United States Department of Labor
Employees' Compensation Appeals Board

C.S., Appellant	)	
and	)	**Docket No. 15-296**
	)	**Issued: April 9, 2015**
DEPARTMENT OF THE ARMY, TRAINING & DOCTRINE COMMAND, Kandahar Province, Afghanistan, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 21, 2014 appellant, through counsel, filed a timely appeal from a September 3, 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 this case.

ISSUE

The issue is whether appellant met his burden of proof to establish that he sustained an employment-related injury on July 14, 2012.

On appeal counsel asserts that the September 3, 2014 OWCP decision is contrary to law and fact.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

This case has previously been before the Board. In a March 19, 2014 decision, the Board found the case not in posture for decision. The Board found the opinion of Dr. Paul M. Joslin, a Board-certified internist, was sufficient to require further development of the medical record and remanded the case to OWCP to refer appellant, an updated statement of accepted facts, and the medical evidence of record to an appropriate Board-certified specialist for an examination, diagnosis, and a rationalized opinion as to whether appellant established that employment factors caused or aggravated his back or left lower extremity condition.[2] The law and facts of the previous Board decision are incorporated herein by reference.

Subsequent to the Board's March 19, 2014 decision, OWCP requested that the employing establishment provide a copy of appellant's position description and information regarding his deployment to Afghanistan, the date he stopped work, and the reason for his departure. It also referred appellant to Dr. John J. Sand, a Board-certified neurologist, for a second opinion evaluation. Dr. Sand was provided a statement of accepted facts and a set of questions.

On May 13, 2014 the employing establishment forwarded a position description and two Notifications of Personnel Action (Form 50). The first Form 50, effective August 29, 2011, indicated that appellant's appointment on that date was "excepted" and not to exceed October 28, 2013 and was subject to completion of 14 months. The second Form 50, effective October 28, 2012, indicated that appellant was terminated due to the expiration of appointment.

In a May 21, 2014 report, Dr. Sand noted his review of the medical record and the July 2012 incident. He indicated that neurological examination revealed that appellant was awake, alert, and oriented. Mental status was intact, and speech and language were normal. Pseudobulbar affect was not noted during the evaluation, and cranial nerves II through XII were intact. Motor examination revealed minimal weakness of the left hip and knee flexors with otherwise normal strength and tone throughout. Sensory examination was normal to touch, pin and stereognosis. Gait was normal on heels, on toes, and in tandem. Romberg test was negative. Finger to nose and heel to shin were normal, and rapid alternating movements were minimally slowed in the left foot. Dr. Sand diagnosed generalized muscle weakness. He advised

[2] Docket No. 13-1409 (issued March 19, 2014). Appellant filed a traumatic injury claim, alleging that on July 14, 2012 he sustained mono peripheral neuropathy of the lower left leg and foot. He indicated that, after sitting for 45 minutes at a remote Afghanistan location while in full combat gear, his left foot became numb and he could not walk normally when he stood, which caused him to fall. Appellant was treated by an Army medic that day and did not receive treatment from a physician until July 20, 2012. He was medically evacuated to the United States on August 15, 2012. In reports dated January 15 and 16, 2013, Dr. Joslin described the history of injury. He diagnosed left lower extremity paresis and numbness, lumbar radiculopathy and cerebrovascular disease. Dr. Joslin indicated that his medical opinion and explanation as to how the reported work incident caused or aggravated the diagnosed conditions would include two possibilities, both related to appellant's work in Afghanistan: first, that appellant's left lower extremity weakness, numbness, and foot drop were due to lumbar radiculopathy which would presumably be caused by disc bulging related to carrying an 80- to 100-pound pack. He opined that this would be a less likely explanation, in light of the absence of focal disc protrusion, spinal stenosis or foraminal encroachment shown on a September 11, 2012 lumbar magnetic resonance imaging (MRI) scan, indicating that the most likely explanation was that appellant's left lower extremity paresis, sensory deficit and foot drop were caused by an ischemic cerebrovascular accident in the right middle cerebral artery distribution, due to dehydration and hypovolemia in combination with extreme heat while on patrol in Afghanistan. Dr. Joslin concluded that appellant had recovered completely.

that appellant had a slowly resolving left lower extremity weakness syndrome, with symptomatology that had been stable for approximately one year, with minimal residual. Dr. Sand opined that appellant's history was consistent with a small right frontal cerebral infarction with sudden onset, stability for a few days or weeks, and then slow improvement over 3 to 12 months. He also stated that the history would also be consistent with peripheral nerve injury, stating that if this were the case, he would expect more sensory symptoms including pain and numbness. Dr. Sand indicated that it was difficult to reconstruct "this unusual situation" almost two years after the onset of symptoms, especially since neurologic evaluation and subsequent testing did not occur for weeks or months after the onset of symptoms. He stated that there would always be some question as to the diagnosis and causes of appellant's left leg weakness, but felt that the most likely diagnosis was a small right frontal cerebral infarction. Dr. Sand indicated that this was not due to dehydration because appellant would have had additional symptoms and bilateral findings. He concluded that the diagnosis of probable stroke was not related to work activities and indicated that a less likely alternative diagnosis was a peripheral nerve injury such as an L6 radiculopathy, which would be related to his work activities.

On May 27, 2014 appellant forwarded copies of an award presented to appellant and of a photograph of him with the gear he wore when traveling in Afghanistan from one command outpost to another. He also provided a Department of Defense Directive dated January 23, 2009 concerning civilian expeditionary workforce. This included the employing establishment's policy regarding employees who became ill or when injured while deployed.

In a supplemental report dated July 2, 2014, Dr. Sand indicated that appellant had a high likelihood that his left leg weakness was due to a stroke and was unrelated to work. He concluded, "I cannot be completely certain as to the cause of [appellant's] difficulties, but feel a diagnosis of stroke with reasonable certainty." On July 28, 2014 Dr. Sand indicated that there were no clear test results indicating a stroke and electrodiagnostic testing suggested lumbar radiculopathy which would be a lower back problem. He stated that the minimal findings on examination revealed weakness most consistent with stroke or other upper motor neuron cause, rather than radiculopathy. Dr. Sand further opined that the sudden onset of symptoms was much more stroke-like rather than a radiculopathy. He concluded that uncertainty remained as to the diagnosis of either stroke or radiculopathy or both but that the findings on examination and the sudden onset of symptoms were more suggestive of stroke and were therefore unrelated to appellant's employment.

In a merit decision dated September 3, 2014, OWCP found that, based on Dr. Sand's opinion that appellant's condition was likely caused by suspected stroke, unrelated to employment, appellant did not establish that he sustained an employment-related medical condition.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of establishing the essential elements of his or her claim including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was timely filed within the applicable time limitation period of FECA, that an injury was sustained in the performance of duty as alleged

and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury. Regardless of whether the asserted claim involves traumatic injury or occupational disease, an employee must satisfy this burden of proof.[3]

OWCP regulations, at 20 C.F.R. § 10.5(ee) define a traumatic injury as a condition of the body caused by a specific event or incident or series of events or incidents within a single workday or shift.[4] To determine whether an employee sustained a traumatic injury in the performance of duty, OWCP must determine whether "fact of injury" is established. First, an employee has the burden of demonstrating the occurrence of an injury at the time, place, and in the manner alleged, by a preponderance of the reliable, probative, and substantial evidence. Second, the employee must submit sufficient evidence, generally only in the form of medical evidence, to establish a causal relationship between the employment incident and the alleged disability and/or condition for which compensation is claimed. An employee may establish that the employment incident occurred as alleged, but fail to show that his or her disability and/or condition relates to the employment incident.[5]

Causal relationship is a medical issue, and the medical evidence required to establish a causal relationship is rationalized medical evidence.[6] The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[7] Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[8]

ANALYSIS

The Board finds this case is not in posture for decision as to whether appellant sustained an employment-related injury on July 14, 2012. In its September 3, 2014 decision, OWCP found that the weight of the medical evidence rested with Dr. Sand who provided a second opinion evaluation. The Board finds, however, that a conflict exists in the medical evidence with respect to whether appellant's diagnosed conditions were caused or aggravated by the July 12, 2012 incident.

In reports dated January 15 and 16, 2013, Dr. Joslin, an attending internist, diagnosed left lower extremity paresis and numbness, lumbar radiculopathy, and cerebrovascular disease. He indicated that there were two possibilities regarding how the July 2012 incident caused or

[3] *Gary J. Watling*, 52 ECAB 278 (2001).

[4] 20 C.F.R. § 10.5(ee) (1999, 2011); *Ellen L. Noble*, 55 ECAB 530 (2004).

[5] *Supra* note 3.

[6] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[7] *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

[8] *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

aggravated the diagnosed conditions, both related to appellant's work in Afghanistan: first that his left lower extremity weakness, numbness, and foot drop were due to lumbar radiculopathy which would presumably be caused by disc bulging related to carrying an 80- to 100-pound pack. Dr. Joslin opined that this would be a less likely explanation, in light of the absence of focal disc protrusion, spinal stenosis, or foraminal encroachment shown on a September 11, 2012 lumbar MRI scan, and that the most likely explanation was that appellant's left lower extremity paresis, sensory deficit, and foot drop were caused by an ischemic cerebrovascular accident in the right middle cerebral artery distribution, due to dehydration and hypovolemia in combination with extreme heat while on patrol in Afghanistan. He concluded that appellant had recovered completely.

In reports dated May 21, July 2 and 28, 2014, Dr. Sand diagnosed generalized muscle weakness, stating that appellant had a slowly resolving left lower extremity weakness syndrome, with symptomatology that had been stable for approximately one year, with minimal residual. He opined that the history would be consistent with a small right frontal cerebral infarction with sudden onset, stability for a few days or weeks, and then slow improvement over 2 to 12 months. However, the history would also be consistent with peripheral nerve injury, and that, if this were the case, he would expect more sensory symptoms including pain and numbness. Dr. Sand indicated that it was difficult to reconstruct "this unusual situation" almost two years after the onset of symptoms, especially since neurologic evaluation and subsequent testing did not occur for weeks or months after the onset of symptoms. He stated that, while there would always be some question as to the diagnosis that caused appellant's left leg weakness, there was a high likelihood that he had a small right frontal cerebral infarction. Dr. Sand opined that this was not due to dehydration because then appellant would have had additional symptoms and bilateral findings and concluded that the diagnosis of probable stroke was not related to work activities. He indicated that a less likely alternative diagnosis was a peripheral nerve injury such as lumbar radiculopathy, which would be related to his work activities. In a supplemental report dated July 2, 2014, Dr. Sand indicated that appellant had a high likelihood that his left leg weakness was due to a stroke and was unrelated to work, indicating that the minimal findings on examination revealed weakness most consistent with stroke or other upper motor neuron cause, rather than radiculopathy. He further opined that the sudden onset of symptoms was much more stroke-like rather than a radiculopathy. Dr. Sand concluded that uncertainty remained as to the diagnosis of either stroke or radiculopathy or both but that the findings on examination and the sudden onset of symptoms were more suggestive of stroke and were therefore unrelated to appellant's employment.

If there is disagreement between OWCP's referral physician and the employee's treating physician, OWCP will appoint a third physician who shall make an examination.[9] For a conflict to arise, the opposing physicians' viewpoints must be of virtually equal weight and rationale.[10] Dr. Joslin and Dr. Sand are in agreement that the most likely cause of appellant's lower extremity weakness was a stroke. They, however, disagree as to whether the stroke was caused by the July 14, 2012 employment incident. The Board finds their opinions to be of equal weight as to whether the diagnosed stroke was caused by the July 14, 2012 employment incident. The

[9] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

[10] *Darlene R. Kennedy*, 57 ECAB 414 (2006).

Board will set aside the September 3, 2014 decision and remand the case for OWCP to refer appellant to an impartial medical specialist to resolve the conflict. The impartial medical specialist should review the reports of both Dr. Joslin and Dr. Sand, along with the case record and statement of accepted facts, and provide a rationalized opinion as to whether appellant's diagnosed condition was caused or aggravated by the July 14, 2012 incident. After such further development as it deems necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds this case is not in posture for decision as there is an unresolved conflict in medical evidence regarding whether appellant met his burden of proof to establish that he sustained an employment-related injury on July 14, 2012.

ORDER

IT IS HEREBY ORDERED THAT the September 3, 2014 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: April 9, 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