United States Department of Labor
Employees' Compensation Appeals Board

R.B., Appellant	)	
and	)	**Docket No. 11-390**
	)	**Issued: December 28, 2011**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION, Asheville, NC, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 7, 2010 appellant filed a timely appeal from the September 3, 2010 Office of Workers' Compensation Programs' (OWCP) decision, which found that his eye condition was not causally related to the accepted employment injury.[1] Pursuant to the Federal Employees' Compensation Act[2] (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 sustained a right eye condition as a consequence of his accepted employment conditions.

[1] The record also contains a September 3, 2010 decision, denying appellant's claim for additional impairment to the larynx. Appellant did not appeal from this decision.

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On November 15, 1993 appellant, then a 57-year-old staff surgeon, filed an occupational disease claim alleging that his workplace exposure to staph endocarditis caused his prosthetic valve endocarditis. He stopped work on September 3, 1992.[3] OWCP accepted appellant's claim for endocarditis valve, unspecified; depressive disorder; congestive heart failure; impotence of organic origin; acute cerebrovascular disease; degenerative diseases of the basal ganglia; chronic obstructive asthma; adhesive capsulitis of the left shoulder; closed fracture of the ribs (right) and closed fracture of the right clavicle.[4] Appellant was hospitalized on several occasions, the most recent in June 2010. He received wage-loss compensation benefits.[5]

On October 25, 2005 appellant presented to an emergency room after falling down five to six steps at home. In a November 17, 2005 report, Dr. Walter A. Brzezinski, a Board-certified internist, noted that appellant's problems began with mitral valve disease complicated by staph endocarditis. He noted that appellant's heart disease had been complicated by factors such as numerous embolic events including cerebrovascular accidents (CVA). Dr. Brzezinski opined that the numerous CVA's caused dementia and basal ganglia infarcts that left him with a Parkinsonian like illness. He stated that appellant's hospitalization was precipitated by loss of balance caused by his dementia and Parkinsonism which were a direct result of his longstanding mitral valve disease. In a November 21, 2005 discharge summary, Dr. Brzezinski noted that appellant sustained injuries in his fall that included a subdural hematoma, left temporal confusion, right subarachnoid hemorrhage, right maxillary sinus fracture and right orbital wall fracture. Following appellant's fall, OWCP accepted the claim for Parkinsonism secondary to multiple infarcts, closed skull fracture and subdural hematoma.

On February 8, 2006 Dr. Brzezinski advised that appellant was seeing an ophthalmologist for the blow-out fracture of his right eye as he had some decline in his vision. On September 27, 2007 Dr. Elizabeth Sharpe, a Board-certified ophthalmologist and treating physician, diagnosed optic atrophy in the right eye secondary to trauma from his fall. She noted that in October 2005, appellant had a stroke caused by his first injury and fell down a flight of stairs onto the sidewalk sustaining a head injury.

In a letter dated December 8, 2008, appellant's attorney requested that OWCP accept optic atrophy in the right eye and requested a schedule award for complete loss of vision in the right eye and any impairment to the left eye. He indicated that appellant was legally blind in the right eye secondary to his work-related fall and resulting subdural hematoma. In an accompanying December 2, 2008 report, Dr. Sharpe diagnosed ischemic optic atrophy in the right eye. She explained that appellant became legally blind in the right eye secondary to the optic atrophy which was "subsequent to his fall and subdural hematoma." Dr. Sharpe provided documentation and explained that legal blindness could be seen in his Humphrey visual field and

[3] Appellant subsequently retired on disability on February 18, 1994.

[4] Appellant has nonwork conditions including dyspnea, aphasia, dysphagia, severe bladder dysfunction and an eye condition.

[5] Appellant also received schedule awards to include: 15 percent bilateral lungs, 50 percent left arm, 51 percent larynx, 40 percent left leg, 57 percent sexual function, 21 percent right leg, 33 percent right arm.

the optic atrophy was demonstrated on ocular coherence tomography. She opined that there was "a direct link and connection from his subdural hematoma to his legal blindness." Dr. Sharpe advised that the "blindness in his right eye has subsequently caused him to lose depth perception, which in the future may put him at increased risk for falls. The legal blindness also limits his ability to read for sustained periods of time as it puts extra strain on his better eye."

In a January 9, 2009 letter, OWCP informed appellant's attorney of the evidence needed to support the claim. In a letter dated February 5, 2009, appellant's attorney noted that numerous conditions were work related and reiterated that appellant's claim should be expanded to include the right eye condition. He repeated his request to expand acceptance of appellant's claim on April 7, 2009. On May 14, 2009 OWCP advised appellant's attorney that the file was being reviewed by OWCP's medical adviser. On June 12, 2009 it advised the attorney that a decision on acceptance of an eye condition would not be addressed until appellant's claim for a schedule award for another condition was resolved. On January 27, 2010 counsel again requested expansion of the claim for an eye condition.

In a May 4, 2010 decision, OWCP's hearing representative directed further development of the claim.[6] Regarding the blindness in the right eye, she directed OWCP to refer the file to OWCP's medical adviser to address whether appellant's right eye blindness was related to the subdural hematoma.[7] If additional information was needed, OWCP should send the statement of accepted facts to Dr. Sharpe and request a reasoned medical report explaining how the subdural hematoma caused or contributed to appellant's blindness in the right eye.

On June 22, 2010 OWCP referred the case to OWCP's medical adviser. In a June 23, 2010 report, the medical adviser noted that appellant's diagnosis of optic atrophy on the right with blindness secondary to a remote subdural hematoma after a fall down a flight of stairs seemed "speculative" and "unlikely" in the absence of an actual skull fracture. Furthermore, it was unlikely that involvement of the bony optic canal with injury to the optic nerve occurred.

In a letter dated June 28, 2010, OWCP provided Dr. Sharpe with a copy of OWCP's medical adviser's report and requested her opinion on causal relationship. In a July 9, 2010 report, Dr. Sharpe noted first treating appellant in 1997 and most recently examining him on April 14, 2010. She diagnosed ischemic optic atrophy in the right eye. Dr. Sharpe opined that he became legally blind in the right eye secondary to the optic atrophy which was subsequent to his fall and subdural hematoma. She referred to the test results in appellant's Humphrey visual field and explained that the optic atrophy was demonstrated on ocular coherence tomography. Dr. Sharpe advised that there was a direct link and connection from his subdural hematoma to his legal blindness. Furthermore, she explained that the blindness in his right eye caused him to lose depth perception, which placed him at risk for falls. Dr. Sharpe also advised that the legal blindness limited his ability to read for sustained periods of time as it placed extra strain on his better eye.

[6] The hearing was requested following issuance of a January 29, 2010 OWCP decision denying an additional schedule award for the larynx.

[7] The hearing representative noted that appellant was too ill to attend a second opinion examination.

In an August 11, 2010 report, OWCP's medical adviser reviewed Dr. Sharpe's July 9, 2010 report and opined that it was "speculative" and not a rationalized opinion. He advised that the blindness and fall/subdural hematoma were not causally related.

By decision dated September 3, 2010, OWCP denied appellant's claim. It found the medical evidence of record insufficient to establish that appellant sustained an eye condition causally related to his accepted July 3, 1992 employment injuries.

LEGAL PRECEDENT

To establish a causal relationship between the condition as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence based on a complete medical and factual background, supporting such a causal relationship.[8] Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[9] Rationalized medical evidence is 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 supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[10] 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.[11]

FECA provides compensation for the disability of an employee resulting from personal injury sustained while in the performance of her duty.[12] It is an accepted principle of workers' compensation law that when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent, intervening cause attributable to the employee's own intentional conduct.[13]

Section 8123(a), in pertinent part, provides that, if there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[14]

---

[8] *Id.*

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

[10] *Leslie C. Moore*, 52 ECAB 132 (2000).

[11] *Ernest St. Pierre*, 51 ECAB 623 (2000).

[12] 5 U.S.C. § 8102(a).

[13] *Albert F. Ranieri*, 55 ECAB 598 (2004).

[14] 5 U.S.C. § 8123(a).

ANALYSIS

The Board finds that there is an unresolved conflict in the medical evidence. Appellant's treating physician, Dr. Sharpe, a Board-certified ophthalmologist, and treating physician, opined that there was "a direct link and connection from his subdural hematoma to his legal blindness." An OWCP medical adviser opined that appellant's diagnosis of optic atrophy on the right with blindness secondary to a remote subdural hematoma after a fall down a flight of stairs seemed speculative and unlikely in the absence of an actual skull fracture.

A conflict exists between Dr. Sharpe and OWCP's medical adviser which requires the case be referred to an impartial medical examiner. OWCP regulations state that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[15] The Board will set aside OWCP's September 3, 2010 decision and remand the case to OWCP for referral to an impartial medical examiner to resolve the conflict on the issue of whether appellant's right eye condition was caused or aggravated by any of employment-related conditions, or the October 25, 2005 fall.[16] Following such further development as may be deemed necessary, OWCP shall issue an appropriate final decision on whether appellant sustained a right eye condition as a consequence of his accepted employment injuries.

CONCLUSION

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

[15] 20 C.F.R. § 10. 321(b). *See also R.H.*, 59 ECAB 382 (2008).

[16] The hearing representative's May 4, 2010 decision indicated that, at that time, appellant was too ill to attend a second opinion examination. If appellant's current health status precludes him from attending an impartial medical examination, OWCP shall forward the complete medical record and a statement of accepted facts to the impartial medical examiner for review and a reasoned opinion on the cause of appellant's right eye condition.

ORDER

IT IS HEREBY ORDERED THAT the September 3, 2010 decision of the Office of Workers' Compensation Programs be set aside and remanded.

Issued: December 28, 2011
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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