United States Department of Labor
Employees' Compensation Appeals Board

B.F., Appellant **and** **DEPARTMENT OF VETERANS AFFAIRS, WEST LOS ANGELES VA MEDICAL CENTER, Los Angeles, CA, Employer**	)	**Docket No. 18-0658** **Issued: September 21, 2020**

Appearances:
Azu Osemene, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On February 5, 2018 appellant, through counsel, filed a timely appeal from an August 9, 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 to consider 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 met his burden of proof to expand the acceptance of his claim to include additional conditions as causally related to the accepted October 30, 2013[3] employment injury.

FACTUAL HISTORY

On November 4, 2013 appellant, then a 61-year-old medical technician, filed a traumatic injury claim (Form CA-1) alleging that, on that day, he injured his left shoulder, left upper thigh, and left knee when he slipped and fell on a wet floor at work while in the performance of duty. He stopped work on the date of injury.

In a November 5, 2013 doctor's first report of injury and November 27, 2013 attending physician's report (Form CA-20), Dr. Daniel M. Silver, an attending orthopedic surgeon, noted a history of injury that on "November 4, 2013" appellant slipped and fell on a puddle of water in a breakroom. He diagnosed severe left knee strain/sprain, tear of the lateral and medial menisci of the left knee, cervical and lumbar strains/sprains, and degenerative disc disease. In the November 27, 2013 Form CA-20 report, Dr. Silver checked a box marked "Yes" indicating that appellant's cervical and lumbar strains/sprains and degenerative disc disease were caused or aggravated by an employment activity. In a November 27, 2013 work status report, he indicated that appellant remained temporarily totally disabled for six weeks.

In a November 27, 2013 work status report, Dr. Silver indicated that appellant remained temporarily totally disabled for six weeks.

On December 19, 2013 OWCP informed appellant that his claim was formally accepted for sprains of the neck, back, right shoulder, and right upper arm, contusion of the left knee, and tears of the lateral and medial menisci of the left knee.

On February 14, 2014 appellant underwent authorized left knee arthroscopy with total lateral and partial menisectomies, which was performed by Dr. Silver.

In an August 6, 2014 medical report, Dr. Richard A. Rogachefsky, a Board-certified orthopedic surgeon serving as an OWCP referral physician, listed appellant's accepted employment-related conditions and opined that he also had a temporary aggravation of his preexisting cervical and lumbar degenerative disc disease due to his accepted employment injury.

OWCP continued to receive additional medical evidence, including reports and disability slips dated May 13 through November 10, 2015 from Dr. Jacobo W. Chodakiewitz, an attending physician specializing in pain medicine and neurosurgery. Dr. Chodakiewitz noted a history of the October 30, 2013 employment injury and discussed examination findings. He diagnosed cervical and lumbar radiculopathy, dizziness, concussion, post-traumatic cephalgia headache and dizziness, probable postconcussional, temporomandibular joint (TMJ) pain, cervical and lumbar

[3] Although appellant listed November 4, 2013 as the date of injury, OWCP subsequently determined that the correct date of injury was October 30, 2013.

more than thoracic radiculopathy, bilateral shoulder, wrist and knee pain, status post 2014 left knee surgery without improvement, cognitive impairment, emotional distress, sleep impairment, and sexual dysfunction. Dr. Chodakiewitz initially advised that appellant was temporarily disabled for five weeks from May 13 to June 17, 2015 and subsequently found that he remained temporarily totally disabled.

A June 16, 2015 cervical spine computerized tomography (CT) scan by Dr. Sandhya V. Reddy, a diagnostic radiologist, provided an impression of mild-to-moderate disc degenerative disease of the cervical spine from C3-4 to C6-7. In a lumbar spine CT scan report of even date, she provided an impression of mild-to-moderate disc degenerative disease at L2-3 to LS-S1.

By decision dated November 3, 2015, OWCP denied expansion of the claim to include additional conditions as causally related.[4]

On November 27, 2015 appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review.

In a November 3, 2014 report, Dr. Marc L. Nehorayan, a Board-certified psychiatrist, diagnosed recurrent major depressive episode, most recent episode industrially, related that meets the threshold of predominant cause, history of sleep apnea, aggravated by industrial conditions secondary to pain, cognitive disorder not otherwise specified, history of adult deficit hyperactivity disorder, controlled with current medication of Ritalin under Axis I; negative personality traits, nothing arising to the level of a characterological disorder under Axis II category; orthopedic injury, as described by Dr. Silver, history of sleep apnea, aggravated by industrial injuries and pain, head injury with loss of consciousness, rule out post-concussion syndrome under Axis III; occupational injury, post-concussional headache, and chronic pain under Axis IV; and a global assessment functioning (GAF) score of 55 under Axis V. He advised that greater than 50 percent of the predominant cause of appellant's psychiatric injury was a compensable consequence of his October 30, 2013 employment injury. Dr. Nehorayan concluded that he was temporarily totally disabled from work on a psychiatric and orthopedic basis.

Dr. Chodakiewitz, in a November 11, 2015 supplemental report, a November 13, 2015 addendum to the November 11, 2015 report, and disability slips dated November 13, 2015 and January 13 and February 24, 2016, reiterated his prior diagnoses of cervical and lumbar radiculopathy, dizziness, concussion, post-traumatic cephalgia headache and dizziness, probable postconcussional, TMJ pain, cervical and lumbar more than thoracic radiculopathy, bilateral shoulder, wrist and knee pain, status post 2014 left knee surgery without improvement, cognitive impairment, emotional distress, sleep impairment, and sexual dysfunction. He also continued to advise that appellant was temporarily totally disabled from work and opined that his diagnosed conditions were directly caused by his October 30, 2013 employment injury.

A January 7, 2016 functional capacity evaluation (FCE) revealed diagnoses of radiculopathy in the cervical region, other spondylosis with radiculopathy in the lumbar region,

[4] OWCP also denied appellant's claims for compensation for the period May 13 through October 30, 2015, finding that the medical evidence of record was insufficient to establish that he was totally disabled during the claimed period due to the accepted employment injury.

discitis unspecified in the thoracic region, and left other meniscus derangements, unspecified medial meniscus of the right knee, and unspecified pain, and activity, other involving external motion. It indicated that deference should be made to appellant's treating physician regarding his capacity to perform his usual work duties and listed his physical restrictions.

In a January 14, 2016 report, Dr. Pedram Navab, Board-certified in neurology and sleep medicine, examined appellant and diagnosed obstructive sleep apnea, sleep onset and maintenance insomnia, and anxiety and depression. He opined that his arousal disorder was industrially related. Dr. Navab noted that industrially caused pain and mood disorders such as, major depressive disorder or post-traumatic stress disorder can cause or aggravate physical conditions such as insomnia, hypersomnia, and arousal issues.

In a December 21, 2015 report, Dr. Roy D. Nini, a Board-certified physiatrist, noted a history that appellant slipped and fell at work on "November 30, 2013." He provided assessments of cervical spondylosis, cervical and lumbar radiculitis, cervical foramnal stenosis, and neck and lower back pain. On February 8, 2016 appellant underwent a C7-T1 epidural steroid injection by Dr. Nini.

By decision dated March 7, 2016, an OWCP hearing representative affirmed the November 3, 2015 decision, finding that appellant had not established any additional conditions causally related to the accepted employment injury.[5]

In a February 26, 2016 report, Dr. Edward Ritvo, a Board-certified psychiatrist serving as an OWCP referral physician, reviewed the medical record and the statement of accepted facts (SOAF). He diagnosed: mood disorder secondary to chronic pain under Axis I; moderate psychosocial stressors under Axis IV; and a GAF score of 65 under Axis V. Dr. Ritvo reported no diagnosis under Axis II and deferred to an appropriate specialist under Axis III. He indicated that appellant continued to suffer from residuals of his accepted injury as he had emotional distress (mood disorder secondary to chronic pain which was a result of his employment injury). Dr. Ritvo related, however, that his emotional distress did not rise to the level of warranting specific disability. He maintained that appellant's primary disability limitation was due to physical results of his initial trauma in 2013.

In additional reports dated February 24 and March 9, 2016, Dr. Chodakiewitz noted appellant's continuing complaints of headaches and dizziness since his employment injury. He reaffirmed his prior opinion that appellant's physical injuries and ongoing pain of cognitive and sleep impairment, emotional distress, and sexual dysfunction were compensatory consequences of his work injury. In disability slips dated April 4 and 11, 2016, Dr. Chodakiewitz released him to return to work on April 11, 2016 with no restrictions.

Dr. Navab, in an additional report dated March 4, 2016, diagnosed moderate obstructive sleep apnea with severe exacerbation in the supine position, mild oxygen desaturations, light to moderate snoring, sleep maintenance, lack of slow-wave sleep, and periodic limb movements in sleep insomnia based on his review of appellant's history and medical records, and his clinical

[5] OWCP also denied appellant's Form CA-7 claims for compensation for total disability commencing May 13, 2015.

examination. He opined that his sleep-related complaints were causally related to his industrial-related injuries and resultant in the development of industrial-related pain, emotional stressors, and arousal and sleep disturbances. Dr. Navab related that it was well documented that emotional and generalized anxiety disorders, as well as, other mood-related disorders can contribute to both insomnia and hypersomnia states. He noted that appellant's polysonmogram (PSG) revealed sleep maintenance insomnia, which could be due to awakenings related to pain in his neck, left knee, and lower back. In addition, Dr. Navab harbored racing thoughts with regard to his unemployment and financial constraints, which also contributed to his insomnia.

In an April 11, 2016 report, Dr. Robert A. Moore, Board-certified in neurology and sleep medicine, serving as an OWCP referral physician, reviewed the medical record and the SOAF. He reported examination findings and provided impressions of the accepted conditions of cervical and lumbar sprains, post-traumatic headaches, right shoulder sprain, left knee contusion, left knee medial and lateral menisci tears, and obstructive sleep apnea syndrome. Dr. Moore noted that appellant appeared to suffer from residuals of his employment injury primarily on an orthopedic basis. He noted, however, that while his diagnoses did not differ from those contained in the SOAF, appellant had a nonindustrial-related sleep-related obstructive breathing disorder, which was diagnosed preinjury. Dr. Moore added a diagnosis of post-traumatic cephalgia as the medical records indicated that he struck his head at the time of his injury. He indicated that appellant's industrial injury did not aggravate his preexistent obstructive sleep apnea syndrome. Dr. Moore related that his headache complaints were directly caused by the mechanism of his work injury. He further related that appellant had no disability related to his preexistent obstructive sleep apnea syndrome. Dr. Moore indicated that he had no reason to disagree with Dr. Silver's finding that 25 percent of appellant's neck and back conditions were secondary to preexistent degenerative arthritis. He indicated that from a neurological and sleep-related standpoint, appellant had no disability related to these diagnoses. Dr. Moore noted that he clearly appeared to have a disability related to multiple orthopedic injuries. He did not disagree with the functional limitations placed on appellant by Dr. Silver in his February 2015 report and advised that from a neurological and sleep-related standpoint, no additional functional limitations were warranted.

Dr. Nini, in additional reports dated February 8, March 21, and June 9, 2016, provided assessments of cervical facet syndrome and muscle spasm.

In a May 16, 2016 report, Dr. Kevin F. Hanley, Board-certified in neurology and sleep medicine, serving as an OWCP second opinion physician, reviewed the medical record and the SOAF. He diagnosed the conditions of lumbar, cervical, and thoracic sprains, left knee lateral meniscus tear, and left shoulder sprain/strain accepted by OWCP. Dr. Hanley advised that appellant continued to suffer residuals from his "November 4, 2013" employment injury. He noted that although his physical examination showed positive clinical findings, limitation of motion of the neck and left shoulder, as well as, positive findings in the left knee, appellant suffered mainly from a subjective pain syndrome. Dr. Hanley related that all of the above-listed conditions were a direct consequence of the industrial injury and that no aggravation of a preexisting condition or prior injury was involved.

A February 29, 2016 report by Dr. Nini reiterated his prior cervical and lumbar assessments.

A June 9, 2016 cervical x-ray report by Dr. Jerrold Mink, a Board-certified diagnostic radiologist, provided an impression of multilevel degenerative disc disease of the cervical spine.

Reports dated May 2 and June 23, 2016 by Dr. Paul H. Lee, a Board-certified gastroenterologist and internist, related a history of the October 30, 2013 employment injury and discussed examination findings. Dr. Lee provided assessments of cervical spondylosis, cervical and lumbar radiculitis, neck and lower back pain, cervical foraminal stenosis, cervical facet syndrome, muscle spasm, and right first carpometacarpal (CMC) arthropathy. In a July 12, 2016 report and June 23, 2016 prescription, he recommended that appellant continue light-duty work with restrictions for six weeks.

In a January 27, 2016 report, Dr. Navab indicated that the findings of a PSG were consistent with moderate obstructive sleep apnea with severe exacerbation while in the supine position, central sleep apneas, light to moderate snoring, mild oxygen desaturations, lack of restorative slow wave sleep, latency to sleep onset that was longer than expected at 21.0 minutes (normally 10 to 20 minutes) indicating difficulty falling asleep, latency to rapid eye movement (REM) sleep onset that was premature at 69.5 minutes (normally 90 to 120 minutes), sleep efficiency that was reduced at 69.0 percent (normally 85 to 99 percent) due to long latency to sleep onset, and episodes of wake after sleep onset (WASO) and periodic limb movements during sleep. He advised that a second study dedicated to continuous positive airway pressure (CPAP) may be beneficial.

In an August 25, 2016 report, Dr. Katrin Malakuti, a licensed clinical psychologist, noted a history of the October 30, 2013 employment injury, a review of appellant's medical records, and examination findings. She diagnosed cognitive disorder not otherwise specified-with impairments in executive functioning, composite memory and attention, and major depressive disorder, recurrent episode, moderate under Axis 1; sequelae to work injury, interpersonal, occupational, financial under Axis IV; and a GAF score of 59 under Axis V. Dr. Malakuti deferred a diagnosis under Axis II and deferred primary treating physician under Axis III. Based on the information provided, she opined within a reasonable degree of medical probability that the diagnosed conditions were predominantly caused by the documented injury to his neck, both shoulders, lower back, left leg and knee, chronic pain, and reliance on pain medication for the past several years. Dr. Malakuti indicated that both appellant's self-report and neurocognitive test results supported that his cognitive functions had declined and deteriorated as a direct consequence of his neurological disability.

By decision dated October 6, 2016, OWCP expanded the acceptance of appellant's claim to include temporary aggravation of preexisting lumbar and cervical degenerative disc disorder (resolved as of April 11, 2016). It found, however, that the medical evidence of record was insufficient to establish that the acceptance of his claim should be expanded to include the additional medical conditions of cognitive and major depressive disorders, insomnia, anxiety, sleep apnea, cervical spondylosis, cervical stenosis, cervical and lumbar radiculitis, brachial neuritis, cervical facet syndrome, or any additional diagnosis casually related to the accepted employment injury.[6]

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[6] OWCP found that the temporary aggravation of appellant's preexisting cervical and lumbar degenerative disc disease had ceased.

OWCP thereafter received additional medical evidence. In a June 2, 2016 report, Dr. Chodakiewitz noted that he had reviewed additional medical records and appellant's complaint of pain and need for surgery. He opined that his previous opinions remained unchanged.

In additional reports dated October 13, 2016 to May 15, 2017 and a letter dated November 15, 2016, Dr. Lee provided examination findings and noted that appellant continued to have axial neck pain right greater than left with parasthesias in the upper extremities especially after working. He reiterated his diagnoses of cervical spondylosis, cervical and lumbar radiculitis, neck and lower back pain, and cervical foraminal stenosis. Dr. Lee also diagnosed cervical disc herniation and cervical and lumbar sprain and noted appellant's work restrictions. He opined that his claim should include cervical and lumbar radiculitis and cervical and lumbar strain. In prescriptions dated December 1 and 19, 2016, Dr. Lee placed appellant off work from December 5 to 19, 2016 and noted that he could return to work on December 20, 2016.

In a January 19, 2017 report, Dr. Nouzhan Sehati, a Board-certified neurosurgeon, noted a history of injury that on "November 4, 2013" appellant injured his neck and back when he slipped and fell at work. He provided examination findings and advised that appellant was status post his 2013 slip and fall injury with complaints of chronic neck pain. Dr. Sehati noted that imaging of the cervical spine showed multilevel degenerative disc disease.

In a February 16, 2017 report, Dr. Nini opined that his diagnoses of cervical and lumbar radiculitis and cervical and lumbar strain should be included in appellant's case. He noted positive radicular signs on his physical examination which correlated with the findings of a December 23, 2014 cervical spine magnetic resonance imaging (MRI) and June 16, 2015 lumbar and cervical spine computerized tomography (CT) scans, which described conditions that often lead to radiculopathy, and Dr. Chodakiewitz's May 13, 2015 electromyogram (EMG) which showed increased irritability in the bilateral C6 myotomes and at the L5 and S1 myotomes, which were compatible with root irritation at the foraminal level. Dr. Nini indicated that appellant's positive response to cervical epidural injections also supported the presence of radiculopathy.

In a March 29, 2017 report, Dr. Michael Shehata, Board-certified in cardiovascular disease and clinical cardiac electrophysiology, performed a radiofrequency ablation of a left lateral accessory pathway, a transseptal puncture, and an intracardiac echocardiography. He noted a pre-procedure diagnosis of supraventricular tachycardia (SVT) and a post-procedure diagnosis of orthodromic reciprocating tachycardia (ORT).

On June 20, 2017 appellant, through counsel, requested reconsideration of the October 6, 2016 decision and submitted additional medical evidence from Dr. Lee. In prescription notes dated April 3, and June 5 and 22, 2017, Dr. Lee advised that appellant was temporarily totally disabled from work for two weeks beginning June 26, 2017, provided work restrictions, and ordered medication. In a June 5, 2017 report and June 22, 2017 letter, he reviewed appellant's medical record and discussed examination findings. Dr. Lee restated his prior cervical and lumbar assessments and opinion that appellant's claim should include cervical and lumbar radiculitis and cervical and lumbar strain. He indicated that appellant's positive past response to cervical epidural injections also supported the presence of radiculopathy.

OWCP, by decision dated August 9, 2017, modified its October 6, 2016 decision, finding that the medical evidence of record was sufficient to expand the acceptance of appellant's claim to include mood disorder due to known physiological condition, unspecified, and that he had continuing residuals related to his accepted conditions of temporary aggravation of lumbar intervertebral disc degeneration and temporary aggravation of cervical disc degeneration. However, it denied the expansion of the acceptance of his claim to include cognitive disorder, major depressive disorder, insomnia, anxiety, sleep apnea, cervical spondylosis, cervical stenosis, cervical and lumbar radiculitis, brachial neuritis, and cervical facet syndrome.

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.[7]

Causal relationship is a medical question that requires medical evidence to resolve the issue.[8] 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 accepted employment injury.[9]

ANALYSIS

The Board finds that appellant has not met his burden of proof to expand the acceptance of his claim to include additional conditions causally related to the accepted October 30, 2013 employment injury.

In a November 27, 2013 Form CA-20 report, Dr. Silver diagnosed cervical and lumbar strains/sprains and degenerative disc disease. He checked a box marked "Yes" indicating that the diagnosed conditions were caused or aggravated by the accepted October 30, 2013 employment injury. However, Dr. Silver did not explain how the accepted employment injury caused or aggravated appellant's diagnosed conditions. The Board has held that answering "Yes" in response to a form question without the necessary rationale explaining how the accepted employment injury could result in the diagnosed conditions is insufficient to meet appellant's burden of proof.[10] Dr. Silver's remaining reports dated November 5 and 27, 2013 described appellant's employment injury and diagnosed severe left knee strain/sprain and addressed appellant's disability from work. He did not, however, specifically relate appellant's conditions

[7] *W.L.*, Docket No. 17-1965 (issued September 12, 2018); *V.B.*, Docket No. 12-0599 (issued October 2, 2012); *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004).

[8] *E.M.*, Docket No. 18-1599 (issued March 7, 2019); *Robert G. Morris,* 48 ECAB 238 (1996).

[9] *See M.M.*, Docket No. 19-0061 (issued November 21, 2019); *P.M.,* Docket No. 18-0287 (issued October 11, 2018).

[10] *G.V.,* Docket No. 20-0055 (issued April 21, 2020); *K.B.,* Docket No. 19-0398 (issued December 18, 2019); *M.O.,* Docket No. 18-1056 (issued November 6, 2018); *Sedi L. Graham,* 57 ECAB 494 (2006).

and disability from work to the accepted employment injury. Medical evidence that does not offer an opinion regarding the cause of an employee's condition is of no probative value on the issue of causal relationship.[11] For these reasons, Dr. Silver's reports are insufficient to establish expansion of the acceptance of appellant's claim.

In reports and disability slips dated May 13, 2015 through June 2, 2016, Dr. Chodakiewitz related a history of the employment injury and diagnosed cervical and lumbar radiculopathy, concussion, post-traumatic cephalgia headache and dizziness, probable post-concussional, TMJ pain, cervical, lumbar, and thoracic radiculopathy, bilateral shoulder, wrist and knee pain, status post 2014 left knee surgery without improvement, cognitive impairment, emotional distress, sleep impairment, and sexual dysfunction. He also addressed appellant's disability and work capacity. Dr. Chodakiewitz, opined in his November 13, 2015 and February 24 and March 9, 2016 reports that appellant's physical conditions, ongoing pain of cognitive and sleep impairment, emotional distress, and sexual dysfunction, were directly caused by the employment injury. In a June 2, 2016 report, he advised that his opinion on causal relationship remained unchanged. While Dr. Chodakiewitz provided an affirmative opinion on causal relationship, he provided no supporting medical rationale explaining how appellant's diagnosed conditions and resultant disability had been caused by the accepted work injury. A medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale.[12] For these reasons, the Board finds that Dr. Chodakiewitz' reports are insufficient to establish expansion of the acceptance of appellant's claim.

In reports dated December 21, 2015, February 8 and 29, March 21, and June 9, 2016, and February 16, 2017, Dr. Nini described appellant's history of injury. He diagnosed cervical spondylosis, cervical and lumbar radiculitis, cervical foraminal stenosis, neck and lower back pain, moderate obstructive sleep apnea with severe exacerbation in the supine position, mild oxygen desaturations, light-to-moderate snoring, sleep maintenance, lack of slow-wave sleep, periodic limb movements in sleep insomnia, and cervical facet syndrome and muscle spasm. However, Dr. Nini did not provide an opinion on causal relationship. As noted above, medical evidence that does not offer an opinion on the cause of an employee's condition is of no probative value on the issue of causal relationship.[13] For these reasons, Dr. Nini's reports are insufficient to meet appellant's burden of proof regarding expansion of his claim.

In his March 4, 2016 report, Dr. Navab explained how emotional and generalized anxiety disorders, other mood-related disorders, and appellant's PSG results and racing thoughts regarding his unemployment and financial constraints could have contributed to his insomnia and hypersomnia states. However his opinion is speculative. Medical reports without adequate rationale on causal relationship are of diminished probative value and are insufficient to meet an

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[11] *See T.D.,* Docket No. 18-1157 (issued March 26, 2019); *L.B.,* Docket No. 18-0533 (issued August 27, 2018); *D.K.,* Docket No. 17-1549 (issued July 6, 2018).

[12] *See S.S.,* Docket No. 19-1803 (issued April 1, 2020); *S.J.,* Docket No. 19-0489 (issued January 13, 2020); *G.M.*, Docket No. 19-0933 (issued October 1, 2019); *S.O.*, Docket No. 19-0307 (issued June 18, 2019); *V.T.*, Docket No. 18-0881 (issued November 19, 2018).

[13] *See supra* note 11.

employee's burden of proof.[14] As such, Dr. Navab's report is insufficient to establish appellant's burden of proof.

Dr. Lee, in reports dated May 2, 2016 to May 15, 2017, related appellant's history of injury on October 30, 2013. He provided assessments of cervical spondylosis, cervical and lumbar radiculitis, neck and lower back pain, cervical foraminal stenosis, cervical facet syndrome, muscle spasm, right first CMC arthropathy, cervical disc herniation, and cervical and lumbar sprain. In the June 5 and 22, 2017 reports, Dr. Lee opined that appellant's claim should include cervical and lumbar radiculitis and cervical and lumbar strain as his positive past response to cervical epidural injections also supported the presence of radiculopathy. However, he did not explain how the October 30, 2013 employment injury caused the diagnosed conditions.[15] Dr. Lee's remaining prescription notes December 1, 2016 to June 22, 2017 placed appellant off work, but did not provide an opinion on the issue of causal relationship between the additional diagnosed conditions and the accepted employment injury.[16] For these reasons, the Board finds that the medical evidence from him is insufficient to establish appellant's burden of proof.

Dr. Malakuti's August 25, 2016 report described a history of the October 30, 2013 employment injury. She diagnosed: cognitive disorder not otherwise specified-with impairments in executive functioning, composite memory and attention, and major depressive disorder, recurrent episode, moderate under Axis 1; sequelae to work injury, interpersonal, occupational, financial under Axis IV; and a GAF score of 59 under Axis V. Dr. Malakuti deferred a diagnosis under Axis II and deferred primary treating physician under Axis III. She opined that his conditions were predominantly caused by the injury to his neck, both shoulders, lower back, left leg and knee, chronic pain, and reliance on pain medication for the past several years. Dr. Malakuti related that appellant's self-report and neurocognitive test results supported a decline and deterioration of his cognitive functions due to his neurological disability. While she provided an explanation that his diagnosed conditions resulted from the accepted employment injury, she did not provide sufficient medical rationale explaining the basis of her opinion.[17] This report is, therefore, also insufficient to establish additional conditions as causally related to the accepted employment injury.

Dr. Nehorayan's November 3, 2014 report diagnosed recurrent major depressive episode, most recent episode industrially, related that meets the threshold of predominant cause, history of sleep apnea, aggravated by industrial conditions secondary to pain, cognitive disorder not otherwise specified, history of adult deficit hyperactivity disorder, controlled with current medication of Ritalin under Axis I; negative personality traits, nothing arising to the level of a characterological disorder under Axis II; orthopedic injury, as described by Dr. Silver, history of sleep apnea, aggravated by industrial injuries and pain, head injury with loss of consciousness, rule out post-concussion syndrome under Axis III; occupational injury, post-concussional headache,

[14] *J.R.*, Docket No. 20-0292 (issued June 26, 2020); *C.J.*, Docket No. 18-0148 (issued August 20, 2018); *Franklin D. Haislah*, 52 ECAB 457 (2001).

[15] *Supra* note 11.

[16] *See supra* note 11

[17] *See supra* note 14.

and chronic pain under Axis IV; and a GAF score of 55 under Axis V. He opined that the October 30, 2013 employment injury was greater than 50 percent of the predominant cause of appellant's psychiatric injury. Dr. Nehorayan provided an affirmative opinion on causal relationship, but provided no supporting medical rationale explaining how appellant's diagnosed conditions had been caused by the accepted work injury. As noted above, a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale.[18] As such, Dr. Nehorayan's report is insufficient to establish that appellant sustained additional conditions due to the accepted October 30, 2013 employment injury.

Likewise, Dr. Ritvo's February 26, 2016 report is insufficient to establish additional employment-related conditions as he did not adequately explain how the accepted employment injury caused appellant's diagnosed emotional and physical conditions.[19]

Dr. Navab's January 14, 2016 report diagnosed obstructive sleep apnea, sleep onset and maintenance insomnia, and anxiety and depression. He opined that appellant's arousal disorder was industrially related. Although Dr. Navab explained that industrially caused pain and mood disorders such as, major depressive disorder or post-traumatic stress disorder could cause or aggravate physical conditions such as insomnia, hypersomnia, and arousal issues, he did not specifically relate appellant's conditions to the accepted employment injury.[20] In his remaining January 27, 2016 report, he noted the findings of a PSG. Dr. Navab did not, however, offer an opinion on causal relationship.[21] For these reasons, his reports are insufficient to meet appellant's burden of proof.

Likewise, Dr. Sehati's January 19, 2017 report is insufficient to establish further expansion of the acceptance of appellant's claim as he did not provide sufficient rationale explaining how his findings of chronic neck pain and multi-level degenerative disc disease of the cervical spine was causally related to the accepted employment injury.[22] As such, his report is insufficient to meet appellant's burden of proof.

Additionally, the medical evidence from Dr. Shehata addressed appellant's heart condition, but did not provide a history of injury or opinion addressing causal relationship.[23] Thus, the Board finds that this evidence is insufficient to establish an additional employment-related condition.

Appellant also submitted diagnostic studies dated June 16, 2015 and June 9, 2016 and a January 7, 2016 FCE. However, the Board has consistently held that diagnostic test studies,

[18] *See supra* note 12.

[19] *See supra* note 14.

[20] *See supra* note 9.

[21] *See supra* note 11.

[22] *See supra* note 14.

[23] *E.G.,* Docket No. 17-1955 (issued September 10, 2018).

standing alone, lack probative value as they do not address whether the accepted employment injury caused the diagnosed condition.[24]

As the medical evidence of record is insufficient to establish causal relationship between the additional diagnosed conditions of cognitive disorder, major depressive disorder, insomnia, anxiety, sleep apnea, cervical spondylosis, cervical stenosis, cervical and lumbar radiculitis, brachial neuritis, and cervical facet syndrome and the accepted employment injury, the Board finds that appellant has not met his burden of proof.

On appeal counsel contends that the medical evidence of record is sufficient to establish further expansion of the claim. As found above, the evidence submitted did not provide medical rationale from a physician explaining the causal relationship between appellant's additional conditions and the accepted employment injury. Thus, the Board finds that appellant has not met his burden of proof.

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 his burden of proof to expand the acceptance of his claim to include additional conditions causally related to the accepted October 30, 2013 employment injury.

ORDER

IT IS HEREBY ORDERED THAT the August 9, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 21, 2020
Washington, DC

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

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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

[24] *See supra* note 11.