United States Department of Labor
Employees' Compensation Appeals Board

A.L., Appellant	)	
and	)	
DEPARTMENT OF HOMELAND SECURITY, CUSTOMS & BORDER PROTECTION, DALLAS/FORT WORTH AIRPORT, Irving, TX, Employer	)	**Docket No. 20-0658** **Issued: October 5, 2022**

Appearances:
Jesus Velasquez, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On February 3, 2020 appellant, through counsel, filed a timely appeal from a November 7, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the

[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.

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.[3]

ISSUE

The issue is whether appellant has met her burden of proof to establish a medical condition causally related to the accepted December 19, 2016 employment incident.

FACTUAL HISTORY

On January 11, 2017 appellant, then a 30-year-old customs and border protection officer, filed a traumatic injury claim (Form CA-1) alleging that on December 19, 2016 she sustained injuries to her jaw, right ear, right eye, hips, mid- and lower back, right hand, neck, and right shoulder during a training exercise while in the performance of duty. She stopped work on December 20, 2016. A supervisor related that appellant had notified a firearms supervisor prior to training that she had torn two muscles in her hips and indicated that a witness statement conflicted with appellant's account of the nature of the injury.

In a development letter dated January 26, 2017, OWCP informed appellant that she had submitted insufficient factual and medical evidence to establish her claim. It advised her of the type of evidence needed and provided a questionnaire for her completion. OWCP afforded appellant 30 days to respond.

On May 5, 2016 Dr. Philip Woodward, Board-certified in emergency medicine, examined appellant following a motor vehicle accident (MVA). Examinations of the head/eyes, neck, back, and upper extremities were normal, with full range and painless range of motion of the neck, back, and extremities. Dr. Woodward observed multiple abrasions on the left forearm. A computerized tomography (CT) scan of the head and brain taken on that date demonstrated possible mild frontal scalp soft tissue swelling. Dr. Woodward stated his impression of an MVA and diagnosed an anxiety reaction.

In a report dated May 9, 2016, Dr. Sadat A. Shamim, a neurology and cerebrovascular disorders specialist, examined appellant for a concussion. Appellant told Dr. Shamim that she had been involved in an MVA during which her vehicle was rear ended and she hit her head on the steering wheel. Dr. Shamim noted that CT scans of the head, spine, and neck were unremarkable. He diagnosed post-concussion syndrome.

In an emergency department report dated June 2, 2016, Dr. Betzaida G. Valentin, an emergency medicine specialist, examined appellant for complaints of thoracic and lumbar pain. Appellant told Dr. Valentin that she had been involved in an MVA when she was at a red light and

[2] 5 U.S.C. § 8101 *et seq*.

[3] The Board notes that, following the November 7, 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*.

was rear ended by another vehicle traveling at approximately 60 miles per hour. She hit her head on the steering wheel before airbags were deployed. On physical examination of the back Dr. Valentin observed thoracic and lumbar midline tenderness. An x-ray taken on that date demonstrated a normal lumbar spine. Dr. Valentin diagnosed neck sprain.

Magnetic resonance imaging (MRI) scans of appellant's cervical and lumbar spine obtained on September 16, 2016 demonstrated nonspecific loss of lordosis and a minimal left foraminal disc bulge at L4-5 without significant neural compromise, respectively. The MRI scans were otherwise normal.

An MRI arthrogram of appellant's left hip dated October 11, 2016 demonstrated cortical irregularity and bone edema involving the area of the anterior-inferior iliac spine and anterior column of the left ischium and infraperitoneal pelvic free fluid. An arthrogram of the right hip obtained on the same date demonstrated no fracture or dislocation.

In a report dated October 21, 2016, Dr. Kyle Stuart, a Board-certified orthopedic surgeon, reviewed his treatment of appellant for complaints of left hip pain. He diagnosed bilateral hip femoroacetabular impingement, bilateral os acetabuli, and a right hip labral tear. In a follow-up report dated November 30, 2016, Dr. Stuart noted that recent bilateral hip injections had improved her symptoms, but that she remained unable to run or perform her regular occupation due to pain. He recommended bilateral staged hip arthroscopy and labral repair.

On January 6, 2017 Dr. Andrew Indresano, a Board-certified orthopedic surgeon, followed up with appellant for complaints of cervical and lumbar region discomfort. Appellant told Dr. Indresano that she had significant improvement of the neck and lower back following physical therapy. However, while at work, she hit a bag with a baton, and experienced immediate upper cervical and thoracic discomfort. On physical examination Dr. Indresano observed moderate bilateral cervical and lumbar paraspinal tenderness to palpation, full strength and normal sensation of the upper extremities, and a positive Tinel's sign at the right elbow. He diagnosed cervicalgia, radiculopathy, and lower back pain.

In an undated report, noting a date of initial visitation of February 2, 2017, Dr. Russell B. Skinner, a specialist in family medicine, holistic medicine, and physical medicine and rehabilitation, examined appellant for complaints of severe pain in her head, neck, face, right eye, right side of jaw, hips, and lower back. Appellant told Dr. Skinner that on December 19, 2016 she was engaged in a work-related training drill when she was injured when she struck a standing punching bag with her baton. As soon as she struck the bag, she felt an immediate pain in her groin muscles and pain that traveled on the right side from the top of her neck down her right arm. Appellant felt a shock-like sensation by her right ear and a cramp-like sensation down the right side of her face. Dr. Skinner noted that appellant had been involved in an MVA on May 4, 2016, and had been diagnosed with post-traumatic concussion syndrome, injuries to the eyes, neck, back, jaw, and hips, as well as post-traumatic stress disorder (PTSD) and a temporomandibular (TMJ) condition. On physical examination of the cervical and lumbar spine he observed decreased range of motion and pain, as well as a positive straight leg raise test and light sensitivity. An electromyogram (EMG) taken on February 7, 2017 demonstrated right C7 subacute and chronic radiculopathy with mild active denervation, chronic neurogenic chances, and re-innervation. Dr. Skinner diagnosed aggravations of cervicalgia, cervical radiculopathy, right hip sprain, TMJ

disorder, and post-concussion syndrome. He also diagnosed sprain of the ligaments of the lumbar spine, right hip effusion, and left hip contusion.

Dr. Skinner opined that the incident of December 19, 2016 caused lumbar sprain, right hip effusion, left hip contusion, right hip sprain, and aggravation of cervical radiculopathy. He explained that a sudden jarring or twisting motion could cause damage to the body's soft tissues leading to joint effusion, contusion or aggravation of an existing sprain. Dr. Skinner opined that appellant was asked to use her baton to strike a punching bag while moving side to side, which was exactly the kind of sudden jarring and twisting motion that could lead to soft tissue damage in the lower back and hips causing joint effusion, a contusion, or aggravate an existing sprain. He explained that where a patient had existing loss of cervical lordosis, sudden jarring or twisting could also lead to damage of the ligaments of the neck. Dr. Skinner opined that appellant's use of a baton to strike a punching bag while moving side to side caused damage to the ligaments of the neck that led to additional loss of lordosis and aggravated existing cervical radiculopathy.

On February 9, 2017 appellant responded to OWCP's development questionnaire and described the incident of December 19, 2016. She noted that she had advised a supervisor she had upcoming surgery on her hip and that her jaw was out of alignment. Appellant stated that she was told to "just to go through the motions" on upcoming training, but that, at training, a supervisor told her that she should "do something in the scenario today or [she] should go out on light duty." She was handed a baton at training and was instructed to use the baton to strike a punching bag. When appellant struck the bag, she felt immediate pain in her groin muscles and pain traveling on the right side from the top of her neck down her arm. As she continued, she felt a shock-like sensation by her right ear and cramping in the right side of her face from her ear to her jaw and cheek. After the exercise, appellant had severe ear pain. She noted that, prior to her claimed December 19, 2016 work injury, she was involved in an MVA on May 4, 2016 on her way home from work, as a result of which she suffered a severe concussion, injuries to her eyes, neck, back, jaw, and hips, burns to the left arm, PTSD, and a TMJ condition. Appellant alleged that the incident of December 19, 2016 exacerbated these injuries to her jaw, right ear, right eye, right hand, right shoulder, bilateral hip, neck, mid-back, and lower back, and may have caused new conditions to develop in these areas.

In a note dated March 9, 2017, Dr. Skinner followed up with appellant, who reported fewer headaches and less tension in the head and around the eye. On physical examination of the neck he observed restricted extension, rotation, and lateral flexion. Dr. Skinner diagnosed a cervical sympathetic nerve injury, cervical radiculopathy, and pain of the head and neck region. On April 5, 2017 Dr. Brian Mann, a chiropractor, observed pain on palpation of the right hip, a positive log roll test of the bilateral hips, limited range of motion of the cervical spine, a palpable spasm of the right upper trapezius, and pain on palpation of the upper cervical spine. He diagnosed right hip sprain, cervical sympathetic nerve injury, and cervical radiculopathy.

OWCP referred appellant's claim, along with a statement of accepted facts (SOAF) and a copy of the record, to Dr. Jack H. Henry, a Board-certified orthopedic surgeon, for a second opinion examination to determine whether appellant sustained a diagnosed medical condition caused, aggravated, or precipitated by the incident of December 19, 2016. In an April 7, 2017 report, Dr. Henry recounted appellant's history of injury on December 19, 2016, noting that she had previously been involved in an MVA in May 2016. Physical examination of the spine, upper

extremities, and lower extremities were normal. Dr. Henry observed negative orthopedic tests, normal strength, normal sensation, and range of motion within normal limits. He observed that she was able to perform heel-to-toe walking without difficulty. Dr. Henry opined that there was no evidence of any conditions or diagnosis caused, aggravated, or precipitated by the December 19, 2016 work incident, because there was documentation of record that her lower back pain, bilateral hip, groin, shoulder, and neck pain with radicular symptoms in the left upper extremity were present prior to December 19, 2016. He opined that all of her symptoms and complaints may be related to the MVA in May 2016. Dr. Henry noted that appellant had undergone a functional capacity evaluation on April 11, 2017, but that she rendered self-limiting effort, and that the results were, thus, invalid. He opined that she should be able to return to her date-of-injury position at full duty.

By decision dated May 10, 2017, OWCP denied appellant's claim, finding that appellant had not submitted sufficient medical evidence to establish a causal relationship between her diagnosed conditions and the accepted December 19, 2016 employment incident. It accorded Dr. Henry's second opinion report the weight of the medical evidence.

OWCP subsequently received a note dated May 4, 2017, wherein Dr. Skinner related that appellant experienced daily headaches and difficulty with concentration. Dr. Skinner noted appellant's physical examination findings and diagnosed right hip sprain, a cervical sympathetic nerve injury, cervical radiculopathy, and head and neck pain. He recommended that appellant return to light-duty work. In a follow-up report dated June 22, 2017, Dr. Skinner observed pain on palpation of appellant's hips and lumbar and cervical spine, as well as limited range of motion of the lumbar spine.

On April 4, 2018 appellant, through counsel, requested reconsideration of OWCP's May 10, 2017 decision.

In a report dated February 24, 2018, Dr. Erwin A. Cruz, a Board-certified neurologist, examined appellant for evaluation and management of seemingly neurological symptoms subsequent to an injury at work. He noted that she had been involved in an MVA in May 2016 and that she sustained a head injury in that incident, later being diagnosed with a concussion and being treated for post-concussion syndrome. Dr. Cruz described the incident of December 19, 2016 and opined that it had exacerbated her post-concussion syndrome. He observed that appellant had a longstanding history of anxiety and panic attacks subsequent to the May 2016 MVA and that she had been diagnosed with PTSD. Neurological and neuromuscular examinations were normal. Appellant complained of pain at her posterior ear on tapping of the knees, which Dr. Cruz observed did not make sense. Dr. Cruz diagnosed status post cervical spine sprain/strain and exacerbation of post-concussion syndrome. He explained that in the work-related training exercise of that date, appellant hit a punching bag and jarred her body from side to side with great force, which caused impulsive force to be transmitted to the head, resulting in brain movement and exacerbating her preexisting post-concussive syndrome.

By letter dated March 26, 2018, Dr. Skinner responded to Dr. Henry's second opinion report. He reproduced his medical opinion from his February 2, 2017 report regarding permanent aggravation of cervicalgia, cervical radiculopathy, lumbar spine and right hip sprain, left hip contusion, TMJ disorder and post-concussion syndrome as a result of the incident of

December 19, 2016. Dr. Skinner stated that appellant was incapable of returning to work at that time.

OWCP determined that a conflict in the medical evidence existed between appellant's treating physician, Dr. Skinner, and Dr. Henry, OWCP's second opinion physician, regarding whether appellant's diagnosed conditions were caused, or aggravated by the accepted employment incident of December 19, 2016. In a June 29, 2019 memorandum to the file, recording a physician search conducted on June 12, 2018, it noted that an impartial medical examiner (IME) search for appellant's zip code had been exhausted. In a June 29, 2019 appointment schedule notification report (ME023), OWCP noted the bypass reasons for 14 physicians. It noted that Dr. Michael Lecompte, an osteopathic physician Board-certified in orthopedic surgery, had been selected as the IME.

In an August 1, 2018 report, Dr. Lecompte noted that appellant had been seen on that date. He reviewed appellant's history of injury, medical record, and history of diagnostic testing. On physical examination, Dr. Lecompte observed mild muscle tightness in the left paravertebral musculature. Range of motion testing of the hips caused groin pain, while such testing of the left shoulder caused left axilla pain. He diagnosed post-concussion syndrome and PTSD resulting from her MVA on May 4, 2016. Dr. Lecompte opined that the December 19, 2016 event was a panic attack secondary to the May 4, 2018 MVA. He stated that the December 19, 2016 employment incident did not precipitate her concussion or PTSD, and that it was secondary to her prior mental state rather than an aggravation of that state. Dr. Lecompte noted that appellant had preexisting PTSD, panic attacks, and concussion. He opined that appellant was totally disabled, but that this disability was not related to the December 19, 2016 employment incident.

By letter dated September 10, 2018, OWCP requested that Dr. Lecompte resubmit his August 1, 2018 report because it appeared to be missing a page. It also requested that he list the diagnosed conditions that were, in his opinion, caused or aggravated by the December 19, 2016 employment incident. In a letter dated October 3, 2018, Dr. Lecompte clarified that there were no ICD-10 codes to list as caused or aggravated by the December 19, 2016 employment incident because he had found she sustained no injuries on that date. He stated that appellant had a panic attack on December 10, 2016, which was precipitated by her prior PTSD, secondary to the May 4, 2016 MVA.

By decision dated October 15, 2018, OWCP denied modification of its May 10, 2017 decision. It found that the August 1, 2018 report from Dr. Lecompte was accorded the special weight of the evidence.

On July 18, 2019 appellant, through counsel, requested reconsideration of OWCP's October 15, 2018 decision. Counsel argued that appellant had submitted sufficient evidence to establish her claim and that the selection of Dr. Lecompte as an IME was "suspicious" because at least four other physicians had been bypassed due to no number available to reach them, despite their telephone numbers being easily searchable and operational. Counsel further argued that Dr. Lecompte's report had been used to determine whether appellant's psychological and neurological conditions were related to the December 19, 2016 employment incident despite his Board certification as an orthopedic surgeon placing him outside the appropriate specialties for those conditions.

Counsel also submitted progress reports from Dr. Gloria Simms, a Board-certified neurologist, dated May 30 and June 4, 2019. Dr. Simms reviewed appellant's history of injury on May 4 and December 2016. She noted headaches and migraine. Dr. Simms diagnosed PTSD, chronic mixed headache syndrome, chronic pain syndrome, photophobia, and mild cognitive disorder. She observed that appellant had a severe impact after her MVA, which appellant noted included no head injury. Dr. Simms stated that active mood disorder was probably part of the triggers for uncontrollable headaches and other symptoms.

By letter dated January 22, 2019, Dr. Skinner provided a response to Dr. Lecompte's report. He opined that, based on appellant's history, physical examination findings, and diagnostic studies, Dr. Lecompte was incorrect in stating that appellant's injuries resulted from a preexisting condition. He observed that appellant's physical and psychological conditions had significantly improved prior to the employment incident of December 19, 2016. Dr. Skinner noted that he was unsure how Dr. Lecompte concluded that appellant's symptoms were a result of the May 4, 2016 MVA, opining that with appellant's improvement, something had to occur for such a physical and psychological setback.

By decision dated November 7, 2019, OWCP denied modification of its October 15, 2018 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[4] has the burden of proof to establish the essential elements of his or her claim, including that the individual is an employee of the United States within the meaning of FECA, that the claim was timely filed within the applicable time limitation of FECA,[5] that an injury was sustained in the performance of duty as alleged, and that any disability or medical condition for which compensation is claimed is causally related to the employment injury.[6] These are the essential elements of each and every compensation claim, regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[7]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether fact of injury has been established. There are two components involved in establishing fact of injury. The first component is that the employee must submit sufficient evidence to establish that he or she actually experienced the employment incident at the time and place, and in the manner alleged. The second component is

[4] *Supra* note 2.

[5] *F.H.*, Docket No. 18-0869 (issued January 29, 2020); *J.P.*, Docket No. 19-0129 (issued April 26, 2019); *Joe D. Cameron*, 41 ECAB 153 (1989).

[6] *L.C.*, Docket No. 19-1301 (issued January 29, 2020); *J.H.*, Docket No. 18-1637 (issued January 29, 2020); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[7] *P.A.*, Docket No. 18-0559 (issued January 29, 2020); *K.M.*, Docket No. 15-1660 (issued September 16, 2016); *Delores C. Ellyett*, 41 ECAB 992 (1990).

whether the employment incident caused a personal injury and can be established only by medical evidence.[8]

The medical evidence required to establish a causal relationship between a claimed specific condition and an employment incident is rationalized medical opinion evidence.[9] The opinion of the physician must be based on a complete factual and medical background of the employee, 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 specific employment incident identified by the employee.[10]

In any case where a preexisting condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation, acceleration, or precipitation, the physician must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.[11]

Section 8123(a) provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[12] The implementing regulations provides that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[13] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an IME for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[14]

[8] *T.H.*, Docket No. 19-0599 (issued January 28, 2020); *K.L.*, Docket No. 18-1029 (issued January 9, 2019); *John J. Carlone*, 41 ECAB 354 (1989).

[9] *S.S.*, Docket No. 19-0688 (issued January 24, 2020); *A.M.*, Docket No. 18-1748 (issued April 24, 2019); *Robert G. Morris*, 48 ECAB 238 (1996).

[10] *T.L.*, Docket No. 18-0778 (issued January 22, 2020); *Y.S.*, Docket No. 18-0366 (issued January 22, 2020); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013); *see L.C.*, *supra* note 6; *R.D.*, Docket No. 18-1551 (issued March 1, 2019).

[12] 5 U.S.C. § 8123(a).

[13] 20 C.F.R. § 10.321.

[14] *A.G.*, Docket No. 18-0749 (issued November 7, 2018); *C.S.*, Docket No. 18-0952 (issued October 23, 2018); *R.C.*, 58 ECAB 238 (2006).

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish a medical condition causally related to the accepted December 19, 2016 employment incident.

OWCP found a conflict in the medical opinion evidence between appellant's treating physician, Dr. Skinner, who opined that the accepted employment incident of December 19, 2016 caused lumbar sprain, right hip effusion, left hip contusion, right hip sprain, and aggravation of cervical radiculopathy, and the second opinion physician, Dr. Henry, who opined that there was no evidence of any conditions or diagnosis caused, aggravated, or precipitated by the December 19, 2016 employment incident. It properly referred appellant to Dr. Lecompte, serving as the IME, to resolve the conflict, pursuant to 5 U.S.C. § 8123(a).

In his August 1, 2018 report, Dr. Lecompte conducted a physical examination and reviewed the SOAF, appellant's history of injury, medical record, and record of diagnostic testing. He opined that the December 19, 2016 event was a panic attack secondary to the May 4, 2018 MVA. Dr. Lecompte stated that the December 19, 2016 incident did not precipitate her concussion or PTSD, and that it was secondary to her prior mental state rather than an aggravation of that state. He noted that appellant had preexisting PTSD, panic attacks, and concussion. In a letter dated October 3, 2018, Dr. Lecompte stated that appellant sustained no injuries on December 19, 2016.

The Board finds that Dr. Lecompte's impartial medical report represents the special weight of the medical evidence, as he had full knowledge of the relevant facts and evaluated the course of appellant's condition. Dr. Lecompte's opinion is based on a proper factual and medical history and his report contained a detailed summary of this history. He is also a specialist in the appropriate field for appellant's claimed orthopedic conditions. Following physical examination, Dr. Lecompte found no basis on which to attribute causal relationship between any diagnosed condition and the incident of December 19, 2016. He attributed appellant's diagnosed conditions to a MVA on May 4, 2016. Dr. Lecompte's opinion, as set forth in the August 1, 2018 report and letter dated October 3, 2018, is found to be probative evidence and reliable.[15] The Board, therefore, finds that the IME's opinion constitutes the special weight of the medical evidence.

As Dr. Skinner was on one side of the conflict, his subsequent reports and letters are insufficient to create a new conflict in medical opinion or to overcome the special weight properly accorded to the IME.[16]

Dr. Simms' reports dated May 30 and June 4, 2019 did not contain an opinion on causal relationship. As the Board has held, medical evidence which does not offer an opinion regarding

[15] *K.V.*, Docket No. 18-0947 (issued March 4, 2019); *M.E.*, Docket No. 18-1135 (issued January 4, 2019); *Michael S. Mina*, 57 ECAB 379 (2006); *Kathryn Haggerty*, 45 ECAB 383, 388 (1994) (the opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion are facts, which determine the weight to be given to each individual report).

[16] *Id*.

the cause of an employee's condition is of no probative value on the issue of causal relationship.[17] Thus, these reports are insufficient to establish appellant's claim, as they do not specifically address whether appellant's diagnosed conditions are causally related to the December 19, 2016 employment incident.[18]

On appeal counsel argues that Dr. Lecompte's report should not be afforded the special weight of the evidence as IME because he was not a Board-certified specialist in neurology or psychiatry. The Board notes that appellant has not claimed an emotional condition such as PTSD as work related under this claim, but rather has claimed a variety of physical conditions of the jaw, right ear, right eye, neck, right shoulder, right hand, back, and bilateral hips. While Dr. Lecompte referred to appellant's diagnosed psychiatric condition of PTSD and characterized the incident of December 19, 2016 as a panic attack, the Board finds that he was qualified within the appropriate medical specialty to resolve the conflict of medical opinion in this case.[19] As the medical evidence of record is insufficient to establish a medical condition causally related to the accepted December 19, 2016 employment incident, the Board finds that appellant has not met her 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 her burden of proof to establish a medical condition causally related to the accepted December 19, 2016 employment incident.

[17] *See D.C.*, Docket No. 19-1093 (issued June 25, 2020); *L.B.*, Docket No. 18-0533 (issued August 27, 2018); *D.K.*, Docket No. 17-1549 (issued July 6, 2018).

[18] *Id*.

[19] *See D.S.*, Docket No. 18-0353 (issued February 18, 2020); *J.R.*, Docket No. 16-1097 (issued December 5, 2016).

ORDER

IT IS HEREBY ORDERED THAT the November 7, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 5, 2022
Washington, DC

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

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board