United States Department of Labor
Employees' Compensation Appeals Board

J.R., Appellant	)	
and	)	**Docket No. 19-1321**
	)	**Issued: February 7, 2020**
DEPARTMENT OF THE ARMY, ARMY CORPS OF ENGINEERS, Jacksonville, FL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On May 28, 2019 appellant filed a timely appeal from an April 30, 2019 merit decision[1] of the Office of Workers' Compensation Programs (OWCP).[2] Pursuant to the Federal Employees'

[1] The Board notes that, during the pendency of this appeal, OWCP issued a June 14, 2019 nonmerit decision, which denied reconsideration of the April 30, 2019 merit decision that is the subject of the current appeal. The Board and OWCP may not simultaneously exercise jurisdiction over the same issue(s). 20 C.F.R. §§ 501.2(c)(3), 10.626. *See W.D.*, Docket No. 19-1124 (issued October 22, 2019); *Douglas E. Billings*, 41 ECAB 880 (1990). Consequently, OWCP's June 14, 2019 decision is set aside as null and void.

[2] The record also contains an April 26, 2019 decision denying appellant's request for reconsideration of a March 27, 2002 decision that reduced his compensation to zero based on its finding that he had failed to cooperate with vocational rehabilitation as it was untimely and insufficient to demonstrate clear evidence of error. Appellant has not appealed this decision and thus it is not before the Board at this time. *See* 20 C.F.R. § 501.2(c).

Compensation Act[3] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[4]

ISSUE

The issue is whether appellant has met his burden of proof to establish ischemic cardiomyopathy, persistent atrial fibrillation, and congestive heart failure as a consequence of his accepted employment injury.

FACTUAL HISTORY

This case has previously been before the Board.[5] The facts and circumstances as set forth in the Board's prior decisions are incorporated herein by reference. The relevant facts are as follows.

On June 5, 1996 appellant, then a 42-year-old former hydrological technician, filed an occupational disease claim (Form CA-2) alleging that he sustained staphylococcus aureus and dermatitis herpetiformia causally related to factors of his federal employment. He stopped work on February 2, 1996, when he was removed from employment.

Initially, by decisions dated October 7, 1996 and August 14 and December 3, 1997, OWCP denied appellant's occupational disease claim, finding that he had failed to establish exposure to coliform bacteria in the course of his federal employment.

Appellant appealed to the Board. By decision dated November 19, 1999, the Board reversed the August 14 and December 3, 1997 decisions.[6] The Board found that appellant had established that he had sustained staphylococcus aureus and dermatitis herpetiformia due to exposure to coliform positive waste water while in the performance of duty.

By decision dated July 31, 2001, OWCP reduced appellant's wage-loss compensation to zero as he had failed to participate in vocational rehabilitation under 5 U.S.C. § 8113(b). By decision dated January 2, 2002, an OWCP hearing representative affirmed the July 31, 2001 decision. Appellant subsequently requested reconsideration. By decision dated March 27, 2002, OWCP denied appellant's request for reconsideration of the merits of his claim under 5 U.S.C. § 8128(a). Appellant appealed to the Board. By decision dated August 27, 2002, the Board

[3] 5 U.S.C. § 8101 *et seq.*

[4] The Board notes that following the April 30, 2019 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.*

[5] Docket No. 98-1039 (issued November 19, 1999); Docket No. 02-0986 (issued August 27, 2002); *Order Dismissing Appeal*, Docket No. 02-1763 (issued January 28, 2003); Docket No. 13-0211 (issued June 25, 2013).

[6] *Id*.

affirmed the January 2 and March 27, 2002 decisions.[7] The Board found that OWCP had properly reduced appellant's wage-loss compensation to zero as he had failed to participate in vocational rehabilitation.

On February 22, 2006 OWCP indicated that it was expanding the acceptance of appellant's claim to include streptococcal septicemia, dermatitis herpetiformis, contact dermatitis other agent, sebaceous cyst, and actinic keratosis.

By decision dated May 17, 2012, OWCP denied appellant's request for reconsideration, finding that it was untimely filed and failed to demonstrate clear evidence of error. Appellant appealed to the Board. By decision dated June 25, 2013, the Board affirmed the May 17, 2012 decision.[8]

On February 3, 2017 OWCP received a report dated January 18, 2017, from Dr. Bharat Upadhyay, a Board-certified internist and pulmonologist. He diagnosed nonrheumatic mitral valve regurgitation (MR) and dyspnea on exertion and noted that appellant had been hospitalized a week earlier. Dr. Upadhyay related, "I think his MR is due to [his] infection acquired through his skin infection, septicemia during [the] industrial injury leading to severe MR and [congestive heart failure] as a direct result of [the] industrial injury, and it should be part of this industrial injury."

On February 10, 2017 Dr. Presad Chalasani, Board-certified in internal medicine and cardiovascular disease, discussed appellant's history of recurrent staph dermatitis and bacteremia and vascular heart disease and noted that he had previously undergone valve surgery. He diagnosed coronary artery disease, apparently severe recent MR, hyperlipidemia, hypertension, a positive perfusion scan, and valvular heart disease. Dr. Chalasani recommended a heart catheterization.

In a report dated December 7, 2017, Dr. Sabrina Akrami, an osteopath who specializes in cardiology, reviewed appellant's history of severe MR and pulmonary hypertension.[9] She noted that he had previously experienced severe aortic stenosis treated with a valve replacement and "ligation of the left atrial appendance and right atrial appendance, recurrent staph dermatitis." Dr. Akrami advised that appellant should have surgery performed at another facility given his high-risk status. She indicated that he had a history of "endocarditis sepsis valvular infections in the past." Dr. Akrami diagnosed nonrheumatic MR, a prosthetic heart valve, dyspnea on exertion, and an aortocoronary bypass graft.

On January 4, 2018 Dr. Tomas D. Martin, Board-certified in thoracic and cardiovascular surgery, requested authorization from OWCP for a replacement of a mitral valve and aortic valve.

On January 24, 2018 Dr. David I. Krohn, a Board-certified internist serving as a district medical adviser (DMA), noted that he had no medical records to review prior to

[7] *Supra* note 5.

[8] *Id*.

[9] On March 7, 2017 Dr. William H. Heitman, Board-certified in thoracic and cardiovascular surgery, diagnosed nonrheumatic MR and recommended an MR repair or replacement.

November 16, 2017. He opined that Dr. Akrami's December 7, 2017 report was insufficient to establish that appellant required surgery due to his accepted employment injury.

In a development letter dated January 29, 2018, OWCP advised appellant that the evidence of record was insufficient to establish that a replacement of his mitral and aortic valve was medically necessary and causally related to his accepted conditions. It attached a copy of the DMA's January 24, 2018 report for review by his physician.

Thereafter, appellant submitted an April 24, 2018 letter, asserting that his streptococcal septicemia and post-traumatic wound infection had affected his aortic and mitral values. He indicated that he had undergone surgery on his aortic valve in December 2011 and his mitral valve in January 2018.

In a development letter dated January 15, 2019, OWCP advised appellant that it had accepted streptococcal septicemia, dermatitis herpetiformis, actinic reticuloid and actinic granuloma, sebaceous cyst, actinic keratosis, post-traumatic wound infections, other specified inflammations of eyelid, and nonrheumatic mitral valve insufficiency due to his accepted employment injury. It noted that he had requested authorization for surgical replacement of his aortic valve and mitral value. OWCP indicated that the "procedures were associated with a heart condition" but that it had not accepted a heart condition as employment related. It requested that appellant submit a detailed report from his attending physician supported by rationale addressing whether he sustained an additional condition due to his employment injury. OWCP afforded appellant 30 days to provide the necessary evidence.

On February 9, 2019 appellant advised that he had a heart value replacement due to mitral valve insufficiency in January 2018. He asserted that he was initially diagnosed with the condition in February 2005.

Thereafter, appellant resubmitted an April 19, 2010 report from Dr. Rogena Johnson, Board-certified in family medicine. Dr. Johnson related that appellant had developed methicillin resistant staphylococci (MRSA) from occupational exposure to a skin infection, and that the bacteria was the same as from his original infection. She related that he had severe aortic stenosis likely due to valve damage from the bacteremia. Dr. Johnson indicated that appellant's mitral valve was also affected. She related that his "current cardiac condition is the direct result of his occupational exposure which led to bacteremia and valve damage."

In a report dated July 2, 2012, Dr. Johnson diagnosed MRSA due to appellant's employment work injury.

On February 11, 2019 Dr. Sambit Mondal, Board-certified in cardiovascular disease, advised that a list of procedures performed, including the January 20, 2018 mitral valve replacement, were medically necessary.

OWCP prepared a statement of accepted facts (SOAF) on February 15, 2019. It listed the accepted conditions as streptococcal septicemia, dermatitis herpetiformis, contact dermatitis other agent, sebaceous cyst, actinic keratosis, and a post-traumatic wound infection.

On February 15, 2019 OWCP requested that Dr. Krohn, the DMA, review the SOAF and the evidence of record and address whether the replacement of appellant's aortic and mitral valves was medically necessary and causally related to the accepted employment injury. It advised that the accepted conditions were streptococcal septicemia, dermatitis herpetiformis, actinic reticuloid and actinic granuloma, sebaceous cyst, actinic keratosis, post-traumatic wound infections, other specified inflammations of eyelid, and nonrheumatic mitral valve insufficiency.

In a report dated February 25, 2019, Dr. Krohn asserted that he had reviewed the medical evidence, including Dr. Akrami's December 7, 2017 report. He found that her report was insufficient to show causal relationship between the mitral valve replacement and the work injury. Dr. Krohn noted that OWCP had not accepted bacterial endocarditis. He opined that the mitral valve replacement was medically necessary but that the medical evidence failed to support that it developed from his skin infection based on the lack of contemporaneous medical evidence showing valvular disease caused by his infection. Dr. Krohn further advised that MRSA, a staph infection, was a different bacteria than the accepted condition of streptococcal septicemia. He noted that OWCP could request an opinion from appellant's cardiologist regarding whether endocarditis caused his valvular problems.

In a development letter dated March 19, 2019, OWCP again noted that the requested surgical authorization was associated with a heart condition and that it had not accepted a heart condition. It provided appellant with Dr. Krohn's February 25, 2019 report and afforded him 15 days to submit additional medical evidence supporting that he sustained a heart condition requiring various procedures due to his employment injury.

Thereafter, appellant resubmitted a January 12, 2010 report from Dr. Brent M. Schillinger, a Board-certified dermatologist, who diagnosed staph folliculitis and cellulitis with "persistent underlying [s]taphylococcus [a]ureus." He further resubmitted a hospital report dated December 21, 2011 from Dr. Patrick T. Mangonon, a Board-certified cardiothoracic surgeon, who noted that appellant had a history of "recurrent staph dermatitis" that had become invasive resulting in MRSA.

By decision dated April 30, 2019, OWCP denied expansion of the acceptance of appellant's claim to include a consequential heart condition. It found that he had not submitted evidence sufficient to establish causal relationship between his ischemic cardiomyopathy, persistent atrial fibrillation, and congestive heart failure and his accepted employment injury. OWCP noted that appellant had only submitted a February 11, 2019 report from Dr. Mondal in response to its January 15 and March 19, 2019 development letters.

LEGAL PRECEDENT

The 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, establishing causal relationship. 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.[10]

Causal relationship is a medical issue and the medical evidence required to establish causal relationship is rationalized medical evidence.[11] 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.[12]

In discussing the range of compensable consequences, once the primary injury is causally connected with the employment, the question is whether compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury. The rules that come into play are essentially based upon the concepts of direct and natural results and of the claimant's own conduct as an independent intervening cause. 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.[13]

ANALYSIS

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

In its April 30, 2019 decision denying appellant's claim for a consequential heart condition, OWCP indicated that on January 4, 2018 his medical provider had requested expansion of his claim to include ischemic cardiomyopathy, persistent atrial fibrillation, and chronic systolic (congestive heart) failure. The record indicates that on January 4, 2018 Dr. Martin requested authorization from OWCP to perform a replacement of an aortic valve and mitral value.

In denying appellant's request to expand acceptance of his claim to include a heart condition, OWCP asserted that it had accepted nonrheumatic mitral valve insufficiency, which is a heart condition. It listed the accepted conditions as streptococcal septicemia, dermatitis herpetiformis, actinic reticuloid and actinic granuloma, sebaceous cyst, actinic keratosis, post-traumatic wound infections, other specified inflammations of eyelid, and nonrheumatic mitral valve insufficiency. OWCP did not acknowledge that it had accepted staphylococcus aureus as employment related.

OWCP further indicated that appellant had only submitted a February 11, 2019 report from Dr. Mondal in response to its January 15 and March 19, 2019 requests for additional evidence. Appellant, however, submitted an April 19, 2010 report from Dr. Johnson, who opined that appellant had MRSA due to his skin infection, noting that the bacteria was the same as found

[10] *K.W.*, Docket No. 18-0991 (issued December 11, 2018).

[11] *G.R.*, Docket No. 18-0735 (issued November 15, 2018).

[12] *Id*.

[13] *K.S.*, Docket No. 17-1583 (issued May 10, 2018); Arthur Larson & Lex K. Larson, *The Law of Workers' Compensation* § 3.05 (2014).

originally. Dr. Johnson found that he had valve damage and aortic stenosis which she attributed to his employment exposure. Appellant had also submitted a January 18, 2017 report from Dr. Upadhyay, who diagnosed mitral valve regurgitation and opined that it was causally related to appellant's employment injury of septicemia. Dr. Upadhyay asserted that the work injury directly led to congestive heart failure and mitral valve condition.

While not discussed in the April 30, 2019 decision, OWCP had further developed the issue of whether appellant required a mitral valve and aortic valve replacement as a consequence of his employment injury by referring the evidence to a DMA, Dr. Krohn. It had provided him with a SOAF that listed the accepted conditions as streptococcal septicemia, dermatitis herpetiformis, actinic reticuloid and actinic granuloma, sebaceous cyst, actinic keratosis, and post-traumatic wound infections. OWCP had advised Dr. Krohn on February 15, 2019 that it had also accepted other specified inflammations of eyelid and nonrheumatic mitral valve insufficiency due to the employment injury.

In a February 25, 2019 report, Dr. Krohn opined that the medical evidence was insufficient to establish causation between the mitral valve replacement and appellant's employment injury. He indicated that he had reviewed the accepted conditions in the SOAF of streptococcal septicemia, dermatitis herpetiformis, contact dermatitis, actinic keratosis, and post-traumatic wound infection. Dr. Krohn asserted that the mitral valve replacement was medically necessary, but that it had not resulted from his skin infection. He further noted MRSA, a staph infection, was a different bacteria than the accepted condition of streptococcal septicemia. However, OWCP failed to advise Dr. Krohn that it had accepted that appellant sustained staphylococcus aureus due to appellant's employment injury. It is also unclear whether Dr. Krohn was aware that OWCP had accepted mitral valve insufficiency as employment related. OWCP's procedures and Board precedent dictate that when an OWCP medical adviser, second opinion specialist, or referee physician renders a medical opinion based on a SOAF which is incomplete or inaccurate or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.[14]

It is well established that proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares the responsibility in the development of the evidence to see that justice is done.[15] Once it undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[16] Accordingly, the Board finds that the case must be remanded to OWCP.[17]

On remand OWCP should clarify the accepted conditions and prepare an updated SOAF. It should then refer the case record, together with the SOAF, to a second opinion physician to

[14] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990). *See also M.D.*, Docket No. 18-0468 (issued September 4, 2018); *Paul King*, 54 ECAB 356 (2003).

[15] *S.S.*, Docket No. 18-0397 (issued January 15, 2019).

[16] *Id.*; *see also R.M.*, Docket No. 16-0147 (issued June 17, 2016).

[17] *J.T.*, Docket No. 18-1300 (issued March 22, 2019).

determine whether appellant's claim should be expanded and whether he required an aortic and mitral valve replacements due to his accepted employment injury. Following this and any further development deemed necessary, OWCP should issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the April 30, 2019 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: February 7, 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
Employees' Compensation Appeals Board