United States Department of Labor
Employees' Compensation Appeals Board

M.P., Appellant	)	
and	)	**Docket No. 23-1131**
	)	**Issued: June 18, 2024**
DEPARTMENT OF THE ARMY, U.S. ARMY INSTALLATION MANAGEMENT COMMAND, DEPARTMENT OF PUBLIC WORKS, Fort Greely, AK, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On August 22, 2023 appellant filed a timely appeal from a June 2, 2023 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.[2]

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish a recurrence of total disability commencing June 20, 2017 causally related to his accepted May 10, 2012

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the June 2, 2023 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*.

employment injury; and (2) whether appellant has met his burden of proof to expand the acceptance of his claim to include tinnitus, vertical nystagmus, and concussion causally related to the accepted May 10, 2012 employment injury.

FACTUAL HISTORY

On May 11, 2012 appellant, then a 59-year-old motor vehicle operator, filed a traumatic injury claim (Form CA-1) alleging that on May 10, 2012 when in the vehicle shop, he felt light-headed, sat on a trash can, blacked out, and fell face first to the floor, injuring the left side of his face and the bridge of his nose while in the performance of duty. In an accompanying statement, he explained that several hours prior to losing consciousness, he injured his left hamstring when crouching with his left leg extended to hook a ripper shank chain to a crawler bulldozer and the hook slipped, pulling him forward. Appellant stopped work on May 10, 2012. OWCP accepted the claim for abrasion or friction of face, neck, and scalp without infection, sprain of left hip and thigh, and neck sprain. It paid appellant wage-loss compensation on the supplemental rolls, effective July 16, 2012.

On July 25, 2012 appellant underwent OWCP-authorized surgical repair of an acute left proximal hamstring muscle avulsion. He returned to full-time modified work on September 10, 2012, and to full-duty work on November 5, 2012. Appellant remained under medical care.[3] OWCP paid appellant wage-loss compensation for intermittent work absences on the supplemental rolls through June 9, 2017.

In reports dated from June 1 through 16, 2017, Dr. Ray Andreassen, an osteopath specializing in family practice, recounted a history of the May 10, 2012 employment injury, noting appellant's worsening disequilibrium and increased left lower extremity pain. On examination, he observed swelling of the left calf. Dr. Andreassen diagnosed a left thigh injury with sequelae, left hamstring rupture, left lower extremity pain and edema, severe recurring positional vertigo, mental status reduction, cervical spondylosis with myelopathy, cervical radiculopathy, cervicalgia, giddiness, and dizziness. He opined that appellant's symptoms were directly related to the May 10, 2012 employment injury where he fell forward and landed on his face. Dr. Andreassen held appellant off work commencing June 16, 2017.[4]

On June 22, 2017 appellant filed a claim for compensation (Form CA-7) for disability from work for the period June 11 through 23, 2017.[5]

In a July 7, 2017 development letter, OWCP notified appellant that his claim for compensation implicated a recurrence of disability commencing June 20, 2017. It advised him of the additional factual and medical evidence needed and provided a questionnaire for his completion. OWCP afforded appellant 30 days to respond.

[3] In an August 31, 2016 report, Verna J. Schad, a family nurse practitioner, recounted that appellant experienced balance problems after "bouncing around on the tractor" or holding his head in certain positions.

[4] Dr. Andreassen reiterated these findings in reports dated from July 10 through 27, 2017.

[5] Appellant subsequently filed a series of CA-7 forms for disability from work for intermittent periods from June 26, 2017 through May 11, 2018.

In response, appellant submitted a series of reports dated July 5 through September 18, 2017 by Dr. Richard A. Mesher, a Board-certified psychiatrist and neurologist, recounting a history of the May 10, 2012 employment injury. On examination, Dr. Mesher observed mild edema of the left lower extremity, mild difficulty with tandem gait, and lateral wobbling on Romberg testing. Magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) scans of the brain were normal, and an MRI scan of the cervical spine demonstrated degenerative spondylosis without canal impingement. Dr. Mesher diagnosed a closed head injury causing vestibular dysfunction.

In a July 7, 2017 report, Dr. Daniel M. Zeitler, a Board-certified otolaryngologist, recounted a history of the May 10, 2012 employment injury and progressive disequilibrium. On examination, he observed "[u]p beating vertical nystagmus in gaze right and left positions," extinguished with fixation, which could indicate a central nervous system problem. Dr. Zeitler administered rotational chair sinusoidal testing and velocity step testing, which were normal.

In an August 10, 2017 narrative report, Dr. Andreassen diagnosed medial head biceps femoris tendon tear, degenerative cervical disc disease with myelopathy, cervical radiculopathy, lumbar spondylosis, medical meniscus tear, left hamstring rupture, mild proximal patellar tendinopathy, left eye contusion, upbeat vertical nystagmus, and possible cranial nerve damage. He opined that the force of the May 10, 2012 forward fall onto a concrete shop floor exacerbated preexisting cervical degenerative disc disease, causing spinal nerve impingement and cervical radiculopathy. Dr. Andreassen noted that a July 7, 2017 videonystagmography (VNG) study was within normal limits but that appellant's upbeating vertical nystagmus and impaired equilibrium could be caused by the occupational head injury. He found appellant totally and permanently disabled from work effective June 16, 2017.[6]

In reports dated September 5 and 14, 2017, Dr. Thomas B. Curtis, a Board-certified physiatrist, recounted a history of injury and treatment. He opined that appellant's left ischial pain was possibly due to pressure of fixation hardware or bursalgia. Dr. Curtis found appellant totally disabled from work commencing June 1, 2017.[7] In reports dated October 2, 2017, Dr. Peter S. Jiang, an anesthesiologist, diagnosed chronic regional pain syndrome of the left lower extremity, and chronic postoperative pain.

On October 2, 2017 OWCP referred appellant, along with the medical record, a statement of accepted facts (SOAF), and a series of questions to Dr. James Schwartz, a Board-certified orthopedic surgeon, for a second opinion to determine the status of appellant's accepted conditions and his work capacity.

[6] OWCP received additional reports from Dr. Andreassen dated from September 18, 2017 through May 8, 2018 reiterating prior findings and diagnoses. He continued to hold appellant off work.

[7] OWCP also received imaging studies. A July 6, 2017 cervical MRI scan demonstrated mild multilevel degenerative spondylosis, moderate left-sided foraminal narrowing at C4-5, and narrowing of the left subarticular recess at C6-7. A July 6, 2017 MRI scan of the brain demonstrated moderate scattered hyperintense foci in the deep white matter. A July 6, 2017 MRA scan of the head and neck was within normal limits. August 31, 2017 MRI scans of the left hip, bony pelvis, and left thigh demonstrated a metallic artifact indicative of prior surgical reattachment of the proximal hamstring tendon insertion.

In a November 7, 2017 report, Dr. Schwartz reviewed the medical record and SOAF, and noted findings on examination. He diagnosed possible central nervous system injury that did not appear work related and idiopathic cervical spondylosis. Dr. Schwartz opined that the accepted injuries had resolved, with residual swelling and tendinosis in the left hamstring. He opined that appellant could perform work at the medium physical demand level.

On January 25, 2018 OWCP referred appellant, along with the medical record, a SOAF, and a series of questions to Dr. Linda M. Wray, a Board-certified neurologist, for a second opinion to determine the status of appellant's accepted conditions and his work capacity.

In a February 13, 2018 report, Dr. Wray reviewed the SOAF and medical record. On examination of appellant, she observed a normal gait and unremarkable neurologic findings. Dr. Wray diagnosed a May 10, 2012 vasovagal episode due to acute pain, resulting in "a possible mild concussion, a cervical strain superimposed on preexisting multilevel cervical degenerative disease," dizziness and imbalance of unknown etiology, and worsening chronic left lower extremity pain and swelling without evidence of a neurologic diagnosis or cause. She opined that any neurologic condition caused by the May 10, 2012 employment injury had resolved without residuals. Dr. Wray returned appellant to full-duty work with no restrictions.

In reports dated from February 16 through April 2, 2018, Dr. Cary S. Keller, an orthopedic surgeon, diagnosed a left hamstring strain and bilateral pedal edema, left greater than right. He held appellant off work.[8] In reports dated from April 12 through 21, 2018, Dr. Jeffrey A. Zuckerman, a Board-certified radiologist, noted that diagnostic intra-articular injections did not relieve appellant's symptoms, while injections at the left hamstring attachment produced substantial relief. He diagnosed postoperative nerve damage, neurologic injury, and hamstring fibrosis.

OWCP determined that a conflict existed in the medical opinion evidence between the treating physician, Dr. Andreassen, and the referral physician, Dr. Schwartz, regarding the nature and extent of the accepted conditions and appellant's work capacity. It referred appellant, along with the medical record, a SOAF, and a series of questions to Dr. Alan B. Brown, a Board-certified orthopedic surgeon, to resolve the conflict.

In a May 14, 2018 report, Dr. Brown reviewed the medical record and SOAF. On examination, he noted tenderness to palpation over the left hamstring tendon insertion, pain with right-sided cervical spine rotation, and absent deep tendon reflexes at L4 and S1. Dr. Brown indicated that the only objective finding related to the accepted injuries was postsurgical status. He opined that the May 10, 2012 employment injury did not aggravate or exacerbate degenerative disc disease or degenerative joint disease. Dr. Brown noted the remote possibility that appellant's left lower extremity pain could be caused by an allergic reaction to the surgical anchor screws. He opined that from an orthopedic standpoint, appellant could resume his date-of-injury position as a motor vehicle operator without restrictions.

By decision dated July 6, 2018, OWCP found that appellant had not established a recurrence of disability commencing June 20, 2017 due to his accepted May 10, 2012 employment injury. It found that the opinion of the impartial medical examiner (IME), Dr. Brown, constituted

[8] OWCP continued to receive diagnostic studies.

the special weight of the medical evidence and established that appellant had not sustained a material change/worsening of the accepted work-related conditions.

OWCP received a June 21, 2018 report by Dr. Gary I. Molk, a Board-certified orthopedic surgeon, who observed pitting edema of the bilateral lower extremities. In reports dated from July 12 through September 13, 2018, Dr. Todd Capistrant, an osteopath Board-certified in family practice, diagnosed a postsurgical fascial defect, sacral segmental and somatic dysfunction, and segmental and somatic dysfunction of a lower extremity. Dr. Capistrant opined that appellant's worsening pain could be caused by metal breakdown in the surgical anchor screws.

In reports dated from July 25, 2018 through February 14, 2019, Dr. Andreassen opined that appellant remained disabled from work due to a systemic reaction to the surgical anchor screws as he had a strong sensitivity to nickel.[9] He attributed appellant's balance problems to previously unappreciated consequences of the May 10, 2012 fall.[10]

On April 4, 2019 appellant, through counsel, requested reconsideration.

In reports dated from February 4 through September 26, 2019, Dr. Andreassen opined that all of appellant's health issues originated with the accepted May 10, 2012 employment injury, OWCP-authorized surgery, and a reaction to the surgical anchor screws. OWCP received information from the manufacturer of the anchor screws used in the OWCP-authorized July 25, 2012 left hamstring tendon repair, indicating that the screws were made of a titanium alloy with a small percentage of nickel.

By decision dated June 27, 2019, OWCP denied modification of the July 6, 2018 decision.

In a report dated June 25, 2019, Dr. Andreassen related appellant's symptoms of increased left lower extremity swelling. In a July 22, 2019 report, Dr. Michael B. Gerhardt, a Board-certified orthopedic surgeon, obtained left hip x-rays demonstrating two anchors in the ischium near the surgical repair site. In a September 9, 2019 report, he explained that sciatic nerve neurolysis was required to address scar tissue formation causing sciatic nerve entrapment, which was indicated by appellant's symptoms of radicular pain when sitting. Dr. Gerhardt noted that hardware removal was indicated as appellant's metal allergy could contribute to his pain symptoms.

On October 10, 2019 appellant underwent OWCP-authorized left proximal hamstring repair, anchor screw removal, and sciatic nerve neurolysis. Dr. Gerhardt submitted progress notes dated from October 16 through November 4, 2019. He held appellant off work.

On June 25, 2020 appellant, through counsel, requested reconsideration. In an August 4, 2020 report, Dr. Andreassen recounted that following the October 10, 2019 surgery, appellant had regained his ability to drive, and his mobility and cognitive function had improved.

[9] September 21, 2018 metal sensitivity assay (MELISA) laboratory tests demonstrated appellant's strong sensitivity to nickel.

[10] In a January 15, 2019 report, Dr. Suezie Kim, a Board-certified orthopedic surgeon, opined that there was very little evidence that the anchor screws caused appellant's continuing left thigh pain, as a January 14, 2019 MRI scan of the left hip was negative for postsurgical complications.

In a September 23, 2020 development letter, OWCP notified appellant of the additional evidence needed to establish his claim for a recurrence of disability commencing June 20, 2017, and provided a questionnaire for his completion. It afforded him 30 days to respond.

In response, appellant, through his then-counsel, submitted a completed development questionnaire, signed on October 22, 2020. He noted that he performed full-duty work as a motor vehicle operator from November 15, 2012 through June 1, 2017, but continued to experience left lower extremity pain. Appellant asserted that bouncing and jerking motions while driving large vehicles and a batwing mower aggravated his dizziness, disequilibrium, and left lower extremity pain. From June 1 through 20, 2017, he performed light duty, entering computer data in an office setting. As these duties increased his dizziness, Dr. Andreassen held him off work commencing June 20, 2017. Appellant contended that his dizziness, disequilibrium, vertical nystagmus, and hearing loss were all related to the accepted May 10, 2012 employment injury.

OWCP received a September 17, 2018 report by Dr. Brian Samuel Droker, a Board-certified psychiatrist and neurologist, who observed upward nystagmus with sustained gaze, beating lateral nystagmus to the left. Dr. Droker opined that the temporal relationship to the occupational head injury suggested post-traumatic head injury sequelae. In a May 27, 2020 report, Dr. Gerhardt attributed appellant's left lower extremity symptoms to chronic nerve irritation. He recommended corticosteroid injections.

A September 3, 2020 CT scan of the pelvis demonstrated extraction of suture anchors in the left ischial tuberosity without signs of osteomyelitis or recurrent tear.

Appellant submitted reports by Dr. Andreassen dated from September 9 through December 11, 2020 diagnosing cervical spondylosis with myelopathy, and unspecified osteomyelitis. Dr. Andreassen noted continued head and left thigh pain with balance issues. In a September 18, 2020 report, Dr. Anthony Rumsey, a chiropractor, diagnosed atlas subluxation complex by x-ray. In a February 17, 2021 report, Dr. Nancy E. Cross, a Board-certified anesthesiologist and pain medicine physician, diagnosed multilevel cervical degenerative disc, cervical stenosis, cervical pain, cervical facet joint pain, left lower extremity pain, and low back pain.

In an August 27, 2021 development letter, OWCP advised appellant of the deficiencies of his claim for consequential conditions of nystagmus, right-sided hearing loss with tinnitus, and post-concussion syndrome. It afforded him 30 days to complete an attached questionnaire and submit additional evidence.

In response, appellant's then-counsel submitted appellant's completed development questionnaire, signed on September 16, 2021. Appellant noted tinnitus in his right ear beginning in October 2012 but advised that he was unsure if it was occupationally related as he had a history of sinus problems.

Appellant submitted additional evidence, including a February 6, 2013 report wherein Dr. Richard Raugust, a Board-certified otolaryngologist, noted that appellant reported experiencing vertigo for several months. Dr. Raugust advised that appellant "most likely has benign positional vertigo that could have been triggered certainly by a head injury and a concussion or it just could have gone spontaneously."

A September 15, 2021 audiogram demonstrated sensorineural hearing loss, left greater than right, consistent with eustachian tube dysfunction.

In reports dated from August 19, 2021 through February 9, 2022, Dr. Andreassen recounted appellant's symptoms of bilateral tinnitus, greater on the left. He attributed appellant's vertical nystagmus tinnitus to post-concussive syndrome caused by the accepted May 10, 2012 employment injury. Dr. Andreassen opined that appellant's "head and neck trauma most likely caused the tinnitus with the auditory nerves." He submitted additional reports dated through February 9, 2022 diagnosing chronic peripheral venous insufficiency, an unspecified vestibular disorder of the right ear, chronic fatigue, cervical myelopathy, and cervical disc degeneration.

By decision dated June 2, 2023, OWCP denied modification of the prior decision regarding appellant's recurrence of disability claim, and denied expansion of acceptance of appellant's claim to include hearing loss, nystagmus, and a concussion. It found that the medical evidence of record presented insufficient medical rationale to establish a causal relationship between the additional conditions and the accepted May 10, 2012 employment injury.

LEGAL PRECEDENT -- ISSUE 1

An employee seeking benefits under FECA[11] has the burden of proof to establish the essential elements of his or her claim including that any disability or specific condition for which compensation is claimed is causally related to the employment injury.[12] Under FECA, the term disability means incapacity, because of an employment injury, to earn the wages that the employee was receiving at the time of injury.[13] For each period of disability claimed, the employee has the burden of proof to establish that he or she was disabled from work as a result of the accepted employment injury.[14] Whether a particular injury causes an employee to become disabled from work, and the duration of that disability, are medical issues that must be proven by a preponderance of probative and reliable medical opinion evidence.[15]

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 that had resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness. The term also means an inability to work when a light-duty assignment made specifically to accommodate an employee's physical limitations due to the work-related injury or illness is withdrawn (except when such withdrawal occurs for reasons of misconduct,

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[11] *Supra* note 1.

[12] *See D.S.*, Docket No. 20-0638 (issued November 17, 2020); *F.H.*, Docket No. 18-0160 (issued August 23, 2019); *C.R.*, Docket No. 18-1805 (issued May 10, 2019); *Kathryn Haggerty*, 45 ECAB 383 (1994); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[13] 20 C.F.R. § 10.5(f); *J.S.*, Docket No. 19-1035 (issued January 24, 2020).

[14] *T.W.*, Docket No. 19-1286 (issued January 13, 2020).

[15] *S.G.*, Docket No. 18-1076 (issued April 11, 2019); *Fereidoon Kharabi*, 52 ECAB 291, 293 (2001).

nonperformance of job duties or a reduction-in-force), or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations.[16]

When an employee, who is disabled from the job he or she held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence establishes that, light-duty can be performed, the employee has the burden of proof to establish by the weight of reliable, probative, and substantial evidence a recurrence of total disability. As part of this burden of proof, the employee must show either a change in the nature and extent of the injury-related condition, or a change in the nature and extent of the limited-duty requirements.[17] An employee who claims a recurrence of disability resulting from an accepted employment injury has the burden of proof to establish that the disability is related to the accepted injury. This burden requires furnishing medical evidence from a physician who, on the basis of a complete and accurate factual and medical history, concludes that the disabling condition is causally related to the employment injury, and supports that conclusion with sound medical reasoning.[18]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or IME) who shall make an examination.[19] This is called an IME and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[20] When a 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.[21]

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met his burden of proof to establish a recurrence of total disability commencing June 20, 2017 causally related to his accepted May 10, 2012 employment injury.

Appellant returned to full-time, modified-duty work on September 10, 2012, and to full-duty on November 5, 2012. He performed full-time light-duty work from June 1 through 20, 2017 when he stopped work and alleged a recurrence of total disability commencing that date.

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[16] 20 C.F.R. § 10.5(x); *see E.D.*, Docket No. 21-1368 (issued September 7, 2023); *D.T.*, Docket No. 19-1064 (issued February 20, 2020).

[17] *C.B.*, Docket No. 19-0464 (issued May 22, 2020); *see R.N.*, Docket No. 19-1685 (issued February 26, 2020); *Terry R. Hedman*, 38 ECAB 222 (1986).

[18] *Id*.

[19] 5 U.S.C. § 8123(a); *see R.S.,* Docket No. 10-1704 (issued May 13, 2011); *S.T.,* Docket No. 08-1675 (issued May 4, 2009).

[20] 20 C.F.R. § 10.321.

[21] *K.D.,* Docket No. 19-0281 (issued June 30, 2020); *J.W.,* Docket No. 19-1271 (issued February 14, 2020); *Darlene R. Kennedy,* 57 ECAB 414 (2006); *Gloria J. Godfrey,* 52 ECAB 486 (2001); *James P. Roberts,* 31 ECAB 1010 (1980).

OWCP properly determined that a conflict in medical opinion existed between Dr. Andreassen, appellant's treating physician, and Dr. Schwartz, the second opinion physician, on the issue of whether the May 10, 2012 employment injury continued to disable appellant from work. Accordingly, pursuant to 5 U.S.C. § 8123(a), it referred appellant to Dr. Brown, serving as the IME, to resolve the conflict.[22] In a May 14, 2018 report, Dr. Brown noted appellant's history, reviewed the medical record and SOAF, and noted detailed examination findings demonstrating that the accepted injuries had resolved without residuals. He explained that the accepted injuries had not aggravated any preexisting conditions. Dr. Brown examined appellant, reviewed his medical records, and reported an accurate history. He indicated that the physical findings and diagnostic studies established that the accepted conditions of face, neck, or scalp abrasions, neck sprain, left hip and thigh sprain, and left hamstring avulsion had resolved. Dr. Brown's opinion regarding these conditions is, therefore, entitled to the special weight of the medical evidence.[23]

The Board further finds that the medical evidence received subsequently to Dr. Brown's opinion is insufficient to create a new conflict of medical evidence. Dr. Andreassen provided additional reports, dated through February 9, 2022, noting continued left lower extremity pain and swelling not relieved by OWCP-authorized October 10, 2019 sciatic nerve neurolysis and anchor screw removal. Dr. Andreassen, however, did not sufficiently explain with medical rationale how appellant's disability was causally related to the accepted employment injury.[24] The Board has held that a medical opinion not supported by medical rationale is of little probative value.[25]

Drs. Capistrant, Cross, Droker, Jiang, Mesher, Molk, Rumsey,[26] Zeitler, and Zuckerman did not address whether appellant was disabled for work commencing June 20, 2017 due to the accepted conditions. As these physicians did not address the claimed period of disability, their opinions are insufficient to establish his claim or to create a conflict with Dr. Brown's opinion.[27] The Board notes that while Dr. Gerhardt held appellant off work following the October 10, 2019 OWCP-authorized surgery, he did not provide a rationalized medical opinion regarding appellant's work capacity prior to the procedure.

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[22] *C.F.,* Docket No. 21-0003 (issued January 21, 2013); *V.K.*, Docket No. 19-0422 (issued June 10, 2020); *G.B.*, Docket No. 19-1510 (issued February 12, 2020); *R.H.*, 59 ECAB 382 (2008).

[23] *L.L.*, Docket No. 22-0188 (issued February 10, 2023); *R.N.*, Docket No. 19-0994 (issued November 7, 2019).

[24] *T.P.*, Docket No. 22-1335 (issued June 23, 2023); *see K.B.*, Docket No. 18-0226 (issued August 6, 2018).

[25] *Id*.

[26] The Board notes that, pursuant to 5 U.S.C. § 8101(2), Dr. Rumsey is considered a physician as defined by FECA since he diagnosed a spinal subluxation as demonstrated by x-ray to exist. *See D.M.,* Docket No. 14-1473 (issued October 14, 2014).

[27] *E.D.*, *supra* note 16.

OWCP also received the results of diagnostic studies and laboratory tests. However, diagnostic studies, standing alone, lack probative value on the issue of causal relationship as they do not address causation.[28]

Appellant also submitted reports from a nurse practitioner. The Board has held that the reports of nurse practitioners do not constitute probative medical evidence as nurse practitioners are not physicians under FECA.[29] Consequently, this report is of no probative value regarding appellant's disability claim.

Accordingly, the Board finds that the special weight of the medical evidence is represented by the IME, Dr. Brown and establishes that appellant did not sustain a recurrence of total disability commencing June 20, 2017, causally related to his accepted May 10, 2012 employment injury. As such, appellant has not met his burden of proof.

LEGAL PRECEDENT -- ISSUE 2

When an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.[30]

Causal relationship is a medical question that requires rationalized medical opinion evidence to resolve the issue.[31] A physician's opinion on whether there is causal relationship between the diagnosed condition and an accepted injury must be based on a complete factual and medical background.[32] Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty and must be supported by medical rationale, which explains the nature of the relationship between the diagnosed condition and the accepted employment injury.[33]

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[28] *O.R.*, Docket No. 23-0156 (issued August 22, 2023); *K.R.*, Docket No. 20-1103 (issued January 5, 2021); *F.S.*, Docket No. 19-0205 (issued June 19, 2019); *A.B.*, Docket No. 17-0301 (issued May 19, 2017).

[29] Section 8101(2) of FECA provides that a physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by state law. 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t). *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3a (May 2023); *David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006) (lay individuals such as nurses, physician assistants, and physical therapists are not competent to render a medical opinion under FECA); *see also S.P.*, Docket No. 23-0622 (issued September 13, 2013) (nurse practitioners are not considered physicians under FECA).

[30] *See D.W.*, Docket No. 22-0109 (issued May 17, 2022); *A.A.*, Docket No. 19-1165 (issued December 16, 2019); *M.B.*, Docket No. 19-0485 (issued August 22, 2019); *R.J.*, Docket No. 17-1365 (issued May 8, 2019); *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004).

[31] *E.M.*, Docket No. 18-1599 (issued March 7, 2019); *Robert G. Morris*, 48 ECAB 238 (1996).

[32] *M.V.*, Docket No. 18-0884 (issued December 28, 2018); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[33] *Id*.

A claimant bears the burden of proof to establish a claim for a consequential injury.[34] As part of this burden, he or she must present rationalized medical opinion evidence, based on a complete factual and medical background, establishing causal relationship. The opinion must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship of the diagnosed condition and the accepted employment injury.[35]

ANALYSIS -- ISSUE 2

The Board finds that appellant has not met his burden of proof to expand the acceptance of his claim to include tinnitus, vertical nystagmus, and concussion causally related to the accepted May 10, 2012 employment injury.

In a February 13, 2018 report, Dr. Wray, a second opinion physician, diagnosed a May 10, 2012 vasovagal episode due to acute pain, resulting in "a possible mild concussion, a cervical strain superimposed on preexisting multilevel cervical degenerative disease," dizziness and imbalance of unknown etiology, and worsening chronic left lower extremity pain and swelling without evidence of a neurologic diagnosis or cause. However, she advised that there were no neurologic sequelae of the accepted injuries evident on examination and opined that any possible neurologic condition caused by the May 10, 2012 employment injuries had resolved without residuals. Dr. Wray found that it was only "possible" that appellant sustained a concussion on May 10, 2012; her report shows that appellant did not sustain the work-related medical conditions he claimed in connection with his expansion claim. As Dr. Wray reviewed the medical record and supported her conclusion with medical rationale, the Board finds that her report represents the weight of the medical evidence with respect to appellant's request that the acceptance of his claim be expanded to include additional conditions.[36]

Appellant submitted additional evidence regarding his claimed additional work-related conditions. In an August 10, 2017 report and in additional reports dated through February 14, 2019, Dr. Andreassen opined appellant's nystagmus and disequilibrium to the accepted May 10, 2012 head injury. In reports dated from August 19, 2021 through February 9, 2022, he attributed tinnitus to post-concussive syndrome caused by the May 10, 2012 employment injury. Similarly, Dr. Mesher, in reports dated from July 5 through September 18, 2017, recounted a history of the May 10, 2012 employment injury and diagnosed vestibular dysfunction caused by a closed head injury. Dr. Andreassen and Dr. Mesher did not, however, explain physiologically how the accepted employment injury resulted in a concussion, nystagmus, or tinnitus. The Board has held that a report is of limited probative value regarding causal relationship if it does not contain medical rationale explaining how a given medical condition is causally related to employment injury.[37]

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[34] *See R.B.*, Docket No. 23-0361 (issued September 14, 2023); *T.S.*, Docket No. 23-0175 (issued June 23, 2023); *C.H.*, Docket No. 20-0228 (issued October 7, 2020).

[35] *Id*.

[36] *D.H.*, Docket No. 21-0102 (issued July 28, 2021).

[37] *See D.R.*, Docket No. 21-1056 (issued April 13, 2023); *R.B.*, Docket No. 22-0713 (issued July 26, 2022); *A.P.*, Docket No. 20-1668 (issued March 2, 2022); *D.S.*, Docket No. 21-0673 (issued October 10, 2021).

Thus, the reports of Drs. Andreassen and Mesher are insufficient to establish expansion of the acceptance of appellant's claim.

Dr. Droker, in a September 17, 2018 report, opined that appellant's beating lateral nystagmus could be a post-traumatic sequela of the May 10, 2012 employment injury. The Board finds that Dr. Droker introduced an equivocal aspect to his opinion by indicating that appellant's nystagmus could have been related to the May 10, 2012 employment injury. The Board has long held that an opinion, which is equivocal or speculative in nature is of limited probative value regarding the issue of causal relationship.[38] As such, Dr. Droker's report is insufficient to meet appellant's burden of proof.

In a February 6, 2013 report, Dr. Raugust noted that appellant reported experiencing vertigo for several months. He advised that appellant "most likely has benign positional vertigo that could have been triggered certainly by a head injury and a concussion or it just could have gone spontaneously." However, he did not relate the diagnosed condition to the accepted May 10, 2012 employment injuries. The Board has held that medical evidence that does not offer an opinion regarding the cause of an employee's condition or disability is of no probative value on the issue of causal relationship.[39] As such, Dr. Raugust's report is insufficient to meet appellant's burden of proof.

Dr. Zeitler, in a July 7, 2017 report, noted the 2012 occupational injuries but attributed appellant's vertical nystagmus to a possible a central nervous system condition. His report tends to negate causal relationship and is therefore insufficient to establish expansion of the acceptance of appellant's claim.

The record also contains a September 15, 2021 audiogram. However, the Board has held that diagnostic studies, standing alone, lack probative value on the issue of causal relationship as they do not provide an opinion as to whether the accepted employment factors caused a diagnosed condition.[40] Consequently, this evidence is insufficient to meet appellant's burden to expand the acceptance of his claim.

As appellant has not submitted rationalized medical evidence to expand the acceptance of his claim to include tinnitus, vertical nystagmus, and concussion as causally related to the accepted employment injury, the Board finds that he 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.

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[38] *S.L.*, Docket No. 23-0152 (issued May 16, 2023); *see L.L.*, Docket No. 21-0981 (issued July 1, 2022); *C.A.*, Docket No. 21-0601 (issued November 15, 2021); *J.P.*, Docket No. 19-0216 (issued December 13, 2019); *T.M.*, Docket No. 08-0975 (issued February 6, 2009).

[39] *See F.S.*, Docket No. 23-0112 (issued April 26, 2023); *L.B.*, Docket No. 18-0533 (issued August 27, 2018); *D.K.*, Docket No. 17-1549 (issued July 6, 2018).

[40] *See V.A.*, Docket No. 21-1023 (issued March 6, 2023); *M.K.*, Docket No. 21-0520 (issued August 23, 2021).

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish a recurrence of total disability commencing June 20, 2017 causally related to his accepted May 10, 2012 employment injury. The Board further finds that appellant has not met his burden of proof to expand the acceptance of his claim to include tinnitus, vertical nystagmus, and concussion causally related to the accepted May 10, 2012 employment injury.

ORDER

IT IS HEREBY ORDERED THAT the June 2, 2023 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 18, 2024
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

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