United States Department of Labor
Employees' Compensation Appeals Board

D.R., Appellant	)	
and	)	**Docket No. 16-1395**
	)	**Issued: February 2, 2017**
DEPARTMENT OF THE NAVY, NAVAL RESERVE, Norfolk, VA, Employer	)	

Appearances:
Appellant, pro se
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 June 20, 2016 appellant filed a timely appeal from a December 22, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP).[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 met his burden of proof to establish that he sustained a stroke causally related to factors of his federal employment.

[1] Under the Board's *Rules of Procedure*, an appeal must be filed within 180 days from the date of issuance of an OWCP decision. An appeal is considered filed upon receipt by the Clerk of the Appellate Board. *See* 20 C.F.R. § 501.3(e)-(f). One hundred and eighty days from December 22, 2015, the date of OWCP's last decision was June 19, 2016, a Sunday; consequently, the period for filing the appeal ran to the next business day Monday, June 20, 2016. *See* 20 C.F.R. § 501.3(f)(2). The appeal was received on Monday, June 20, 2016 rendering it timely.

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On April 29, 2015 appellant, then a 63-year-old warrior and family support program specialist, filed an occupational disease claim (Form CA-1) alleging that he sustained a stroke as a result of stress and added job responsibilities as a defense travel administrator. He noted that the job position forced him to become an expert in defense travel system, supplies, and joint travel federal regulations. Appellant indicated that he first became aware of his condition and realized that it resulted from his employment on April 25, 2015. He stopped work on April 26, 2015.

In an April 27, 2015 letter, Vicki Rose, an employing establishment management support specialist, related that appellant notified her by telephone on April 25, 2015 that he had a stroke while on travel status when he left the Navy Operational Support Center (NOSC) where he was conducting deployment readiness training. Appellant stated that his job duties had caused him stress for the last four years. Ms. Rose explained that appellant had to become the subject matter expert in various programs over the last few years, which had been added to his responsibilities. Appellant believed that he did not get any rest while away from the job because there was no one else at the command that could fill in for him when he was out of the office. He further noted that he received numerous telephone calls at his home on the weekends and when traveling. Ms. Rose reported that appellant had previously suffered a minor stroke about four months before he started his current position.

The employing establishment submitted various documents including a position description for a warrior and family support program specialist.

Appellant was initially treated in the hospital and he provided hospital records dated April 25 to 27, 2015. In an April 26, 2015 report, Dr. Gabriel Gabasan, a Board-certified internist, indicated that appellant was transported to the hospital *via* emergency medical services (EMS) after onset of right-sided weakness. He related that on April 25, 2015 appellant noticed acute onset of right hand pain in the afternoon, but did not think much of it. Appellant explained that during dinner he experienced right leg weakness and urinary evacuation. He indicated that he spent the rest of the night in his hotel room and that around 2:00 a.m. he went to use the bathroom and had difficulty moving his right arm and leg and had slurred speech. Appellant sought treatment at an urgent care center, from which he was transported to the hospital. Dr. Gabasan reviewed appellant's history and related that appellant had a previous cerebral vascular accident (CVA) in 2011. Upon examination, he observed no gross deficits or focal weakness neurologically. Strength was equal and bilaterally symmetric in upper and lower extremities. Cardiovascular examination showed regular rate and rhythm with no murmurs, rubs, or gallops. Dr. Gabasan related that a computerized tomography (CT) scan of the brain showed no acute abnormality. He noted that appellant would be admitted for observation for right-sided hemiparesis and hypertension.

Dr. Gabasan reexamined appellant on April 27, 2015 and in a progress note of that date related left-sided weakness on his upper and lower extremities and positive right-sided paresis. He related that a magnetic resonance imaging (MRI) scan of the brain demonstrated an acute lacunar infarct involving left modular pyramid superiorly, small chronic lacunar infarct, and

white matter leukoaraiosis, and cerebral atrophy. Dr. Gabasan diagnosed right-sided hemiparesis and acute CVA -- left medullary.

Appellant also underwent a neurological consultation with Dr. Mridula Prasad, a Board-certified psychiatrist and neurologist, who indicated, in an April 27, 2015 report, that around 5:00 p.m. on April 25, 2015 appellant was on his way to his car after finishing work when he suddenly lost control of his bladder and noticed right arm weakness. Later that night he observed that his right arm weakness had worsened and he had weakness in his right leg. Appellant went to urgent care for medical treatment and was transported by EMS to the emergency room where he was admitted. Dr. Prasad related that appellant had been stressed at work from working more than 40 hours a week and travelling. Upon examination, she observed focal motor and sensory deficits. Cardiovascular examination revealed regular rate rhythm with no murmurs, rubs, or gallops. Dr. Prasad related that neurologic examination showed impaired right side. She reported that general sensory examination showed impaired position of appellant's right foot and impaired pin and touch distally of both legs. Dr. Prasad discussed various laboratory results. She diagnosed acute right (dominant) hemiparesis secondary to left medullary pyramidal acute infarct and stroke. Dr. Prasad conducted a follow-up examination and in an April 28, 2015 progress note indicated no new symptoms and no changes.

In various diagnostic examination reports dated April 28, 2015, Dr. Anand S. Jagannath, a Board-certified diagnostic radiologist, related that a CT angiography of the brain did not show an aneurysm, but most likely secretions in a mucous retention cyst of the left sphenoid sinus. A CT angiography of the neck revealed atherosclerotic disease of the carotid arteries, fusiform mild stenosis of the left proximal internal carotid artery, marked ectasis of the distal internal carotid arteries bilaterally, and cervical spondylosis.

In a magnetic resonance angiography of the head and neck, Dr. Jason L. Pennypacker, a Board-certified vascular, interventional, and diagnostic radiologist, noted an incidental aneurysm within the cephated portion of the left sphenoid sinus. He reported that the remainder of the arteriographic evaluation of the head and neck was within normal limits.

On April 29, 2015 appellant was admitted to a rehabilitation hospital. In an April 30, 2015 examination report, Dr. Steven Morganstein, Board-certified in physical medicine and rehabilitation, related that appellant was traveling on business on April 25, 2015 and experienced acute onset of right hand pain. Appellant did not think much of it until he went to dinner and experienced an episode of right leg weakness and urinary incontinence. He spent the rest of the night in his hotel room and around 2:00 a.m. he attempted to use the bathroom and experienced trouble with his right arm and leg, increased weakness, and slurred speech. Appellant went to urgent care for treatment where he was taken to the emergency room. He was admitted for further evaluation and possible treatment of stroke. Dr. Morganstein discussed the results of various diagnostic testing and the medical treatment appellant received at the hospital. Appellant advised Dr. Morganstein that on April 29, 2015 he had been transferred to the rehabilitation hospital for continuation of therapy. Dr. Morganstein reviewed appellant's history, which included a stroke in 2011 with no residual deficits, and provided examination findings. He reported that appellant had ambulatory dysfunction secondary to left medullary infarction with right hemiplegia, dysphagia, and deep venous thrombosis prophylaxis.

In a May 18, 2015 narrative report, Dr. Morganstein reiterated that appellant was hospitalized on April 24, 2015 for treatment of acute onset of right-sided weakness and found to have a left hemisphere ischemic infarct. He related that, since appellant was admitted to the rehabilitation hospital, appellant had made progress with functional mobility, but still required assistance with ambulation, transfers, and activities of daily living. Dr. Morganstein indicated that an initial CT scan of the brain showed no bleed and an MRI scan of the brain revealed evidence of the CVA. He noted diagnoses of acute ischemic stroke with right hemiparesis, hypertension, and diabetes mellitus. Dr. Morganstein opined that appellant remained totally disabled from work and would require further intensive therapies to maximize his functional independence.

Appellant was discharged from the rehabilitation hospital on May 22, 2015. According to the discharge report, Dr. Morganstein noted that appellant had achieved his inpatient rehabilitation goals. He diagnosed ambulatory dysfunction secondary to left medullary infarct, right hemiparesis, hypertension, diabetes mellitus, right foot drop, and hypomagnesemia. Dr. Morganstein indicated that appellant was returning home and would follow up with his primary care physician on May 28, 2015. He provided appellant's laboratory results.

By letter dated June 4, 2015, OWCP advised appellant that the evidence submitted was insufficient to establish his claim. It requested that he respond to the attached questionnaire and provide medical evidence to establish that he sustained a diagnosed condition as a result of factors of his employment. Appellant was afforded 30 days to submit this additional evidence.

Dr. Joseph Olinger, a Board-certified family practitioner, treated appellant and, in an attending physician's report dated June 22, 2015, explained that on April 25, 2015 appellant experienced right-sided paralysis and speech impairment from left-sided infarction. He noted a history of hypertension and type 2 diabetes. Dr. Olinger diagnosed left lacunar infarct with right-sided paralysis. He checked a box marked "yes" that appellant's condition was caused or had been aggravated by his employment. Dr. Olinger reported that high levels of work stress and excess travel exacerbated appellant's hypertension and diabetes.

On June 25, 2015 OWCP received appellant's response to its questionnaire. Appellant related that he believed that the nature of his job contributed to his condition. He explained that he was responsible for the training and preparation of service members and their loved ones for deployment overseas by organizing deployment readiness training events prior to their deployment. Appellant related that it was a constant battle to get the service members and their family members to attend the training and that he often received a call at the last minute from NOSC asking him how to get a family member and his family to an event. He reported that organizing the event required arranging all travel arrangements such as coordinating flights, lodging, and meals. Appellant described the various problems that often occurred when trying to coordinate with so many different individuals and the stressful impact it caused. He noted that he often received telephone calls from members at all hours of the day and night regarding requirements, flights, and orders. Appellant related that he was also responsible for providing returning service members with a returning warrior workshop (RWW) and with other resources to assist them in reintegrating into civilian life. He explained that the resources necessary were as complex and varied as to the member's needs and required a great deal of coordination with

hotels and event facilitators. Appellant noted that he was responsible for conducting five deployment readiness trainings and three RWWs events annually throughout the region.

Appellant asserted that the pressures of his job were crippling and caused a rise in his blood sugar and blood pressure. He also pointed out that approximately 2½ years ago a study was conducted, which determined that his position required 2 people to adequately fulfill its obligation. Appellant reported that he had exposure to no other conditions outside of his federal employment that would cause him stress and that he had no similar disability or symptoms prior to this injury. He indicated that his wife first noticed the onset of his condition about two years ago and that each stroke seemed to take a greater toll on him, leaving him physically and emotionally exhausted.

Dr. Olinger continued to treat appellant and in progress notes dated June 1 and 25, 2015 noted that he examined appellant for follow-up of right-sided stroke on April 25, 2015. He discussed appellant's stroke symptoms and the treatment he received. Dr. Olinger noted that diagnostic examinations revealed a lacunar infarct on appellant's left side. He reviewed appellant's history and noted a past medical history of type 2 diabetes, essential hypertension, stroke, hyperlipidemia, lipoprotein deficiencies, and arthritis. Upon examination, Dr. Olinger observed normal speech and no slurring. Neurological examination revealed marked weakness of the right hand and arm and the right leg. Deep tendon reflexes demonstrated 2+ in the upper and lower extremities. Dr. Olinger diagnosed left-sided lacunar infarction, hemiplegia affecting right dominant side, and diabetes mellitus without complication type 2, uncontrolled, essential hypertension, and lipoprotein deficiencies. He reported that appellant continued to make progress, but would not be able to work for at least one year as he continued with occupational, physical, and speech therapy.

In a July 1, 2015 statement, appellant described his activities one week prior to his stroke incident. He noted that on April 19, 2015 he attended church. From April 20 through 22, 2015 appellant prepared for his business trip by fielding calls from soldiers, checking orders, and communicating with event resources and staff. On April 23, 2015 he traveled. On April 24, 2015 appellant set up the building for the event and continued communicating with traveling sailors. He indicated that he first began to notice symptoms of dizziness and fatigue. On April 25, 2015, when the event started, appellant worked with the staff, resources, presenters, sailors, and families to ensure proper execution of the event. He explained that during the event he became increasingly dizzy, but thought it was due to the stress of the event. Appellant related that after the event the symptoms increased and he returned to his hotel and went to bed. On April 26, 2015 he was returning to go home, but noticed that he was unable to drive. Appellant went to the emergency room and was admitted to the hospital. He reported that he had no history of heart problems and was not a smoker. Appellant resubmitted hospital records and diagnostic examination reports dated April 26 to 28, 2015.

Dr. Olinger provided a narrative report dated August 21, 2015, where he indicated that he had evaluated appellant on May 22 and June 22, 2015. He related that appellant was initially traveling for work in Pennsylvania when he began to feel fatigue and unsteady on his feet. Appellant went to sleep and woke up with right-sided weakness of his arm and leg, some speech deficits, and difficulty walking. He was admitted to the hospital and diagnosed by MRI scan with a left-sided lacunar infarction/stroke causing worsening right-sided hemiplegia and speech

deficit. Dr. Olinger reported that appellant also suffered a myocardial infarction on July 15, 2015 which required the placement of a stent followed by a triple coronary artery bypass graft on July 20, 2015. He related that appellant continued with physical, occupational, and speech therapy. Dr. Olinger diagnosed left-sided lacunar infarction with right hemiplegia and dysarthria, atherosclerotic coronary artery disease status post myocardial infarction, surgical coronary artery bypass grafting, hypertension, type 2 diabetes mellitus, and hyperlipidemia.

Dr. Olinger indicated that appellant was under enormous stress with his work, traveled often, and was being asked to take on additional responsibility. He related that at one point a study indicated that two people were needed to do appellant's job, but appellant was given additional responsibility, sufficient for a third person. Dr. Olinger opined that the stress and responsibilities of appellant's job contributed significantly and directly to the events which have ensued, primarily the stroke and heart attack requiring stenting and subsequent bypass surgery. He reported that the elements of the job creating this stress were travel commitments, stress of added responsibilities, and the time required for him to complete the work of three individuals. Dr. Olinger explained that this level of work-related stress and travel contributed significantly to markedly elevated stress hormones, hypertension, and difficult to control diabetes. He reported that at the time appellant was home and continuing with therapy, which would likely go for up to one year to achieve maximum medical improvement.

Appellant submitted various physical therapy and occupational therapy reports.

On September 21, 2015 appellant retired due to disability.

OWCP denied appellant's claim in a decision dated December 22, 2015. It accepted that the factors of employment occurred as alleged and that he sustained a stroke, but denied his claim finding that the medical evidence failed to establish that his medical condition was causally related to factors of his employment.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative, and substantial evidence[3] including that he or she sustained an injury in the performance of duty and that any specific condition or disability for work for which he or she claims compensation is causally related to that employment injury.[4] In an occupational disease claim, appellant's burden requires submission of the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which

[3] *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan,* 20 ECAB 55, 58 (1968).

[4] *M.M.,* Docket No. 08-1510 (issued November 25, 2010); *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton,* 40 ECAB 1143, 1145 (1989).

compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[5]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[6] 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 identified by the employee.[7]

Where an employee is on temporary-duty assignment away from his federal employment, he or she is covered by FECA 24 hours a day with respect to any injury that results from activities essential or incidental to his temporary assignment.[8]

However, the fact that an employee is on a special mission or in travel status during the time a disabling condition manifests itself does not raise an inference that the condition is causally related to the incidents of employment.[9] The medical evidence must establish a causal relationship between the condition and factors of employment.[10]

ANALYSIS

Appellant alleged that he sustained a stroke due to factors of his employment. OWCP accepted his employment duties as a warrior and family support specialist and that he sustained a stroke, but denied his claim because the medical evidence failed to establish a causal relationship between factors of his employment and his medical condition. The Board finds that appellant did not meet his burden of proof to establish that his stroke was causally related to his federal employment duties.

Appellant was initially treated in the hospital by Drs. Gabasan and Prasad. In reports dated April 26 and 27, 2015 both physicians provided a detailed account of the symptoms appellant experienced on April 25 and 26, 2015 and noted that he was traveling for work. Drs. Gabasan and Prasad provided physical examination findings and related that diagnostic testing revealed an acute lacunar infarct. Although they provided medical diagnoses of right-sided hemiparesis and CVA of the left medullary and noted that appellant was stressed at work, none of the physicians provided an opinion on the cause of appellant's stroke. The Board has

[5] *R.H.*, 59 ECAB 382 (2008); *Ernest St. Pierre*, 51 ECAB 623 (2000).

[6] *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *D.I.*, 59 ECAB 158 (2007).

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

[8] *See Cherie L. Hutchings*, 39 ECAB 639 (1988).

[9] *See William B. Merrill*, 24 ECAB 215 (1973).

[10] *Samuel P. Isenberger*, Docket No. 06-864 (issued June 23, 2006).

held 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.[11]

Likewise, Dr. Morganstein's rehabilitation notes dated April 30 to May 22, 2015 and the various diagnostic examination reports dated April 28, 2015 by Drs. Jagannath and Pennypacker also fail to contain any opinion on the cause of appellant's stroke. These reports, therefore, are insufficient to establish appellant's claim.[12]

Subsequently, appellant was treated by Dr. Olinger. In various notes dated June 1 to 25, 2015, Dr. Olinger related that on April 25, 2015 appellant experienced acute onset of right-sided weakness and paralysis. He provided examination findings and diagnosed left lacunar infarct. In a June 22, 2015 attending physician's report, Dr. Olinger checked a box marked "yes" that appellant's condition was caused or aggravated by his employment. The Board has held that a report that addresses causal relationship with a check mark, without more by way of medical rationale, is of diminished probative value.[13] Dr. Olinger further explained in an August 21, 2015 narrative report that appellant was under enormous stress and had taken on additional responsibility at work. He noted that although a study indicated that two people were needed to do appellant's job, appellant was given additional responsibility, sufficient for a third person. Dr. Olinger reported that the stress and responsibilities of appellant's job contributed significantly and directly to the events which have ensued, primarily the stroke, and heart attack. He explained that the elements of appellant's job creating this stress were travel commitments, stress of added responsibilities, and the time required for him to complete the work of three individuals. Dr. Olinger opined that this level of work-related stress and travel contributed significantly to markedly elevated stress hormones, hypertension, and difficult to control diabetes. The Board notes that although Dr. Olinger reports contain an accurate description of appellant's employment duties and affirmative statements of causation, they do not contain a sufficient explanation, based on medical rationale, of how any of his duties would have physiologically caused or contributed to a stroke.[14] Dr. Olinger failed to explain how appellant's particular employment duties caused or contributed to his medical condition.[15] His opinion, therefore, is insufficient to establish causal relationship.

Thus, the Board concludes that while appellant was on travel status at the time of his stroke, he has not submitted the necessary medical evidence to establish causal relationship between his medical condition and factors of his federal employment.[16]

[11] *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *J.F.*, Docket No. 09-1061 (issued November 17, 2009); *A.D.*, 58 ECAB 149 (2006).

[12] *Id*.

[13] *K.A.*, Docket No. 16-592 (issued October 26, 2016).

[14] *See M.M.*, Docket No. 15-607 (issued May 15, 2015); *M.W.*, Docket No. 14-1664 (issued December 5, 2014).

[15] *Id*.

[16] *Supra* note 10.

On appeal appellant alleges that a causal relationship was established between his work environment and his stroke. He described the problems and stressful responsibilities of his work environment and noted that he had been in rehabilitation treatment since April 2015. Appellant pointed out that he was not working due to paralysis on his right side and that he was financially ruined. As found above, however, the medical evidence of record is not of sufficient probative value to establish that his stroke was causally related to factors of his employment.[17]

Appellant may submit new evidence or argument with a 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. §§ 10.606 through § 10.607.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he sustained a stroke causally related to his federal employment.

ORDER

IT IS HEREBY ORDERED THAT the December 22, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 2, 2017
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

[17] *Supra* note 7.