United States Department of Labor
Employees' Compensation Appeals Board

N.R., Appellant	)	
and	)	**Docket No. 16-0417**
	)	**Issued: August 11, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Seattle, WA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 4, 2016 appellant filed a timely appeal from a December 23, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 the claim.

ISSUE

The issue is whether appellant met his burden of proof to establish a recurrence of disability as of April 26, 2010 causally related to his December 11, 2007 employment injuries.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has been previously before the Board.[3] By decision dated May 8, 2009, the Board reversed OWCP's February 22, 2008 decision and found that appellant's fall on December 11, 2007 occurred in the performance of duty.[4] The case was remanded to OWCP for further development on the nature and extent of any disability related to the December 11, 2007 injury. The fact and circumstances surrounding the prior decision are hereby incorporated by reference.

Following the Board's May 8, 2009 remand, the relevant facts follow: OWCP accepted on June 5, 2009 appellant's claim for the conditions of: left temporal bone fracture, concussion with moderate loss of consciousness, meningitis (resolved), and head, face and neck contusions except eyes, and reactive confusion and paid appropriate benefits. The record reflects that appellant returned to full-time full duty in 2008 following the December 11, 2007 work injury. He stopped work on April 26, 2010. As of May 23, 2010, appellant has been in receipt of retirement benefits from the Office of Personnel Management (OPM).

On August 26, 2014 appellant filed a recurrence (Form CA-2a) claiming wage-loss compensation effective April 26, 2010 and continuing due to a change or worsening of his accepted work-related conditions.

In an August 11, 2014 report, Dr. Denise A. Hastings, a Board-certified internist, indicated that appellant was disabled and unable to work as he could not perform the essential functions of his position. She indicated that he suffered from head and neck pain as well as arm, shoulder and knee pain and has permanent cognitive loss after the closed head injury. Dr. Hastings noted that appellant was on medications for seizures and neuropathic pain and saw a counselor for chronic pain and depression.

In an October 17, 2014 letter, OWCP advised appellant of the deficiencies in his claim and requested medical evidence which clearly explained the material worsening in his condition based on objective findings. Appellant was afforded 30 days to provide the requested information.

OWCP thereafter received additional medical evidence. In a November 18, 2011 report, Dr. Thomas J. Degan, a Board-certified orthopedic surgeon, presented examination findings for appellant's left and right knees and diagnosed bilateral knee pain. A magnetic resonance imaging (MRI) scan was ordered to rule out right medial meniscus tear.

In an October 22, 2014 letter, Dr. Hastings indicated that appellant was disabled and not able to perform all of the essential functions of his work duties. She noted that appellant

[3] Docket No. 08-1202 (issued May 8, 2009).

[4] On January 5, 2008 appellant, then a 47-year-old mail handler, filed a traumatic injury claim (Form CA-1) alleging that on December 11, 2007 at approximately 2:18 p.m., he sustained injuries when he fell in the men's locker room while getting ready for work and hit his head on the floor. He was transported by ambulance to the Harborview Medical Center.

reported a worsening of his bilateral neck, arm, elbow and back pain and that he had permanent cognitive loss after his closed head injury.

By decision dated December 9, 2014, OWCP denied the recurrence claim as the medical evidence did not establish that appellant was disabled due to a material change or worsening of his accepted work-related conditions.

On March 23, 2015 OWCP received appellant's March 17, 2015 request for reconsideration. Medical reports, operative reports and diagnostic testing which predated the recurrence claim of April 20, 2010 were received. Additional medical reports and diagnostic testing were received.

Diagnostic testing provided included the following: an October 21, 2011 x-ray of left knee noted history of persistent pain after fall and contained an impression of mild degenerative disease with osteochondromatosis. An October 21, 2011 x-ray of right knee noted a fall and contained an impression of mild degenerative changes with joint effusion. A December 2, 2011 MRI scan right knee noted small to moderate volume knee effusion and tears in the medial and lateral menisci with mild soft tissue edema in collateral ligaments. A June 5, 2013 x-ray of right elbow noted a history of right elbow pain for two to three years and contained an impression of spurring of the lateral humeral epicondyle. A June 29, 2015 computerized tomography (CT) scan of temporal bone did not show any change from prior scan. Diffuse soft tissue thickening of the left and right tympanic membrane noted with minimal soft tissue thickening noted in left hypotympanum without bony Eustachian tube obstruction. A July 15, 2015 brain MRI scan was reported as unremarkable with no evidence of an acoustic neuroma or significant interval change. An August 3, 2015 audiology test report was provided.

Several reports from Dr. Dennis Zhou, a neurologist, were received. In his August 12, 31, October 7 and 21, 2011 reports, Dr. Zhou noted that appellant was seen for neurological consultation for his possible seizures. He noted the December 11, 2007 work injury and appellant's present complaints. Dr. Zhou indicated probable major depression, head injury at work on December 11, 2007, possible seizure times two, hypertension and asthma, neck pain, arms paresthesia with weakness/atrophy in left. He advised that he was not convinced that appellant had epileptic seizures, but that appellant did have major depression. Dr. Zhou noted that appellant fell on December 11, 2007 and had possible skull-base fracture with blood in the left ear. He indicated that appellant had post-traumatic changes over frontal lobes bilaterally on MRI scan, but that he was not sure of the clinical significance. Dr. Zhou concluded that there were no active neurological issues in appellant's case.

In an August 25, 2011 report, Brian J. Silverman, O.D., an optometrist, noted that appellant reported poor vision in both eyes stemming from a head injury to the right side of forehead in December 2007. He also reported hospitalization with meningitis with poor vision ever since the work injury. An impression of traumatic retinopathy both eyes with moderate visual acuity potential; mild nuclear sclerotic changes in both eye, and decreased visual acuity stemming from head injury was provided. Medical reports and testing pertaining to appellant's eyes, including a July 24, 2014 prescription for eyeglasses were provided.

In a September 23, 2011 report, Dr. Arpenik Avakian, a Board-certified ophthalmologist, provided an impression of maculae scarring in both eyes, more pronounced in the right eye, possibly representing residual changes from remote head trauma and macular commotion.

In a January 20, 2012 report, Dr. Degan noted appellant's left elbow pain had started about the same time as his knee pain began. He reviewed x-rays and provided an impression of lateral epicondylitis versus medical epicondylitis and possible anterior elbow pain, and right knee torn meniscus. Arthroscopic knee surgery was suggested.

Medical reports from Dr. David Taibleson, a Board-certified family practitioner, were received. In a February 15, 2012 report, Dr. Taibleson noted the history of injury and provided an impression of chronic dizziness, headache and depression. In a June 27, 2012 report, he provided an impression of uncontrolled diabetes type 2, hypothyroidism, hypertension, depression and right knee pain. In an October 10, 2012 report, Dr. Taibleson noted appellant's complaints of chronic neck pain and headaches and that he felt disabled from his 2006 head injuries, but had not obtained a new psychiatrist. He noted that appellant had not been checking his blood sugar levels, that he had not had an eye examination, that he had chronic mastoid problems, for which surgery had been offered, and a history of seizures.

Progress notes and diagnostic studies were provided by Dr. Tyler Kimbrough, a Board-certified otolaryngologist. In a January 20, 2012 note, Dr. Kimbrough noted a history of chronic bilateral ear disease and that appellant had three operations on his ears. He advised that appellant had complete conductive loss in both ears at low frequency, which may be either ossicular discontinuity or otosclerosis, but that it was hard to determine given appellant's prior ear surgeries. Dr. Kimbrough interpreted a February 15, 2012 CT scan temporal bones. He provided an impression of chronic otomastoiditis, bilateral, soft tissue density within old mastoidectomy cavity, and filling the epitympanum both ears. No erosion of the horizontal canal was noted and the remainder of the middle ear space was well aerated. A large perforation in the left tympanic membrane was seen.

Several reports and audiological tests were provided by Dr. Jay Thal Rubinstein, a Board-certified otolaryngologist. In a June 17, 2014 report, Dr. Rubinstein diagnosed chronic tubotympanic suppurative otitis media, bilateral. On March 11, 2014 he noted that appellant returned for follow up of his otorrhea. In an April 16, 2014 report, Dr. Rubinstein indicated that appellant returned with usual complaints of pain and indicated that bright lights bothered him. He noted that appellant stopped using his eardrops and had left-sided otorrhea. Dr. Rubinstein suctioned out thick glue in left middle ear and instructed appellant to use bilateral eardrops. He noted that appellant went to the emergency room as he was having fever and neck stiffness.

In a July 2, 2015 report, Dr. Donald M. Lum, a Board-certified ophthalmologist, diagnosed bilateral central serous retinopathy and blurred vision. In a September 22, 2015 report, he noted appellant's complaints of blurred vision and tinnitus which interrupted his sleep. Dr. Lum noted that appellant had unremarkable brain MRI scan on July 15, 2015 and his past history included the work injury. He diagnosed central serous retinopathy, bilateral, blurred vision, Type II or unspecified type diabetes mellitus.

In a July 10, 2015 report, Dr. Benjamin Poderski, a neurologist, indicated that appellant presented with new neurologic concerns of intense buzzing and an electric sensation inside his head. Appellant indicated that, when he coughed, he got a feeling of static coming from his head which goes through his body. Dr. Poderski noted that there had been no documented seizures since the onset of head trauma. An updated brain imaging was recommended given appellant's history of skull fracture, head trauma and meningitis.

In an October 5, 2015 report, Dr. Chiaki Dupre Gauntt, a Board-certified ophthalmologist, noted the history of the work injury and appellant's visual symptoms, which included floaters that appellant stated blocked his vision. Past ocular history included history of CSR OD with decreased vision; central serous chorioretinopathy of right eye, and subjective visual disturbance. An assessment of subjective visual disturbance of both eyes, diplopia and metamorphopsia were provided. Dr. Gauntt indicated that there was a mild decrease of retinal tissue in the right eye, which was an expected finding with the history of central serous chorioretinopathy (blisters in the macula), which had healed. He reported that appellant's optic nerve scans were essentially normal and appellant needed a good refraction (fitting glasses) and eye movement measurement. Dr. Gauntt indicated that there were no neuro ophthalmology-related issues on examination and that appellant's vertigo may have an impact on his visual perception.

By decision dated November 5, 2015, OWCP denied modification of its December 9, 2014 decision.

On November 16, 2015 OWCP received appellant's November 10, 2015 request for reconsideration. Duplicative copies of evidence previously of record were received. Additional evidence included copies of diagnostic testing of May 20, 2010, August 15 and 25, October 14, 2011, January 11, 2012, June 29 and July 15, 2015.

In a June 25, 2010 report, Dr. Gary Allen Stobbe, a Board-certified neurologist, reported the history of the December 11, 2007 work injury and that appellant returned to full-time light duty on January 16, 2008. He noted appellant's complaints of significant increase in memory difficulties, dizziness and headaches over the past month and that the increase was without any clear etiology. Dr. Stobbe noted that appellant's complaints of dizziness, headache, and cognitive disturbance dated back to a closed head injury that involved a left cerebral contusion and a left temporal skull fracture in December 2007. Considering that appellant did have a residual ongoing from those injuries, Dr. Stobbe stated the recent worsening could be of any cause, noting that individuals who have residual neurological complaints have "reduced neurological reserve" and, therefore, any physical or psychological stressor could aggravate his symptoms. From a neurological standpoint, the concern of increased migraine headache phenomenon could aggravate those complaints. Also development of partial seizures would be another potential cause considering he was in risk stage for developing seizures. Dr. Stobbe advised that he doubted that there would be other intracranial processes. He noted that appellant has had an updated brain MRI scan, which would be reviewed. Dr. Stobbe provided recommendations to rule out evidence of other conditions and, assuming no new medical processes, recommended continuing treatment of the benign positional vertigo.

In a July 2, 2015 report, Dr. Lum followed up on appellant's bilateral central serous retinopathy and blurred vision and provided single field vision analysis.

In an October 9, 2015 report, Dr. Seth R. Schwartz, a Board-certified otolaryngologist, saw appellant for chronically draining ears. He noted that appellant had a chronic history of otorrhea and ear infections, that he has had multiple ear surgeries in both ears and a traumatic accident at work in 2007 when he fell down the stairs and suffered a traumatic brain injury, intracranial hemorrhage, transverse left temporal bone fracture and orthopedic injuries. Dr. Schwartz opined that appellant had mild conductive loss in both ears. He indicated that appellant had long-standing bilateral ear problems and provided a detailed discussion of appellant's ear conditions. Surgery was discussed.

In an October 29, 2015 report, Dr. Grazia S. Cinciripini, an ophthalmologist, diagnosed monocular diplopia of both eyes, mytopia with astigmatism, bilateral; exophoria, central serous retinopathy, bilateral and visual field defect. He provided a discussion on appellant's diagnoses and his vision, noting that the optic nerve appeared healthy and MRI scan of brain in July 2015 was within normal limits.

By decision dated December 23, 2015, OWCP denied modification of its prior decision.

LEGAL PRECEDENT

FECA pays compensation for the disability of an employee resulting from personal injury sustained while in the performance of duty.[5] Disability means the incapacity, because of an employment injury, to earn the wages the employee was receiving at the time of injury. It may be partial or total.[6]

A recurrence of disability means an inability to work, after an employee has returned to work, caused by a spontaneous change in a medical condition which resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness.[7]

It is the employee's burden to establish that the claimed recurrence is causally related to the original injury.[8] Causal relationship is a medical issue that can generally be resolved only by rationalized medical opinion evidence.[9]

An individual who claims a recurrence of disability resulting from an accepted employment injury has the burden of establishing that the disability is related to the accepted injury. This burden requires furnishing medical evidence from a physician who, on the basis of a

[5] 5 U.S.C. § 8102(a).

[6] 20 C.F.R. § 10.5(f).

[7] *Id*. at § 10.5(x).

[8] *Id.* at § 10.104. *See also Mary A. Ceglia*, 55 ECAB 626, 629 (2004).

[9] *See Jennifer Atkerson*, 55 ECAB 317 (2004).

complete and accurate factual and medical history, concludes that the disabling condition is causally related to the employment injury and who supports that conclusion with sound medical reasoning.[10] Where no such rationale is present, medical evidence is of diminished probative value.[11]

In order to establish that a claimant's alleged recurrence of the condition was caused by the accepted injury, medical evidence of bridging symptoms between his present condition and the accepted injury must support the physician's conclusion of a causal relationship.[12]

ANALYSIS

OWCP accepted that appellant's fall on December 11, 2007 resulted in left temporal bone fracture, concussion with moderate loss of consciousness, meningitis (resolved), and head and face contusions. Following the December 11, 2007 work injury, appellant returned to full-time full duty in 2008. He stopped work on April 26, 2010 and has been in receipt of retirement benefits from OPM as of May 23, 2010.

On August 26, 2014 appellant filed a recurrence claim for wage-loss compensation effective April 26, 2010 and continuing, which OWCP denied as the medical evidence failed to establish a change or worsening of his accepted work-related conditions. Appellant has the burden of providing sufficient evidence, including rationalized medical evidence, to establish the causal relationship asserted.[13]

Appellant submitted numerous reports from multiple medical providers regarding his complaints of chronic neck pain, headaches, cognitive disturbances, dizziness, eye, ear, and orthopedic conditions. While several conditions have been diagnosed, the medical reports of record fail to contain adequate rationale on causal relationship.[14] Furthermore, for conditions not accepted by OWCP as being employment related, it is the employee's burden to provide rationalized medical evidence sufficient to establish causal relation, not OWCP's burden to disprove such relationship.[15]

In 2010 appellant was treated by Dr. Stobbe for an increase in dizziness, headaches, and cognitive disturbances. In his June 25, 2010 report, Dr. Stobbe reported the history of injury and

[10] *Dennis E. Twardzik*, 34 ECAB 536 (1983); *Max Grossman*, 8 ECAB 508 (1956).

[11] *Michael Stockert*, 39 ECAB 1186, 1187-88 (1988); *see Ronald C. Hand*, 49 ECAB 113 (1957).

[12] *Mary A. Ceglia*, *supra* note 8.

[13] *Ricky S. Storms*, 52 ECAB 349 (2001).

[14] *See D.U.*, Docket No. 10-144 (issued July 27, 2010) (medical reports not containing adequate rationale on causal relationship are of diminished probative value and are insufficient to meet the claimant's burden of proof); *Richard A. Neidert*, 57 ECAB 474 (2006); *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value); *Jimmie H. Duckett*, 52 ECAB 332 (2001).

[15] *G.A.*, Docket No. 09-2153 (issued June 10, 2010); *Jaja K. Asaramo*, 55 ECAB 200 (2004); *Alice J. Tysinger*, 51 ECAB 638 (2000).

that appellant had complaints of dizziness, headache and cognitive disturbance dating back to a closed head injury that involved a left cerebral contusion and left temporal skull fracture in December 2007. While he indicated that appellant had residuals ongoing from those injuries, he did not indicate whether the residuals were supported by objective data, whether the conditions had worsened, and whether they prevented appellant from work. Furthermore, Dr. Stobbe advised that the recent worsening of appellant's condition could be from any cause and noted that any physical or psychological stressor could aggravate his symptoms. Thus, his June 25, 2010 report is insufficient to support appellant's claim.[16]

Dr. Degan provided reports of November 18, 2011 and January 20, 2012 pertaining to appellant's bilateral knee pain and bilateral elbow pain. He diagnosed a right knee torn meniscus and possible diagnosis regarding appellant's left elbow, but he did not indicate the cause of such conditions. The Board has found that medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[17] Furthermore, it is unclear whether Dr. Degan was aware of the December 11, 2007 work injury. Accordingly, his reports are of limited probative value.

In her reports of August 11 and October 22, 2014, Dr. Hastings indicated that appellant was disabled and not able to perform all of the essential functions of his position. She reported that appellant had bilateral neck, arm, elbow, and back pain and that he had permanent cognitive loss after the closed head injury. However, Dr. Hastings did not provide any medical explanation as to how the closed head injury caused these newly diagnosed conditions pertaining to appellant's arm, elbow and back or worsened any accepted conditions. The lack of medical rationale and lack of objective findings to show that appellant was disabled due to a material change/worsening of his accepted work-related conditions greatly diminishes the probative value of Dr. Hastings' opinion.[18]

With regard to his neurological concerns, appellant sought treatment from Dr. Zhou in 2011, Dr. Taibleson in 2012 and Dr. Poderski in 2015. None of these reports, however, support causation or a worsening of appellant's accepted conditions. Dr. Zhou noted the history of the December 11, 2007 work injury and presented examination findings. He concluded that there were no active neurological issues and that he was not convinced that appellant had epileptic seizures. While Dr. Zhou indicated that appellant had post-traumatic changes over frontal lobes bilaterally on MRI scan, he advised that he was not sure of the clinical significance. He also reported that appellant had probable major depression. However, this diagnosis is equivocal and Dr. Zhou provides no medical rationale to support causal relationship.[19] The Board has held that a medical report is of limited probative value on the issue of causal relationship if it contains a

[16] *Id*.

[17] *R.E.*, Docket No. 10-679 (issued November 16, 2010); *K.W.*, 59 ECAB 271 (2007).

[18] *Roma A. Mortenson-Kindschi*, 57 ECAB 418 (2006).

[19] *M.W.*, 57 ECAB 710 (2006).

conclusion regarding causal relationship which is unsupported by medical rationale.[20] Thus, Dr. Zhou's reports are insufficient to establish appellant's claim.

In his reports, Dr. Taibleson noted the history of injury. In his February 15, 2012 report, an impression of chronic dizziness, headache and depression and, in his June 27, 2012 report, an impression of uncontrolled diabetes type 2, hypothyroidism, hypertension, depression and right knee pain was provided. However, he only generally noted the employment incident but did not relate any of the conditions to the traumatic injury. To be of probative value, a physician's opinion on causal relationship should be one of reasonable medical certainty.[21] Thus, Dr. Taibleson's reports do not support causation or worsening residuals of the accepted injuries.

Dr. Poderski, in his July 10, 2015 report, indicated that appellant presented with new neurologic concerns and ordered a brain MRI scan given his history of skull fracture, head trauma and meningitis. He did not diagnose any condition or worsening residuals related to the work injury. Thus, Dr. Poderski's report does not support causation or worsening residuals of the accepted injuries. Furthermore, the July 15, 2015 brain MRI scan was reported as unremarkable with no evidence of an acoustic neuroma or significant interval change.

Medical reports pertaining to appellant's bilateral eye conditions were also received. In an August 25, 2011 report, Dr. Silverman noted that appellant had reported hospitalization with meningitis with poor vision ever since the December 2007 head injury to right side of forehead. He provided an impression of traumatic refinopathy both eyes with moderate visual acuity potential, mild nuclear sclerotic changes in both eyes and decreased visual acuity stemming from head injury. While Dr. Silverman supported causal relationship, his report is of limited probative value as it is unsupported by medical rationale.[22] In his September 23, 2011 report, Dr. Avakian provided an impression of maculae scarring both eyes, possibly representing residual changes from remote head trauma and macular commotion. The equivocal nature of the opinion on causation and the lack of medical rationale diminishes the probative value of Dr. Avakian's opinion.[23] Dr. Lum provided several diagnoses, but failed to offer an opinion on causation. In his October 5, 2015 report, Dr. Gauntt noted the history of the work injury and indicated that there was a mild decrease of retinal tissue in the right eye, which was an expected finding with the history of central serous chorioretinopathy (blisters in the macula), which had headed. He reported that appellant's optic nerve scans were normal, there were no neuro ophthalmology-related issues on examination and that appellant's vertigo may have an impact on his visual perception. Dr. Gauntt also indicated that appellant needed glasses and eye movement measurements. However, he offered no opinion on the cause of appellant's central serous chorioretinopathy or appellant's vertigo. Dr. Cinciripini also provided several diagnoses for appellant's eye conditions, but provided no opinion on the cause of such conditions.[24]

[20] *T.M.*, Docket No. 08-975 (issued February 6, 2009); *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

[21] *See Beverly R. Jones*, 55 ECAB 411 (2004).

[22] *T.M., supra* note 20.

[23] *See M.W., supra* note 19; *Roma A. Mortenson-Kindschi, supra* note 18.

[24] *See supra* note 16.

Furthermore, he reported that appellant's optic nerve appeared healthy and the July 2015 MRI scan of the brain was within normal limits. Accordingly, the reports from Drs. Silverman, Avakian, Lum, Gauntt, and Cinciripini are insufficient to establish appellant's recurrence claim.

Appellant submitted several reports from Drs. Kimbrough, Rubinstein, and Schwartz concerning his ears, conditions not accepted in this claim. In his January 20, 2012 report, Dr. Kimbrough noted a history of chronic bilateral ear disease, that appellant has had three operations on his ears, that he has had recurrent drainage and infections in his ears for several years and wears bilateral hearing aids. He reported that appellant has complete conductive hearing loss in both ears at low frequency and interpreted a February 15, 2012 CT scan of the temporal bones to show bilateral chronic otomastoiditis and large perforation in the left tympanic membrane. Dr. Kimbrough did not provide an opinion on cause of the diagnosed ear conditions[25] and it is not clear that he was aware of the work injury. Thus, his report is insufficient to establish appellant's claim.

Dr. Rubinstein examined appellant in 2014. He diagnosed chronic bilateral tubotympanic suppurative otitis media and provided follow-up reports on appellant's otorrhea. Dr. Rubinstein did not provide an opinion on cause of the diagnosed bilateral ear conditions and it is not clear that he was aware of the work injury. Thus, his reports are insufficient to establish appellant's claim.[26]

In an October 9, 2015 report, Dr. Schwartz noted appellant's history of ear conditions and the December 11, 2007 work injury. While he opined that appellant has mild conductive loss in both ears and was seen for chronically draining ears, Dr. Schwartz did not provide an opinion on causation. Thus, this report is insufficient to establish appellant's claim.

The diagnostic reports appellant submitted are likewise insufficient to establish his recurrence claim. Appellant submitted x-ray reports of his elbows and knees, MRI scan reports of his knees, brain, head, and cervical spine, CT scans of temporal bone and abdomen/pelvis, EEG scans along with hearing and vision tests. While some of the tests describe appellant's current medical conditions or find no changes from past conditions, the interpreting physician fails to provide any opinion on the cause of appellant's current medical conditions. The Board has found that medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[27] Therefore, these diagnostic reports also fail to establish causal relationship and appellant's recurrence claim.

Appellant was advised by October 22, 2014 letter of the evidence needed to establish his claim for recurrence of disability, including rationalized medical evidence from his attending physician supporting a causal relationship between the accepted conditions and his condition on

[25] *Id.*

[26] *Supra* note 13.

[27] *Supra* note 17.

and after April 26, 2010. As he did not submit such evidence, he failed to meet his burden of proof.[28]

On appeal, appellant takes issue with the amount of disability retirement benefits he receives from OPM. This matter, however, is outside of the purview of the Board[29] and is irrelevant to his recurrence claim. The Board also notes that appellant appointed counsel after this appeal was filed. On May 12, 2016 the Board received a brief from appellant's counsel. Counsel argued that OWCP should have doubled appellant's files, and that appellant was involuntarily separated, which caused him to seek OPM retirement. As previously noted, it is appellant's burden of proof to establish a recurrence of disability, during the period alleged, with rationalized medical evidence.[30]

Appellant may submit new evidence or argument as part of a formal written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish a recurrence of his medical conditions causally related to his December 11, 2007 employment injury.

[28] *Beverly A. Spencer*, 55 ECAB 501 (2004).

[29] The Board's jurisdiction is limited to the review of final adverse decisions issued under FECA. *See* 20 C.F.R. §§ 501.2(c) and 501.3(a).

[30] *Supra* note 9.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated December 23, 2015 is affirmed.

Issued: August 11, 2016
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board