



## ISSUE

The issue is whether appellant has met her burden of proof to establish that acceptance of the claim should be expanded to include the additional conditions of concussion and postconcussion syndrome.

## FACTUAL HISTORY

This case has previously been before the Board.<sup>3</sup> The facts and circumstances as presented in the prior appeal are incorporated herein by reference. The relevant facts are as follows.

On January 27, 2015 appellant, then a 45-year-old practical nurse, filed a traumatic injury claim (Form CA-1) alleging that on December 4, 2014 she sustained a laceration to her right lateral forehead, a concussion, and head trauma when she fell while in the performance of duty.

In a February 3, 2015 development letter, OWCP requested that appellant provide additional factual and medical evidence in support of her traumatic injury claim. It afforded her 30 days to respond.

In emergency room records from December 4 through 6, 2012, appellant indicated that she fell to the ground and hit her head. She did not remember falling. Appellant reported that she had chest pain and drowsiness before falling. Dr. Jeffrey Robinson, an internist, found a superficial and clean abrasion over the right side of the forehead with no active bleeding. Appellant related experiencing chest palpitations on December 4, 2014. Her blood pressure and glucose levels were elevated. Dr. Robinson reviewed appellant's history noting that she had felt poorly as of December 2, 2014. He noted that she had a small laceration to the right side of her scalp and that the bleeding was controlled. Appellant was also experiencing weakness on her left side. Dr. Robinson admitted her due to her syncope with weakness, chest pain, and low magnesium.

During appellant's December 4, 2014 hospitalization, Dr. Peter J. Kah, a Board-certified family practitioner, described her history of syncope and ongoing pounding sensation and chest pain. He diagnosed palpitations, syncope, and chest pain.

Dr. Albert Robert Blacky, a Board-certified cardiologist, noted appellant's history of malaise and occasional episodes of pain to the center of her chest. He concluded that the etiology of her syncopal episode was unclear and that her cardiac evaluation was unremarkable. Dr. Blacky also noted that appellant's hypertension was under control with therapy as was her diabetes with oral medication.

Appellant sought medical treatment on December 10, 22, and 27, 2014 from Dr. Dinu C. Nodit, a Board-certified neurologist. Dr. Nodit reported that she had sustained a large laceration on her forehead from her trauma that the previous week when she lost consciousness at work falling face down on the floor. He reported that appellant had a history of headaches and diabetes, but no loss of consciousness or seizures in the past. Dr. Nodit reviewed her diagnostic head studies including a head computerized tomography (CT) scan and a magnetic resonance imaging scan of

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<sup>3</sup> Docket No. 16-0822 (issued August 29, 2016).

her brain, which were normal. He diagnosed left hemiparesis, syncope, neck pain, and numbness. Dr. Nodit reported post-traumatic headaches. He further diagnosed postconcussion syndrome, neck pain, and syncope. Dr. Nodit also opined that appellant's memory loss was "probably due to a postconcussion syndrome related to [appellant's] closed head trauma." He again found that she had no abnormalities on diagnostic testing.

Appellant experienced a second episode of dizziness on January 14, 2015. Dr. Douglas Holland, a physician Board-certified in emergency medicine, noted that she reported symptoms of light-headedness and weakness. He diagnosed muscle weakness and acute headache.

Dr. Jonathan G. Martin, a Board-certified family practitioner, related appellant's history of a headache on January 13, 2015 and left-sided weakness on January 14, 2015. He reviewed her history and found that she had an inconsistent examination with no focal neurologic deficits. Dr. Martin suggested that the possible etiologies were migraines and atypical migraine symptoms. He found that it was not clear that appellant's current condition was related to the December 4, 2014 employment injury.

On February 2, 2015 Dr. Stephen Russell, a physician Board-certified in emergency medicine, examined appellant for an additional episode of syncope and indicated that this incident occurred at home. He diagnosed syncope and possible seizure.

By decision dated March 6, 2015, OWCP denied appellant's traumatic injury claim, finding that she had not established that her injury occurred in the performance of duty as alleged.

On March 18, 2015 appellant requested an oral hearing before an OWCP hearing representative. She denied complaining of chest pains or dizziness and asserted that her blood pressure and blood sugar were within the normal range. Appellant contended that the medical supply cart extended approximately one quarter of the way in front of the bathroom entryway. She presumed that she tripped on the cart when exiting the bathroom and hit her head on the cart causing the gash on her forehead. Appellant again asserted that blood was found on the corner of the supply cart and that she hit her head on the cart. She noted that she experienced migraines and seizures following her fall on December 4, 2014.

OWCP subsequently received notes dated April 9 and May 14, 2015 from Dr. Megumi Vogt, a Board-certified neurologist, who diagnosed "spells" and postconcussion syndrome. Dr. Vogt noted that appellant was experiencing an increased number of falls with repeated head trauma worsening her postconcussive symptoms. She reported that appellant experienced episodes of sharp headaches before her falls. Dr. Vogt also noted ongoing cognitive difficulties, balance problems, and fatigue. She diagnosed nonepileptic seizures, memory lapse, classic post-traumatic migraines, and postconcussion syndrome.

In a May 29, 2015 report, Dr. M.W. Rhyne, Jr., an optometrist, examined appellant and diagnosed traumatic brain injury, estropia, and hypertropia. He diagnosed strabismus, specifically estropia, finding that one of her eyes turned while the other was used for seeing. Dr. Rhyne noted that this condition could be caused by trauma. He also explained that appellant had a vertical estropia which could be caused by trauma.

In a June 15, 2015 note, Dr. Vogt examined appellant due to postconcussion syndrome and nonepileptic seizures. She found that appellant experienced daily migraines. Dr. Vogt also diagnosed depression. She reported ongoing problems with balance, vertigo, diplopia, migraines, memory, concentration, and fatigue.

OWCP subsequently received a February 27, 2015 note, wherein Dr. Vogt noted examining appellant due to “spells.” Dr. Vogt noted appellant’s history of a fall on December 4, 2014 with syncope. She reported that appellant returned to work for a few days, but began to see bursts of flashes of lights and became dizzy. Appellant fell and hit her head again. She had repeated loss of consciousness and fall. Appellant reported ongoing dizziness and balance problems resulting in stumbles or falls. She also reported left eye tics and left arm and leg contractions then shaking for a few minutes preceding falls or periods of confusion. Appellant then experienced severe headaches. Dr. Vogt diagnosed spells with loss of time/memory of uncertain etiology, as well as concussion with postconcussive symptoms.

Dr. Russell, in a July 17, 2015 report, noted his examination of appellant due to a fall at home. He noted that she sustained a head injury several months ago with loss of consciousness and had developed postconcussive syndrome. Dr. Russell diagnosed multiple facial abrasions and head injury.

On July 24, 2015 Dr. Robert S. Page, a Board-certified family practitioner, completed a note describing his observations on December 4, 2014. He noted that appellant was face down on the floor just inside the door. Dr. Page rolled her over and saw a bleeding laceration and contusion on her head.

In June 29, July 27, and August 3, 2015 notes Dr. Denise M. Stillman, a clinical psychologist, indicated that she provided appellant with cognitive behavior therapy to cope with depression and impairment secondary to traumatic brain injury. Appellant attributed her brain injury to her fall and head injury at work. Dr. Stillman diagnosed depressive disorder.

In an August 4, 2015 note, Dr. Angela H. Schupp, a Board-certified pediatrician, noted that appellant was seeing a psychologist regularly and had previously used Prozac for 10 years. She noted appellant’s possible seizure disorder, postconcussion syndrome, dizziness, and memory issues. Dr. Schupp also noted that appellant had received a new prescription for vision. She diagnosed asthma, fibromyalgia, hypertension, major depression, allergic rhinitis, and sleep apnea.

On August 11, 2015 Dr. Vogt diagnosed nonepileptic spells and postconcussion syndrome with significant postconcussion migraines. She noted that appellant experienced worsening of her depression. In a September 22, 2015 note, Dr. Vogt repeated appellant’s diagnoses.

An oral hearing was held before an OWCP hearing representative on October 15, 2015.

By decision dated January 6, 2016, OWCP’s hearing representative found that appellant had sustained an idiopathic fall, which was not considered to have arisen in the performance of duty as it was caused by a preexisting diabetic condition.

Appellant, through counsel, appealed the January 6, 2016 decision to the Board. By decision dated August 29, 2016, the Board set aside the January 6, 2016 hearing representative’s

decision, finding that appellant's December 4, 2014 fall was an unexplained fall that had occurred in the performance of duty, and that any injury established as resulting from this fall was compensable.<sup>4</sup> The Board remanded the case for OWCP to determine if appellant sustained an injury due to her fall on December 4, 2014.

By decision dated October 31, 2016, OWCP again denied appellant's traumatic injury claim, finding that the medical evidence of record was insufficient to establish causal relationship between her diagnosed conditions and the accepted December 4, 2014 employment injury.

On November 7, 2016 appellant, through counsel, requested an oral hearing before an OWCP hearing representative. She provided a November 7, 2016 note from Dr. Schupp, who opined that appellant had no episodes of syncope prior to 2015.

During the oral hearing, held on June 15, 2017 counsel asserted that appellant's claim should be accepted for laceration to the forehead, concussion, head trauma, and postconcussion syndrome. Appellant testified that following her December 4, 2014 fall, she had experienced 15 concussions from falling. She also reported abrasions and lacerations to her face.

Appellant subsequently submitted reports from: Dr. David L. Buckner, a Board-certified internist; Dr. James J. Kennedy, a Board-certified psychiatrist; and Dr. Jacob P. Barbee, a Board-certified family practitioner, diagnosing severe recurrent major depressive disorder. Dr. Kennedy and Dr. Barbee noted that she attributed her depression to a fall at work and a traumatic brain injury.

By decision dated August 23, 2017, OWCP's hearing representative reversed the October 31, 2016 decision in part, finding that appellant's December 4, 2014 employment incident resulted in a scalp laceration. She also affirmed the October 31, 2016 decision in part, finding that the medical evidence of record was insufficient to establish causal relationship between appellant's additional diagnosed conditions and her accepted December 4, 2014 employment incident.

By decision dated August 24, 2017, OWCP formally accepted appellant's December 4, 2014 employment injury for laceration of the scalp.

On July 5, 2018 appellant, through counsel, requested reconsideration of the August 23, 2017 OWCP hearing representative's decision and submitted additional medical evidence. In a June 7, 2018 note, Dr. Neil Allen, a Board-certified neurologist, reported reviewing appellant's medical records. He described her history of injury on December 4, 2014, including her striking her head when she fell. Dr. Allen opined that the additional conditions of concussion, brief loss of consciousness, and postconcussion syndrome were due to the December 4, 2014 employment injury. He noted that appellant denied symptoms related to these conditions prior to her work injury. Dr. Allen found, "Given [appellant's] history of blunt force trauma to the head, subjective complaints of head pain, dizziness, altered balance, and loss of memory, exam[ination] findings of laceration, abrasion, and tenderness over the head and scalp, and negative CT scan findings the most appropriate diagnosis would be concussion." He further opined that appellant continued to exhibit symptoms of acute concussion despite beginning the chronic stage of injury. Dr. Allen

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<sup>4</sup> *Id.*

noted that a direct blow to the head is the most common mechanism of concussion and that her episode of syncope and the resulting fall on December 4, 2014 directly caused her concussion and subsequent postconcussion syndrome.

By decision dated August 15, 2018, OWCP denied modification of the August 23, 2017 OWCP hearing representative's decision.

### **LEGAL PRECEDENT**

Where an employee claims that, a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.<sup>5</sup>

To establish causal relationship between the condition claimed and the employment event or incident, the employee must submit rationalized medical opinion evidence based on a complete factual and medical background, supporting such causal relationship.<sup>6</sup> 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 claimant.<sup>7</sup> The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.<sup>8</sup>

### **ANALYSIS**

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

OWCP accepted that on December 4, 2014 appellant sustained a scalp laceration as a result of her fall while in the performance of duty. Appellant has also claimed that she sustained a concussion and postconcussion syndrome as a result of the December 4, 2014 employment incident.

In support of her request for reconsideration, appellant submitted a June 7, 2018 note from Dr. Allen. Dr. Allen reviewed her medical records and described her history of injury on December 4, 2014. He opined that the additional conditions of concussion, brief loss of consciousness, and postconcussion syndrome were due to the December 4, 2014 employment injury. Dr. Allen noted that appellant denied symptoms related to these conditions prior to her work injury. He also found that, "Given [appellant's] history of blunt force trauma to the head, subjective complaints of head pain, dizziness, altered balance, and loss of memory, exam[ination]

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<sup>5</sup> *P.M.*, Docket No. 18-0287 (issued October 11, 2018); *V.B.*, Docket No. 12-0599 (issued October 2, 2012); *Jaja K. Asaramo*, 55 ECAB 200 (2004).

<sup>6</sup> *P.M.*, *id.*; *M.W.*, 57 ECAB 710 (2006); *John D. Jackson*, 55 ECAB 465 (2004).

<sup>7</sup> *P.M.*, *id.*; *John W. Montoya*, 54 ECAB 306 (2003).

<sup>8</sup> *P.M.*, *id.*; *H.H.*, Docket No. 16-0897 (issued September 21, 2016); *James Mack*, 43 ECAB 321 (1991).

findings of laceration, abrasion, and tenderness over the head and scalp and negative CT scan findings the most appropriate diagnosis would be concussion.” Dr. Allen noted that a direct blow to the head was the most common mechanism of concussion and concluded that appellant’s episode of syncope and that the fall on December 4, 2014 directly caused her concussion and subsequent postconcussion syndrome.

The Board finds that, while Dr. Allen’s opinion regarding causal relationship lacks sufficient medical rationale to meet appellant’s burden of proof to establish her claim, it was based upon an accurate medical history and provided medical rationale explaining how the forces of impact in the accepted employment injury could result in a concussion and subsequent postconcussion syndrome. As such, the opinion of Dr. Allen is sufficient to require OWCP to further develop the medical evidence in this claim.<sup>9</sup>

It is well established that proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter.<sup>10</sup> While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence and to see that justice is done.<sup>11</sup> Thus, the Board will remand the case to OWCP for further development of the medical evidence to obtain a rationalized medical opinion as to whether the accepted employment incident of December 4, 2014 was sufficient to have caused a concussion and postconcussion syndrome. On remand, OWCP should prepare a statement of accepted facts which includes the accepted conditions of the case and then obtain a second opinion examination on the issue of causal relationship. After such further development as may be deemed necessary, it shall issue a *de novo* decision.

### CONCLUSION

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

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<sup>9</sup> *A.M.*, Docket No. 18-1098 (issued April 22, 2019); *R.H.*, Docket No. 17-1966 (issued March 6, 2018); *John J. Carlone*, 41 ECAB 354 (1989).

<sup>10</sup> *A.M.*, *id.*; *A.M.*, Docket No. 18-0630 (issued December 10, 2018); *Vanessa Young*, 56 ECAB 575 (2004).

<sup>11</sup> *A.M.*, *id.*; *M.B.*, Docket No. 17-0536 (issued June 22, 2017); *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *Jimmy A. Hammons*, 51 ECAB 219 (1999); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

**ORDER**

**IT IS HEREBY ORDERED THAT** the August 15, 2018 merit decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision.

Issued: February 19, 2020  
Washington, DC

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

Janice B. Askin, Judge  
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge, dissenting,

The majority opinion finds that, although the medical report of Dr. Neil Allen, a Board-certified neurologist, was insufficient to meet appellant's burden of proof to establish their claim, it was sufficient to require the Office of Workers' Compensation Programs to further develop the medical evidence. I disagree.

As a standard proposition, the Board has long held that the weight of medical opinion is determined by the opportunity for thoroughness of examination, the accuracy, and completeness of the physician's knowledge of the facts of the case, the medical history provided, the care of analysis manifested, and the medical rationale expressed in support of stated conclusions.<sup>1</sup>

The Federal (FECA) Procedural Manual also sets out parameters for the weighing of medical evidence.<sup>2</sup> It describes a comprehensive report as one which reflects that all testing and analysis necessary to support the physician's final conclusions were performed. OWCP's procedures provide that, in general, greater probative value is given to a medical opinion based on

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<sup>1</sup> *R.C.*, Docket No 14-1964 (issued January 22, 2015); *Anna C. Leanza*, 48 ECAB 115 (1996).

<sup>2</sup> Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.810.6(a)(4) (September 2010).

an actual examination. An opinion based on a cursory or incomplete examination will have less value compared to an opinion based on a more complete evaluation.<sup>3</sup>

The case at bar raises a novel constellation of facts where appellant's physician is providing a causal opinion without examining appellant. While arguably considered a treating physician, Dr. Allen never saw in person nor physically examined appellant. He premised his opinion solely on what he characterized as medical records that he had reviewed. Dr. Allen did not, however, identify the records provided for his review nor describe the reports on which he relied.

It is an important distinction that the medical report of Dr. Allen in this case is being used to remand the case for further development.<sup>4</sup> The majority finds that, although his opinion contains insufficient medical rationale to establish the claim, it is sufficient to remand for OWCP to further develop the claim. This is effectuated by the 30-year-old Board-created standard, which provides that "when there is sufficient evidence to establish that the incident occurred, as alleged, but the medical evidence was insufficiently developed to establish the component of fact of injury, evidence submitted by appellant, which contains a history of injury, an absence of any other noted trauma, and an opinion that the condition found was consistent with the original injury is sufficient, given the absence of any opposing medical evidence, to require further development of the record."<sup>5</sup> It could be characterized as a reduced subjective standard, which effectively shifts the burden of proof to OWCP. This case was previously denied by OWCP based on in-person physical examination(s), which were found to be insufficient under the same reduced standard.

Especially, in this posture, I believe certain basic medical examination parameters must be met. Dr. Allen espoused an opinion on causal relationship without the benefit of direct physical examination or observations and based his findings on the second-hand opinion(s) of what we believe to be other physicians. This is the type of injury that, lends itself to physical examination for the purposes of diagnosis and causation, where the physician is able to palpate the patient, question and receive a first-hand account of the injury and compare same. This remains critical even when the only issue is causation. I do not agree that words of causation in the ordinary course alone can be separated from an examination of appellant by appellant's physician.

Of course, there are occasions where a physical examination cannot be conducted, such as when appellant is deceased. In that situation, record reviews are required and the weight of medical reports in the first instance are weighed using the above-mentioned criteria. But those circumstances are rare and that is inapplicable in the present case.

One could argue that this type of situation is similar to the use by OWCP of a district medical adviser (DMA). The Board has found that the unique status of the DMA, which allows for an advisory medical opinion without a physical examination, can be of sufficient probative

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<sup>3</sup> *Id.*

<sup>4</sup> *R.H.*, Docket No. 17-1966 (issued March 6, 2018); *John J. Carlone*, 41 ECAB 354 (1989).

<sup>5</sup> *Id.*

value in certain circumstances.<sup>6</sup> I believe that there is an important distinction between a DMA as described in *Jackson* and a treating physician such as Dr. Allen in this case. A treating physician and DMA do not share the same status. DMAs have a much more defined and narrow purpose. They are generally charged with the computations of schedule awards, the medical necessity of requested surgeries, and other such issues that do not require an in-person examination. As well, they operate under parameters that, ensure appropriate review of the evidence, as they have the benefit of the complete OWCP record, as well as a statement of accepted facts created by OWCP, which they must follow for the purposes of history, knowledge, and analysis. In Dr. Allen's situation, there are no such safeguards.

If Dr. Allen had physically examined appellant, noted an in-person history, reviewed the entire record, and made his own conclusions, I would be inclined to perhaps be satisfied with his knowledge and understanding of the matter and agree with the majority that his opinion would be sufficient to remand for OWCP to pay for a second opinion physician to further develop the medical evidence. However, the majority finding in my view, without the benefit of in-person physical examination, effectively shifts the burden of proof to OWCP to disprove the claim based on a medical report that is of questionable probative value, leading to what I fear will be the advent of mail order medicine.

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

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<sup>6</sup> *Melvina Jackson*, 38 ECAB 443 (1987) (regarding the importance, when assessing medical evidence, of such factors as a physician's knowledge of the facts and medical history, and the care of analysis manifested and the medical rationale expressed in support of the physician's opinion).