United States Department of Labor
Employees' Compensation Appeals Board

L.G., Appellant	)	
and	)	**Docket No. 18-0321**
	)	**Issued: October 25, 2018**
DEPARTMENT OF THE TREASURY, OFFICE OF THE SECRETARY, Washington, DC, Employer	)	

Appearances:
Steven E. Brown, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On November 30, 2017 appellant, through counsel, filed a timely appeal from a June 6, 2017 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 this case.

[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.*

ISSUE

The issue is whether appellant has established that the acceptance of the claim should be expanded to include the additional conditions of concussion; postconcussion syndrome; post-traumatic migraine; occipital headaches and fatigue; occipital neuritis; neck sprain; cervical strain syndrome with cervicalgia; saccadic eye movement deficiency and vestibular dysfunction; cervical, lumbar, and brachial radiculopathy symptoms; ulnar neuropathy; and carpal tunnel syndrome.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts and circumstances outlined in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On October 21, 2013 appellant, then a 31-year-old economist, filed a traumatic injury claim (Form CA-1) alleging that, on August 16, 2013, she sustained injuries when she fell down stairs while entering the building where she worked.

By decision dated January 7, 2014, OWCP initially denied the claim, finding that appellant had not established that the claimed incident occurred as alleged. On February 4, 2015 it accepted her claim for knee sprain, bilateral ankle sprain, right tibia contusion, and lumbar sprain.

In correspondence dated February 12, 2015, counsel requested that the acceptance of appellant's claim be expanded to include the additional conditions of: myofascial pain syndrome; reflex sympathetic disorder (RSD) which affected his lower right and upper left extremities; a concussion; postconcussion syndrome; post-traumatic migraine; occipital headaches and fatigue; occipital neuritis; neck sprain; cervical strain syndrome with cervicalgia; saccadic eye movement deficiency and vestibular dysfunction; cervical, lumbar, and brachial radiculopathy symptoms; ulnar neuropathy; and carpal tunnel syndrome.

Medical evidence subsequently submitted included an October 19, 2014 report in which Dr. Henry M. Friedman, an optometrist, noted seeing appellant for a vision and eye health examination due to dizziness with eye movement, headache and eyestrain associated with reading, and blurred distance vision, all of which began with a concussion injury on August 16, 2013. Following eye examination, Dr. Friedman had advised that appellant's saccadic eye movements showed occasional undershoots and her binocular coordination was grossly abnormal, and noted that testing caused pain. He recommended a program of vision therapy to improve spatial localizing skills, binocular posturing, and visual-vestibular integration in an aid to eliminate dizziness, headache, and eyestrain. In a January 30, 2015 report, Dr. Friedman opined that appellant's symptoms were atypical of most developmental or stress-induced visual problems and, therefore, it seemed logical that they were the result of brain injury.

In follow-up reports dated May 27 to September 16, 2015, Dr. James Weiss, a Board-certified orthopedic surgeon, noted appellant's complaints of RSD in her hands and continued upper and lower back, right hip and thigh, and right knee symptoms, and had been seen by a

[3] Docket No. 17-1448 (issued December 19, 2017).

neurosurgeon, had a sleep study done, was going to vision therapy, physical therapy, and had acupuncture treatments. He noted gradual improvement but opined that appellant continued to have significant residuals.

In a report dated October 19, 2015, Dr. Kevin Crutchfield, a Board-certified neurologist, noted a current diagnosis of resolving post-traumatic occipital neuritis, with secondary headaches associated with sensitivity to fluorescent lighting and computer screens. He advised that appellant continued to improve clinically, but had not reached maximum medical improvement and needed ongoing care for trauma-induced migraine headaches. Dr. Crutchfield noted that appellant's visual disturbances and psychological issues further limited her ability to work, but that from a neurological standpoint she could have returned to part-time work in July 2015. He opined that, with a high degree of medical certainty or probability of at least 51 percent certainty, that August 16, 2013 employment injury clearly initiated appellant's inability to function in her prior employed position.

In October 2015 OWCP referred appellant to Dr. Donald Heitman, a Board-certified orthopedic surgeon, and Dr. Chandra Sharma, Board-certified in psychiatry and neurology, for second opinion evaluations. Each OWCP referral physician was to provide an opinion on as to appellant's current condition, whether any diagnoses were a consequence of the August 16, 2013 employment injury, whether the diagnosed RSD was caused by the employment injury, whether appellant continued to suffer residuals of the employment injury, and any period of total disability due to the work-related condition.

In a report dated October 28, 2015, Dr. Heitman noted the history of injury and his review of the medical record including diagnostic testing. He described appellant's complaints of low back bilateral knee, and bilateral ankle pain. Dr. Heitman found tenderness on examination of the right lumbosacral junction, right patellofemoral joint line, bilateral Achilles tendon, and right ankle joint with full range of motion of both knees and both ankles. He opined that appellant had a chronic lumbar strain with radiculopathy and advised that it could be connected to the work injury, but noted that diagnostic studies did not show any significant findings in the low back. Dr. Heitman found no current findings of knee or ankle pathology bilaterally and advised that he could not comment regarding RSD as that was out of his scope of expertise. He concluded that appellant had reached maximum medical improvement with respect to the accepted lumbar sprain, bilateral ankle sprain, and tibia contusion, that she required no further treatment, had no continuing residuals, and that there no periods of total disability for the accepted conditions.

In a report dated November 23, 2015, Dr. Sharma noted the history of injury, her review of the medical record, and appellant's complaints of neck, upper and lower back, and right hip pain, and RSD involving both feet and the left arm, and vision problems. Following neurological examination, Dr. Sharma diagnosed multiple subjective pains and normal neurological examination. She opined that there were no neurological injuries sustained from the employment injury, and that no further treatment was warranted. Dr. Sharma related that the subjective pains were related to the employment injury, but did not cause any neurological problems. Regarding RSD, she indicated that the sensory changes reported in appellant's feet and left hand were causally related, but again opined that these changes did not affect neurological function. Dr. Sharma opined that appellant had no periods of total neurological disability and could work without restriction.

Additional medical evidence included follow-up treatment notes dated January 11 and May 6, 2016 in which Dr. Weiss noted that appellant was doing better, but still had residual tenderness, noting that the right hip still caused discomfort. On May 12, 2016 Dr. Weiss indicated that he had reviewed medical records, including Dr. Heitman's report and opined that he disagreed with the Dr. Heitman's conclusions. He indicated that diagnostic studies would be negative for RSD, and he found that appellant did have objective findings and needed continuing treatment. Dr. Weiss opined that, due to her employment injuries, appellant was totally disabled from August 16, 2013 to January 17, 2014, and partially disabled from January 17 to June 17, 2014.

In a June 29, 2016 report, Dr. Crutchfield reiterated his opinion that the August 16, 2013 fall had resulted in a stretch injury to her greater occipital nerve that caused post-traumatic occipital neuritis, which had induced chronic, secondary headaches, and photosensitivity which made it impossible to perform office work. He opined that appellant's signs and symptoms were caused by head and neck trauma she suffered when she fell on the stairs on August 16, 2013.

In a September 28, 2016 report, Dr. Weiss noted that he had not seen appellant for approximately five months and she had improved significantly. He advised that she still had very slight residual myofascial symptoms and slight RSD.

By letter dated March 15, 2017, counsel again requested that OWCP accept additional conditions of: myofascial pain syndrome; RSD, which affects both her lower right extremity and her upper left extremity; concussion; postconcussion syndrome; post-traumatic migraine; occipital headaches and fatigue; occipital neuritis; neck sprain; cervical strain syndrome with cervicalgia; saccadic eye movement deficient and vestibular dysfunction; cervical, lumbar, and brachial radiculopathy symptoms; ulnar neuropathy; and carpal tunnel syndrome. He contended that all of these conditions were part of the original claim, but were never developed despite medical evidence of record from appellant's treating physicians, and a decision had not been made on the February 12, 2015 request for expansion of the claim to include these same additional conditions. Counsel, therefore, requested that OWCP review the medical evidence of record and develop whether the additional conditions should be accepted.

By development letter dated May 4, 2017, OWCP advised appellant that it had reviewed the medical evidence submitted and found it insufficient to expand acceptance of the claim to include the additional claimed conditions. It informed appellant of the type of evidence needed to establish expansion of the claim. This was to include a report from a treating physician who should provide a history of the injury including any similar problems which may have preexisted the conditions for which she was treated, current clinical findings and results of diagnostic testing, and any diagnosis or diagnoses resulting from the employment injury, along with a report of any condition of the injured member or body part which preexisted the claimed conditions. The physician was to also provide a rationalized medical opinion regarding causal relationship, if any, between the accepted work injury and the condition or conditions for which appellant was currently being treated. OWCP afforded appellant 30 days to submit the necessary evidence.

By letter dated May 30, 2017, counsel contended that the evidence already of record was sufficient to establish that the claimed conditions were employment related, and that expansion of the acceptance of the claim was therefore warranted. He noted that the issue of claim expansion has never been developed. Counsel requested that OWCP review the entire case file and all of the

medical evidence previously submitted and issue a decision on the claim expansion request. He noted that "in the event that you find the medical evidence is not sufficient, please explain specifically why it is not."

By decision dated June 6, 2017, OWCP denied appellant's request to expand the acceptance of the claim to include additional diagnoses. It noted that "upon receipt of [the March 15, 2017] request, the evidence of record since the issuance of the [February 4, 2015] acceptance letter was thoroughly reviewed." OWCP found that the evidence was insufficient to establish additional diagnoses causally related to the accepted injury as appellant had not provided a rationalized medical opinion from a qualified physician in response to its May 4, 2017 development letter.

LEGAL PRECEDENT

An employee has the burden of proof to establish that any specific condition for which compensation is claimed is causally related to the employment injury.[4] Causal relationship is a medical issue, and the medical evidence required to establish causal relationship is rationalized medical evidence.[5] The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[6] Neither the mere fact that a disease or condition manifests itself during a period of employment, nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[7]

When an injury arises in the course of employment, every natural consequence that flows from that injury likewise arises out of the employment, unless it is the result of an independent intervening cause attributable to claimant's own intentional misconduct.[8] Thus, a subsequent injury, be it an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.[9] A claimant bears the burden of proof to establish a claim for a consequential injury. As part of this burden, he or she must present rationalized medical opinion evidence.[10]

[4] *Kenneth R. Love*, 50 ECAB 276 (1999).

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

[6] *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

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

[8] *Mary Poller*, 55 ECAB 483, 487 (2004); 1 Arthur Larson & Lex K. Larson, *The Law of Workers' Compensation* 10-1 (2006).

[9] *D.K.*, Docket No. 17-1549 (issued July 6, 2018).

[10] *Charles W. Downey*, 54 ECAB 421 (2003).

ANALYSIS

The Board finds that appellant has not established that the claimed additional conditions of concussion; postconcussion syndrome; post-traumatic migraine; occipital headaches and fatigue; occipital neuritis; neck sprain; cervical strain syndrome with cervicalgia; saccadic eye movement deficiency and vestibular dysfunction; cervical, lumbar, and brachial radiculopathy symptoms; ulnar neuropathy; and carpal tunnel syndrome were caused or aggravated by the August 16, 2013 employment injury.[11]

The opinion of a physician supporting causal relationship must be based on a complete factual and medical background, supported by affirmative evidence, must address the specific factual and medical evidence of record, and must provide medical rationale explaining the nature of the relationship between the diagnosed condition and the established incident or factor of employment.[12] No such evidence is of record in this case.

The diagnostic studies of record did not provide a cause of any diagnosed conditions, and 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.[13] Moreover, when diagnostic testing is delayed, uncertainty mounts regarding the cause of the diagnosed condition and a question arises as to whether that testing in fact documents the injury claimed by the employee. The greater the delay in testing, the greater the likelihood that an event not related to employment has caused or worsened the condition for which the employee seeks compensation.[14] Most of the diagnostic testing in this case was performed in February 2014, almost six months after the employment injury. Furthermore, none of the test results revealed a trauma-induced diagnosis.

Dr. Friedman's reports are also insufficient to meet appellant's burden of proof. He merely reported that appellant's symptoms of dizziness with eye movement, headache and eyestrain associated with reading, and blurred distance vision began with a concussion injury on August 16, 2013, and it seemed logical that they were the result of a brain injury. As noted, postconcussion syndrome has not been accepted as employment related. This report does not establish that the diagnosed conditions were directly caused or a consequence of the accepted injury.[15]

On October 19, 2015 Dr. Crutchfield noted a current diagnosis of resolving post-traumatic occipital neuritis, with secondary headaches. It is unclear from his reports whether he considered

[11] With regard to the claimed RSD condition, the Board found in its prior decision that appellant had not met her burden of proof, as Dr. Sharma's November 23, 2015 second opinion, which found no evidence of RSD, carried the weight of the medical evidence. *Supra* note 3. The Board's prior findings with regard to the condition of RSD are *res judicata*. *See A.C.*, Docket No. 18-0484 (issued September 7, 2018). With regard to the issue of expansion of the claim to include the additional condition of myofascial pain syndrome, OWCP did not address that condition in its June 6, 2017 decision. Thus, this issue is not presently before the Board. *See* 20 C.F.R. §§ 501.2(c) and 501.3.

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

[13] *Willie M. Miller*, 53 ECAB 697 (2002).

[14] *Mary A. Ceglia*, 55 ECAB 626 (2004).

[15] *Supra* note 13.

that the additional diagnoses of post-traumatic migraine headaches, vestibular dysfunction, and saccadic eye movement were related to postconcussion syndrome and/or occipital neuritis, which are not employment related. If not, other than his general conclusion that all diagnoses were caused by the August 16, 2013 employment injury, Dr. Crutchfield provided no additional rationale explaining exactly how the employment injury caused any of his diagnosed conditions. Medical conclusions unsupported by rationale are of diminished probative value and are insufficient to establish causal relation.[16]

Regarding the diagnoses of neck sprain, cervical strain syndrome with cervicalgia, cervical, lumbar, and brachial radiculopathy, as indicated above, Dr. Crutchfield provided insufficient rationale to support any of his diagnoses.

OWCP referred appellant to Dr. Heitman, an orthopedic surgeon, and Dr. Sharma, a neurologist, for second opinion evaluations. Neither physician found additional employment-related conditions. Dr. Heitman advised that appellant had no continuing residuals of the accepted conditions, and Dr. Sharma advised that appellant had no neurological injuries due to the employment injury.

Rationalized medical evidence is evidence which relates a work incident or factors of employment to a claimant's condition, with stated reasons of a physician. The opinion must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship of the diagnosed condition and the specific employment factors or employment injury.[17] The Board finds that appellant has not submitted sufficient rationalized medical evidence to establish causal relationship between the August 16, 2013 employment injury and the claimed additional conditions of concussion; postconcussion syndrome; post-traumatic migraine; occipital headaches and fatigue; occipital neuritis, neck sprain; neck sprain; cervical strain syndrome with cervicalgia; saccadic eye movement deficiency and vestibular dysfunction; cervical, lumbar, and brachial radiculopathy symptoms; ulnar neuropathy; and carpal tunnel syndrome.

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 has not met her burden of proof to establish that the acceptance of the claim should be expanded to include additional conditions of concussion; postconcussion syndrome; post-traumatic migraine; occipital headaches and fatigue; occipital neuritis; neck sprain; cervical strain syndrome with cervicalgia; saccadic eye movement deficiency and vestibular dysfunction; cervical, lumbar, and brachial radiculopathy symptoms; ulnar neuropathy; and carpal tunnel syndrome.

[16] *J.B.*, Docket No. 08-1721 (issued January 26, 2009); *Albert C. Brown*, 52 ECAB 152 (2000).

[17] *C.O.*, Docket No. 10-189 (issued July 15, 2010).

ORDER

IT IS HEREBY ORDERED THAT the June 6, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 25, 2018
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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

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