United States Department of Labor
Employees' Compensation Appeals Board

H.A., Appellant	)	
and	)	**Docket No. 16-1184**
	)	**Issued: April 20, 2017**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION, San Francisco, CA, Employer	)	

Appearances:
Mark S. Coby, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 11, 2016 appellant, through counsel, filed a timely appeal from a November 13, 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.[3]

[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.*

[3] The record provided the Board includes evidence received after OWCP issued it November 13, 2015 decision. The Board is precluded from considering evidence that was not part of the case record at the time OWCP issued its final decision. 20 C.F.R. § 501.2(c)(1).

ISSUE

The issue is whether appellant met his burden of proof to establish consequential hand and thumb arthritis condition causally related to his accepted employment injury.

FACTUAL HISTORY

This case has previously been before the Board.[4] The facts and the circumstances as set forth in the prior Board decision are incorporated herein by reference. The relevant facts are set forth below.

On December 31, 1996 appellant, then a 43-year-old industrial hygienist, filed an occupational disease claim (Form CA-2) for a lupus condition which he attributed to the drug isoniazid (INH) he was given as a result of a purified protein derivative conversion. He first became aware of his condition and its relation to his employment on June 7, 1993. OWCP accepted that appellant developed drug-induced lupus erythematous and paid wage-loss and medical benefits. By decision dated February 21, 2002, it granted a schedule award for 44 percent permanent impairment of each arm and 8 percent permanent impairment of each leg due to the accepted condition.[5]

Appellant subsequently developed bilateral sensorineural hearing loss. Following further development, on August 8, 2003, OWCP accepted his claim for binaural sensorineural hearing loss secondary to the INH-induced lupus erythematosus. It also authorized a hearing aid for appellant's left ear. Based on the evidence of record, appellant had 83 percent hearing loss in the left ear and 0 percent hearing loss in the right ear. By decision dated August 6, 2007, OWCP granted him a schedule award for 83.3 percent hearing loss in the left ear.[6] Appellant appealed that decision to the Board and, by decision dated January 29, 2009, the Board affirmed, as modified, OWCP's August 6, 2007 decision. The Board noted that appellant had sought an increased schedule award and, contrary to the May 29, 2008 denial of his request for an oral hearing, an increase in permanent impairment was not subject to time limitations or to the clear evidence of error standard. OWCP was instructed to review this evidence on remand and issue an appropriate decision. By decision dated March 13, 2009, it granted appellant an additional 3 percent impairment to his left ear, for a total impairment of 86 percent loss of hearing in the left ear.

On July 2, 2013 appellant filed a claim for recurrence (Form CA-2a), claiming that he had developed bilateral osteoarthritis of the hands as a consequential injury. In a June 22, 2013 report, Dr. David I. Daikh, an internist and rheumatologist, reported that he had followed appellant for several years due to his drug-induced lupus and the various manifestations of that condition. He noted that most recently appellant had developed increasingly significant hand and thumb pain, which he opined was significantly worsened by his underlying lupus-related

[4] Docket No. 08-1750 (issued January 29, 2009).

[5] The period of the award ran from January 8, 2001 to March 2, 2007.

[6] The date of maximum medical improvement was March 11, 2003. The schedule award ran for 43.16 weeks, covering the period March 3 through December 30, 2007.

arthritis and secondary chronic hand swelling. Dr. Daikh also provided numerous reports from 2009, 2010, and 2011 which contained examination findings of appellant's hands. Appellant eventually underwent surgery of his thumbs to relieve the pain. He was also briefly admitted to the hospital on March 9, 2012 for chest pain which he also claimed was related to his accepted conditions.

OWCP referred appellant's claim, along with the statement of accepted facts and medical record, to Dr. Rajiv Dixit, a Board-certified internist and rheumatologist, for a second opinion examination. In an October 24, 2013 report, Dr. Dixit provided results on examination and noted that a substantial proportion of appellant's disability with his hands was related to pain at the base of his thumbs, right greater than left. He opined that this was from osteoarthritis of the first carpometacarpal (CMC) joint and was unrelated to appellant's lupus or his occupation.

OWCP determined that there was a conflict in medical opinion between Dr. Daikh and Dr. Dixit and referred appellant, along with the statement of accepted facts, list of questions and medical records, to Dr. Bruce J. Dreyfuss, a Board-certified internist and rheumatologist, to resolve the conflict in medical opinion. In an April 6, 2015 report, Dr. Dreyfuss provided results on examination and diagnosed systemic lupus erythematosus (SLE), accepted secondary to isoniazid therapy, small joint synovitis, bilateral hands, secondary to SLE, small joint osteoarthritis of the bilateral fingers, bilateral carpometacarpal joint osteoarthritis, loss of grip strength, bilateral, and history of recurrent, episodic chest pain, consistent with diagnosis of pericarditis/pleuritic, and hearing loss, AS, accepted secondary to isoniazid therapy. He opined that SLE does not cause osteoarthritis and thus appellant's osteoarthritis had not been caused by his accepted SLE. Dr. Dreyfuss explained that appellant would have developed osteoarthritis in his hands independently of developing SLE. He further opined that the SLE influenced appellant's osteoarthritis in that the symptoms of his underlying osteoarthritis were made worse with increasing activity of the lupus. However, Dr. Dreyfuss opined that appellant did not have an aggravation within OWCP's definition of aggravation because symptom escalation was not the equivalent of aggravation of the underlying condition. He concluded that there was no etiological relationship between appellant's osteoarthritis and his industrial SLE.[7]

By decision dated July 7, 2015, OWCP denied appellant's claim for an osteoarthritis condition of the bilateral hands. It found that the weight of the medical evidence, as represented by the impartial medical specialist, established that his osteoarthritis condition was not causally related to the accepted lupus condition.

On July 21, 2015 OWCP received appellant's request for an oral hearing before an OWCP hearing representative, which was held on September 24, 2015. Appellant argued that Dr. Daikh's opinion that his osteoarthritis was related to the work injury should hold more weight because he had been treating him for years, while OWCP's physicians had not even touched him.

[7] Dr. Dreyfuss further opined that appellant's symptoms and hospitalization of March 9, 2012 was causally related to his accepted drug-induced lupus condition as lupus was a well-known cause of pleuritic and pericarditis. OWCP subsequently expanded the accepted conditions to include pericarditis secondary to lupus.

In a September 15, 2015 report, Dr. Pablo Leon, a Board-certified surgeon, noted that appellant had a history of drug-induced lupus and that the major problem from his drug-induced lupus had been arthritis, most notably in the hands, including the metacarpophylangeal (MCP) joints and/or the proximal interphalangeal (PIP) joints of all his fingers, both thumbs and accompanied by swelling, redness, and pain. He indicated that he had taken care of appellant for arthritis of the first carpometacarpophylangeal (CMC) joint at the base of the thumbs. Dr. Leon opined that, although this joint was a common site of osteoarthritis, it was also likely that a significant amount of appellant's disability was due to his lupus arthritis. He explained that appellant's lupus arthritis, involving the PIP joint and MCP joints of his hands, had most likely contributed to the arthritis his thumb CMC joint since arthritis in one joint adversely affects the adjacent joint. Thus, Dr. Leon explained that appellant's pain would have been significantly improved if he did not have arthritis related to lupus in his fingers and in his thumbs even in the presence of osteoarthritis in the CMC joint. He explained that it was likely that appellant had to rely significantly more on his thumb function over many years due to significant lupus arthritis of the other joints of his hand and that his thumb pain has significantly increased to the point that he had to undergo surgery of his thumb to control the pain. Dr. Leon further opined that the impact of the osteoarthritis at the base of the thumbs was significantly greater because of his lupus arthritis.

By decision dated November 13, 2015, an OWCP hearing representative affirmed OWCP's July 7, 2015 decision as the weight of the medical evidence rested with the impartial medical examiner.

LEGAL PRECEDENT

The Board has held that, if a member weakened by an employment injury contributes to a later injury, the subsequent injury will be compensable as a consequential injury, if the further medical complication flows from the compensable injury, so long as it is clear that the real operative factor is the progression of the compensable injury.[8]

A claimant bears the burden of proof to establish a claim for a consequential injury.[9] As part of this burden, he or she must present rationalized medical opinion evidence showing causal relationship.[10] The opinion of the physician must be based on a complete factual and medical background of the employee, 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 or employment injury.[11]

Section 8123(a) of FECA provides, in pertinent part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee,

[8] *R.M.*, Docket No. 16-0147 (issued June 17, 2016); *S.M.*, 58 ECAB 166 (2006); *Raymond A. Nester*, 50 ECAB 173, 175 (1998).

[9] *J.A.*, Docket No. 12-603 (issued October 10, 2012).

[10] *L.B.*, Docket No. 16-0092 (issued March 24, 2016).

[11] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 465 (2005).

the Secretary shall appoint a third physician who shall make an examination."[12] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[13]

ANALYSIS

OWCP accepted that appellant developed drug-induced lupus erythematosus. It subsequently accepted degenerative and vascular disorders of ear, bilateral, and sensorineural hearing loss, bilateral, secondary to the drug-induced lupus erythematosus and pericarditis secondary to lupus. Appellant alleges that his bilateral hand and thumb osteoarthritis were related to his accepted conditions, which OWCP denied.

OWCP developed the claim and determined that a conflict of medical opinion existed between Dr. Daikh, the treating physician, who opined that appellant's osteoarthritis condition was related to the accepted lupus condition, and Dr. Dixit, the second opinion physician, who indicated that there was no connection between the bilateral hand and thumb osteoarthritis and the accepted lupus condition. Therefore, it properly referred appellant to Dr. Dreyfuss, a Board-certified internist and rheumatologist, for an impartial medical opinion to resolve the conflict, pursuant to 5 U.S.C. § 8123(a).

In his April 6, 2015 report, Dr. Dreyfuss reviewed appellant's medical history and statement of accepted facts and conducted a physical examination. He opined that SLE did not cause osteoarthritis and that appellant would have developed osteoarthritis in his hands independently of developing SLE. Dr. Dreyfuss further opined that the SLE influenced appellant's osteoarthritis in that the symptoms of his underlying osteoarthritis were made worse with increasing activity of the lupus. However, he opined that appellant did not have an aggravation within OWCP's definition of aggravation because symptom escalation was not the equivalent of aggravation of the underlying condition. Dr. Dreyfuss, therefore, found no etiological relationship between appellant's osteoarthritis and his industrial SLE

The Board finds that Dr. Dreyfuss had full knowledge of the relevant facts and evaluated the course of appellant's condition. Dr. Dreyfuss is a specialist in the appropriate field. His opinion is based on proper factual and medical history and his report contained a detailed summary of this history. Dr. Dreyfuss addressed the medical records and made his own examination findings to reach a reasoned conclusion regarding appellant's condition.[14] Specifically, he found that appellant did not have an aggravation within OWCP's definition of

[12] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207, 210 (1993).

[13] *See Roger Dingess*, 47 ECAB 123, 126 (1995); *Juanita H. Christoph*, 40 ECAB 354, 360 (1988); *Nathaniel Milton*, 37 ECAB 712, 723-24 (1986).

[14] *See Michael S. Mina*, 57 ECAB 379 (2006) (the opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion are facts, which determine the weight to be given to each individual report).

aggravation because symptom escalation was not the equivalent of aggravation of the underlying condition. The Board finds that his opinion constitutes the special weight of the medical evidence.

In his September 15, 2015 report, Dr. Leon contended, in pertinent part, that appellant's lupus arthritis involving the fingers and thumbs at the PIP and MCP joints of his hands had most likely contributed to the arthritis in his thumb at the CMC joint since arthritis in one joint adversely affects the adjacent joint. He indicated that even in the presence of the osteoarthritis in the CMC joint, appellant's pain would have been improved if he did not have arthritis related to lupus in his fingers and thumbs at the PIP and MCP joints. Dr. Leon, however, failed to provide a well-rationalized explanation as to how and whether those conditions, which have not been accepted by OWCP, were causally related to the accepted conditions.[15] The fact that work activities produced pain or discomfort revelatory of an underlying condition does not raise an inference of an employment relation.[16] Thus, Dr. Leon's report is of diminished probative value and is insufficient to overcome the special weight properly accorded to Dr. Dreyfuss' report as the impartial medical examiner or to create a new conflict.[17]

On appeal, counsel contends that Dr. Dreyfuss mischaracterized the findings of the treating physician and failed to explain how he came to the conclusion that the accepted condition was not responsible for the arthritis in appellant's extremities. For the reasons stated above, the Board finds that Dr. Dreyfuss' opinion represents the weight of the medical opinion evidence.

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 consequential hand and thumb arthritis condition causally related to his accepted conditions.

[15] *See T.M.*, Docket No. 08-975 (issued February 6, 2009) (for conditions not accepted or approved by OWCP as being due to an employment injury, the claimant bears the burden of proof to establish that the condition is causally related to the employment injury through the submission of rationalized medical evidence).

[16] *See Wilbur D. Starks*, 23 ECAB 85 (1971).

[17] *See Dorothy Sidwell*, 41 ECAB 857 (1990).

ORDER

IT IS HEREBY ORDERED THAT the November 13, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 20, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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