United States Department of Labor
Employees' Compensation Appeals Board

W.H., Appellant	)	
and	)	**Docket No. 16-1047**
	)	**Issued: October 25, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Port Chester, NY, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On April 22, 2016 appellant filed a timely appeal from a December 9, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether OWCP met its burden of proof to terminate appellant's wage-loss compensation and medical benefits effective March 23, 2015 as she had no further disability or need for medical treatment due to her November 10, 2005 employment injury; (2) whether she met her burden of proof to establish that she had continuing employment-related disability subsequent to March 23, 2015; and (3) whether appellant sustained a traumatic brain injury and/or postconcussion syndrome causally related to her November 10, 2005 employment injury.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On November 21, 2005 appellant, then a 37-year-old postmaster, filed a traumatic injury claim (Form CA-1) alleging that on November 10, 2005 she sustained multiple injuries after she fell down stairs. She stopped work on November 11, 2005 and did not return. OWCP accepted the claim for a closed fracture of the nasal bone, vertigo, a broken tooth, a laceration of the liver, an open lip wound, a left black eye, and a lesion of the ulnar nerve (complex regional pain syndrome) of the right hand. It paid appellant compensation for total disability beginning February 19, 2006.

Appellant was admitted to the hospital following her injury from November 10 to 17, 2005. In a November 17, 2005 discharge summary, Dr. Jay A. Yelon, an osteopath, noted that appellant fell down a flight of 10 to 14 stairs and that a witness indicated that she lost consciousness or was unresponsive for an unknown duration. He noted that appellant experienced vertigo and headaches at the hospital. A magnetic resonance imaging (MRI) scan of the brain dated November 15, 2005 was normal. Dr. Yelon diagnosed a fall, liver laceration, oral trauma, and benign positional vertigo.

Dr. Yelon, on January 9, 2006, advised that he had treated appellant at the hospital on November 10, 2005 after she fell down a flight of stairs sustaining a grade III liver injury, facial fractures, dental fractures, and a mild traumatic brain injury. He found that she was permanently disabled and referred her to a "neuropsychologist for her postconcussive syndrome."

In a report dated November 10, 2006, Dr. Andrew Decker, a Board-certified neurologist and OWCP referral physician, diagnosed complex regional pain syndrome of the right hand, postconcussion syndrome with "postconcussion headaches and problems with memory and attention as well as altered personality," postconcussion vertigo, insomnia, difficulties with depth perception, small disc herniations at C3-4, and annual tears at L4-5 and L5-S1. He attributed the diagnosed conditions to the November 10, 2005 employment injury and found that appellant was totally disabled.

On March 3, 2008 Dr. Decker reevaluated appellant at the request of OWCP. He diagnosed complex regional pain syndrome, postconcussion syndrome including headaches and difficulty with memory and attention, postconcussion vertigo, insomnia, and continued neck and back pain due to her November 10, 2005 work injury. Dr. Decker opined that appellant had reached maximum medical improvement and was permanently disabled.

Appellant continued to receive treatment following her injury. An October 16, 2009 MRI scan of the brain showed a focal cystic cavitation and a small amount of gliosis unchanged since a prior study. A November 17, 2013 computerized tomography (CT) scan of the brain showed no abnormality. A December 18, 2013 MRI scan study of the brain showed no abnormal decreased white matter but indicated that 70 percent of mild traumatic brain injuries did not show decreased white matter. The study further found "[a]nterior corpus callosal focal encephalomalacia and gliosis, possibly posttraumatic in nature."

On January 16, 2014 Dr. Robert J. Friedman, an attending Board-certified neurologist, diagnosed a history of a mild traumatic brain injury, post-traumatic headaches with some

features of migraines, and a sleep disturbance. He noted that a brain MRI scan study showed "a small cystic area in the anterior corpus callosum," but was otherwise normal. Dr. Friedman recommended Botox injections to treat the headaches. In a March 19, 2014 status report, he noted that the Botox injections did not provide relief. On October 1, 2014 Dr. Friedman discussed appellant's continued "intractable headaches" that were not helped with Botox injections. He indicated that he should rule out a traumatic brain injury and diagnosed post-traumatic headaches with features of a migraine, chronic migraine, and sleep disturbance.

The Office of Inspector General (OIG) with the employing establishment conducted an investigation from July 29 to December 6, 2014. In an investigative report dated December 10, 2014, an investigator related that appellant performed physical activities during this time without evidence of pain, including "bending, reaching, lifting, and driving." The investigator related, "Specifically, [appellant] was videotaped shopping, visiting a country club on several occasions, going to a horse stable, participating in leisure activities, and carrying a large Christmas tree."

OWCP, in a memorandum to the file, described the contents of photographic and video evidence obtained by the OIG's office. It noted that the video showed appellant driving her car, carrying bags from a supermarket, pumping gas, and loading and unloading a Christmas tree.

On January 5, 2015 OWCP referred appellant to Dr. Melvin Grossman, a Board-certified neurologist, for a second opinion examination. In its referral letter to appellant, it advised her that it was sending surveillance video and photographs to the physician.

In a report dated January 21, 2015, Dr. Grossman reviewed the history of injury and the medical record. On examination he found no postural dizziness with movement of the head and neck, no antalgia, tenderness of the right neck but full motion, a negative straight leg raise, and blunted sensation to vibration of the right knee. Dr. Grossman advised that appellant had no evidence of a cervical or lumbar condition based on the neurological examination. He opined that the November 17, 2001 CT scan of the brain and December 8, 2013 MRI scan study of the brain were normal and that a July 2014 electromyogram/nerve conduction velocity (EMG/NCV) study showed possible left ulnar neuropathy. Dr. Grossman determined that the surveillance video showed that appellant had no difficulties using her arms, hands, legs, and feet or with balance, but noted that she had not complained of cervical or lumbar difficulties on examination. He asserted that the surveillance video would neither "include or disclude the possibility of migraines or vertigo." Dr. Grossman indicated that appellant's current complaints of vertigo and headaches were subjective in nature and had "not resolved based on the information at hand." He diagnosed chronic daily headaches and vertigo without objective correlation and noted that she only occasionally took medication for her headaches. Dr. Grossman opined that appellant could work as a postmaster or in another sedentary or light-duty capacity, but that he was "not certain if that would trigger headaches or vertigo if some of the vertigo has been postural." He recommended vocational rehabilitation to see if activity caused either headaches or vertigo and an evaluation by an otolaryngologist with further objective testing to confirm whether she experienced vertigo. Dr. Grossman found no work restrictions based on the normal neurological examination. He concluded, "The migraine headaches are extremely subjective as is vertigo and it [is] very hard to come to any further statements in terms of the lack of objectivity." In a work restriction evaluation dated January 21, 2015, Dr. Grossman found that appellant could perform

her usual position and provided limitations of no twisting, bending/stooping, or climbing, and no lifting more than 10 to 20 pounds.

OWCP notified appellant on February 9, 2015 of its proposed termination of her wage-loss and medical benefits as she had no residuals of her accepted employment injury.

In a report dated February 18, 2015, Dr. Friedman related that appellant "has post-traumatic headaches that are a direct result of her November 10, 2005 work injury. Appellant has a postconcussion syndrome/mild traumatic brain injury that is related to that injury. She may have depression that needs to be treated." Dr. Friedman opined that appellant was unable to return to her usual employment.

Dr. Janet Tamai, an osteopath, evaluated appellant on March 2, 2015 for headaches, nausea, arm pain, and vertigo. She obtained a history of her experiencing "multiple medical and neurological problems that resulted from a fall down a flight of stairs at her workplace in November 2005." Dr. Tamai noted that appellant had a history of syncope and reviewed her complaints of severe headaches, light sensitivity, a painful right arm and hand, vertigo, and migraines treated with medication. On examination she found sensitivity to cold on the right side and 4/5 muscle strength of the right hand. Dr. Tamai diagnosed a traumatic brain injury, concussion syndrome, panic attacks, complex regional pain syndrome of the right upper extremity, migraines, insomnia, and vertigo of central origin. She reviewed the December 18, 2013 brain MRI scan study and its finding of post-traumatic anterior corpus callosal focal encephalomalacia and gliosis. Dr. Tamai attributed appellant's condition to her accepted employment injury and advised that she was totally disabled from employment.

Appellant, on March 9, 2015, challenged the proposed termination of her compensation. She noted that she had consistently sought medical treatment subsequent to her fall in November 2005.

In a March 23, 2015 decision, OWCP terminated appellant's wage-loss and medical benefits effective that date. It found that Dr. Grossman's report represented the weight of the evidence and established that she had no further disability or residuals of her accepted conditions arising from the November 10, 2005 work injury. OWCP also indicated that reports from appellant's physicians did not establish any other injury-related conditions.

On May 1, 2015 Dr. Stephanie Renfrow, a clinical psychologist, discussed the difficulties with appellant's emotions and cognition subsequent to a November 10, 2005 fall. She reviewed appellant's history of a fall down a flight of stairs on November 10, 2005 and subsequent hospitalization, noting that appellant relearned walking, talking, and driving over the course of several months. Dr. Renfrow indicated that appellant and her husband divorced and her daughter had adjustment issues as a result of appellant's impairment from her brain injury. Following testing, she opined that appellant "most likely suffers from mild neurocognitive impairment resulting from a head injury accrued as a result of her accident on November 10, 2005.…" Dr. Renfrow diagnosed a mild neurocognitive disorder due to a traumatic brain injury and recurrent, severe major depressive disorder with anxious distress.

On May 29, 2015 OWCP noted that appellant had requested a copy of the surveillance video. It provided her with a copy on June 10, 2015.

Dr. Tamai, in an August 6, 2015 report, discussed appellant's history of falling down a flight of concrete stairs on November 10, 2005, resulting in hospitalization due to a lacerated liver, facial and dental fractures, and a mild traumatic brain injury. Following her injury appellant could not walk due to vertigo. Dr. Tamai related that brain MRI scan studies in October 2009 and December 2013 were abnormal. She reviewed the surveillance and found that it did "not indicate any physical activities which [appellant] has claimed she cannot perform and does not indicate [she] has misrepresented her medical conditions." Dr. Tamai further opined that the video evidence was irrelevant to appellant's psychological disability. She advised, "The differential movement of the skull and the brain when [appellant's] head struck the concrete stairs resulted in direct brain injury due to diffuse axonal shearing and contusion." Dr. Tamai related:

> "Traumatic brain injury occurs when an external mechanical force causes brain dysfunction. [Appellant] sustained a closed head injury when she fell down the stairs at work; the violent blow to her head striking the concrete stairs caused a traumatic brain injury. This is what caused a loss of consciousness for several hours. [Appellant's] traumatic brain injury was diagnosed immediately after the fall during her hospitalization.
>
> "Brain injuries do not heal like other injuries. Secondary neurological damage does not all occur immediately at the moment of impact but evolves afterward. Recovery is a functional recovery, based on mechanisms that remain uncertain and no two brain injuries are alike."

Dr. Tamai advised that appellant developed white matter lesions, encephalomalacia, and gliosis as demonstrated on MRI scan studies due to her November 11, 2005 injury. She noted that encephalomalacia and gliosis caused brain damage and that symptoms "include lack of coordination, vertigo, and headache." Dr. Tamai further diagnosed postconcussion syndrome causing symptoms that included headaches, lack of concentration, a sleep disorder, and vertigo due to the November 10, 2005 employment injury. She noted that appellant received a diagnosis of vertigo "immediately after the fall during her hospitalization." Dr. Tamai additionally diagnosed post-traumatic headaches, syncope, and major depressive disorder as a result of her November 2005 fall. She concluded:

> "[Appellant] suffered a diffuse axonal injury as a result of the fall on November 10, 2005. The injury is a result of the brain moving back and forth in the skull as a result of acceleration and deceleration. When acceleration or deceleration causes the brain to move within the skull, axons, the parts of the nerve cells that allow neurons to send messages between them are disrupted. As tissue slides over tissue, a shearing injury occurs."

Dr. Tamai advised that losing consciousness was the primary symptom of a diffuse axonal injury. She opined that appellant was unable to work as a postmaster.

On September 21, 2015 appellant requested reconsideration. In a September 14, 2015 statement, she argued that OWCP posed leading questions to Dr. Grossman when it asked if it was more medically probable that her ongoing symptoms were due to the accepted conditions or the progression of a preexisting problem. Appellant also contended that OWCP submitted the surveillance video to Dr. Grossman without informing her until its termination decision or providing her with a copy of the investigative report and video. She noted that the copy she received upon request did not indicate whether it was edited. Appellant contended that Dr. Grossman found that she still had residuals of her vertigo and did not address her ulnar nerve lesion. She asserted that his report was equivocal and not reasoned. Appellant argued that she submitted sufficient evidence to outweigh his opinion.

By decision dated December 9, 2015, OWCP denied modification of its March 23, 2015 decision. It found that Dr. Renfrow's report was not rationalized and referred to problems with family members. OWCP further found that neither Dr. Renfrow nor Dr. Tamai explained how the surveillance video confirmed a lack of difficulty with cognition.

On appeal appellant questions OWCP's finding that the report from Dr. Renfrow was of little probative value and that her emotional condition resulted from family difficulties. She maintains that the opinion of Dr. Tamai is entitled to more weight than the opinion of Dr. Grossman, who conducted a cursory examination. Appellant also notes that, contrary to Dr. Grossman's finding, she took multiple medications for migraines over the years.

LEGAL PRECEDENT -- ISSUE 1

Once OWCP accepts a claim and pays compensation, it has the burden of justifying modification or termination of an employee's benefits. It may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[2] OWCP's burden of proof in terminating compensation includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[3]

The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability compensation.[4] To terminate authorization for medical treatment, OWCP must establish that appellant no longer has residuals of an employment-related condition which require further medical treatment.[5]

ANALYSIS -- ISSUE 1

OWCP accepted that appellant sustained a closed fracture of the nasal bone, vertigo, a broken tooth, a laceration of the liver, an open lip wound, a left black eye, and a lesion of the ulnar nerve, or complex regional pain syndrome, of the right hand as a result of a fall down stairs

[2] *Elaine Sneed*, 56 ECAB 373 (2005); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

[3] *Gewin C. Hawkins*, 52 ECAB 242 (2001).

[4] *T.P.*, 58 ECAB 524 (2007); *Pamela K. Guesford*, 53 ECAB 727 (2002).

[5] *Id*.

on November 10, 2005. She stopped work on November 10, 2005 and received compensation from OWCP. In a decision dated March 23, 2015, OWCP terminated appellant's compensation effective that date after finding that the opinion of Dr. Grossman, who provided a second opinion examination, established that she had no further disability or residuals arising from the November 10, 2005 employment injury.

The Board finds that Dr. Grossman's opinion is insufficient to support the termination of either appellant's wage-loss compensation or authorization for medical benefits. In his report dated January 21, 2015, Dr. Grossman found no evidence of a cervical or lumbar condition based on the neurological examination and that the surveillance video established that she had no difficulty using her hands, arms, legs, and feet. He found no objective evidence supporting appellant's complaints of headaches and vertigo. Dr. Grossman diagnosed chronic daily headaches and vertigo without objective support. He further indicated that appellant's headaches and vertigo had "not resolved based on the information at hand" and that the surveillance video neither proved nor disproved "the possibility of migraines or vertigo." Dr. Grossman advised that she could work in her usual employment or other sedentary or light duty, but opined that such activity might trigger either the headaches or vertigo. He recommended an evaluation by an otolaryngologist and objective testing to further investigate the vertigo and a referral for vocational rehabilitation to see if activity resulted in headaches or vertigo. Dr. Grossman's report is internally inconsistent as he found that appellant had no objective evidence of an accepted condition but further determined that work activity might trigger the accepted condition of vertigo. Additionally, he recommended further diagnostic testing to corroborate the vertigo. Dr. Grossman's opinion regarding whether appellant had any continuing disability or need for medical treatment due to her November 10, 2005 employment injury is thus equivocal in nature and not of a sufficient degree of medical certainty to support a termination of compensation.[6] OWCP did not ask Dr. Grossman to clarify his report.

The remaining evidence received by OWCP prior to its March 23, 2015 termination is insufficient to meet its burden of proof. Instead, the evidence supports that appellant had residuals from her work injury. Dr. Friedman, in a report dated February 18, 2015, found that appellant was unable to return to work as a result of her November 10, 2005 employment injury. On March 2, 2015 Dr. Tamai diagnosed multiple conditions, including vertigo and complex regional pain syndrome of the right upper extremity as a result of appellant's work injury. She opined that appellant was totally disabled.[7] The Board, consequently, finds that OWCP failed to meet its burden of proof to terminate appellant's wage-loss compensation and authorization for medical treatment.[8]

[6] *See A.H.*, Docket No. 15-0557 (issued May 8, 2015); *P.B.*, Docket No. 13-0636 (issued November 14, 2013).

[7] As appellant's argument that she was unaware of the surveillance video until OWCP's termination of her compensation, the Board notes OWCP disclosed the existence of the video in its January 5, 2015 letter referring her to Dr. Grossman. There is no evidence of wrongdoing on the part of OWCP with regard to the video. *See N.M.*, Docket No. 15-1553 (issued March 2, 2016); *R.B.*, Docket No. 15-0420 (issued August 10, 2015).

[8] In view of the Board's disposition of the termination of appellant's compensation, the issue of whether she has established that she had continuing employment-related disability subsequent to March 23, 2015 issue 2, is moot.

LEGAL PRECEDENT -- ISSUE 3

Appellant bears the burden of proof to establish that a condition not accepted or approved by OWCP is causally related to an employment injury.[9] Causal relationship is a medical issue, and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[10] The opinion of the physician must be based on a complete factual and medical background of the claimant,[11] must be one of reasonable medical certainty[12] explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[13]

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility to see that justice is done.[14] The nonadversarial policy of proceedings under FECA is reflected in OWCP's regulations at section 10.121.[15]

ANALYSIS -- ISSUE 3

Appellant received treatment in the hospital following her November 10, 2005 fall from Dr. Yelon. On January 9, 2006 Dr. Yelon diagnosed a grade III liver injury, facial fractures, dental fractures, and a mild traumatic brain injury. He further found that she had vertigo "presumably secondary to her traumatic brain injury." Dr. Yelon attributed the conditions to appellant's November 10, 2005 work injury and advised that she was permanently disabled from employment. OWCP accepted appellant's claim for a closed fracture of the nasal bone, vertigo, a broken tooth, a laceration of the liver, an open lip wound, a left black eye, and a lesion of the ulnar nerve of the right hand.

The Board finds that the case is not in posture for decision regarding whether appellant's claim should be expanded to include a traumatic brain injury or postconcussion syndrome. Appellant submitted medical evidence from Dr. Friedman, Dr. Renfrow, and Dr. Tamai supporting that she sustained additional conditions due to her work injury. The evidence from OWCP's physician, Dr. Decker, also supports additional work-related conditions. In reports dated November 10, 2006 and March 3, 2008, Dr. Decker found that appellant sustained, in addition to the accepted conditions, postconcussion syndrome causing headaches and difficulty with attention and memory.

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[9] *See V.B.*, Docket No. 12-0599 (issued October 2, 2012); *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[10] *John J. Montoya*, 54 ECAB 306 (2003).

[11] *Tomas Martinez*, 54 ECAB 623 (2003); *Gary J. Watling*, 52 ECAB 278 (2001).

[12] *Supra* note 10.

[13] *Judy C. Rogers*, 54 ECAB 693 (2003).

[14] *Jimmy A. Hammons*, 51 ECAB 219 (1999).

[15] 20 C.F.R. § 10.121.

Dr. Friedman, on February 18, 2015, diagnosed post-traumatic headaches and postconcussion syndrome/mild traumatic brain injury due to her November 10, 2005 injury. In a report dated March 2, 2015, Dr. Tamai diagnosed a traumatic brain injury, concussion syndrome, panic attacks, migraines, insomnia, as well as vertigo and complex regional pain syndrome of the right upper extremity. She advised that a December 18, 2013 MRI scan study of appellant's brain showed post-traumatic changes. Dr. Tamai attributed the diagnosed conditions to the work injury.

Dr. Renfrow, on May 1, 2015, performed psychological testing and found a probable mild neurocognitive impairment from the November 10, 2005 head injury. She also diagnosed major depressive disorder with anxiety.

On August 6, 2015 Dr. Tamai discussed appellant's history of falling down concrete stairs on November 10, 2005 and subsequent hospitalization. She advised that the October 2009 and December 2013 brain MRI scan studies showed abnormal white matter lesions, encephalomalacia, and gliosis. Dr. Tamai reviewed the surveillance video and found that it did not show any misrepresentation of a medical condition. She explained the mechanism by which appellant striking her head on the stairs caused diffuse axonal shearing and contusion and a "direct brain injury." Dr. Tamai noted that appellant's traumatic brain injury was diagnosed immediately after her fall and that she experienced vertigo while in the hospital for her fall. She also diagnosed postconcussion syndrome causing headaches, reduced concentration, a sleep disorder, and vertigo as a result of the November 10, 2005 work injury.

As noted, proceedings under FECA are not adversarial in nature and while appellant has the burden of establishing entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.[16] Dr. Tamai, Dr. Renfrow, and Dr. Friedman diagnosed additional conditions resulting from the November 10, 2005 work injury, including headaches, problems with cognition, a traumatic brain injury, and postconcussion syndrome. Although their reports are insufficiently rationalized to meet appellant's burden of proof, they stand uncontroverted in the record and raise an inference of causal relationship sufficient to require further development by OWCP.[17] Accordingly, the Board finds that the case must be remanded to OWCP. On remand, it should further develop the medical record to determine whether appellant sustained additional conditions causally related to her accepted employment injury. Following this and such further development as OWCP deems necessary, it shall issue an appropriate decision.

CONCLUSION

The Board finds that OWCP improperly terminated appellant's wage-loss compensation and medical benefits effective March 23, 2015 as she had no further disability or need for medical treatment due to her November 10, 2005 employment injury. The Board further finds that the case is not in posture for decision regarding whether she sustained a traumatic brain

[16] *Phillip L. Barnes*, 55 ECAB 426 (2004).

[17] *Id.*; *see also C.V.*, Docket No. 14-1940 (issued May 26, 2015).

injury and/or postconcussion syndrome causally related to her November 10, 2005 employment injury.

ORDER

IT IS HEREBY ORDERED THAT December 9, 2015 decision of the Office of Workers' Compensation Programs is reversed and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: October 25, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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