent placement requiring anti-platelet therapy. He reported that, in preparation for an epidural steroid

[4] OWCP authorized an epidural injection on October 4, 2013.

[5] A copy of the study is not found in the case record.

[6] In a November 18, 2013 report, Dr. H. Mobley, an OWCP medical adviser, discussed appellant's medication management.

injection on October 17, 2013, she was required to stop Plavix, an anticoagulant, and begin bridging with Lovenox, a different anticoagulant. Appellant maintained that since the last injection she had developed multiple syndromes and side effects including labile blood pressure, shortness of breath, diaphoresis, and frequent headaches. Dr. Saad indicated that she had been hospitalized in January 2014 for further evaluation and testing. He concluded that appellant "attributes her current status of symptoms to last [epidural steroid injection]."

On January 17, 2014 Dr. Cantu described appellant's report that she was improved but still fatigued with intermittent dizziness. He noted that she had stent procedures in 2005 and 2006. In a January 17, 2014 attending physician's report, Dr. Cantu noted that appellant had severe hypertension after a steroid injection and then became hypotensive and had to be hospitalized. He advised that appellant could not work.

On January 17, 2014 Dr. Borshch reported seeing appellant for follow-up evaluation of pain and medication management. He described examination findings and diagnosed lumbosacral neuritis radiculitis, chronic pain syndrome, and longtime medication use.

In treatment notes and duty status reports dated February 3 to March 17, 2014, Dr. Cantu diagnosed herniated lumbar disc and hypotension and advised that appellant could not work. In correspondence dated March 19, 2014, he advised that he had treated appellant for her work injury since 2004 and that she had experienced urgency and incontinence since that date. Dr. Cantu asked that incontinence be accepted as employment related. He noted that Dr. Stephenson was treating appellant for incontinence and reported that a November 2013 electrodiagnostic study conducted by Dr. Jackson concluded that appellant had lumbar nerve damage that caused her incontinence.[7] Dr. Jackson advised that appellant could not work.

Dr. Borshch continued to submit reports describing appellant's pain and medication management. On March 14, 2014 he noted appellant's report that she had been held off work for some time due to cardiac issues. On June 12, 2014 Dr. Borshch reported that she had a lumbar epidural steroid injection that day. On July 2, 2014 he reported that appellant's pain was 90 percent improved. Dr. Borshch saw her in follow-up on August 11, 2014.

In reports dated February 19 to June 25, 2014, Dr. Stephenson noted that appellant was having severe lumbar spasms, and that she had an urodynamic study which demonstrated moderate incontinence.

In a July 11, 2014 report, Dr. Cantu advised that appellant had a recent acute anteroseptal myocardial infarction that required stenting of the left anterior descending artery on December 19, 2013. He opined, "It is our opinion the myocardial infarction occurred as a direct result of her stopping the Plavix prior to her epidural spinal injection for her work injury." Dr. Cantu noted that appellant subsequently developed congestive heart failure "with volume overload after her myocardial infarction" which required continuous treatment for blood pressure

[7] *Supra* note 5.

and heart failure management. Appellant also submitted a publication regarding epidural injections and blood thinners.[8]

In a September 3, 2014 decision, OWCP denied the claim. It found the medical evidence insufficient to establish a December 13, 2013 recurrence because appellant had provided no medical evidence of disability due to an adverse reaction to epidural steroid injections.

Appellant's counsel timely requested a hearing before an OWCP hearing representative. He asked that OWCP accept acute anteroseptal myocardial infarction and neurogenic bladder. In reports dated September 11, 2014 to February 18, 2015, Dr. Borshch discussed physical examination findings and appellant's pain and medication management. He reiterated his diagnoses. On November 20, 2014 Dr. Borshch performed lumbar epidural steroid injection. On February 18, 2015 he additionally diagnosed enthesopathy of knee and hip.

In correspondence dated October 19, 2014, Dr. Stephenson advised that appellant had continued to have persistent back pain, with primary complaints of chronic lumbar back pain and severe urinary incontinence. She noted magnetic resonance imaging (MRI) scan and electrodiagnostic study findings, advising that they were consistent with a neurogenic bladder. Dr. Stephenson concluded that neurogenic bladder should be accepted. She also submitted reports dated August 27 to December 23, 2014 noting appellant's complaints of muscle spasms and urinary continence. Dr. Stephenson advised that appellant could not work.

A February 15, 2015 note with an illegible signature indicated that appellant had reached maximum medical improvement.

In a report dated February 23, 2015, Dr. Francis X. Burch, Board-certified in internal medicine and rheumatology, noted that appellant had an extremely complex prior history with employment injuries in 2004 and 2005, lupus, and coronary artery disease. He reported reviewing May 26, 2010 and April 26, 2014 lumbar spine MRI scans and a November 6, 2013 electrodiagnostic study.[9] Dr. Burch advised that he would continue the job restrictions provided by Dr. Stephenson.

At a hearing held on March 9, 2015 counsel argued that, based on the medical evidence of record, the claim should be expanded to include incontinence and myocardial infarction. Appellant testified that in the fall of 2013 she had to stop taking Plavix because an epidural steroid injection was scheduled, and that in December 2013 she had a myocardial infarction. She stated that she had not returned to work and had applied for disability retirement.

By decision dated April 15, 2015, an OWCP hearing representative found that the medical evidence of record was insufficient to establish a recurrence, noting that the record had very limited documentation from a physician regarding the December 2013 myocardial infarction and did not contain a well-reasoned opinion regarding the cause of the attack. She

[8] The record also includes an occupational disease claim and medical evidence regarding a June 18, 2014 fall in which appellant lacerated her thumb. OWCP adjudicated this claim separately.

[9] *Supra* note 5. The 2010 MRI scan demonstrated disc bulges at L3-4 and L5-S1 and multilevel facet joint arthrosis. A report of the April 26, 2014 study is not found in the case record.

affirmed the September 3, 2014 decision. The hearing representative also informed counsel and appellant to pursue acceptance of additional conditions with OWCP.

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.[10] This term also means an inability to work when a light-duty assignment made specifically to accommodate an employee's physical limitations due to her work-related injury or illness is withdrawn (except when such withdrawal occurs for reasons of misconduct, 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.[11]

An individual who claims a recurrence of disability resulting from an accepted employment injury has the burden to establish 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.[12]

ANALYSIS

The Board finds that appellant failed to meet her burden of proof to establish a recurrence of disability on November 8, 2013 causally related to accepted employment injuries. The accepted injuries under this combined claim are lumbago, lumbar sprain, and thoracic or lumbosacral neuritis or radiculitis, degeneration of lumbar or lumbosacral intervertebral disc, and displacement of lumbar intervertebral disc without myelopathy. Appellant has not returned to work since the claimed recurrence.

At the March 9, 2015 hearing, appellant testified that in the fall of 2013 she had to stop taking Plavix because an epidural steroid injection had been scheduled, and that in December 2013 she had a myocardial infarction. Any medical condition resulting from authorized examination or treatment may form the basis of a compensation claim for impairment or disability, regardless of the compensability of the original injury.[13] The Board, however, finds that appellant has submitted insufficient medical evidence to support that the claimed recurrence was related to treatment for the accepted conditions.

In July 2014 appellant submitted a publication regarding epidural injections and blood thinners. The Board has long held that excerpts from publications have little probative value in

[10] 20 C.F.R. § 10.5(x); *see Theresa L. Andrews*, 55 ECAB 719 (2004).

[11] *Id.*

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

[13] *D.B.*, 58 ECAB 354 (2007); *see* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Authorizing Examination and Treatment*, Chapter 3.300.2.b (February 2012).

resolving medical questions unless a physician shows the applicability of the general medical principles discussed in the articles to the specific factual situation at issue in the case.[14] There is no such opinion in this case.

Dr. Saad, appellant's attending cardiologist, did not report that appellant had a myocardial infarction and, as discussed below, appellant did not submit hospital records.

Appellant did not respond to the development letter sent to her by OWCP on March 24, 2014. On the recurrence claim form filed on January 3, 2014, she asserted that on the day following the October 17, 2013 steroid injection she had shortness of breath, increased blood pressure, and that her kidneys stopped functioning. However, the first medical evidence of record that mentioned any reactions to the October 17, 2013 procedure is a November 15, 2013 note from Dr. Cantu who advised that appellant had a complication from treatment. There is no contemporaneous medical evidence showing that appellant had an immediate reaction following the October 17, 2013 steroid injection. Likewise, although the record indicates that she was hospitalized on at least one occasion for hypotension and/or hypertension, and that she suffered a myocardial infarction, the record contains no records of the hospitalization(s) or treatment notes describing specific symptoms and sequelae.

As noted above, appellant's burden requires that she furnish 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 who supports that conclusion with sound medical reasoning.[15] Where no such rationale is present, the medical evidence is of diminished probative value.[16]

The record indicates that Dr. Borshch performed an epidural steroid injection on October 17, 2013. At that time he advised that there were no complications and appellant was discharged home. On November 7, 2013 Dr. Borshch advised that appellant reported that she was doing much better with pain control. He provided physical examination findings, noting no apparent cardiopulmonary distress. While Dr. Borshch noted on March 14, 2014 that appellant reported that she had been off work for some time due to cardiac issues, he provided no opinion or rationale to support disability. In his later reports, Dr. Borshch merely described appellant's pain and medication management and also diagnosed enthesopathy of knee and hip, conditions that are not accepted by OWCP.

As noted above, the earliest mention by a physician that appellant had complications from the October 17, 2013 epidural steroid injection is a November 15, 2013 note in which Dr. Cantu reported that appellant should be excused from work from November 1 to 3, 2013 because she had a complication from treatment for her work-related injury. On November 22, 2013 he reported a history that appellant's blood pressure had been elevated since her last steroid injection and that she had a cardiology appointment the following week. Dr. Cantu advised that her high blood pressure was not related to her injection and not work related. On December 24,

[14] *Roger G. Payne*, 55 ECAB 535 (2004).

[15] *Supra* note 12.

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

2013 he noted that appellant was hospitalized due to complications including hypertension after an epidural steroid injection and had not worked since December 13, 2013, was under a cardiologist's care, and could not work because she felt fatigued and rundown. On March 19, 2014 Dr. Cantu advised that he had treated appellant for a work injury since 2004 and that she had experienced urgency and incontinence since that date. He reported Dr. Stephenson's findings and conclusions asked that incontinence be accepted. On July 11, 2014 Dr. Cantu concluded that appellant's myocardial infarction resulted from her ceasing to take Plavix prior to the epidural spinal injection for her employment injury, thereby resulting in blood pressure and heart failure management. He continued to advise that appellant could not work. However, Dr. Cantu did not explain why he initially opined that appellant's elevated blood pressure was not related to the epidural steroid injection and later changed his mind. He did not provide any medical rationale explaining how and why appellant was disabled due to treatment for the effects of an employment injury. Medical opinions based upon an incomplete history or which are speculative or equivocal in character have little probative value.[17]

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.[18] Neither Dr. Borshch nor Dr. Cantu provided sufficient rationale. Their opinions are, therefore, of diminished probative value.[19]

Although Dr. Stephenson advised that appellant could not work, she diagnosed urinary incontinence caused by the employment injury, and this has not been accepted. She provided no opinion regarding whether appellant was disabled due to the accepted conditions and exhibited no knowledge of the modified duties she was performing when she stopped work. As noted by the OWCP hearing representative in the April 15, 2015 decision, appellant should pursue acceptance of this additional condition with OWCP. Dr. Stephenson's opinion is insufficient to establish a recurrence of disability on November 8, 2013.

Dr. Saad, an attending cardiologist, reported that since an epidural injection appellant had developed multiple syndromes and side effects including labile blood pressure, shortness of breath, diaphoresis, and frequent headaches. He noted that she was hospitalized in January 2014 for further evaluation and testing. In regard to causal relationship, Dr. Saad merely advised that appellant attributed her current symptoms to her last epidural steroid injection. He provided no personal conclusion as to the cause of her symptoms and hospitalization. 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.[20]

[17] *Frank Luis Rembisz*, 52 ECAB 147 (2000).

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

[19] *See T.M.*, Docket No. 08-975 (issued February 6, 2009). *See also supra* note 12 (the Board has held that contemporaneous evidence is entitled to greater probative value than later evidence).

[20] *Willie M. Miller*, 53 ECAB 697 (2002).

Likewise, Dr. Burch's opinion is of insufficient rationale to establish a November 8, 2013 recurrent. In his February 23, 2015 report, Dr. Burch merely noted that appellant had an extremely complex prior history, and, without further explanation, advised that he would continue the job restrictions provided by Dr. Stephenson.

As appellant did not submit sufficient medical evidence to establish a recurrence of disability on November 8, 2013 causally related to accepted employment injuries, she did not meet her burden of proof.[21]

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant did not meet her burden of proof to establish a recurrence of disability on November 8, 2013 causally related to accepted employment injuries.

ORDER

IT IS HEREBY ORDERED THAT the April 15, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 17, 2016
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[21] *Supra* note 16.