

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of KIRK BURDGE and DEPARTMENT OF THE ARMY,
LETTERKENNY ARMY DEPOT, Chambersburg, PA

*Docket No. 03-1886; Submitted on the Record;
Issued March 15, 2004*

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether appellant sustained an emotional condition causally related to his federal employment.

On April 23, 1996 appellant, then a 25-year-old mechanic, filed a notice of traumatic injury (Form CA-1) alleging that on April 10, 1996 a coworker swinging a sledge hammer caused a piece of metal from a broken sprocket to strike his cheek and lodge in his neck. In support of his claim, appellant submitted an April 10, 1996 report, from Dr. Fred Fotek, a surgeon, who wrote that he removed a broken sprocket found deep in appellant's neck musculature. Appellant remained off work until April 23, 1996, when he returned to light duty. In a May 14, 1996 decision, the Office of Workers' Compensation Programs accepted appellant's claim for a condition of foreign body open wound, complicated, to the neck. The Office paid intermittent wage loss until appellant returned to work full time with no restrictions on September 30, 1996.

On September 18, 1997 appellant returned to light duty with reduced hours but stopped work on November 7, 1997 and filed a recurrence claim that the Office eventually accepted. In a November 7, 1997 report, Dr. Raymond Reichwein, a neurologist, diagnosed neck myofascial pain syndrome with paroxysmal common migraine headaches and modest depression, secondary to chronic pain and lightheadedness largely related to mild postconcussive syndrome. Dr. Reichwein also stated that appellant reported being struck on the head in a fight two weeks ago.

On November 19, 1997 appellant's employment was terminated for misconduct, allegedly threatening his supervisor. A December 5, 1997 magnetic resonance imaging (MRI) scan revealed a fibrous scar between the sternocleidomastoid and trapezius muscles on the left side of appellant's neck that corresponded with where the metallic body was removed. In a February 26, 1998 report, Dr. John Keifer, a pain management specialist, wrote that appellant presented with recurring tingling and jitteriness on both upper extremities from his arm to his fingertips. He diagnosed myofascial pain with traumatic scar on his left mastoid and recurrent

headaches. On December 1, 1998 appellant filed a notice of recurrence writing that, since November 1997, he has had neck pain and pressure on his skull with cognitive impairment in concentration and memory. In a January 27, 1999 decision, the Office accepted appellant's claim.

In a February 5, 1999 letter, the Office referred appellant for a second opinion. In a February 22, 1999 report, Dr. Kornel Lukacs, a neurologist, wrote that appellant described pressure he felt in his shoulders, neck and head, with tingling in his fingers and headaches. On examination Dr. Lukacs found a full range of motion in his neck, no muscle spasms, tenderness, sensory loss or any objective evidence of a residual condition related to his accepted injuries. He opined that appellant's depression was not work related and that appellant was significantly recovered. He recommended no further medical treatments but appellant should return to work on light duty and a work hardening program. Dr. Lukacs also recommended a functional capacity evaluation.

Appellant began a work hardening program on April 5, 1999. A functional capacity evaluation was performed on April 14, 1999 and it was reported that appellant was believed to have put forth sub-maximum effort due to a fear of pain. No musculoskeletal deficits were found that would account for his perceived pain. The report indicated that appellant could perform at the light to medium light-duty level. It was also noted that appellant volunteered that he felt no pain driving, hunting, fishing or helping his relatives with excavating or replacing windows.

In an April 29, 1999 letter, Drs. Reichwein and Kevin Hargrave, both neurologists, stated that appellant reported constant neck pain with some numbness in his fingers. They reported normal strength in all extremities and no symptoms of radiculopathy. The physicians agreed with Dr. Lukacs' report that appellant had no deficits on neurological examination. They recommended that appellant receive bio feedback and psychotherapy to deal with chronic pain syndrome.

In a December 15, 1999 report, the Office proposed terminating appellant's compensation finding the weight of the evidence with Dr. Lukacs. In a letter dated January 5, 2000, appellant's representative wrote that appellant was still experiencing pain and needed more medical tests. No new medical evidence was submitted. On January 19, 2000 the Office finalized the termination.

In a February 3, 2000 letter, appellant requested a hearing and submitted an August 24, 1999 report from Dr. Reichwein, who stated that appellant continued to have prominent and fairly constant left neck pain that increased with all range of motion. He added that appellant also suffered from migraine headaches often preceded by neck pain. Dr. Reichwein opined that these conditions limited appellant's functional capacity. In a July 26, 2000 letter, appellant's representative argued that his accepted injury caused his bad temper that led to his termination from his federal employment.

In a September 22, 2000 decision, the hearing representative affirmed the January 19, 2000 termination finding that the weight of the medical evidence rested with Dr. Lukacs' well-rationalized report.

In an April 19, 2001 letter, appellant requested reconsideration. In support of his request, he submitted a report from Dr. Michael Weicks, a pain management specialist. In his December 22, 2000 report, Dr. Weicks stated that appellant presented with full range of motion in his cervical spine with no cutaneous abnormalities noted in his posterior lateral left neck. He diagnosed chronic neck pain of myofascial origin but probably the result of intramuscular scar tissue that was noted on past MRI scans and was probably causing small nerve irritation.

Appellant also submitted a January 25, 2001 report, from Dr. Robert Gerwin, a specialist in pain management and rehabilitative medicine, who stated that a review of an MRI scan reveals long-standing tissue damage and scarring where the surgical procedure was performed. He noted that palpation of that area revealed irregular and inconsistent muscle and scar tissue. He stated that appellant also reported that the skin on his left side of the neck had a burning sensation. Dr. Gerwin noted that appellant's symptoms were highly suggestive of a complex regional pain syndrome that was consistent with a soft tissue injury. He opined that appellant's depression was an understandable consequence of his accepted injury and should be considered a consequence of that injury.

In a March 31, 2001 report, Dr. Gerwin stated that he found a residual scar resulting from the accepted injury with tenderness that activated pain by physical stress and activity. He diagnosed myofascial pain, headaches and depression resulting, in part, from appellant's inability to work.

In a July 23, 2001 decision, the Office denied modification finding that the new medical evidence lacked supporting objective evidence. In an October 10, 2001 letter, appellant requested reconsideration and submitted a September 24, 2001 report from Dr. Gerwin, who wrote that MRI scans and objective testing show a fibrotic scarring in the posterior cervical triangle that is in the muscles of the posterolateral neck on the left side. He stated:

"The disruption of the local tissue is undoubtedly disrupted small nerve fibers that innervate muscle and blood vessels in that area. They can be a source of pain when adequately stimulated.... Activity, particularly intense physical activity, which is consistent with the kind of work that he does as manual laborer or a construction worker, is associated with increased movement and activation of the muscles in this area. We know from other muscle models that activation can take a nontender area of muscle and turn it into a major locus of pain. Disruption of adequate blood flow in an area scarring may cause ischemia if the demand of metabolic activity of the muscle in that area rises and local scarring does not permit adequate blood flow to the area.

"[Appellant] consistently points to that area as the primary source of pain. If he continues to be more active ... the pain spreads toward the midline posterior cervical muscles, not an unusual occurrence of referred pain.... His reports of pain associated with increased activity are consistent over time. Generally, it takes hours to a day or two for him to begin to get pain in the back of the neck with increased activity and then the pain becomes so severe that he vomits, has nausea and severe headaches.

“There is no doubt in my mind that the pain, as he describes it, is legitimate and is coming from the region of injured soft tissue in the back of the neck. In my opinion the severity of the pain is not at all unusual.”

In a November 6, 2001 letter, the district medical adviser found a conflict in the medical evidence and referred appellant for an independent medical examination (IME) to resolve the issue of whether appellant had any residuals of the accepted injury.

In a December 28, 2001 report, Dr. Francis Janton, a Board-certified neurologist, serving as the IME, stated that appellant described migraine headaches and pain in the left posterior neck region that throbbed, burned and tingled at times, felt as if the back of his skull was being pulled off, ranged from a 2 to 10 on a pain scale of 10 and increased with physical activity. Dr. Janton indicated that his review of the record and physical examination of appellant supported the diagnosis of persistent post-traumatic neck pain and intermittent migraine headaches without aura. He opined that the condition was clearly connected to the accepted injury. Dr. Janton found that the injury-related factors include persistent severe pain as well as the anticipation of pain with work-related activities. He noted that the objective findings are nil, but the subjective complaints establish the diagnosis. He added that appellant was disabled from any form of repetitive physical activity including light duty. Finally, Dr. Janton noted that appellant's prognosis was rather poor and that the psychological effects of his illness have taken on a major, if not predominant role and that future treatment should include ongoing psychological counseling ... for depression.

In a January 31, 2002 decision, the Office accepted appellant's claim for medical services and wage-loss compensation effective December 28, 2001, the day of Dr. Janton's report. The Office further noted that the medical evidence of record from appellant's treating neurologists, Drs. Hargrave and Reichwein, and an April 1999 functional capacity evaluation support that appellant was capable of light duty and the reports from Dr. Gerwin do not specifically address appellant's disability status. The decision also stated that appellant should be referred for a psychiatric evaluation.

In a February 25, 2002 report, Dr. Peter Rao, a psychiatrist, wrote that appellant reported that he had no family history of psychiatric symptoms and that, between the time of his accepted injury and when he was terminated, he developed symptoms of depression, including readily losing his temper and other temperamental changes. Appellant also reported unremitting daily dysphoria with diurnal variation, apathy, anergy, anhedonia, sleep disturbance and poor appetite.

Dr. Rao diagnosed appellant with recurrent major depression, without psychotic features with a history of chronic pain. He wrote that the October 1997 fight could have, but probably did not, affect appellant's mood as he was not rendered unconscious and there is no medical history to the contrary. He added that it would be reasonable to assume that appellant's depression started after his industrial accident and has been either persistent or recurrent.

Dr. Rao further stated that in general he did not believe that appellant's emotional condition was a consequence of the accepted injury noting that depression is a common illness with multiple factors involved at the outset. He added that the accepted incident did not specifically put appellant at risk of depression and that the accident is remote to any depression

appellant is currently suffering. Dr. Rao also ruled out any direct relationship between appellant's condition and the October 1997 fight and his history of alcohol use. Regarding appellant's ability to work, Dr. Rao opined that appellant was severely depressed with melancholic features that needed to be treated seriously and aggressively. He added that "this illness does not necessarily cause impairment in functioning in daily activities although for some people this does occur. Depression would give some nonspecific limitation in terms of the how well he would psychologically function at a job, though there is no specific and direct relationship." Dr. Rao concluded that "Depression is considered in general a treatable psychological problem. [Appellant] does need aggressive anti-depressant treatment along with weekly psychotherapy, which should last for four months. Once he has made improvement in his depression, I do not believe there is any psychological reason that he cannot be employed full time."

In a July 22, 2002 report, Dr. Gerwin found that appellant was feeling better but still had difficulty concentrating. He noted that appellant had been approved for C3 diagnostic block and denervation.

In a January 7, 2003 decision, the Office denied that appellant's emotional condition was related to his accepted injury giving the weight of the medical evidence to Dr. Rao's report.

In a January 20, 2003 letter, appellant, through his representative, requested reconsideration arguing that he needed a neuro-psychological examination not just a psychiatric one.

Appellant requested a review of the written record.¹ In an April 28, 2003 decision, the Branch of Hearings and Review affirmed the January 7, 2003 denial finding that the weight of the medical evidence rested with Dr. Rao. The reports of Dr. Gerwin were found to be of diminished probative value as they lacked sufficient rationale to support the opinion that appellant's emotional condition was causally related to his accepted injury and because Dr. Gerwin was not a specialist in psychiatric disorders.

The Board finds this case should be remanded for further development.

An employee who claims benefits under the Federal Employees' Compensation Act² has the burden of establishing the essential elements of his or her claim.³ The claimant has the burden of establishing by the weight of reliable, probative and substantial evidence that the condition, for which compensation is sought is causally related to a specific employment incident or to specific conditions of the employment. As part of this burden, the claimant must present rationalized medical opinion evidence, based upon a complete and accurate factual and medical

¹ Appellant also requested reconsideration of the January 31, 2002 denial of retroactive wage loss. The Board notes that there is no indication in the record of a final decision on that request. In his appeal to the Board, appellant, through his representative, specifically requested a review of the April 28, 2003 decision that affirmed the Office's January 7, 2003 denial of an emotional condition as work related.

² 5 U.S.C. §§ 8101-8193.

³ *Ruthie Evans*, 41 ECAB 416, 423-24 (1990); *Donald R. Vanlehn*, 40 ECAB 1237, 1238 (1989).

background, establishing causal relationship.⁴ However, it is well established that proceedings under the Act are not adversarial in nature and while the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.⁵ Once the Office undertakes to develop the medical evidence it has the responsibility to obtain an evaluation that resolves the issue.⁶

In the present case, the Office found that appellant failed to establish that he had an emotional condition causally related to his accepted injury. In doing so, the Office relied on Dr. Rao's February 25, 2002 report that addressed the critical issue of causal relationship by writing that in *general* (emphasis added) he did not believe that appellant's emotional condition was a consequence of the accepted injury noting that depression is a common illness with multiple factors involved at the outset. He added that the accepted incident did not *specifically* (emphasis added) put appellant at risk of depression and that the accident is *remote* (emphasis added) to any depression appellant is currently suffering. Dr. Rao also wrote that it was reasonable to assume that appellant's psychiatric problems began after the industrial accident and have been persistent or recurrent since then. The Board finds these statements on causal relationship to be vague, ambiguous and speculative. Moreover, Dr. Rao did not rule out, or discuss, the impact of the accident on appellant's emotional health, though several other doctors in the record attributed appellant's depression to the accepted condition, nor did the Office request a clarification of these ambiguous and speculative statements. As the Office referred appellant to Dr. Rao, it has the responsibility to obtain an evaluation that resolves the issue.⁷

Additionally, the Office accepted that appellant has a current residual disability related, including severe chronic pain. In accepting that these residuals were related to the accepted April 10, 1996 injury, the Office relied on the report of Dr. Gerwin, who also found that appellant had an emotional condition consequential to the April 10, 1996 injury.

Additionally, Drs. Hargrave, Reichwein and Janton each concluded that appellant's accepted condition had a psychological component. In his November 7, 1997 report, Dr. Reichwein diagnosed depression secondary to pain resulting from the accepted injury. In their April 29, 1999 report, Drs. Hargrave and Reichwien stated that appellant's medical condition was not neurological, but should be treated with psychological counseling and biofeedback. Dr. Janton, who the Office selected to conduct a referee medical examination, also stated in his December 28, 2001 report, that psychological effects of appellant's illness had taken on a major, if not predominant role in his medical problems.

The Board notes that, while none of these reports of appellant's attending physicians and the Office's independent medical examiner are completely rationalized, they are consistent in indicating that appellant sustained a consequential emotional condition causally related to the employment-related injury on April 10, 1996. While the reports are not sufficient to meet

⁴ *Brian E. Flescher*, 40 ECAB 532, 536 (1989); *Ronald K. White*, 37 ECAB 176, 178 (1985).

⁵ *Dorothy L. Sidwell*, 36 ECAB 699 (1985); *William J. Cantrell*, 34 ECAB 1233 (1983).

⁶ *Mae Z. Hackett* 34 ECAB 1421 (1983).

⁷ *Id.*

appellant's burden of proof to establish his claim, they raise an inference between appellant's claimed condition and the employment injury of April 10, 1996 and are sufficient to require the Office to further develop the medical evidence and the case record.⁸

Accordingly, the case will be remanded to the Office for further evidentiary development regarding the issue of whether appellant sustained an emotional condition as a consequence of the accepted employment-related injury on April 10, 1996. The Office should prepare a statement of accepted facts and obtain a medical opinion on this matter. After such development of the case record as the Office deems necessary, an appropriate decision shall be issued.

It is hereby ordered that the April 28, 2003 decision of the Office of Workers' Compensation Programs is set aside the case is remanded for further action consistent with this decision.

Dated, Washington, DC
March 15, 2004

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member

⁸ See *Robert A. Redmond*, 40 ECAB 796, 801 (1989).