United States Department of Labor
Employees' Compensation Appeals Board

V.D., Appellant	)	
and	)	
DEPARTMENT OF THE ARMY, U.S. ARMY MEDICAL RESEARCH INSTITUTE OF INFECTIOUS DISEASES, Fort Detrick, MD, Employer	)	**Docket No. 16-1345** **Issued: September 27, 2017**

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 10, 2016 appellant filed a timely appeal from a December 14, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] Pursuant to the Federal

[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 Boards. *See* 20 C.F.R. § 501.3(e)-(f). One hundred and eighty days from OWCP's December 14, 2015 decision was Saturday, June 11, 2016. As the deadline for filing fell on a weekend, it was extended to the next business day, Monday, June 13, 2016. 20 C.F.R. § 501.3(f)(2). Because using June 14, 2016, the date the appeal was received by the Clerk of the Appellate Boards, would result in the loss of appeal rights, the date of the postmark is considered the date of filing. The date of the U.S. Postal Service postmark is June 10, 2016, rendering the appeal timely filed. 20 C.F.R. § 501.3(f)(1).

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 claim.[3]

ISSUE

The issue is whether appellant met her burden of proof to establish an injury causally related to the accepted April 30, 2013 employment incident.

FACTUAL HISTORY

On May 5, 2015 appellant, then a 50-year-old supervisory biologist, filed a traumatic injury claim (Form CA-1) alleging that on April 30, 2013 she received a purified protein derivative (PPD) skin test (tuberculosis test) on her left forearm as part of routine occupational health testing, which caused a severe reaction on the test site, including erythema, inflammation, and swelling. She also alleged that the skin test worsened ongoing pain and inflammation of her right shoulder and right arm, which had been caused by an earlier smallpox vaccination on the right arm.[4]

In a May 11, 2015 letter, OWCP advised appellant of the deficiencies in her claim and provided her the opportunity to submit additional factual and medical evidence. This included a detailed narrative medical report from her treating physician, which contained a history of the injury and a medical explanation with objective evidence of how the reported work incident caused or aggravated the claimed condition. Appellant was afforded 30 days to submit such evidence.

OWCP received a position description, which indicated that appellant was required to receive vaccines because of her exposure to highly infectious agents and toxins, along with Notification of Personnel Action (SF-50) forms dated December 16, 2012 and January 11, 2015.

In a May 20, 2013 report, Dr. Patricia I. Dillon, Chief of the Medical Biosurety Program at the Barquist Army Health Clinic, stated that appellant demonstrated hypersensitivity to medications after receiving a smallpox immunization in July 2012 that had not completely resolved. The immune-triggered inflammatory process tended to occur in the right shoulder area involving the joint and overlying muscles. X-rays confirmed that there was an inflammatory reaction in the bursa region of the shoulder joint and appellant also continued to experience chronic pain. Dr. Dillon reported that on April 30, 2013 a routine PPD was placed on her left forearm as part of routine occupational health testing and, 48 hours later, the testing site demonstrated a severe reaction with erythema and warmth over the PPD placement site extending approximately 4 inches x 2 inches in diameter. By May 16, 2013, the PPD site

[2] 5 U.S.C. § 8101 *et seq.*

[3] Appellant submitted additional evidence with her appeal. The Board's review is limited to the evidence that was before OWCP at the time of its final decision. Therefore, the Board lacks jurisdiction to review this additional evidence. 20 C.F.R. § 501.2(c)(1).

[4] Under File No. xxxxxx829, date of injury July 23, 2012, OWCP accepted right brachial plexus neuritis and right shoulder myositis due to contact dermitis.

continued to appear inflamed and the left arm was moderately swollen from the wrist to the mid-humorous region. In addition, her right shoulder area was experiencing more pain and tenderness at both the inner joint and overlying muscular area. Appellant also experienced difficulties sleeping as the pain would frequently wake her. Dr. Dillon advised that the working diagnosis was that the smallpox vaccination triggered a hypersensitivity immune cascade. She opined that the most recent PPD placement introduced an antigen that her immune system rejected and exacerbated the inflammatory response at the local site and increased the ongoing inflammation at the contralateral shoulder joint.

In a May 22, 2013 report, Dr. Norman E. Stone, a Board-certified orthopedic surgeon, reported that appellant returned for reevaluation of her right shoulder pain after an atypical reaction to a smallpox vaccination last summer. He noted that she had made significant progress until late April 2013, when she had a left forearm PPD skin test. Dr. Stone reported that it subsequently erupted into a significant local soft tissue reaction. Simultaneously, appellant had a resurgence of pain in the right shoulder. Dr. Stone reported physical examination findings and assessed right shoulder pain, which he opined was likely due to several orthopedic conditions. He noted that the flare up of pain after the left forearm PPD skin test was an unclear connection. Dr. Stone also assessed left forearm pain after PPD skin test, possibly mild myositis.

In a May 28, 2014 report, Dr. Wayne O. Wolverton, an internist, noted the history of right shoulder pain following her smallpox vaccination. He also noted that appellant recently had a PPD skin test and developed local reaction and simultaneous exacerbation of her right shoulder pain. Dr. Wolverton noted that testing was negative and while her local reaction has subsided over several days, she continued to have right shoulder pain and insomnia due to shoulder pain. He provided provisional diagnosis of Type III immune complexes.

Appellant submitted several reports on June 9, 2015.

In an August 16, 2013 report, Dr. Stout noted fluid in the subdeloid bursa. An immunology study for raised antibody titer was performed, but found no clear etiology. Dr. Stout opined that CRPS tissue trauma was a possibility.

In a September 6, 2013 report, Dr. Brian J. Stout, a Board-certified internist and rheumatologist, noted right lateral shoulder pain and left extensor surface arm pain following smallpox vaccination to the right shoulder over one year prior and subsequent PPD skin test placement on contralateral arm. He opined that overall appellant's pain pattern appeared most consistent with neurologic pain in the arm, possibly a complex regional pain syndrome (CRPS) phenomenon. Dr. Stout further opined that appellant's trapezial pain was most consistent with myofascial pain syndrome, likely from protection of the right shoulder.

In a December 12, 2013 report, Dr. Dillon continued to report on appellant's condition. She indicated that it was not clear which of the contributing factors were the cause of her continuing pain and weakness of the right arm: whether it be an overall Type III hypersensitivity reaction, a local inflammatory reaction of the right shoulder bursa, damage/inflammation to the nerves that supply the shoulder and neck region.

A copy of a Q Sense Test report dated March 12, 2014 and a hand screen test report dated March 11, 2014, which indicated muscle weakness in the nerves of the hands, was provided along with copies of physical therapy progress notes.

In a May 24, 2014 report, Dr. Dillon reported on the history of the August 1, 2012 reaction to the smallpox vaccination and her subsequent reaction to the PPD skin test site. She noted that there was some consensus that the PPD skin test triggered underlying immune reaction responsible for the chronic brachial plexus neuritis. Over time the neuritis persisted and met the criteria for neuralagic amyothrophy (Parsonage-Turner Syndrome). Dr. Dillon noted that the source for the underlying nerve disorder initiated by the smallpox vaccine, and then exacerbated by the placement of a PPD antigen on the contralateral arm was investigated. She diagnosed brachial neuropathy induced by a smallpox vaccination which resulted in severe loss of muscle strength and grip in the right hand, which appeared to be permanent in nature.

By decision dated June 22, 2015, OWCP denied the claim because the factual component of fact of injury had not been met. It noted that appellant had not responded to its questionnaire and therefore the facts surrounding her claim could not be established. OWCP also noted that the medical evidence submitted did not contain a diagnosis.

On July 22, 2015 OWCP received appellant's July 20, 2015 request for a representative of OWCP's Branch of Hearings and Review to review the written record. Appellant submitted her responses to OWCP's development questionnaire, medical records from the employing establishment's health unit, and an e-mail indicating that she first notified her employing establishment of the injury due to the PPD skin test on May 21, 2013.

In a July 14, 2015 report, Dr. Dillon reported that on July 23, 2012 appellant was immunized with the smallpox vaccination as required by her work and had a serve reaction. It presented as a robust local response with a large blister and then whole-body rash. The nerves beneath the vaccination site became overactive in the right shoulder/arm area and sent continuous messages to the brain. Dr. Dillon noted that a thorough workup by several specialists concluded that appellant has CRPS triggered by the local nerve responses to the smallpox vaccination. Unfortunately, it has been three years since appellant's injury from that vaccine and to date her symptoms have shown no improvement. Appellant's syndrome has progressed to the point that the right hand and arm have suffered loss of strength objectively documented by several clinicians. Dr. Dillon reported that one year following the smallpox vaccination, appellant had PPD skin testing required for her position. She noted that, in 2012, appellant had a PPD skin test without issue but, one year later, she experienced a robust reaction to the PPD skin test. Dr. Dillon indicated that more advanced blood tests were performed and confirmed that appellant did not have tuberculosis. She noted that Dr. Jay Montgomery, a Board-certified immunologist, had concluded that some component of her immune system must have become primed by the smallpox vaccination resulting in the robust PPD response. Dr. Dillon indicated that for the first several months following the PPD response on her left arm, appellant experienced a sense of "heaviness" and pain over the left arm. Over time, the pain sensation reduced, but the sense of "heaviness" persisted. Dr. Dillon stated that it has now been three years since the placement of the smallpox vaccination. The pain persists and appellant has developed muscle weakness of the right extremity essentially making her right arm nonfunctional. Dr. Dillon indicated that those systems were consistent with CRPS.

Furthermore, a recent magnetic resonance imagining (MRI) scan study of the cervical region demonstrated hypodense lesions consistent with CRPS. She advised that appellant's disability was permanent and unlikely to resolve.

By decision dated December 14, 2015, OWCP's hearing representative modified the June 22, 2015 decision to find that the employing establishment had administered the April 30, 2013 PPD skin test. However, it affirmed the denial of the claim on the basis that the diagnosed medical condition of CRPS was not causally related to the April 30, 2013 incident.

LEGAL PRECEDENT

A claimant seeking benefits under FECA[5] 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, including that an injury was sustained in the performance of duty as alleged and that any specific condition or disability claimed is causally related to the employment injury.[6]

To determine if an employee sustained a traumatic injury in the performance of duty, OWCP begins with an analysis of whether "fact of injury" has been established. Generally, fact of injury consists of two components that must be considered in conjunction with one another. The first component is whether the employee actually experienced the employment incident that allegedly occurred.[7] The second component is whether the employment incident caused a personal injury.[8] An employee may establish that an injury occurred in the performance of duty as alleged, but fail to establish that the disability or specific condition for which compensation is being claimed is causally related to the injury.[9]

The fact that a condition manifests itself during a period of employment is not sufficient to establish causal relationship.[10] Temporal relationship alone will not suffice.[11] Entitlement to

[5] *See supra* note 2.

[6] 20 C.F.R. § 10.115(e), (f); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996).

[7] *Elaine Pendleton*, 40 ECAB 1143 (1989).

[8] *John J. Carlone*, 41 ECAB 354 (1989). Causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue. *Robert G. Morris*, 48 ECAB 238 (1996). A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factor(s) must be based on a complete factual and medical background. *Victor J. Woodhams*, 41 ECAB 345, 352 (1989). Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty, and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factor(s). *Id.*

[9] *Shirley A. Temple*, 48 ECAB 404, 407 (1997).

[10] 20 C.F.R. § 10.115(e).

[11] *See D.I.*, 59 ECAB 158, 162 (2007).

FECA benefits may not be based on surmise, conjecture, speculation, or on the employee's own belief of a causal relationship.[12]

In any case where a preexisting condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation, acceleration, or precipitation, the physician must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.[13]

ANALYSIS

OWCP accepted that the April 30, 2013 PPD vaccination/skin test work incident occurred as alleged. It denied appellant's claim, however, as she had failed to submit rationalized medical evidence describing how the accepted incident caused or aggravated any medical condition. The record reflects that OWCP had previously accepted several underlying conditions, under File No. xxxxxx829, as a result of an adverse reaction to a routine smallpox vaccine administered on July 23, 2012.[14]

The medical reports of record fail to provide a firm diagnosis resulting from the 2013 PPD vaccination/skin test. Dr. Dillon described appellant's reaction at the site of the PPD skin test (a severe reaction with erythema and warmth over the PPD skin test placement site and later inflammation), but failed to diagnose any specific condition resulting therefrom. Dr. Stone assessed left forearm pain after PPD skin test, but indicated that the flare up of pain after the left forearm PPD skin test was of unclear origin; possible mild myositis. The Board has held that the mere diagnosis of "pain" does not constitute the basis for payment of compensation.[15] Additionally, a "possible mild myositis" is not a firm diagnosis of a particular medical condition.[16] Dr. Wolverton noted that appellant's reaction to the PPD skin test subsided over several days. Thus, no diagnosis was provided from the reaction to the PPD vaccination/skin test.[17]

[12] *See M.H.*, Docket No. 16-0228 (issued June 8, 2016).

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013).

[14] *See infra* note 4. OWCP did not combine the case records prior to adjudicating her claim for the alleged April 30, 2013 employment injury and; therefore, the factual and medical evidence pertaining to appellant's prior injury is not fully contained in the case record. As noted, on December 4, 2015 OWCP accepted under claim number xxxxxx829, right brachial plexus neuritis and right shoulder myositis. OWCP's procedures provide that cases should be combined when correct adjudication of the issue(s) depends on frequent cross-reference between files. Federal (FECA) Procedure Manual, Part 2 -- Claims, *File Maintenance & Management*, Chapter 2.400.8(c) (February 2000).

[15] *Robert Broome*, 55 ECAB 339 (2004).

[16] *See Deborah L. Beatty*, 54 ECAB 340 (2003) (where the Board found that, in the absence of a medical report providing a diagnosed condition and a reasoned opinion on causal relationship with the employment incident, appellant did not meet her burden of proof).

[17] *Id.*

Dr. Wolverton also provided a provisional diagnosis of Type III immune complexes due to the simultaneous exacerbation of her right shoulder pain. However, this is not a firm diagnosis and Dr. Wolverton did not provide any opinion on how the April 30, 2013 skin test caused or contributed to appellant's underlying right shoulder pain.[18] A medical opinion is especially needed in this case as the record reflects that appellant had preexisting right shoulder pain stemming from her 2012 smallpox vaccine.[19] Accordingly, Dr. Wolverton's report is of limited probative value.

Dr. Stout opined that appellant's pain pattern appeared most consistent with neurologic pain in the arm, possibly a CRPS phenomenon, and that her trapezial pain was most consistent with myofascial pain syndrome, likely from protection of the right shoulder. However, he failed to provide an opinion regarding causal relationship and his report is unclear as to which event, he was referring the smallpox vaccine administered on July 23, 2012 or the 2013 PPD skin test. Lacking a rationalized opinion regarding causal relationship, his report is, therefore, of little probative value in establishing appellant's claim.[20]

Dr. Dillon provided several reports. In her May 20, 2013 report, she reported that the site of the PPD skin test was inflamed and appellant's left arm was moderately swollen from the wrist to the mid-humorous region. However, as noted earlier, no diagnosis was provided in relation to the PPD skin test.[21] Dr. Dillon also reported that the right shoulder area was experiencing more pain and tenderness at both the inner joint and overlying muscular area and the working diagnosis was that the smallpox vaccination triggered a hypersensitivity immune cascade. She opined that the most recent PPD skin test introduced an antigen that her immune system rejected which exacerbated the inflammatory response at the local site and increased the ongoing inflammation at the contralateral shoulder joint. Dr. Dillon, however, failed to provide any medical rationale as to how the PPD placement exacerbated appellant's preexisting inflammatory response and increased the ongoing inflammation at the contralateral shoulder joint.[22] As noted, a medical opinion is especially needed in the case as the record reflects that appellant had a preexisting chronic pain and shoulder problems at the contralateral shoulder joint.[23]

In a May 24, 2014 report, Dr. Dillon indicated that appellant has neuralagic amyothrophy (Parsonage-Turner Syndrome) which resulted in severe loss of muscle strength and grip in the right hand, which appeared permanent in nature. She stated that the source for the underlying nerve disorder was inducted by the smallpox vaccine and then exacerbated by the placement of a PPD antigen on the contralateral arm. However, Dr. Dillon again failed to provide any medical

[18] *Id.*

[19] *See B.T.*, Docket No. 13-138 (issued March 20, 2013).

[20] *See A.M.*, Docket No. 14-1399 (issued September 23, 2014).

[21] *Supra* note 16.

[22] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, *supra* note 8.

[23] *See B.T., supra* note 19.

rationale as to how the PPD placement exacerbated the underlying nerve disorder. Thus, this report is of limited probative value.[24]

In her July 14, 2015 report, Dr. Dillon opined that appellant had CRPS and that the limitations of her right arm were permanent. She indicated that, following the PPD response on her left arm, appellant experienced a sense of "heaviness" and pain over the left arm. Over time, the pain sensation reduced, but the sense of "heaviness" persisted. Dr. Dillon stated that three years have passed since the placement of the smallpox vaccination and the pain persists and appellant has developed muscle weakness of the right extremity essentially making her right arm nonfunctional. She indicated that those systems were consistent with CRPS and noted that a recent MRI scan of the cervical region demonstrated hypodense lesions consistent with CRPS. This diagnosis, however, relates to the earlier smallpox vaccination on the right arm. While Dr. Dillon indicated the sense of "heaviness" persisted on the left arm following the PPD test, she has offered no diagnosis in connection with the PPD skin test.[25] Additionally, while she opined that appellant has CRPS and the limitations of the right arm were permanent, Dr. Dillon has not explained how or whether the PPD skin test merely worsened the symptoms of the already developing CRPS or contributed to its development. Stated differently, she has not explained whether and how the PPD skin test changed the course of the inflammatory response, which she indicated was already present due to the smallpox vaccine. Thus, this report is insufficient to establish causal relationship.[26]

The additional medical evidence is of limited probative value. The medical testing of record failed to offer a medical opinion as to how the reported work incident caused or aggravated a medical condition. The Board has held that medical evidence which 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] Thus, these reports are insufficient to establish appellant's claim.

Causal relationship is a medical question that must be established by probative medical opinion from a physician.[28] In this case, the Board finds that none of the medical evidence constitutes rationalized medical evidence, based upon a specific and accurate history of employment conditions, which are alleged to have caused or exacerbated her preexisting medical condition.[29] Accordingly, the Board finds that, while appellant has established incident, she has failed to meet her burden of proof to establish a causal relationship between the work incident and her diagnosed conditions. Neither the fact that a disease or condition manifests itself during

[24] *See Michael E. Smith*, 50 ECAB 313 (1999).

[25] *See Deborah L. Beatty*, *supra* note 16.

[26] *See Michael E. Smith*, *supra note* 23.

[27] *L.M.*, Docket No. 16-0188 (issued March 24, 2016); *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[28] *W.W.*, Docket No. 09-1619 (issued June 2, 2010); *David Apgar*, 57 ECAB 137 (2005).

[29] *Patricia J. Bolleter*, 40 ECAB 373 (1988).

a period of employment nor the belief that the disease or condition was caused or aggravated by the employment factors or incident is sufficient to establish causal relationship.[30]

On appeal appellant contends that the medical reports support the causal relationship between the April 30, 2013 employment incident and her diagnosed conditions. However, as explained above, the medical evidence is insufficient to establish a medical diagnosis for the accepted employment incident and fails to explain how or whether the PPD skin test merely worsened the symptoms of the already developing CRPS or contributed to its development.

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. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant failed to meet her burden of proof to establish an injury causally related to the accepted April 30, 2013 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the December 14, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 27, 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

[30] *See Dennis M. Mascarenas*, 49 ECAB 215 (1997).