United States Department of Labor
Employees' Compensation Appeals Board

J.B., Appellant	)	
and	)	**Docket No. 20-0597**
	)	**Issued: July 21, 2021**
DEPARTMENT OF AGRICULTURE, U.S. FOREST SERVICE, SALMON-CHALLIS NATIONAL FOREST, Challis, ID, Employer	)	

Appearances:
Alan J. Shapiro, 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
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On January 23, 2020 appellant, through counsel, filed a timely appeal from a December 9, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether OWCP has met its burden of proof to rescind its acceptance of appellant's claim for Lyme disease, toxic effect of venom, and cervical stenosis with radiculopathy and myelopathy.

FACTUAL HISTORY

On July 5, 2005 appellant, then a 54-year-old wilderness ranger, filed a traumatic injury claim (Form CA-1) alleging that on July 4, 2005 he sustained injury from a wood tick bite that he found at the top of his right leg. He did not stop work at that time. On the reverse side of the form appellant's immediate supervisor indicated that appellant notified him that he had experienced a tick bite on his upper right leg, which had become swollen and red.

On July 5, 2005 appellant sought treatment in an emergency department where Dr. Samuel Gardner, an osteopath Board-certified in family medicine, noted that appellant reported that he discovered that he had been bitten by a tick the day before. At the site of the bite, Dr. Gardner noticed a circular erythematous rash or violet-purple area with a red central lesion of approximately two centimeters in diameter. He diagnosed "questionable tick bite." In an August 17, 2005 report, Dr. Martha Buitrago, a Board-certified internist specializing in infectious diseases, indicated that appellant probably suffered from a tick-related illness. She noted that Lyme disease was an extremely difficult diagnosis to make in an area of very little to no incidence. The findings of an August 31, 2005 western blot test revealed an overall negative result for Lyme disease, but also showed two positive Immunoglobulin G (IgG) antibody bands. On August 31, 2005 Dr. Buitrago noted that appellant was status post tick bite and had hypothyroidism, and indicated that the possibility of Lyme disease was discussed, but "not fully diagnosed at this time."

On September 15, 2005 OWCP accepted appellant's claim for insect bite of the right hip/leg and toxic effect of venom.

In an October 12, 2005 report, Dr. Buitrago indicated that appellant's clinical picture was very suspicious for Lyme disease. A western blot test performed on February 22, 2006 indicated negative results. In a February 22, 2006 report, Dr. Thomas Rand, Board-certified in pediatric infectious diseases, indicated that the diagnosis of acute Lyme disease was "quite strong" and maintained that the antibody testing supported a diagnosis of Lyme disease. In a March 20, 2006 report, Dr. Carl D. Vance, a Board-certified internist specializing in endocrinology, noted, "The patient does have Lyme disease and has documented titers." He opined that appellant's condition was appropriately treated in its early stages "so his titers may never convert because of the rapid treatment."

On June 30, 2006 OWCP referred appellant's case to Dr. Jean Weaver, a Board-certified internist who served as an OWCP district medical adviser (DMA), and requested an opinion on whether appellant's claimed conditions were employment related. In a July 7, 2006 report, Dr. Weaver provided a summary of the medical evidence of record and advised that it was highly likely that appellant had employment-related Lyme disease.

On July 10, 2006 OWCP expanded the acceptance of appellant's claim to include Lyme disease. Appellant stopped work on July 23, 2006 and OWCP paid him wage-loss compensation for periods of work stoppage.

On June 7, 2007 OWCP referred appellant's case to Dr. Morley Slutsky, a Board-certified occupational medicine physician serving as a DMA. In a June 14, 2007 report, Dr. Slutsky indicated that Lyme disease had been responsible for severe fatigue and muscles aches, which had reduced appellant's ability to exercise his neck. He opined that, with such limited activity and neck movement, the underlying arthritic changes developed more active inflammation, which in turn limited neck movement further and accelerated spinal degeneration.

On June 21, 2007 expanded the acceptance of appellant's claim to include cervical stenosis with radiculopathy and myelopathy.

In response to appellant's May 2018 request for physical therapy to treat employment-related muscle weakness per Dr. Buitrago's recommendation, OWCP referred appellant's case to Dr. David I. Krohn, a Board-certified internist serving as a DMA. In an August 2, 2018 report, Dr. Krohn asserted that Dr. Buitrago had not provided a well-reasoned narrative explanation as to how appellant's symptoms might have been caused Lyme disease, or the other accepted conditions.

On October 4, 2018 OWCP referred appellant, together with a statement of accepted facts (SOAF) and series of specific questions, for a second opinion examination with Dr. Gabriela Kaufman, a Board-certified internist specializing in infectious diseases. It requested that Dr. Kaufman evaluate whether appellant had residuals of the accepted employment-related conditions, including Lyme disease.

In a November 8, 2018 report, Dr. Kaufman discussed appellant's factual and medical evidence, noting that appellant reported that at work on July 4, 2005 he used a knife to remove a tick (including its head) from his right upper thigh. She advised that appellant further reported that the tick was not engorged and that, the next day, he noticed an area of redness around the bite that looked like a bull's eye. Dr. Kaufman indicated that a western blot test performed on August 31, 2005 showed two IgG antibody bands, and a repeat western blot test performed on February 22, 2006 was entirely negative. She reported the results of her physical examination, noting that appellant did not exhibit any skin rash or edema of the extremities. Dr. Kaufman diagnosed possible insect bite, febrile illness in 2005, arthritis, hypothyroidism, headaches, insulin resistance, hypertension, hypercholesterolemia, skin desquamation on finger pad, and Agent Orange exposure in Vietnam. She indicated that the diagnoses of possible tick bite, generalized weakness, febrile illness, and fatigue "could be related to the 2005 work-related injury." Dr. Kaufman noted, "[u]nfortunately it is not clear what condition the patient had, if the patient more likely than not had Lyme disease." She indicated that appellant had an extensive work-up that was negative and opined that he could have had a viral illness. Dr. Kaufman noted, "[w]ithout definitive diagnosis though, it is impossible to tell if the symptoms the patient is still experiencing are related to the original condition." She advised that, with most viral illnesses, as well as Lyme disease, the lingering symptoms tended to resolve within five years from the original infection. In response to OWCP's question regarding whether appellant continued to have residuals of the accepted insect bite and effect of venom, Dr. Kaufman indicated that he did have residual symptoms, including headaches, arthralgias, weakness, and fatigue, but advised that it was unclear

if these were in any way related to the original insect bite or effect of venom because she did not believe that there was a definitive diagnosis from 2005.

In response to OWCP's question regarding whether appellant continued to have residuals of the accepted Lyme disease condition, she indicated that she did not believe that appellant had Lyme disease. Dr. Kaufman noted that on July 4, 2005 appellant reported a tick bite on his right upper thigh, followed by the appearance of a rash the next day, but that the tick was not engorged at the time he removed it with his knife. She asserted that Lyme disease usually had a two-to-three week incubation period before the onset of symptoms and that, for Lyme disease to be transmitted, the tick had to be attached for at least 48 hours and had to become engorged as it fed. Dr. Kaufman indicated that appellant had been appropriately treated with an initial course of 10 days of doxycycline, followed later by a course of 30 days. She advised that appellant had not seroconverted, meaning that his Lyme IgG antibody titers never became positive. Dr. Kaufman opined that, when patients had residual Lyme disease problems, they seroconverted and had positive western blot results with at least 5 out of 10 bands. She asserted that patients with Lyme disease might not seroconvert if they were treated early, but indicated that the absence of seroconversion meant that the infection was resolved. Dr. Kaufman noted that appellant's western blot results had two bands at most, which could potentially have shown a cross reaction from other conditions. In response to OWCP's question regarding whether appellant had residuals of the accepted cervical spinal stenosis, she indicated that the condition seemed to have been controlled after appellant underwent fusion surgery, but that OWCP might want to obtain an additional report from appellant's surgeon. Dr. Kaufman asserted that appellant's current symptoms could be related to a multitude of diagnoses. She maintained that appellant's physical activity was likely limited by his pain and fatigue, and advised that he could potentially benefit from rheumatology and physiatry evaluations to address his arthralgias, fatigue, and weakness.[3] Dr. Kaufman indicated that a physiatrist would be a more appropriate person to complete a work capacity evaluation form (OWCP-5c).

Dr. Kaufman indicated that, given appellant's symptomatology, he could potentially benefit from physical therapy, but noted that she could state that the symptoms appellant was still experiencing were related to his original injury in 2005. She advised that it might be worth evaluating appellant for any potential effect of Agent Orange that he had been exposed to. Dr. Kaufman maintained that appellant's arthralgias could be due to multiple falls from his work as a rancher while trying to tame horses and noted, "[w]hile I believe the symptoms are real, I cannot state that they are related to his original injury." She indicated that appellant could not perform the full duties of his date of injury job because of the significant physical demands of the job. Dr. Kaufman noted that appellant had weakness, fatigue with physical activity, and pain, and indicated that his age was likely also a limitation. She asserted that appellant might be able to perform a less demanding job, likely on a part-time basis, but his fatigue might be a limiting factor. Dr. Kaufman advised that appellant could benefit from a physiatry evaluation to determine if he has any potential for medical improvement which would allow him to return to work.

[3] Dr. Kaufman advised that appellant's impairing arthralgias and fatigue were not related to the accepted work-related conditions.

On January 17, 2019 OWCP requested that Dr. Buitrago review Dr. Kaufman's November 8, 2018 report, and provide an opinion regarding appellant's employment-related conditions. In a February 13, 2019 report, Dr. Buitrago reported physical examination findings and diagnosed joint pain, metabolic syndrome, and hypertensive disorder. She indicated that, after the incident with the tick bite in 2005, appellant started feeling tired, and had headaches, joint pains and malaise. Dr. Buitrago noted, "[a] lot of his symptoms resolved after oral Doxycycline and IV Ceftriaxone. This leads me to believe that it is possible he has a tick borne illness. Not sure which one. It could have been Lyme's (sic) disease. We are not completely sure."

In a March 21, 2019 letter, OWCP proposed to rescind its acceptance of appellant's claim for Lyme disease, toxic effect of venom, and cervical stenosis with radiculopathy and myelopathy. It indicated that the weight of the medical opinion evidence with respect to whether appellant had employment-related Lyme disease rested with the well-rationalized opinion of Dr. Kaufman, the second opinion physician. OWCP asserted that, because the opinion of Dr. Kaufman "invalidates" the original acceptance of Lyme disease, this opinion "also invalidates" the acceptance of cervical stenosis with radiculopathy and myelopathy as Dr. Slutsky had determined that appellant's cervical spine condition developed as a consequence of his work-related duties and the limitations placed upon his activity due to the accepted condition of Lyme disease. It afforded appellant 30 days to present evidence and argument challenging the proposed rescission action.

In April 3, 2019 statement, appellant argued that tick he saw imbedded in his right hip on July 4, 2005 was so small that it would have been impossible to tell if had been engorged with blood. He noted that he had been working in the woods for six days with no shower facilities when he discovered the tick and suggested that, therefore, the tick had been attached to him for more than 48 hours. Appellant asserted that many of the facts in Dr. Kaufman's November 8, 2018 report were incorrect. He submitted a May 15, 2019 report from Dr. Buitrago who reported physical examination findings and diagnosed joint pain, metabolic syndrome, and hypertensive disorder. Dr. Buitrago provided a discussion of appellant's medical problems since 2005 which was similar to that contained in her February 13, 2019 report.

By decision dated August 8, 2019, OWCP rescinded its acceptance of appellant's claim for Lyme disease, toxic effect of venom, and cervical stenosis with radiculopathy and myelopathy. It found that the weight of the medical opinion evidence rested with the opinion of Dr. Kaufman.

On August 13, 2109 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. During the hearing held on November 5, 2019, counsel argued that Dr. Kaufman's opinion was not sufficiently rationalized to serve as the basis for OWCP's rescission action.

By decision dated December 9, 2019, OWCP's hearing representative affirmed the August 8, 2019 decision.

LEGAL PRECEDENT

Section 8128 of FECA provides that the Secretary of Labor may review an award for or against payment of compensation at any time on his own motion or on application.[4] The Board has upheld OWCP's authority to reopen a claim at any time on its own motion under section 8128 of FECA and, where supported by the evidence, set aside or modify a prior decision and issue a new decision.[5] The Board has noted, however, that the power to annul an award is not an arbitrary one and that an award for compensation can only be set aside in the manner provided by the compensation statute.[6]

Workers' compensation authorities generally recognize that compensation awards may be corrected, in the discretion of the compensation agency and in conformity with statutory provision, where there is good cause for so doing, such as mistake or fraud. Once OWCP accepts a claim, it has the burden of proof to justify termination or modification of compensation benefits. This also holds true where OWCP later decides that it erroneously accepted a claim.[7]

OWCP bears the burden of proof to justify rescission of acceptance on the basis of new evidence, legal argument and/or rationale.[8] Probative and substantial positive evidence or sufficient legal argument must establish that the original determination was erroneous. OWCP must also provide a clear explanation of the rationale for rescission.[9]

ANALYSIS

The Board finds that OWCP did not meet its burden of proof to rescind its acceptance of appellant's claim for Lyme disease, toxic effect of venom, and cervical stenosis with radiculopathy and myelopathy.

The Board finds that the evidence OWCP relied upon to rescind these medical conditions, *i.e.*, the November 8, 2018 report of Dr. Kaufman, the OWCP referral physician, is not sufficiently rationalized to justify OWCP's rescission action.

In her November 8, 2018 report, Dr. Kaufman indicated, in response to OWCP's question regarding whether appellant continued to have residuals of the accepted Lyme disease condition, that she did not believe that appellant had Lyme disease. She noted that on July 4, 2005 appellant reported a tick bite on his right upper thigh, followed by the appearance of a rash the next day, but that the tick was not engorged at the time he removed it with his knife. Dr. Kaufman asserted that

[4] 5 U.S.C. § 8128.

[5] *See L.M.*, Docket No. 19-0705 (issued September 11, 2019); *John W. Graves*, 52 ECAB 160, 161 (2000). *See* also 20 C.F.R. § 10.610.

[6] *D.W.*, Docket No. 17-1535 (issued February 12, 2018).

[7] *V.R.*, Docket No. 18-1179 (issued June 11, 2019).

[8] *See L.G.*, Docket No. 17-0124 (issued May 1, 2018).

[9] *See W.H.*, Docket No. 17-1390 (issued April 23, 2018).

Lyme disease usually had a two-to-three week incubation period before the onset of symptoms and that, for Lyme disease to be transmitted, the tick had to be attached for at least 48 hours and had to become engorged as it fed. She indicated that appellant had been appropriately treated with an initial course of 10 days of doxycycline, followed later by a course of 30 days. Dr. Kaufman advised that appellant had not seroconverted, meaning that his Lyme IgG antibody titers never became positive. She noted that appellant had two positive bands on western blot testing and opined that, when patients had residual Lyme disease problems, they seroconverted and had positive western blot results with at least 5 out of 10 bands.

The Board notes, however, that Dr. Kaufman indicated in portions of her November 8, 2018 report that appellant could have had employment-related Lyme disease or some other insect-venom type disease. These portions render her opinion equivocal with respect to whether appellant actually suffered the accepted employment conditions. The Board has held that an opinion which is equivocal regarding a given medical matter is of limited probative value regarding that matter.[10] Dr. Kaufman indicated that the diagnoses of possible tick bite, generalized weakness, febrile illness from 2005, and fatigue "could be related to the 2005 work-related injury." She noted, "[u]nfortunately it is not clear what condition the patient had, if the patient more likely than not had Lyme disease." Dr. Kaufman advised that appellant had an extensive work-up that was negative and opined that he could have had a viral illness. She noted, "[w]ithout definitive diagnosis though, it is impossible to tell if the symptoms the patient is still experiencing are related to the original condition." While Dr. Kaufman suggested in one part of her report that appellant's lack of seroconversion showed the absence of Lyme disease, in another part of her report she suggested that appellant could have had Lyme disease at some point despite such lack of seroconversion. She noted that patients with Lyme disease might not seroconvert if they were treated early, but indicated that the absence of seroconversion meant that the infection was resolved. Dr. Kaufman's discussion of the accepted condition of toxic effect of venom is similarly equivocal in nature. In response to OWCP's question regarding whether appellant continued to have residuals of the accepted insect bite and effect of venom, Dr. Kaufman also provided an equivocal statement. She indicated that appellant did have residual symptoms, including headaches, arthralgias, weakness, and fatigue, but advised that it was unclear if these were in any way related to the original insect bite or effect of venom because she did not believe that there was a definitive diagnosis from 2005. The Board further notes that Dr. Kaufman did not directly address whether appellant ever suffered employment-related cervical stenosis with radiculopathy and myelopathy. As OWCP based its rescission of this condition on Dr. Kaufman's discussion of Lyme disease, the November 8, 2018 report also fails to provide adequate justification for OWCP's rescission of its acceptance of the condition of cervical stenosis with radiculopathy and myelopathy.

For these reasons, OWCP did not present sufficient evidence to rescind its acceptance of appellant's claim for Lyme disease, toxic effect of venom, and cervical stenosis with radiculopathy and myelopathy.[11]

[10] *See E.B.*, Docket No. 18-1060 (issued November 1, 2018); *Leonard J. O'Keefe*, 14 ECAB 42, 48 (1962).

[11] *See supra* notes 8 and 9.

CONCLUSION

The Board finds that OWCP did not meet its burden of proof to rescind its acceptance of appellant's claim for Lyme disease, toxic effect of venom, and cervical stenosis with radiculopathy and myelopathy.

ORDER

IT IS HEREBY ORDERED THAT the December 9, 2019 decision of the Office of Workers' Compensation Programs is reversed.

Issued: July 21, 2021
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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