United States Department of Labor
Employees' Compensation Appeals Board

J.R., Appellant	)	
and	)	**Docket No. 09-1792**
	)	**Issued: May 25, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Blue Springs, MO, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 6, 2009 appellant filed a timely appeal from the Office of Workers' Compensation Programs' decision dated January 30, 2009 which denied modification of a November 8, 2007 decision that found that she did not establish that she sustained a concussion causally related to her accepted work injury. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over these issues.

ISSUE

The issue is whether appellant met her burden of proof in establishing that she sustained a concussion causally related to her accepted January 10, 2007 work injury.

FACTUAL HISTORY

On January 10, 2007 appellant, then a 41-year-old rural letter carrier, filed a traumatic injury claim alleging that on that date she was rear-ended while in her work vehicle and sustained injuries to her head, neck and left ear. In a January 10, 2007 statement, she indicated that she was slowing down to turn right when she was hit from behind by a dark colored vehicle. Appellant confirmed that she was wearing her seatbelt and alleged that the "impact stunned me." She did not stop work.

In a January 10, 2007 duty status report, Dr. James L. Hart, Board-certified in emergency medicine, noted that appellant was in a motor vehicle collision and had a left ear contusion. In a January 12, 2007 duty status report, Dr. James Webb, a Board-certified family practitioner and osteopath, noted that appellant was rear-ended and suffered a "left contusion to the ear, head and her back hurt." He ordered physical therapy and released her to return to seated work. In a January 16, 2007 report, Dr. Webb diagnosed thoracolumbar strain. In his January 29, 2007 report, the physician diagnosed a lumbar strain.

In a January 17, 2007 physical therapy note, the physical therapist noted that appellant had complaints of "constant dizziness with intermittent headache, indicating the top of the skull described as pressure sensation."

In a March 2, 2007 report, Dr. Regina Aholt, a Board-certified family practitioner, noted that appellant was concerned about memory loss after the motor vehicle accident. She examined appellant and advised that she scored a 30 out of 30 on the "mini" mental status examination. Dr. Aholt indicated that appellant had memory loss after the motor vehicle accident and recommended a follow-up with a neurologist.

A March 8, 2007 computerized tomography (CT) scan read by Dr. Kevin L. Litwin, a Board-certified diagnostic radiologist, revealed a normal CT brain.

Appellant returned to regular duty on March 26, 2007.

The Office accepted her claim for back sprain in lumbar and thoracic regions, and contusion of face, scalp and neck except for eyes. It also accepted the claim for contusion of the left ear and a left shoulder strain.

On March 22, 2007 appellant requested that the Office expand her claim to include certain conditions including headaches, memory and concentration problems. She alleged that she reported the headaches as soon as she was seen in the emergency room and continued to have headaches with memory and concentration problems. Appellant also indicated that a computerized axial tomography scan had been performed.

By letter dated March 26, 2007, the Office advised appellant of the additional evidence needed to expand her claim. It received reports dated March 23 and April 20, 2007 from Dr. Jonathan Blake, a Board-certified orthopedic surgeon and osteopath, who diagnosed thoracic sprain and lumbosacral strain and contusion to the ear.

On May 3, 2007 appellant requested that her claim be expanded to include a concussion. She noted that a concussion was documented during her original emergency room visit.

In a June 5, 2007 decision, the Office denied appellant's claim for a concussion.

On June 21, 2007 appellant requested a review of the written record. She stated that the speed limit was 55 miles per hour on the highway on which she was rear-ended as she was turning onto a side street. Appellant noted that her vehicle was knocked into a concrete post. She provided photographs and a copy of a December 7, 2006 report from Dr. Aholt, which she

alleged supported that she had no prior concussion symptoms. In the December 7, 2006 report, Dr. Aholt noted seeing appellant for a well-woman examination.

On September 5, 2007 the Office received a March 30, 2007 report from Dr. Terrence Riley, Board-certified in preventative medicine, psychiatry and neurology, who noted the motor vehicle accident in which appellant was making a right turn and was struck from the rear. Dr. Riley noted that she was wearing a lap belt when she was struck. He noted that appellant's left ear struck something in the cabin and she was "uncertain whether she was rendered unconscious because she remembers many of the events immediately after the collision." Appellant had instant "maximum pain on the vertex of her scalp, but shortly thereafter she began the headaches bitemporally, parietally, and at the top of her head" that continued ever since. She also reported being unable to concentrate and having memory lapses for two and a half months since the accident. Dr. Riley noted as examples of appellant's concentration and memory loss an incident in which she was speaking with her mother and could not recall a portion of the conversation midway through and a situation where she did not realize a person that her mother was discussing had been a teacher to her children just the year before. He stated that appellant was confused with some of the technical aspects of her work citing that she could not remember some of the forms that she was required to use. Dr. Riley also noted that she forgot all about a planned lunch with her husband. He advised that neurologic examination was normal. The cranial nerves, motor system, reflexes, station and gait, sensation and coordination were normal. Dr. Riley diagnosed postconcussion syndrome and headache. He explained that, although his mental status examination did not disclose gross abnormalities, "certainly the loss of energy and cognitive complaints that she describes are familiar with closed head injuries." Dr. Riley prescribed medication and referred appellant for detailed neuropsychological testing noting that it "would be better able than I am to discern more subtle cognitive deficits from a closed head injury of this nature." He also explained that he reviewed the CT scan of the head and agreed that "it is normal, but of course that does not tell us much detail about a closed head injury such as hers."

In a November 8, 2007 decision, an Office hearing representative affirmed the June 5, 2007 decision. He found that the evidence did not establish that appellant sustained a concussion or postconcussion syndrome as a result of the January 10, 2007 motor vehicle accident.

In a January 7, 2008 report, Dr. Ann Y. Lee, a Board-certified physiatrist, noted the January 10, 2007 motor vehicle accident and diagnosed low back pain likely due to a strain with no neurological deficit and neck pain likely due to cervical strain/whiplash with no neurological deficit. Dr. Lee released appellant to regular duty on February 5, 2008.

The Office requested that an Office medical adviser address whether it was medically reasonable for appellant to experience postconcussion symptoms two and a half months after her injury and whether the Office accept a work-related postconcussion syndrome. On January 18, 2008 the Office medical adviser indicated that he needed all of the records in order to review appellant's claim, including her ambulance records. In a letter dated February 20, 2008, the Office advised appellant that additional evidence was needed.

In a June 30, 2008 statement, appellant indicated that she had a nonwork-related motor vehicle accident on January 15, 2008 and provided a police report and copies of records from an

emergency room visit. She indicated that Dr. Lee reevaluated her before allowing her to continue her ongoing physical therapy. Appellant also submitted treatment notes from Dr. Lee following the January 15, 2008 accident which indicated that appellant was treated for back and neck pain. She provided another copy of the March 8, 2007 CT scan and also a July 19, 2007 cervical spine x-ray from Dr. David Mena, a Board-certified diagnostic radiologist, who noted straightening of the normal cervical lordosis that was likely due to muscle spasm or cervical collar. Dr. Mena noted no obvious injuries. The Office also received January 15, 2008 cervical spine x-ray report from Dr. John E. Scott, a Board-certified diagnostic radiologist, who advised that there was no evidence of spasm, fracture or curvature change.

In a letter dated July 14, 2008, appellant's representative requested that the Office expand the claim to include appellant's left shoulder condition.

In a September 20, 2008 report, the Office medical adviser noted that, in the January 10, 2007 motor vehicle accident, appellant did not lose consciousness. He noted that he had reviewed copies of the emergency room treatment notes dated January 10, 2007. They revealed that appellant had left ear pain and headaches. Additionally, appellant received a 15 on the Glascow Coma Scale, had chief complaints of pain in the head and advised that skull examination revealed no tenderness. The Office medical adviser also indicated that she had no swelling or ecchymosis. Additionally, he noted that initial reports revealed that appellant thought "she thinks the radio struck her in the head." The Office medical adviser noted that "even if the radio struck her in the head, she had no examination findings of a head injury on January 10, 2007." Furthermore, he advised that her CT scan was normal. The Office medical adviser opined that the postconcussion syndrome was not due to the January 10, 2007 accident.

On October 21, 2008 appellant's representative requested reconsideration and submitted a September 10, 2008 report, from Dr. W. John Ellis, Board-certified in family medicine, who opined that appellant sustained a concussion during a motor vehicle accident on January 10, 2007 and had difficulty remembering all of the accident. Dr. Ellis noted that appellant recalled the accident but did not recall hitting a post. After the accident appellant reported feeling "dazed, foggy, and had difficulty concentrating. She had pain in her head and right lower buttock." Appellant also began noticing pain in her neck and between her shoulders. Dr. Ellis noted that her concussion was treated by observation and despite a negative CT scan she had neuropsychological testing, which was consistent with a concussion. He also noted that appellant was in another motor vehicle accident on January 15, 2008 in which she was also rear ended and dazed, but not unconscious. Dr. Ellis indicated that she was already undergoing physical therapy for her neck and at the time, she had more pain in her neck. He indicated that appellant did not think it changed her memory, thinking, dizziness or headaches. Dr. Ellis related that appellant continued to have significant problems from her concussion and brain injury. He indicated that she had headaches that could be tight in the back of the head, top of the head, and sides of the head and had been continuous since the accident. Dr. Ellis also noted that she continued to be dizzy and indicated that she had tenderness of the temporal muscles and temporal arteries, the site of her throbbing headache. He diagnosed a contusion to the left ear; a concussion causing complex integrated cerebral function disturbance due to brain damage and postconcussion headache syndrome; muscle tendon strain of the neck and thoracic spine; strain of the left supraspinatus muscle with left brachial plexus impingement; left brachial plexus impingement aggravating preexisting medial epicondylitis of the left elbow, radial tunnel

syndrome at the left forearm, carpal tunnel syndrome of the left hand;[1] muscle tendon unit strain of the back, iliolumbar ligaments, sacroiliac ligaments, right hip and buttocks with bilateral lumbosacral plexus impingement and contusion and strain of the right lower rectus abdominal muscle. Dr. Ellis opined that the conditions were work related. He explained that the vehicle impact was of such degree that it would be reasonable for her to have a concussion. Dr. Ellis also explained that appellant had a history of concussions in the past which "would make her much more prone to having more significant problems with her brain with this motor vehicle accident. The motor vehicle accident was such that it bent and destroyed metal and plastic." Dr. Ellis opined that "muscles, tendons and ligaments are not as strong as metal and plastic." He noted that appellant sustained muscle and ligament tears in her neck, especially on the left side, and the left supraspinatus muscle.

The Office received additional evidence comprised of copies of previously received reports, diagnostic reports and emergency room reports.

In a January 29, 2009 statement, the employing establishment reported there was no obvious damage to the front of the vehicle indicating that it impacted a post.

By decision dated January 30, 2009, the Office denied modification of its previous decision.

LEGAL PRECEDENT

When an employee claims that he or she sustained an injury in the performance of duty, the employee must submit sufficient evidence to establish that he or she experienced a specific event, incident or exposure occurring at the time, place and in the manner alleged. The employee must also establish that such event, incident or exposure caused an injury. Once an employee establishes an injury in the performance of duty, he or she has the burden of proof to establish that any subsequent medical condition or disability for work, which the employee claims compensation, is causally related to the accepted injury.[2] To meet his or her burden of proof, an employee must submit a physician's rationalized medical opinion on the issue of whether the alleged injury was caused by the employment incident.[3] Medical conclusions unsupported by rationale are of diminished probative value and are insufficient to establish causal relation.[4]

The Federal Employees' Compensation Act[5] provides that, if there is disagreement between the physician making the examination for the Office and the employee's physician, the

[1] The record reflects that appellant has a separate claim, File No. xxxxxxx650 that is accepted for left carpal tunnel syndrome.

[2] *See Leon Thomas*, 52 ECAB 202 (2001).

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

[4] *Albert C. Brown*, 52 ECAB 152 (2000).

[5] 5 U.S.C. §§ 8101-8193, 8123(a).

Office shall appoint a third physician who shall make an examination.[6] In cases where the Office has referred appellant to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[7]

ANALYSIS

This Board finds that this case is not in posture for decision.

The Office accepted appellant's claim for lumbar and thoracic back sprain, and contusion of face, scalp, neck and left ear. It also accepted the claim for a left shoulder strain. Appellant subsequently requested that her claim be accepted for a concussion.

The Board finds that there is an outstanding conflict in the medical evidence between the Office medical adviser and her treating physicians, Dr Ellis and Dr. Riley, regarding whether appellant has a concussion condition causally related to the January 10, 2007 work injury. Therefore, the case must be remanded to the Office for further development.

On September 20, 2008 the Office medical adviser noted that appellant's postconcussion condition was not work related. In support of his opinion, he explained that she did not lose consciousness and that the emergency room records revealed that appellant had left ear pain and headaches. The Office medical adviser also noted the skull examination revealed zero tenderness. He also noted that her CT scan was normal indicating that any postconcussion syndrome was not due to the January 10, 2007 accident.

In contrast, Dr. Ellis noted that appellant sustained a concussion during a motor vehicle accident on January 10, 2007 and had difficulty remembering all of the accident. He noted that after the accident appellant reported feeling "dazed, foggy, and had difficulty concentrating. Appellant had pain in her head and right lower buttock." Dr. Ellis also advised that he was aware of the second motor vehicle accident on January 15, 2008 and explained that she was rear-ended and dazed, but not unconscious. He opined that her concussion was work related and explained that the vehicle impact was of such degree that it would be reasonable for her to have a concussion.

The Board also notes that Dr. Riley also supported work-related postconcussion syndrome. He explained that, despite a normal examination, which would not disclose gross abnormalities, appellant displayed complaints which would be found in closed-head injuries. It should also be noted that Dr. Riley evaluated appellant before the January 15, 2008 nonwork-related motor vehicle accident.

Consequently, the case must be referred to an impartial medical specialist to resolve the conflict in the medical opinion evidence between the Office medical adviser and Drs. Ellis and Riley regarding whether appellant sustained an employment-related concussion. On remand the

[6] 5 U.S.C. § 8123(a); *Shirley Steib*, 46 ECAB 309, 317 (1994).

[7] *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

Office should refer appellant, along with the case file and the statement of accepted facts, to an appropriate specialist for an impartial medical evaluation and report including a rationalized opinion on this matter. After such further development as the Office deems necessary, the Office shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision regarding whether appellant met her burden of proof to establish that she sustained an employment-related concussion causally related to her accepted employment injuries.

ORDER

IT IS HEREBY ORDERED THAT the January 30, 2009 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: May 25, 2010
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

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