United States Department of Labor
Employees' Compensation Appeals Board

S.L., Appellant	)	
and	)	**Docket No. 16-0202**
	)	**Issued: August 23, 2016**
DEPARTMENT OF THE NAVY, NAVAL AIR WARFARE CENTER AIRCRAFT DIVISION, Patuxent River, MD, Employer	)	

Appearances:
Stephen Domenic Scavuzzo, 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
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On November 10, 2015 appellant, through counsel, filed a timely appeal of a May 14, 2015 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)(2014). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney's 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 (2006). 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 established disability as of October 7, 2013, causally related to his December 18, 2003 work injury.

FACTUAL HISTORY

On December 18, 2003 appellant, then a 41-year-old engineering/electronics technician, injured his right leg during a work-related flight from Hawaii to Maryland. Because of severe weather conditions, he had to remain seated during most of the first leg of the flight from Hawaii to the Midwest. As a result of his inactivity, appellant developed a blood clot in his right leg.[3] On January 6, 2004 Dr. Cameron M. Akbari, a Board-certified vascular surgeon, performed a ligation of the right greater saphenous vein (GSV). In February 2004, OWCP accepted appellant's claim for aggravation of right leg superficial thrombophlebitis (ICD-9 451.0). It subsequently expanded the claim to include right leg lymphedema (ICD-9 457.1) and acute venous embolism and thrombosis (ICD-9 453.89).

Appellant received wage-loss compensation for temporary total disability through mid-January 2005. Effective January 18, 2005, he returned to part-time, limited-duty capacity for four hours per day. Appellant gradually increased to full-time, limited-duty work. On May 16, 2005 he resumed his full-time, regular duties.[4] In July 2006, OWCP awarded appellant a schedule award for 50 percent impairment of the right lower extremity due to peripheral vascular disease.

From December 19, 2011 through January 27, 2012, OWCP paid wage-loss compensation for temporary total disability. On the advice of Dr. Akbari, appellant was briefly hospitalized for evaluation and treatment of a suspected right lower extremity deep vein thrombosis (DVT). Appellant was discharged from the hospital on December 22, 2011, and Dr. Akbari cleared him to return to work, effective February 6, 2012.

December 20 to 22, 2011 hospital treatment notes indicated that appellant had changed jobs approximately four weeks prior. His then-current commute was reportedly 90 minutes in each direction, whereas his previous commute was 10 minutes. When cleared to return to work in February 2012, appellant was advised to telecommute two to three days per week. On those days when he had to commute to/from work, appellant was instructed to ride the bus. He was not to drive more than an hour without a break, and when traveling by airplane, appellant was limited to a three-hour flight. Additionally, Dr. Akbari instructed appellant to wear compression stockings at all times.

[3] Appellant had preexisting phlebitis in his right leg. In September 1998, he underwent limited stripping of the saphenous vein tributary in his right calf. Medical records from 1998 to 1999 referenced a circa 1995 right leg "crush injury" that was reportedly diagnosed as superficial phlebitis and cellulitis. These same records revealed that appellant was suspected of being in a hypercoagulable state, which was later diagnosed as factor V Leiden mutation.

[4] Although appellant could sit, walk, and stand during the course of an eight-hour work shift, Dr. Akbari recommended that he take a 5- to 10-minute break every four hours.

The employing establishment indicated that in April 2012, appellant began working for the Naval Research Laboratory (NRL), which was headquartered in Washington, DC. Appellant indicated that he worked in Washington, DC for a few months before returning to his previous worksite in Patuxent River, MD. NRL established an office at the Patuxent River Naval Air Station (NAS). Appellant's NRL assignment (VXS-1) at NAS was located across the street from where he previously worked, and just a 10-minute commute to/from his home. He reportedly spent 70 percent of his time at NAS. When he occasionally had to make the 70-minute commute to Washington, DC, appellant either carpooled or took a commuter bus.

On October 7, 2013 appellant stopped work due to right lower extremity (RLE) complaints. That same day he saw a nurse practitioner, Kimberly Cook, who diagnosed RLE vasculitis and advised that he remain off work for one week. Appellant's recommended treatment included ibuprofen, warm compresses, and elevation of the affected lower extremity. He returned for follow-up on October 14, 2013, at which time he was seen by Dr. Leena M. Kosandal, a Board-certified family practitioner, who diagnosed RLE phlebitis.[5] Dr. Kosandal advised appellant to remain off work at least through October 21, 2013. On October 15, 2013 appellant visited an emergency department with complaints of increased right leg and foot pain. Dr. James I. Damalouji, a surgeon, diagnosed lower extremity thrombophlebitis, and discharged appellant later that same day. On October 16, 2013 appellant saw Dr. Akbari, who admitted him to the hospital for evaluation of right lower extremity cellulitis, phlebitis, and thrombophlebitis. He remained in the hospital through October 18, 2013.

During an October 30, 2013 follow-up examination, Dr. Akbari noted that appellant was having generalized burning pain below the knee to the right foot and "pins and needle" pain on the plantar side of the same foot, which was not consistent with thrombophlebitis. The current RLE physical examination revealed mild swelling and two lesions. One of the lesions was medial to the right shin and was crusted. The other lesion was on the shin itself and there was no break in the skin. According to appellant, the lesions had not improved since before his recent hospitalization. Dr. Akbari indicated that he was not concerned about the noted lesions being infected. He explained that this was a chronic condition that flared up and took a respectable amount of time to clear. Dr. Akbari encouraged appellant to follow-up with his primary care physician for neuropathy. He also noted that appellant would follow-up with infectious disease within a couple weeks. Additionally, Dr. Akbari advised appellant to continue wearing compression stockings and continue his anticoagulation therapy (Lovenox). Appellant was to return in three months for follow-up, or sooner if necessary.

In November 2013, appellant filed a claim for compensation (Form CA-7) for temporary total disability beginning October 7, 2013.

In a December 10, 2013 attending physician's report (Form CA-20), Dr. Kosandal diagnosed superficial phlebitis, lymphedema, and acute venous embolism. She identified December 18, 2003 as the date of injury, and explained that appellant's current condition was employment related because a "long flight resulted in DVT." Lastly, Dr. Kosandal indicated that he remained totally disabled, and had been disabled since September 25, 2013.

[5] Dr. Kosandal and Ms. Cook are both affiliated with the Hollywood Medical Center.

In a January 7, 2014 narrative report, Dr. Kosandal noted a December 2003 history of injury while traveling on a five-hour long flight from Hawaii. She indicated that appellant was unable to move about the plane and developed a DVT of the right leg. Dr. Kosandal further noted that he was prescribed blood thinners and eventually underwent a ligation of the greater saphenous vein, which in turn caused chronic thrombophlebitis and chronic lymphedema. She also noted that appellant had been hospitalized several times and was being followed by a vascular surgeon, Dr. Akbari. According to Dr. Kosandal, he currently experienced severe pain, swelling, and redness to the right lower extremity. She indicated that appellant had permanent venous insufficiency and lymphedema, which required hospitalization for IV antibiotics and IV heparin. Dr. Kosandal further noted that she had recently examined appellant on December 16, 2013.[6] His diagnoses included phlebitis and thrombophlebitis, lymphedema, and acute venous embolism and thrombosis. Dr. Kosandal further indicated that appellant had been advised that he could not perform his usual job duties, especially sitting, standing or driving for extended periods of time. Appellant had also been advised to do minimal activity, rest with his leg elevated above his heart several times a day, and continue wearing compression stockings to prevent any acute venous embolism or thrombosis. Dr. Kosandal explained that since the original incident in 2003, appellant's condition deteriorated and he experienced more frequent and severe episodes of thrombophlebitis. She also explained that he had permanent venous insufficiency and would require lifelong anticoagulants. In conclusion, Dr. Kosandal noted it was her opinion that appellant was unable to return to work indefinitely.

In a February 18, 2014 decision, OWCP denied appellant's claim for wage-loss compensation, finding that he failed to establish a causal relationship between the claimed disability beginning October 7, 2013 and the accepted injury of December 18, 2003.

Appellant requested a hearing before an OWCP hearing representative and submitted additional medical evidence.

In an April 1, 2014 narrative report, Dr. Kosandal referenced her January 7, 2014 report and indicated that appellant currently remained unable to work due to a worsening of his approved conditions. She further explained that appellant's October 2013 hospitalization was a direct result of the December 18, 2003 work-related injury. Dr. Kosandal indicated that appellant's hospitalization was evidence that with each episode of DVT, swelling, and superficial thrombus, his condition worsened. She also referenced a July 2, 2012 ultrasound that reportedly revealed that appellant's clots had damaged the venous valves resulting in venous insufficiency. Dr. Kosandal indicated that the result was cumulative whereby the insufficiency led to more swelling and tissue damage, resulting in further phlebitis and thrombus in the superficial vein system. In addition, appellant now experienced neuropathy of the right lower extremity, which occurred during each episode of thrombophlebitis. He reportedly had not responded well to medication to control his neuropathy. In closing, Dr. Kosandal noted that appellant was unable to work due to a worsening of his approved condition and subsequent hospitalization in October 2013.

[6] Dr. Kosandal's December 16, 2013 treatment notes included a diagnosis of RLE thrombophlebitis. She also provided a December 16, 2013 disability certificate, which indicated that appellant remained unable to return to work.

By decision dated May 5, 2014, OWCP's hearing representative found that appellant's claim for compensation beginning October 7, 2013 was not in posture for decision. She remanded the case to OWCP with instructions to refer appellant for a second opinion evaluation. Additionally, the hearing representative instructed OWCP to obtain medical records regarding appellant's 1995 right leg crush injury.

On remand, appellant submitted June 1995 medical records regarding his right lower extremity. The records revealed that he had been hospitalized from June 8 through 15, 1995. The final diagnosis was acute cellulitis and lymphadenitis of the right leg and right thigh, and right inguinal lymphadenitis. Appellant explained that what had been described as a "crush injury" was merely an infection that arose after a plastic container banged his leg against a deck railing. He and another coworker were carrying the 75-pound container aboard ship when appellant lost his footing. According to appellant, he had an abrasion that did not bleed much, but later became infected.

OWCP also received a September 3, 2013 report from Dr. Joseph P. Catlett, a Board-certified internist with subspecialties in hematology and medical oncology. Dr. Catlett's treatment of appellant dated back to March 1999. He had last seen appellant on January 24, 2012, shortly after his December 2011 hospitalization.[7] In his latest report, Dr. Catlett reiterated appellant's prior history through January 2012, including an earlier reference to a November 2011 change of jobs that resulted in a 90-minute one-way commute. He noted that since appellant's last visit, he continued to take Lovenox, which he tolerated well. Dr. Catlett also noted that appellant had right foot pain that was intermittent and related to the edema he gets at times in his foot. Otherwise, appellant was noted to be doing well. Dr. Catlett's impression was "[h]istory of recurrent venous thrombotic events related to multiple factors, including dyslipidemia, mild obesity, history of tobacco abuse, prolonged commute and hereditary thrombophilia in the form of Factor V Leiden mutation." He also noted that appellant would remain on life-long anticoagulation therapy. Dr. Catlett advised appellant to return for follow-up in six months.

In a June 24, 2014 report, Dr. Akbari indicated that appellant had been under his care since the December 18, 2003 work-related injury of thrombophlebitis and venous insufficiency. He also noted that because of the injury, appellant was hospitalized in October 2013. When Dr. Akbari last examined appellant on April 2, 2014, he noted there was ongoing intermittent RLE edema due to multiple venous thromboses, both superficial and deep. He further noted that appellant was compliant with compression stockings. Appellant reportedly advised Dr. Akbari that he noticed that his condition worsened with working, standing for prolonged periods of time, and air travel. Dr. Akbari anticipated seeing appellant in follow-up on July 2, 2014. In conclusion, he stated that appellant was unable to work due to the above-noted worsening condition.

[7] At that time, he diagnosed recurrent venous thrombotic events related to multiple factors, including dyslipidemia, mild obesity, history of tobacco abuse, prolonged commute, and hereditary thrombophilia in the form of factor V Leiden mutation. Dr. Catlett also noted that appellant would remain on life-long anticoagulation therapy (Lovenox).

OWCP amended the statement of accepted facts (SOAF) and referred appellant for a second opinion evaluation with Dr. James M. Salander, a Board-certified vascular surgeon. The June 11, 20014 SOAF noted that appellant's claim had been accepted for aggravation of right leg superficial thrombophlebitis, right leg lymphedema, and acute venous thrombosis. There was also a list of preexisting conditions, which included right leg phlebitis "following a crush injury at sea…."[8]

In a July 22, 2014 report, Dr. Salander diagnosed chronic venous insufficiency, recurrent superficial thrombophlebitis, recurrent cellulitis, lymphedema, and chronic regional pain syndrome of the right lower extremity, all of which he found causally related to the December 18, 2013 work injury.[9] He further found that appellant continued to experience residuals of the work injury and that his current disability was related to the December 18, 2003 work injury. However, Dr. Salander believed appellant was able to work and had not been totally disabled since October 7, 2013. He provided permanent work restrictions (OWCP-5c) that included a 6- to 8-hour limitation on sitting, less than 30 minutes of walking and standing, a 30-minute limitation on operating a motor vehicle at work, and a similar 30-minute limitation on operating a motor vehicle to/from work. Additionally, appellant was precluded from squatting and kneeling, and was advised to take a 15-minute break every 3 hours.

Following his July 22, 2014 examination by Dr. Salander, appellant sought treatment in the emergency department that same evening. He complained of right calf pain after traveling for four hours earlier in the day.

OWCP sought clarification from Dr. Salander regarding his July 22, 2014 report. In a July 29, 2014 addendum, he noted that prior to 2003 appellant essentially had no chronic symptoms in his right leg. Dr. Salander also noted a prior right leg injury in "1998" with "no apparent long-term problem."[10] He then explained that appellant's airplane ride in 2003 created a clinical cycle of superficial thrombophlebitis, chronic pain, swelling, venous insufficiency, and cellulitis. Dr. Salander further explained that in October 2013, appellant had a significant exacerbation of those symptoms, and now he had a substantial new disability, along with chronic regional pain syndrome related to the exacerbation in October 2013. Lastly, Dr. Salander stated that appellant had been partially disabled since October 2013, and was unable to continue his pre-October 2013 employment.

OWCP requested additional clarification, and in an August 6, 2014 addendum Dr. Salander stated as follows: "[Appellant] has been disabled since last October due to the occurrence of cellulitis and new pain, swelling and tenderness[,] which represents regional sympathetic pain syndrome. He has been totally disabled from [October 7, 2013] to the present. All of this is due to his [December 2003] work injury[.]"

[8] There was no mention of the specific date or year when the right leg crush injury occurred.

[9] Dr. Salander explained that as a result of recurrent episodes of superficial thrombophlebitis, appellant developed a complex regional pain syndrome (reflex sympathetic dystrophy (RSD) or causalgia).

[10] Dr. Salander later clarified that the referenced "1998" injury actually occurred in 1995. In his July 22, 2014 report, Dr. Salander noted that OWCP's SOAF did not include a history of a blunt trauma to the right leg, which occurred in 1995 while aboard ship "and resulted in no fractures … but did result in cellulitis."

On August 14, 2014 OWCP advised appellant that his claim had been expanded to include right lower limb RSD. However, on August 21, 2014, an OWCP senior claims examiner advised that the August 14, 2014 decision had been issued in error. OWCP explained that additional development was required because Dr. Salander purportedly did not have access to medical records regarding appellant's 1995 injury. Consequently, right lower limb RSD was no longer one of appellant's accepted conditions.

In a September 18, 2014 decision, OWCP denied appellant's claim for recurrence of disability beginning October 7, 2013. Relying primarily on Dr. Catlett's September 3, 2013 report and Dr. Salander's July 22, 2014 second opinion examination, OWCP found that appellant's current condition was not the result of a spontaneous change of his employment-related RLE condition. With respect to Dr. Catlett, OWCP interpreted his September 3, 2013 report as attributing appellant's current right lower extremity complaints to, among other things, a prolonged commute dating back to November 2011. It concluded that appellant's prolonged commute represented a new work factor, and advised that he file a separate occupational disease (Form CA-2) claim. Regarding Dr. Salander's findings, OWCP noted that the second opinion physician attributed appellant's disability as of October 2013 solely to the newly diagnosed conditions of cellulitis and RSD, which have not been accepted as related to the December 18, 2013 employment injury.

Appellant requested an oral hearing before an OWCP hearing representative, which was held on February 27, 2015. Appellant's counsel argued that Dr. Salander's opinion established a causal relationship between the claimed disability beginning October 7, 2013 and the December 18, 2003 employment injury. He also argued that OWCP misinterpreted Dr. Catlett's September 3, 2013 report. Lastly, counsel challenged OWCP's finding that appellant's so-called prolonged commute represented a new work exposure.

By decision dated May 14, 2015, the hearing representative affirmed OWCP's September 18, 2014 decision, finding that the evidence of record failed to establish that appellant was disabled due to a material worsening of the accepted work-related conditions. She noted that Dr. Salander examined appellant on July 22, 2014 and "advised that [appellant had] been disabled since October 2013 due to the occurrence of cellulitis and new pain, swelling and tenderness which [represented] regional sympathetic pain syndrome." The hearing representative then concluded that appellant had not "submitted any detailed rationalized medical evidence to support that his claim for disability [was] causally related to the accepted work injury…."

LEGAL PRECEDENT

A recurrence of disability means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition, which resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness.[11] Recurrence of disability also means an inability to work that takes place when a light-duty assignment made specifically to accommodate an employee's physical

[11] 20 C.F.R. § 10.5(x).

limitations due to his or her work-related injury or illness is withdrawn or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations.[12] Generally, a withdrawal of a light-duty assignment would constitute a recurrence of disability where the evidence established continuing injury-related disability for regular duty.[13] A recurrence of disability does not apply when a light-duty assignment is withdrawn for reasons of misconduct, nonperformance of job duties or other downsizing or where a loss of wage-earning capacity determination is in place.[14] Absent a change or withdrawal of a light-duty assignment, a recurrence of disability following a return to light duty may be established by showing a change in the nature and extent of the injury-related condition such that the employee could no longer perform the light-duty assignment.[15]

Where an employee claims a recurrence of disability due to an accepted employment-related injury, he or she has the burden of establishing that the recurrence is causally related to the original injury.[16] This burden includes the necessity of furnishing evidence from a qualified physician who concludes that the condition is causally related to the employment injury.[17] The physician's opinion must be based on a complete and accurate factual and medical history and supported by sound medical reasoning.[18]

ANALYSIS

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. The claimant has the burden to establish his claim for compensation; however, OWCP shares responsibility in the development of the evidence to see that justice is done.[19] In this instance, an OWCP hearing representative previously remanded appellant's recurrence claim for further medical development. Specifically, she instructed OWCP to refer appellant to a second opinion specialist to determine if he continued to exhibit symptomatology causally related to the December 18, 2003 work-related injury, and if so, whether he was disabled beginning October 7, 2013. In accordance with the hearing representative's instructions, OWCP referred appellant to Dr. Salander. The current record includes Dr. Salander's initial July 22, 2014 report, and three addendums dated July 29, August 6, and September 9, 2014.

[12] *Id.*

[13] *Id.*; Federal (FECA) Procedure Manual, Part 2 -- Claims, *Recurrences*, Chapter 2.1500.6a(4) (June 2013).

[14] 20 C.F.R. §§ 10.5(x), 10.104(c) and 10.509; *see* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Recurrences*, Chapter 2.1500.2b (June 2013).

[15] *Theresa L. Andrews*, 55 ECAB 719, 722 (2004).

[16] 20 C.F.R. § 10.104(b); *see* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Recurrences*, Chapter 2.1500.5 and 2.1500.6 (June 2013).

[17] *See S.S.*, 59 ECAB 315, 318-19 (2008).

[18] *Id.* at 319.

[19] *William J. Cantrell*, 34 ECAB 1223 (1983).

Based on a review of Dr. Salander's several reports, it is unclear whether he has a full appreciation of the current accepted conditions as outlined in the June 11, 2014 SOAF. His July 22, 2014 diagnoses included chronic venous insufficiency, recurrent cellulitis, and chronic regional pain syndrome of the right lower extremity, which are not among the current accepted conditions.[20] A physician's opinion on causal relationship must be based on a complete factual and medical background and must be supported by medical rationale.[21] Under the circumstances, additional clarification is necessary.[22] Once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[23]

On remand, OWCP shall obtain clarification from Dr. Salander regarding whether appellant's claimed disability on or after October 7, 2013 is causally related to his December 18, 2013 employment injury. Dr. Salander should also clarify whether appellant's claim should be expanded to include any additional conditions. After OWCP has developed the medical record consistent with the above-noted directive, it shall issue a *de novo* decision.

CONCLUSION

The case is not in posture for decision.

[20] It is unclear whether Dr. Salander believes these conditions have already been accepted or if he is encouraging OWCP to accept them based on his opinion that they are related to appellant's December 18, 2003 employment injury.

[21] *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[22] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *OWCP Directed Medical Examinations*, Chapter 3.500.3f(2) (July 2011). As noted, once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case. *Richard F. Williams*, 55 ECAB 343, 346 (2004).

[23] *Richard F. Williams, id.*

ORDER

IT IS HEREBY ORDERED THAT the May 14, 2015 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: August 23, 2016
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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