# United States Department of Labor
# Employees' Compensation Appeals Board

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| **C.R., Appellant** | ) | |
| **and** | ) | **Docket No. 18-1285** |
| | ) | **Issued: February 12, 2019** |
| **DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION, Neosho, MO, Employer** | ) | |

*Appearances:*
*Appellant, pro se*
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

## ***JURISDICTION***

On June 14, 2018 appellant filed a timely appeal from a March 23, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of this case.[2]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the March 23, 2018 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

## ***ISSUE***

The issue is whether appellant has met his burden of proof to establish consequential conditions of post-traumatic seizure and paroxysmal atrial fibrillation disorder as causally related to his accepted June 22, 2016 employment injury.

## ***FACTUAL HISTORY***

On June 22, 2016 appellant, then a 53-year-old archives technician, filed a traumatic injury claim (Form CA-1) alleging that on that date he fell from the sixth rung of a ladder or from a height of roughly five feet landing on his back on a concrete floor while in the performance of duty. On July 19, 2016 OWCP accepted his traumatic injury claim for T12 vertebra compression fracture and resulting surgery. By decision dated July 19, 2016, it noted that appellant submitted medical evidence in support of his claim for the additional conditions of seizure disorder and irregular heartbeat, however, these conditions had not been accepted as employment related.

On November 30, 2016 OWCP expanded acceptance of appellant's claim to include complete rotator cuff tear of the left shoulder and adhesive capsulitis of the left shoulder as well as surgery for these conditions.[3] On August 9, 2017 it further expanded acceptance of his claim to include bilateral pulmonary embolisms as due to his June 22, 2016 employment injury and resulting spine surgery.

In notes dated June 22, 2016, Dr. Clint R. Dunkle, an osteopath, reported that on that date appellant had slipped and fell from a seven foot ladder and landed on his back on concrete sustaining low back pain. While initially hospitalized for his fall, following the administration of morphine for pain control, he had a tonic-clonic seizure with resulting postictal confusion. Dr. Dunkle reported that the seizure was attributed to the morphine and not the fall. Appellant's family reported that appellant had a history of epilepsy when he was a child as well as a previous head injury. He was not on anti-seizure medication.

On June 22, 2016 Dr. Ahmed T. Robbie, a Board-certified neurologist, reported that appellant had been given morphine for pain control following his June 22, 2016 fall and that he subsequently developed a tonic-clonic seizure which lasted for a few minutes followed by postictal confusion. He noted that as appellant had a history of a head concussion and seizures as a child, he had a low threshold for seizures, and that morphine and pain may have provoked or initiated his June 2016 seizure. Dr. Robbie recommended that appellant avoid morphine as it may provoke his seizures.

In a June 23, 2016 note, Dr. James P. Sisk, an osteopath, reported that appellant fell from a ladder resulting in a compression fracture. Appellant had been given pain medications and subsequently had a seizure with a postictal stage. Dr. Sisk noted that appellant had a history of seizures as a child.

[3] On April 7, 2017 appellant underwent arthroscopic left rotator cuff repair, distal clavicle resection, subacromial decompression, and lysis of adhesions left shoulder.

On June 24, 2016 Dr. Cherylon Yarosh, a Board-certified neurosurgeon, performed appellant's surgical stabilization with T1-L2 instrumentation and arthrodesis. She noted that he sustained acute blood loss, anemia, tachycardia, and a few brief episodes of atrial fibrillation during the surgery which required treatment with a beta blocker.

In a separate June 24, 2016 note, Dr. Robert Lieurance, a Board-certified orthopedic surgeon, opined that appellant's June 22, 2016 seizure was "possibly related" to medications. He noted that appellant had a history of seizures with the last one occurring when he was 13 years old.

On June 25, 2016 Dr. David Zuehlke, a Board-certified cardiologist, described appellant's history of injury on June 22, 2016 and reported that appellant experienced atrial fibrillation during his June 24, 2016 back surgery as well as an episode of paroxysmal atrial fibrillation following his surgery. He reported that appellant had a history of heart palpitations beginning two or three years prior to 2016. Dr. Zuehlke noted that appellant had also had sporadic episodes of short runs of atrial fibrillation occurring about every six months, but no other cardiac history. He reported, "My impression is this [appellant] has paroxysmal fibrillation probably predating his surgery and augmented at this time by hypercatecholaminemia." On June 26, 27, and 28, 2016 Dr. Zuehlke continued to note that appellant experienced episodes of proximal atrial fibrillation and to prescribe medication.

In a report dated July 21, 2016, Dr. Zuehlke noted that on June 26, 2016 appellant had postoperative atrial fibrillation. He suggested that as appellant's catecholamine level dropped following his surgery, the tendency for atrial fibrillation with rapid ventricular response would dissipate. Dr. Zuehlke found that appellant remained in "postoperative atrial fibrillation."[4]

On September 2, 2016 appellant requested that his accepted conditions be expanded to include the additional conditions of paroxysmal atrial fibrillation and post-traumatic seizure.

In a report dated September 26, 2016, Dr. Jorge A. Gonzalez, a neurologist, noted appellant's history of a fall from a ladder in June 2016. He diagnosed T10 compression fracture and single grand-mal or tonic-clonic seizure episode. Dr. Gonzalez found that appellant's electroencephalogram was unremarkable. He noted that appellant reported that he had febrile convulsions as a child, but that this condition had resolved. Dr. Gonzalez reported that appellant had had no additional seizures since his June 2016 fall. He diagnosed singular convulsive event without recurrence and noted that a patient was not considered epileptic until there was evidence of two or more seizures. Dr. Gonzalez completed an addendum opining that appellant's "breakthrough seizure event" was a singular event and therefore not reflective of epilepsy. He

[4] On December 29, 2016 Dr. John F. Swartz, a Board-certified cardiologist, diagnosed persistent atrial flutter associated with rapid ventricular response. He described appellant's history of injury on June 22, 2016 and noted that he experienced a seizure. Dr. Swartz reported that following appellant's T10 through L1 arthrodesis he developed atrial fibrillation. He diagnosed recurrent atrial dysrhythmias first diagnosed after appellant's June 22, 2016 employment injury. Dr. Swartz recommended radiofrequency cardiac catheter ablation to eliminate appellant's atrial flutter. He noted that appellant's previously diagnosed paroxysms of atrial fibrillation were "possibly" the triggering event for his atrial flutter. On January 12, 2017 appellant underwent a radiofrequency cardiac catheter ablation of Type 1 atrial flutter.

further concluded that the seizure was a consequence of appellant's fall and "reaching [the] threshold for seizure due to the rotational, gyrational, and translational forces of the injury."

By development letter dated October 11, 2016, OWCP requested that appellant provide additional medical evidence regarding his claimed conditions of paroxysmal atrial fibrillation and post-traumatic seizure. It afforded him 30 days to respond.

In reports dated June 21 and July 14, 2017, Dr. David I. Krohn, a Board-certified internist acting as a district medical adviser (DMA), reviewed Dr. Zuehlke's June 24 and 25, 2016 notes and opined that appellant's paroxysmal atrial fibrillation "likely" preexisted his 2016 work injury by several years with intermittent alteration of heart rhythm of which appellant was unaware. He found that Dr. Zuehlke's opinion regarding the increased circulating catecholamines was not unreasonable, but was speculative. The DMA opined that it was the natural history of atrial fibrillation to occur sporadically, most often with no identifiable cause. He noted that appellant continued to have episodes of documented atrial fibrillation and atrial flutter episodically for no apparent reason. The DMA concluded, "In my opinion there was no aggravation of this preexisting condition specifically resulting from the episode on June 24, 2016. The condition took its natural course."

With regard to appellant's diagnosed post-traumatic seizure, the DMA noted reviewing a hospital note which reported that appellant had experienced a tonic-clonic seizure with postictal confusion following a lumbar spine computerized tomography (CT) scan on June 22, 2016 while hospitalized for his employment injuries. He reported that appellant had a known history of prior seizures which began in childhood resulting in a diagnosis of epilepsy. The DMA also noted that appellant had a head injury as a child. He reported that the medical evidence did not support recurrence of seizures since June 22, 2016 and opined that appellant had experienced a rare recurrence of his childhood epilepsy during his hospitalization. The DMA opined that the causal relationship between appellant's employment injury and the June 22, 2016 seizure had not been established.

By decision dated August 23, 2017, OWCP denied appellant's claim for the additional conditions of paroxysmal atrial fibrillation and post-traumatic seizure. On August 30, 2017 appellant requested an oral hearing before an OWCP hearing representative.

On February 7, 2018 appellant testified at an oral hearing and noted that he had not received the DMA's reports and requested that the record remain open for 60 days so that he might submit new evidence.

Following the oral hearing, in a February 26, 2018 letter, appellant asserted that he had no history of heart conditions. He denied a preexisting heart condition and alleged that Dr. Zuehlke's reports established his claim for atrial fibrillation. Appellant also asserted that Dr. Sisk's June 22 2016 report established that his seizure occurred due to his fall on June 22, 2016. He submitted treatments notes from Dr. Ely R. Gordon, an osteopath, dated August 13, 2015 and February 11, 2016 indicating that his heart rate was regular with normal rhythm without murmurs, rubs, or gallops.

By decision dated March 23, 2018, OWCP's hearing representative affirmed the August 23, 2017 OWCP decision and found that the June 22 and July 19, 2017 reports from the DMA were entitled to the weight of the medical evidence and demonstrated that appellant's diagnosed post-traumatic seizure and paroxysmal atrial fibrillation disorder were not employment related.

## ***LEGAL PRECEDENT***

It is an accepted principle of workers' compensation law that when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent, intervening cause attributable to the employee's own intentional conduct.[5] The basic rule is that a subsequent injury, whether 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.[6] With respect to consequential injuries, the Board has held that, where an injury is sustained as a consequence of an impairment residual to an employment injury, the new or second injury, even though nonemployment related, is deemed, because of the chain of causation to arise out of and in the course of employment and is compensable.[7]

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, based on a complete factual and medical background, showing causal relationship. Rationalized medical evidence is an opinion of reasonable medical certainty supported by sound medical rationale explaining the nature of the relationship of the diagnosed condition and the specific employment factors or employment injury.[8]

Section 8123(a) provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[9] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.[10] Where a case is referred to an impartial medical examiner for the purpose of resolving a conflict, the opinion of

[5] *D.L.*, Docket No. 18-0629 (issued November 16, 2018); *Albert F. Ranieri,* 55 ECAB 598 (2004); *Clement Jay After Buffalo,* 45 ECAB 707 (1994); *John R. Knox,* 42 ECAB 193 (1990).

[6] *D.L., id.*; *S.M.*, 58 ECAB 166 (2006); *Debra L. Dillworth,* 57 ECAB 516 (2006); *Carlos A. Marrero,* 50 ECAB 117 (1998); A. Larson, *The Law of Workers' Compensation* § 10.01 (2005).

[7] *D.L., id.*; *L.S.*, Docket No. 08-1270 (issued July 2, 2009); *Kathy A. Kelley,* 55 ECAB 206 (2004).

[8] *D.L., id.*; *J.B.*, Docket No. 14-1474 (issued March 13, 2015).

[9] 5 U.S.C. § 8123(a). *See D.L., id.*; *S.R.*, Docket No. 09-2332 (issued August 16, 2010); *Y.A.*, 59 ECAB 701 (2008); *Darlene R. Kennedy,* 57 ECAB 414 (2006).

[10] *D.L., id.*; *A.R.*, Docket No. 09-1566 (issued June 2, 2010); *M.S.*, 58 ECAB 328 (2007); *Bryan O. Crane,* 56 ECAB 713 (2005).

such specialist, if sufficiently well rationalized and based on a proper factual and medical background must be given special weight.[11]

## ***ANALYSIS***

The Board finds that the case is not in posture for a decision.

The record reflects an unresolved conflict of the medical opinion evidence between Dr. Krohn, the DMA, and Dr. Zuehlke, appellant's treating physician, regarding whether appellant's diagnosed paroxysmal atrial fibrillation disorder was casually related to his June 22, 2016 employment injuries.

In June 21 and July 19, 2017 reports, Dr. Krohn reviewed the medical evidence of record. He found, based on Dr. Zuehlke's notes, that appellant's paroxysmal atrial fibrillation "likely" preexisted his 2016 work injury. The DMA further found that Dr. Zuehlke's opinion regarding the increased circulating catecholamines due to surgery was not unreasonable, but was speculative and opined that atrial fibrillation naturally occurred sporadically, most often with no identifiable cause. He concluded that appellant did not sustain an aggravation of his preexisting atrial fibrillation due to his June 24, 2016 surgery.

Dr. Zuehlke reported that appellant experienced atrial fibrillation during his June 24, 2016 back surgery as well as an episode of paroxysmal atrial fibrillation following his surgery. He noted that appellant had a history of heart palpitations beginning two or three years prior to 2016. Dr. Zuehlke opined that appellant's preexisting paroxysmal atrial fibrillation was "augmented" on June 24, 2016 by hypercatecholaminemia due to his back surgery. On July 21, 2016 he suggested that as appellant's catecholamine level fell following his surgery, the tendency for atrial fibrillation with rapid ventricular response would dissipate. Dr. Zuehlke noted that appellant remained in "postoperative atrial fibrillation." His reports support that appellant's hypercatecholaminemia resulting from his accepted back surgery contributed to his paroxysmal atrial fibrillation on and after June 24, 2016.

The Board finds that a conflict in the medical opinion evidence exists between appellant's treating physician, Dr. Zuehlke, who found an aggravation of appellant's preexisting paroxysmal atrial fibrillation by his accepted back surgery, and Dr. Krohn, the DMA, who concluded that appellant's preexisting paroxysmal atrial fibrillation followed its natural course with no employment-related aggravation. These reports are of equal probative value. Both physicians offered a biomechanical explanation for the disparate opinions. Consequentially, the case must be referred to an impartial medical specialist to resolve the existing conflict in the medical opinion evidence regarding whether the aggravation of appellant's paroxysmal atrial fibrillation is a consequence of his accepted back injury and resulting surgery on June 24, 2016 or a natural progression of his underlying condition.[12]

[11] *D.L., id.*; *V.G.*, 59 ECAB 635 (2008); *Sharyn D. Bannick*, 54 ECAB 537 (2003); *Gary R. Sieber*, 46 ECAB 215 (1994).

[12] *M.R.*, Docket No. 17-0634 (issued July 24, 2018); *P.R.*, Docket No. 16-0146 (issued September 9, 2016).

On remand OWCP should refer appellant, along with the case file and a statement of accepted facts (SOAF), to an appropriate specialist for an impartial medical evaluation and a report including a rationalized opinion as to whether or not his paroxysmal atrial fibrillation is causally related to his accepted back injury and resulting surgery on June 22, 2016. Following this further development, OWCP shall issue a *de novo* decision regarding his claim for a consequential condition of paroxysmal atrial fibrillation.

The Board further finds that this case is not in posture for a decision due to an unresolved conflict in the medical opinion evidence regarding whether appellant's tonic-clonic seizure episode is causally related to his accepted June 22, 2016 employment injury.

Appellant provided notes from several physicians addressing the cause of his June 22, 2016 seizure. Drs. Robbie and Lieurance attributed appellant's June 22, 2016 seizure to the administration of morphine for pain control. However, these opinions were equivocal and of diminished probative value.[13] The physicians used words such as "possibly related" and "may have provoked" when discussing the relationship between appellant's seizure and the administration of morphine. Drs. Dunkle and Sisk opined that appellant's June 22, 2016 seizure was due to the administration of morphine following his employment-related fall, but failed to provide any medical reasoning in support of these opinions. A medical report is of limited probative value when the opinion on causal relationship lacks medical rationale.[14]

In his June 21, 2017 report, the DMA noted appellant's history of a June 22, 2016 tonic-clonic seizure with postictal confusion. He found that the seizure occurred following a lumbar spine CT scan on June 22, 2016 while appellant was hospitalized for his employment injuries. The DMA noted that appellant had a known history of childhood head injury and seizures with diagnosis of epilepsy. He opined that appellant had experienced a rare recurrence of his childhood epilepsy during his hospitalization and that the causal relationship between his injury and the June 22, 2016 seizure had not been established.

On September 26, 2016 Dr. Gonzalez reported that appellant had experienced febrile convulsions as child, but that this condition had resolved as he matured. He diagnosed singular convulsive event. Dr. Gonzalez concluded that the June 22, 2016 seizure was a consequence of appellant's fall and "reaching [the] threshold for seizure due to the rotational, gyrational, and translational forces of the injury."

The Board finds that the DMA and Dr. Gonzalez offered reasoned medical explanations for the varying conclusions reached. Dr. Gonzalez found that appellant's childhood seizure disorder had resolved and opined that his June 22, 2016 seizure was a direct consequence of his employment-related fall through the forces of that injury. The DMA attributed appellant's June 22, 2016 seizure to a recurrence of his childhood epilepsy rather than to his fall. As the opposing medical reports are of virtually equal weight and rationale, the Board finds that there is

[13] *See Y.F.*, Docket No. 17-1187 (issued June 5, 2018); *D.D.*, 57 ECAB 734 (2006) (Medical opinions that or speculative or equivocal in character are of diminished probative value).

[14] *R.V.*, Docket No. 18-0522 (issued November 5, 2018); *T.T.*, Docket No. 17-0471 (issued August 8, 2017); *Debra L. Dillworth*, 57 ECAB 516 (2006).

also an unresolved conflict as to whether appellant sustained an employment-related seizure on June 22, 2016.[15]

On remand, OWCP should refer appellant, along with the case file and a SOAF, to an appropriate specialist for an impartial medical evaluation and a report including a rationalized opinion as to whether or not appellant's June 22, 2016 seizure was a consequence of his accepted employment injuries on June 22, 2016. Following this further development, OWCP shall issue a *de novo* decision regarding his claim for a consequential condition of tonic-clonic seizure episode.

## ***CONCLUSION***

The Board finds that the case is not in posture for a decision.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the March 23, 2018 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded for further proceedings consistent with this opinion of the Board.

Issued: February 12, 2019
Washington, DC

Christopher J. Godfrey, 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

[15] *Supra* note 12.