United States Department of Labor
Employees' Compensation Appeals Board

J.G., Appellant	)	
and	)	**Docket No. 24-0265**
	)	**Issued: April 23, 2024**
DEPARTMENT OF HOMELAND SECURITY, U.S. CUSTOMS AND BORDER PROTECTION, Laredo, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On January 23, 2024 appellant filed a timely appeal from a November 28, 2023 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] 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] Appellant submitted a timely request for oral argument before the Board, explaining his disagreement with OWCP's decision. 20 C.F.R. § 501.5(b). Pursuant to the Board's *Rules of Procedure*, oral argument may be held in the discretion of the Board. 20 C.F.R. § 501.5(a). The Board, in exercising its discretion, denies appellant's request for oral argument because arguments on appeal can be adequately addressed in a decision based on a review of the case record. Oral argument in this appeal would further delay issuance of a Board decision and not serve a useful purpose. As such, the oral argument request is denied, and this decision is based on the case record as submitted to the Board.

[2] 5 U.S.C. § 8101 *et seq*.

ISSUE

The issue is whether appellant has met his burden of proof to establish a medical condition causally related to the accepted factors of his federal employment.

FACTUAL HISTORY

On August 30, 2023 appellant, then a 59-year-old customs and border protection officer, filed an occupational disease claim (Form CA-2) alleging that he sustained cardiac atrial flutter (heart rhythm disorder), cardiac arrhythmia (abnormal heart electrical impulses), cardiac atrial fibrillation (irregular rapid heart rate), bradycardia (slow heart rate), and stroke (cerebrovascular accident) as a result of extremely stressful conditions causally related to factors of his federal employment. He noted that he endured considerable and strenuous physical exertion, which included long periods of standing, walking, and running, bending, stooping, crouching, lifting, carrying, reaching overhead, pushing, pulling, crawling, climbing, kneeling, working in confined spaces, sitting, performing an extreme amount of shift work, driving, writing, use of his vision, comprehension/reading, and communication.

In an undated statement, appellant recounted a history of his employment and medical treatment. He also noted that he had retired on July 31, 2021.

In support of his claim, appellant submitted medical records, including hospital records dated April 4, 2014 through September 23, 2023. The April 4, 2014 hospital record indicated that he had undergone ablation of atrial flutter on that date. A hospital record dated August 23, 2018, indicated that appellant had undergone another atrial flutter ablation procedure on that date. The other records provided diagnoses of daily persistent headache, paroxysmal atrial fibrillation, Type 2 diabetes mellitus without complication and without long-term current use of insulin, mixed hyperlipidemia, and essential primary hypertension.

In an October 30, 2018 progress note, Dr. Carlos A. Roman, an attending Board-certified internist, recounted appellant's medical history, including his atrial flutter ablation procedures. He related that appellant currently had several episodes of brief ectopic atrial tachycardia. Dr. Roman related that appellant continued to work in a very stressful job and had been on light duty. He opined that appellant could return to work, but should not be placed under additional stresses.

In a February 5, 2019 progress note, Dr. Roman reviewed appellant's history of present illness and noted his findings on physical examination. He assessed typical atrial flutter and continuous use of anticoagulation medication.

In a May 11, 2020 brain magnetic resonance imaging (MRI) scan report, Dr. James. E. Hammond, a Board-certified diagnostic radiologist, provided an impression of minor chronic small vessel ischemic change.

On May 17, 2021 Dr. Alex J. Blanco, a Board-certified family practitioner, reported that he had been treating appellant for heart disease and cardiac arrhythmias. Appellant had recently reported increased weakness, fatigue, and lethargy, which he believed could be remedied by adjusting his medications. Dr. Blanco advised that appellant should perform light duty, which

would not require running, heavy lifting, or extreme physical activity. He related that these restrictions were temporary.

A June 21, 2021 hospital record, recounted appellant's multiple risk factors of diabetes, hypertension, hyperlipidemia, and atrial fibrillation. It related that appellant woke up that morning with chest pain, palpitations, lightheadedness, left arm and leg numbness.

A June 21, 2021 computerized tomography (CT) scan of the brain read by Dr. Kevin C. Ching, Board-certified in interventional and diagnostic radiology, revealed no evidence of acute intracranial findings and probable chronic sinusitis of the left maxillary sinus.

In patient discharge instructions dated June 21, 2021 and a discharge summary dated June 24, 2021, Dr. Blanco, provided diagnoses of chronic paroxysmal atrial fibrillation with rapid ventricular response (RVR), benign essential hypertension, chest pain, stroke, cerebral vascular accident (CVA), elevated cholesterol, stroke risk, and controlled Type 2 diabetes mellitus.

In a July 2, 2021 note, Dr. Blanco related that appellant had recently been treated for a stroke. He recommended that appellant be placed on modified duty, as he was at risk if required to perform highly vigorous and physical activity as sometimes required by law enforcement.

In an April 12, 2022 report, Dr. Roman noted that appellant wore a 72-hour echocardiography (ECG) Holter monitor, which revealed typical atrial flutter.

In a July 26, 2022 electrocardiogram report, Dr. Roman assessed paroxysmal atrial fibrillation.

OWCP, by development letter dated September 5, 2023, informed appellant of the deficiencies of his claim. It advised him of the type of factual and medical evidence necessary to establish his claim and provided a questionnaire for his completion. OWCP afforded appellant 60 days to respond.

In a September 8, 2023 response and completed questionnaire, appellant described his work duties and the physical demands of his position. Additionally, he described the medical treatment he had received.

Appellant also submitted additional medical evidence. Dr. Roman, in a September 12, 2018 report, related that he had performed an electrophysiologic study, three-dimensional mapping, and catheter ablation of cavotricuspid isthmus.

A February 21, 2019 cardiac perfusion study read by Dr. Ralph Nimchan, a Board-certified internist, revealed a normal left ventricular, left ventricular ejection fraction, left ventricular systolic function, and left ventricular wall motion; moderately dilated left atrium; moderately-to-severely dilated right atrium; transmittal spectral Doppler flow pattern was suggestive of impaired left ventricular relaxation; mild tricuspid regurgitation; mild mitral regurgitation; and mitral valve leaflets appeared thickened, but open well.

In a June 21, 2021 report, Dr. Osama A. Jamil, a Board-certified neurologist, discussed his examination findings and provided assessments of acute ischemic stroke, cerebral infarction due to embolism of right middle cerebral artery, and cerebral infarction due to embolism of right

anterior cerebral artery atherosclerosis. In another report also dated June 21, 2021, Dr. Debra Kennamer Chester, a Board-certified family practitioner, noted a history of appellant's current illness and her examination findings. She provided impressions of CVA and stroke.

In an April 15, 2022 progress note, Dr. Roman noted a history of appellant's current illness. He reiterated his prior assessments of paroxysmal atrial fibrillation, typical atrial flutter, history of CVA, and continuous oral anticoagulation. Dr. Roman also provided an assessment of anxiety. On April 18, 2022 he again performed an electrophysiologic study and three-dimensional mapping. Dr. Roman also performed pulmonary vein isolation, intracardiac ECG, transeptal access, and program stimulation for arrhythmia induction.

Dr. Roman, in a November 16, 2022 report, again diagnosed atrial fibrillation palpitations. In an operative report of even date, he performed an implantable loop recorder insertion.

In a report dated December 7, 2022, Dr. Roman reviewed appellant's medical history and diagnosed sick sinus syndrome and severe bradycardia. An operative report of even date indicated that appellant underwent pacemaker implementation.

In a progress report dated March 16, 2023, Dr. Roman related appellant's medical course. He also recounted that appellant had high levels of stress, had lived a very difficult life with forced labor since childhood, had deployed to multiple theaters with the military, and had just retired from the border patrol. Dr. Roman reiterated that appellant had a history of severe bradycardia, was status post pacemaker insertion, and currently started to have more sustained episodes of atrial fibrillation.

By decision dated November 28, 2023, OWCP denied appellant's occupational disease claim, finding that the medical evidence of record was insufficient to establish a medical condition or injury causally related to the accepted factors of his federal employment.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] 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,[4] 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.[5] 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.[6]

[3] *Id*.

[4] *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).

[5] *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).

[6] *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).

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[7]

Causal relationship is a medical question that requires rationalized medical opinion evidence to resolve the issue.[8] The opinion of the physician must be based upon a complete factual and medical background, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors.[9]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish a medical condition causally related to the accepted factors of his federal employment.

In support of his claim, appellant submitted a series of progress notes and reports from Dr. Roman dated October 30, 2018 through March 16, 2023. In these reports, Dr. Roman diagnosed typical and paroxysmal atrial fibrillation, history of CVA, anxiety, sick sinus syndrome, severe bradycardia, and long-term use of antiarrhythmic drug, a pacemaker, and oral anticoagulation medication. He also recounted a history that appellant worked a stressful job. However, Dr. Roman did not offer an opinion on causal relationship between appellant's diagnosed conditions and the accepted employment factors. The Board has held that medical evidence that does not offer an opinion regarding the cause of an employee's condition is of no probative value on the issue of causal relationship.[10] Therefore, this evidence is insufficient to establish appellant's claim.

The remaining reports by Drs. Blanco, Jamil, and Chester addressed appellant's heart, diabetes, stroke, and brain conditions and surgical treatment. However, they likewise failed to provide an opinion on causal relationship. As explained above, the Board has held that medical evidence that does not offer an opinion regarding the cause of an employee's condition is of no

[7] *P.L.*, Docket No. 19-1750 (issued March 26, 2020); *R.G.*, Docket No. 19-0233 (issued July 16, 2019); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, *id*.

[8] *I.J.*, Docket No. 19-1343 (issued February 26, 2020); *T.H.*, 59 ECAB 388 (2008); *Robert G. Morris*, 48 ECAB 238 (1996).

[9] *D.C.*, Docket No. 19-1093 (issued June 25, 2020); *see L.B.*, Docket No. 18-0533 (issued August 27, 2018).

[10] *T.S.*, Docket No. 23-0539 (issued September 19, 2023); *M.O.*, Docket No. 22-1035 (issued March 22, 2023); *J.B.*, Docket No. 21-0211 (issued March 21, 2023); *M.C.*, Docket No. 22-0992 (issued March 15, 2023); *D.H.*, Docket No. 20-1410 (issued December 21, 2022); *L.B.*, Docket No. 18-0533 (issued August 27, 2018); *D.K.*, Docket No. 17-1549 (issued July 6, 2018).

probative value on the issue of causal relationship.[11] Therefore, this evidence is also insufficient to establish the claim.

Appellant also submitted a series of diagnostic studies. The Board has held, however, that diagnostic studies, standing alone, lack probative value on the issue of causal relationship as they do not address the relationship between the accepted employment factors and the diagnosed conditions.[12]

A series of hospital records provided diagnoses of daily persistent headache, paroxysmal atrial fibrillation, Type 2 diabetes mellitus without complication and without long-term current use of insulin, mixed hyperlipidemia, and essential primary hypertension. However, they did not provide an opinion on causal relationship. As noted above, medical reports which do not offer an opinion on causal relationship are of no probative value.[13] Therefore, this evidence is insufficient to establish appellant's claim.

As the medical evidence of record is insufficient to establish a medical condition causally related to the accepted employment factors, the Board finds that appellant has not met his burden of proof.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish a medical condition causally related to the accepted factors of his federal employment.

[11] *Id.*; *see also T.D.*, Docket No. 22-1078 (issued November 10, 2022).

[12] *H.E.*, Docket No. 22-1129 (issued December 16, 2022); *S.S.*, Docket No. 21-1381 (issued December 7, 2022); *M.S.*, Docket No. 22-0586 (issued July 12, 2022); *M.T.*, Docket No. 20-0184 (issued June 24, 2022).

[13] *Supra* notes 11 and 12.

ORDER

IT IS HEREBY ORDERED THAT the November 28, 2023 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 23, 2024
Washington, DC

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

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

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