

FACTUAL HISTORY

On July 26, 1999 appellant, a 40-year-old engineering technician,¹ filed a traumatic injury claim (Form CA-1) alleging that he had tick borne pathogens due to tick bites he received during the summers for the past six years.² The Office accepted the claim for Lyme disease.

In a September 11, 2000 report, Dr. Curtis J. Fitzsimmons, a treating Board-certified internist with a subspecialty certificate in infectious diseases, based upon a history of the employment injury and physical examination, diagnosed persistent fatigue of unknown etiology. With regard to appellant's symptoms, the physician opined that it appeared "that he did resolve his infection with ehrlichiosis last year," that the Ehrlichia serology test was negative and appellant's "symptoms do not sound particularly consistent with Lyme disease." The physician further noted:

"He has no significant arthritic complaints, but mainly has symptoms of just fatigue. Certainly, multiple possibilities are present including autoimmune processes, hepatitis, diabetes, kidney disease and so forth. In addition, his bipolar disorder may be causing a greater role in his symptoms than maybe first perceived. Chronic fatigue syndrome would be considered as well, but he has not had symptoms for six months yet. Also, it a [sic] diagnosis of exclusion. (2) Bipolar disorder. (3) Irritable bowel syndrome."

In a report dated October 21, 2000, Dr. Fitzsimmons noted that the laboratory tests for Ehrlichia Agent, Babesia microti and Ehrlichea Chaffeensis were negative.

In a February 6, 2001 report, Dr. Fitzsimmons diagnosed chronic fatigue syndrome. He noted that appellant stated that he attributed his symptoms to chronic fatigue syndrome after reading literature on the condition and "that he does not have Lyme or any other tick-borne illness at this time."

Appellant filed a claim for compensation (Form CA-7) on March 20, 2001 for the period September 1, 2000 to unknown.

In a March 21, 2001 attending physician's report (Form CA-20), Dr. James Gruber, an attending Board-certified family practitioner, diagnosed Lyme disease and concluded that appellant was totally disabled from September 1, 2000 to the present. He also concluded that appellant's chronic fatigue, chronic cognitive dysfunction, sleep disturbance and dysfunctional immune system were due to the Lyme disease.

In a letter dated May 3, 2001, the Office informed appellant that there was insufficient medical evidence to support his claim for wage loss due to the accepted condition. Specifically, the Office informed appellant that the medical evidence did not contain any diagnosis of any

¹ Appellant was a temporary employee whose appointment ran from May 18, 1998 through August 14, 1999.

² The Office also informed appellant that his claim was converted to an occupational disease status as his injury occurred over an extended period rather than during a single shift or 24-hour period.

tick-borne medical condition. The Office advised him to submit objective test results supporting his claim for disability due to his accepted condition and informed him the record would remain open for 30 days.

In a May 31, 2001 report, Dr. Gruber diagnosed “late disseminated Lyme disease with profound neuropsychiatric manifestations” and concluded that appellant was totally disabled due to this condition. Dr. Gruber noted that the basis of his diagnosis:

“[Appellant]’s signs and symptoms, his 1996 diagnosis of Lyme disease, his previous infections with [e]hrlichiosis and Rocky Mountain Spotted Fever, for which a coinfection with Lyme disease should be strongly suspected if not assumed, his response to antibiotic treatment including strong and predictable Jarisch Herxheimer reactions, and his history of tick bites while in the employment of the Forest Service.”

Regarding the Office’s request for objective medical testing, Dr. Gruber noted that the requirement for seropositive laboratory results “fall outside the accepted medical protocols for a diagnosis of Lyme disease.” Moreover, he noted that “[t]he diagnosis of Lyme disease is a clinical diagnosis as the laboratory tests available at this time cannot be used definitively to show the presence or absence of Lyme disease.” Dr. Gruber further opined that Lyme disease is a chronic diagnosis and appellant “has had an ongoing infection since at least the summer of 1999, if not earlier, and that the Lyme disease is a direct result of the tick bites” appellant received in the performance of duty. With regards to Dr. Fitzsimmons’ opinion, Dr. Gruber noted:

“It was Dr. Fitzsimmons’ contention that as a result of the tick borne diseases [appellant] was infected with during his employment with the Forest Service, that Human Herpes Virus Six (HHV-6) opportunistically reactivated, damaging [appellant]’s immune system and causing the C[hronic] F[atigue] I[mmune] D[ysfunction] S[ynndrome] to manifest itself. While I would not absolutely rule out this scenario, [appellant]’s history and evolution of symptoms is so indicative of late disseminated Lyme disease as to render Dr. Fitzsimmons’ diagnosis unlikely.”

Dr. Gruber, in an undated letter, received on August 16, 2001, responded to the Office’s request for additional information. He concluded that appellant did “have some component of chronic fatigue” which he attributed to appellant’s disseminated Lyme disease.

In a report dated September 25, 2001, Dr. Richard A. Jacobs, a treating Board-certified internist and clinical professor of medicine, infectious disease and tropical medicine, concluded that “at the present time there is no firm evidence that he has now or has had Lyme disease.” He further stated:

“I want to make it clear that, even if the Lyme disease serologies are negative, this certainly does not exclude a tick-borne illness causing his symptoms. I believe there are other tick-borne illnesses that have not been clearly delineated, but certainly could cause symptoms like [appellant] is experiencing.”

In support of his claim, appellant submitted several articles on Lyme disease and its associated treatment and symptoms.

By decision dated February 15, 2002, the Office denied appellant's claim for a recurrence of disability due to his accepted Lyme disease condition.

Appellant requested an oral hearing before an Office hearing representative in an undated letter received on March 14, 2002. A hearing was held on July 16, 2003 at which appellant was represented by counsel. Cid Morgan, appellant's roommate, also testified at the hearing.

In a report dated April 15, 2002, Dr. Carla M. Brandt, a treating Board-certified neurologist, in the assessment portion stated "[r]ule out Lyme disease versus alternate chronic infectious syndrome." She noted a lumbar puncture might "potentially be helpful with regard to further ruling out Lyme disease."

In a November 18, 2002 report, Dr. Peter Katona, a treating Board-certified internist, reported appellant's occupational history of many tick bites and symptoms of fever, fatigue, arthralgias, intermittent numbness of the upper extremities, myalgias and intellectually dull feeling. A physical examination was unremarkable. With regards to appellant's symptoms, Dr. Katona opined that they "may be caused by a drug reaction or pathology in the cervical spine" and "[a] tick is a much less likely source."

In a report dated January 10, 2003, Dr. Rachel Zabner, a treating Board-certified internist specializing in infectious disease, diagnosed history of Ehrlichia and status post treatment and a fever of unknown origin. Under assessment, she noted:

"The differential at this point is that the patient would have a different tick-related infection such as Babesia, which I have not seen, was checked. Other possibilities would be malaria since there are some cases of that in Indiana. It will be very unlikely but still positive. Other possibilities for the patient's symptoms could be sequelae of these Ehrlichia diseases, which were not too familiar with the long-term results of these diseases. Evidently, he does not have active disease from repeat testing and there is no description of chronic Ehrlichia once they are treated, and the last possibility that some of this patient's symptoms might be related to multiple sclerosis since there is a strong family history."

In a February 10, 2003 report, Dr. Howard L. Rosner, a treating Board-certified anesthesiologist, noted appellant's medical and employment injury which included a nonemployment-related neck injury sustained in 1997. Under impression, Dr. Rosner noted that appellant was "status post rickettsial infection of Rocky Mountain Spotted Fever and ehrlichiosis with neuropathic pain, which is cyclical in nature."

Dr. Zabner diagnosed "a postinfectious syndrome characterized by constitutional symptoms without actual functional disability or serologic evidence of the persistent infection." She noted that "the PCRs for Ehrlichia and Lyme were negative."

In a February 26, 2003 report, Dr. Ramin Gabbai, an attending Board-certified internist, reported appellant had been diagnosed with Rocky Mountain spotted fever and ehrlichiosis. Dr. Gabbai also noted:

“Subsequent to this, the patient developed a chronic syndrome which has debilitated him. A workup was initiated by Dr. Zabner to further investigate the possibility of recurrent Rickettsia and Rocky Mountain spotted fever. The documentation of these tests are not available to me, however, through my conversation with Dr. Zabner, the patient’s workup was negative for any active infectious pathology explaining these symptoms. However, this does not rule out the possibility of chronic and ongoing symptoms as a consequence of these diseases. Moreover, the patient’s general workup does not point to any renal, liver, electrolyte, or hormonal disease that could explain these symptoms.”

Moreover, Dr. Gabbai stated that appellant’s “pattern of symptoms point to a neurological, psychiatric, or combination of neuropsychiatric diseases which may or may not be” due to ehrlichiosis and Rocky Mountain spotted fever.

By decision dated October 14, 2003, the Office hearing representative affirmed the denial of appellant’s recurrence claim. Specifically, the hearing representative found the record lacked a well-rationalized opinion explaining why appellant’s disability as of September 2000 was causally related to his employment injury or addressed his family’s medical history.

LEGAL PRECEDENT

An employee who claims a recurrence of disability due to an accepted employment-related injury has the burden of establishing by the weight of the substantial, reliable and probative evidence that the disability for which he claims compensation is causally related to the accepted injury. This burden of proof requires that a claimant 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 supports that conclusion with sound medical reasoning.³

Causal relationship is a medical issue⁴ and the medical evidence required to establish a causal relationship is rationalized medical evidence. Rationalized medical evidence is medical evidence, which includes a physician’s rationalized medical opinion on the issue of whether there is a causal relationship between the claimant’s diagnosed condition and the implicated employment factors. 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

³ *Ronald A. Eldridge*, 53 ECAB ____ (Docket No. 01-67, issued November 14, 2001).

⁴ *Nicolette R. Kelstrom*, 54 ECAB ____ (Docket No. 03-275, issued May 14, 2003).

supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.⁵

ANALYSIS

In this case, the Office accepted that appellant sustained Lyme disease as a result of tick bites in the course of employment. He filed a claim for compensation beginning September 1, 2000. The Office requested that appellant provide medical evidence that would establish a causal relationship between the accepted condition of Lyme disease and his present disability particularly since the objective tests were negative for any tick-borne medical condition.

In support of his recurrence claim, appellant has submitted medical reports from various physicians including Drs. Brandt, Fitzsimmons, Gabbai, Gruber, Jacobs, Katona, Rosner, and Zabner. In the instant case, the only physician definitively attributing appellant's recurrence of disability to his accepted Lyme disease is Dr. Gruber.

In various reports, Dr. Gruber, an attending Board-certified family practitioner, attributed appellant's disability to his Lyme disease and concluded that appellant was totally disabled due to the Lyme disease. In an attending physician's report dated March 21, 2001, Dr. Gruber also attributed appellant's chronic fatigue, chronic cognitive dysfunction, sleep disturbance and dysfunctional immune system to his Lyme disease. In a May 31, 2001 report, Dr. Gruber diagnosed "late disseminated Lyme disease with profound neuropsychiatric manifestations" which totally disabled appellant. In support of his diagnosis, Dr. Gruber relied upon appellant's 1996 diagnosis of Lyme disease, his symptoms and signs, his history of tick bites. He also noted that the Office's request for seropositive laboratory results "fall outside the accepted medical protocols for a diagnosis of Lyme disease" and that the diagnosis of Lyme disease is a clinical diagnosis as the tests are unreliable. Subsequently, Dr. Gruber diagnosed chronic fatigue which he attributed to appellant's disseminated Lyme disease. In reaching his conclusion that appellant was totally disabled due to Lyme disease, Dr. Gruber has not provided sufficient rationale explaining how appellant was disabled due to Lyme disease particularly in light of the negative laboratory results for the disease. The only rationale provided by Dr. Gruber is that Lyme disease is a clinical disease and that the laboratory tests currently in use "cannot definitely be used to show the presence or absence of Lyme disease." In addition, Dr. Gruber attributes appellant's conditions of chronic fatigue, chronic cognitive dysfunction, sleep disturbance and dysfunctional immune system to his Lyme disease without providing any supporting rationale or documentation. Dr. Gruber's opinion regarding the cause of appellant's condition is speculative and is not supported by medical rationale. The Board has held that an opinion, which is speculative in nature, is of diminished probative value on the issue of causal relationship.⁶ The Board held in *Connie Johns*⁷ that the opinion of the physician must be one of reasonable medical

⁵ *Conard Hightower*, 54 ECAB ____ (Docket No. 02-1568, issued September 9, 2003); *Gary L. Fowler*, 45 ECAB 365 (1994); *Victor J. Woodhams*, 41 ECAB 345 (1989).

⁶ *Ricky S. Storms*, 52 ECAB 349 (2001).

⁷ *Connie Johns*, 44 ECAB 560 (1993); see also *Philip J. Deroo*, 39 ECAB 1294 (1988).

certainty, supported with affirmative evidence, explained by medical rationale and based on a complete and accurate factual and medical background. Dr. Gruber's opinion on causal relationship is of little probative value since it contains a conclusory statement on causal relationship.⁸ Further, Dr. Gruber is not a specialist in the field of infectious diseases while Drs. Fitzsimmons, Jacobs, Rosner and Zabner are Board-certified specialist in the relevant field.⁹

In addition, none of the specialists attributed appellant's disability to recurrent Lyme disease. Dr. Fitzsimmons, a Board-certified internist with a subspecialty certificate in infectious diseases, diagnosed chronic fatigue syndrome and concluded that appellant did not have Lyme disease or any other tick-borne disease. With regards to appellant's ehrlichiosis, Dr. Fitzsimmons opined that it appeared "that he did resolve his infection with ehrlichiosis last year," that the Ehrlichia serology test was negative and appellant's "symptoms do not sound particularly consistent with Lyme disease." Dr. Jacobs, a Board-certified internist and clinical professor of medicine, infectious disease and tropical medicine, concluded in his September 25, 2001 report that "at the present time there is no firm evidence that he has now or has had Lyme disease." Similarly, Dr. Zabner, a Board-certified internist specializing in infectious diseases, noted repeat testing was negative for Ehrlichia and opined a last possibility for the cause of appellant's symptoms might be a strong family history of multiple sclerosis. In a follow-up visit on February 24, 2003, she diagnosed "a postinfectious syndrome characterized by constitutional symptoms without functional disability of serologic evidence of persistent infection" and noted the testing for Ehrlichia and Lyme disease were negative.

Moreover, none of the remaining treating physicians of record attribute appellant's disability to his Lyme disease. Dr. Brand, a Board-certified neurologist, stated in an April 25, 2002 report "[r]ule out Lyme Disease versus alternate chronic infectious syndrome." In a November 18, 2002 report, Dr. Katona, a Board-certified internist, concluded that appellant's condition "may be caused by a drug reaction or pathology in the cervical spine" and that "[a] tick is a much less likely source." In a February 26, 2003 report, Dr. Gabbai, a Board-certified internist, who opined that appellant's "pattern of symptoms point to a neurological, psychiatric, or combination of neuropsychiatric diseases which may or may not be" due to Ehrlichia and Rocky Mountain spotted fever. The physician stated that appellant's "workup was negative for any active infectious pathology explaining these symptoms" and opined that this did "not rule out the possibility of chronic and ongoing symptoms as a consequence of these diseases."

Accordingly, the Board finds that the medical evidence does not establish that appellant sustained a recurrence of disability on and after September 1, 2000 causally related to his accepted Lyme disease. It is appellant's burden of proof and the evidence is insufficient to meet his burden in this case.¹⁰

⁸ *Albert C. Brown*, 52 ECAB 152 (2000).

⁹ See *Lee R. Newberry*, 34 ECAB 1294 (1983) (medical opinions of physicians who have training and knowledge in a specialized medical field have greater probative value).

¹⁰ See *Cleopatra McDougal-Saddler*, 47 ECAB 980 (1996); *Ronald A. Eldridge*, 53 ECAB ____ (Docket No. 01-67, issued November 14, 2001).

CONCLUSION

The Board finds that appellant has not established that he sustained a recurrence of disability on and after September 1, 2000 due to his accepted Lyme disease.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs' hearing representative dated October 14, 2003 is affirmed.

Issued: July 26, 2004
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member