File Number:
HR10-D-H

RECEIVED NOV 24 2010

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 50
LONDON, KY 40742-8300
Phone: (202) 693-0045

NOV 17 2010

Date of Injury: 02/01/1992
Employee:

Dear Mr. :

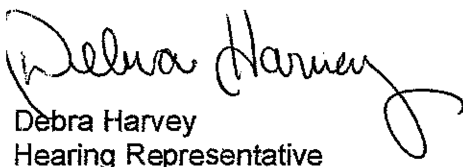
This is in reference to your workers' compensation claim. Pursuant to your request for a hearing, the case file was transferred to the Branch of Hearings and Review.

A hearing was held on 08/23/2010. As a result of such hearing, it has been determined that the decision issued by the District Office should be vacated and the case remanded to the district office for further action as explained in the enclosed copy of the Hearing Representative's Decision.

Your case file has been returned to the Jacksonville District Office. You may contact that office by writing to our Central Mail Room at the following address:

US DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 6 JAC
LONDON, KY 40742-8300

Sincerely,



Debra Harvey
Hearing Representative

PAUL H FELSER
ATTORNEY
P O BOX 10267
SAVANNAH, GA 31412

U.S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs

DECISION OF THE HEARING REPRESENTATIVE

In the matter of the claim for compensation under Title 5, U.S. Code 8101 et seq. of Claimant; Employed by the
Case No. Oral hearing was held in Jacksonville, Florida, on August 23, 2010.

The issue is whether the District Office properly denied the claim for wage loss beginning November 9, 2007

The claimant, date of birth, , , was employed by the , , as a He filed the Form CA-2, Notice of Occupational Disease, on , for Lyme disease caused by a tick bite in the performance of duty. The claim was initially accepted only for a tick bite but was expanded to include Lyme disease in 1999. Since that time, the claim has been expanded to include accepted conditions of babesiosis (accepted on July 8, 2004), ehrlichiosis (accepted on August 11, 2004) and bartonellosis (accepted on April 14, 2008). The claimant began working a sedentary limited duty job as a in October 2001. He stopped working this job on November 9, 2007, and filed the Form CA-2a, Notice of Recurrence. He submitted a written statement saying his stress increased after 9/11 when the work load doubled, as did the stress. He stated he worked through numerous relapses when he should have taken time off from work. On October 29, 2007, he developed "flu like symptoms" followed by night sweats, loss of appetite, weight loss, anxiety, depression, nausea, mental fog, fatigue, and severe back spasms. He stated these were the same symptoms he experienced in 1999 when he relapsed and he was no longer able to work.

Dr. provided a November 26, 2007, report in which he stated the claimant had been diagnosed with chronic Lyme disease and babesiosis dating back to 1992. He stated the claimant was diagnosed with ehrlichiosis. In December 2005 the claimant developed neck pain and symptoms consistent with chronic Lyme and associated diseases. An MRI showed "possible bilateral adenoma vs. intraparotid lymphadenopathy vs. bilateral Warthin's tumor." He stated the claimant was seen on November 13, 2007, "complaining of flu-like symptoms, night sweats, loss of appetite, anxiety, depression, nausea, mental fog, fatigue and severe back spasms." He diagnosed recurrent Lyme and associated diseases. He was prescribed antibiotic therapy and held off work. He was re-tested for all tick-borne illnesses and the results were pending. He stated the claimant "suffers from both physical and neurological disability's directly and causally related to his exposure to tick-borne diseases which occurred from a tick bite at his place of employment in February of 1992."

On January 10, 2010, the District Office requested additional evidence to establish his claim for a recurrence and for wage loss beginning November 9, 2007. On February 8, 2008, his attorney, Paul Felser, requested expansion of the claim to include bartonella, cervical pain, lymph node and immune system damage, chronic back spasms, chronic upper and lower extremity migratory arthralgias, upper and lower extremity polymyalgia, lumbosacral pain and stiffness, persistent cervical and shoulder stiffness, daily fatigue, depression, and neurological components (to include poor short term memory and concentration, trouble focusing, slurred speech, and work grasping). He noted that Dr. had provided medical reports that established a *prima facie* case with respect to causation for these conditions. He stated that Dr. had provided a "well-reasoned explanation of the chronicity and recurrent nature" of the accepted Lyme disease, erlichiosis and babesia. He noted that Dr. had opined the claimant was unable to work due to the ongoing affects of the accepted conditions and the "consequential and/or co-existing conditions which have previously gone undiagnosed."

On March 13, 2008, the Office referred the claim to the Office's District Medical Advisor (DMA). The DMA reviewed Dr. January 28, 2008, report and noted the claimant's immune system "has been severely weakened and compromised from the tick-borne disease rendering them more prone to relapse and other health hazard. Therefore, I would conclude that this condition does make the claimant more susceptible to any form of disease." He stated that the Security Clerk position "is a totally sedentary position and not have any possible exposure to ticks. Therefore, this can clearly be an accepted condition, and therefore, the claimant does not have total disability since he can work at a sedentary limited position." As stated, the Office accepted the claim for bartonellosis. In addition, the Office accepted the claim for recurrence on April 14, 2008.

The claimant filed Forms CA-7, Claims for Compensation, for wage loss beginning February 7, 2008. On April 30, 2008, the Office requested additional evidence to establish the claim for wage loss. The Office requested medical evidence to establish total disability during the entire period claimed. The Office asked the claimant to have his physician "submit a medical report with rationale as to why you stopped working on 02/07/08; why you were no longer able to perform the total sedentary work position as a security clerk based on your current job description; what factors of the current security clerk job caused/aggravated your accepted injury related condition to total disability since you were no longer being exposed to ticks since 2001."

On April 29, 2008, Dr. again reported the claimant was seen on November 13, 2007, with flu like symptoms which he diagnosed as recurrent Lyme and associated diseases. He was placed on antibiotic therapy and was ordered to rest at home. A Western Blot IGM blood test for Lyme was positive. He then noted the diagnosed conditions of bartonella, babesia and ehrlicia. He stated the claimant's "poor response to treatment so far is most likely due to the complications of having yet another tick-borne disease that had gone undetected for so many years, contributing further to his declining

health." He stated after the claimant was unable to return to his date of injury job as a , he assumed the position. He stated this was a stressful position "with a high volume of traffic, post 9/11." He noted the claimant continued to work through his relapses. He stated all the additional conditions that he felt were related or consequential to the tick-borne disease.

He stated the claimant was unable to work as a as he "cannot stand, sit, or bend for extended periods of time due to recurrent back spasms, rib pain, and leg cramps. He also suffers from persistent abdominal pain due to GI tract involvement associated with these diseases." He stated the abdominal symptoms were due to the antibiotics on which the claimant was placed. He noted a lymph swollen node was to be aspirated and biopsied. He stated he recommended a leave of absence from work for approximately 12-24 months as, "This rest and rehabilitation time frame will minimize the risk of jeopardizing this patient's health any further." He was to remain on antibiotic therapy and immune supplements during this period.

On May 5, 2008, the Mr. Felser advised the Office that the claimant had moved from New Jersey to North Carolina. On June 9, 2008, Dr. provided a medical report that stated the lymph node biopsy had established mycoplasma as another tick-borne disease and Mr. Felser requested expansion of the claim to include this condition. The Office referred the case to the DMA for an opinion as to whether the mycoplasma was a result of the tick bite or the Lyme disease. The DMA stated the mycoplasma infections "are common, community-acquired diseases that are usually treated easily and resolve without sequelae. These infections are unrelated to the tick-borne [illegible] of 1992."

The Office then updated a Statement of Accepted Facts (SOAF) and referred the claimant, along with the SOAF and the medical file, to Dr. specialist in infectious diseases, for a second opinion evaluation. This examination was performed on December 8, 2008. Dr. stated the claimant had normal range of motion of all four extremities as well as normal motor strength of all extremities. Strength was classified as 5/5. The claimant was oriented to time, place, and person. He noted no depression or anxiety. The neurological exam showed no evidence of dysesthesias or paresthesias. Babenski sign was negative; deep tendon reflexes were +2 and symmetric intact. The diagnoses were status post treatment for Lyme disease; status post treatment for babesiosis and ehrlichiosis; positive laboratory test for bartonellosis. Differential diagnoses include Whipple's disease, fibromyalgia, and vitamin D deficiency.

Dr. stated the claimant "apparently" has had Lyme disease for more than ten years. He noted that, according to recent literature, most of the symptoms resolve by that time. He stated the significant of the positive test results for bartonellosis was "uncertain." He noted the treatment for babesia and ehrlichiosis. He also stated he had neurological manifestations associated with abdominal complaints suggestive of Whipple's disease. He stated, "It should be noted that Lyme disease can be confused with fibromyalgia, and according to recent literature, fibromyalgia gives symptoms of

vitamin D deficiency." He stated the removal of the left lymph node showed evidence of mycoplasma and stated that "extra pulmonary manifestations of mycoplasma are unusual. It is though possible any extra pulmonary manifestations of mycoplasma could be due to autoimmune phenomena." He opined this condition was not related to the employment injury. He stated the claimant had normal range of motion and muscle strength. He had difficulty lifting, pulling and pushing and could only perform these duties for one hour per day with a 10-poind lifting restriction. He stated the claimant could squat, kneel and climb one hour per day and the physical restrictions "may not have related from the work-related disability. The patient currently may have another disease process as mentioned, and may have an underlying peripheral neuropathy." He stated the claimant could work in a sedentary position. He recommended an EMG study, "possibly a small bowel biopsy for Whipple's disease, a vitamin D level, and neurological evaluation.

A September 28, 2008, evaluation was received from Dr. . In this initial consultation, Dr. stated he was not provided with the complete medical record. He related the history as advised by the claimant. He noted on physical examination the claimant had numerous trigger points over the head and neck area, particularly in the temple. He noted the TMJ locked on the right and the patient had difficulty opening his mouth. He stated the claimant appeared to have a mild facial palsy on the left. The neck had paracervical tightness. There was pain with lateral compression of the wrists and of rotation of both hips but the remainder of the extremity exam was normal. Neurologic examination was basically normal except for hip flexion that was 4/5 bilaterally and associated with pain. He noted the claimant appeared "well-adjusted and appropriate."

He diagnosed a Lyme Borreliosis Complex to include a possible malabsorptive syndrome (rule out gluten intolerance); cognitive dysfunction and CNS instability; mononeuritis multiplex; subcortical involvement (stammering, multiple brain stem findings, ptosis, left facial weakness and frontal paracervical tightness); non-physiologic striae of the hips; dysautonomia; floaters and tinnitus; GI symptoms; mycoplasma; history of marked knee effusion in 1993 with no recurrence, and "probable Borrelia-related degenerative arthritis of both hips with a prior normal MRI but current pain; dyssomnia; major fatigue state; and history of Bartonella positive, "possibly Babesia."

On January 6, 2009, Dr. stated the claimant was experiencing "continued symptoms of significant cognitive dysfunction, major fatigue, GI cramping with pain, recent weight loss -- possibly malabsorptive syndrome, central nervous system irritability, headaches with sensitivity to light and noise, hip pain, numbness in fingers and toes and tremor in upper extremities." He stated the claimant was totally disabled due to his current symptoms and chronic illness. He was to initiate IV antibiotic therapy in the next month. On February 11, 2009, he formally requested this therapy.

The District Office determined there was a conflict in medical opinion and referred the claimant to Dr. , specialist in infectious diseases. Dr. provided an accurate history. Physical examination showed no CVA tenderness with a normal contour of the spine; no clubbing, cyanosis, or edema of the extremities. There was no lymphatic adenopathy noted in the axillae or supraclavicular areas. Neurological

examination was normal. Dr. stated the claimant has "ongoing subjective illness." He stated the history supported Lyme disease. He stated that "whether subsequent tests truly confirm that he has the continued presence of viable Borellia bacteria causing ongoing disease is unclear and that is an ongoing debate amongst physicians in this country and in the world." He stated there was an entity of post-Lyme disease syndrome where Lyme patients continue to have musculoskeletal complaints and cognitive dysfunction. "Again, there is disagreement between the 'Lyme literate community' and the academic scientific community as to whether ongoing antibiotics are useful for this and as to whether these ongoing symptoms are related to presence of persistent infection at all. I do not think me rendering my opinion here can settle that ongoing debate."

Dr. stated he disagreed with the diagnosis of ehrlichiosis. He stated in 2002 the claimant had a positive human monocytic ehrlichiosis IgM antibody at a titer of 1:40. The HGE antibody panel was negative. "That I can tell it was this result that was used to give him a diagnosis of ehrlichiosis." He stated that HGE (now referred to as HGA) has "been found to be a confection with Lyme disease and is transmitted by Ixodes scapularis, the deer tick. Human monocytic ehrlichiosis is not thought to be transmitted by Ixodes scapularis and it is uncommon to find human monocytic ehrlichiosis in the Northeast. In addition, an isolated IgM antibody in the absence of a positive IgG antibody would be more akin to a nonspecific result. In reviewing those records it would be my opinion that he was misdiagnosed with ehrlichiosis and did not and does not have ehrlichiosis. Moreover, human monocytic ehrlichiosis is not known to be a chronic infection." Again, he stated that the "lab findings, timing and unexpected infection (HME rather than HGA) lead to that opinion."

Dr. stated "the diagnosis of Bartonella was by unconventional means. Bartonellas can oftentimes be confirmed by cultures. PCR is sometimes useful. For 'Oroya fever that is seen in the Andes Mountains in South America blood smears sometimes are used to confirm Bartonella bacilliformis infection. However, in other species of bartonella infections it is uncommon to use blood smears to diagnosis Bartonella for human disease. With no blood cultures, pathology, or serology results to substantiate the positive smear I really do think it is unclear as to whether the patient had Bartonella. Whether Bartonella is commonly transmitted by ticks is a matter of debate. There have been case reports of Bartonella being transmitted by Ixodes ticks, but it is certainly not accepted that this is a major way of Bartonella being transmitted to cause human disease."

He continued:

> "We also need to discuss his diagnosis of babesiosis. Typical diagnosis of human babesiosis would be based on acute illness and blood smears showing intraerythocytic parasites. With consistent clinical syndrome a positive PCR may be used to substantiate the diagnosis as well. It is not commonly accepted that the babesiosis persists over years but with or without treatment it is described to have persistent blood smears on the

order of months, sometimes. That I can tell the patient had a FISH test (an in situ hybridization test, akin to a stain) show positive. I did not see any positive PCR. In my review of guidelines of a diagnosis of babesiosis I do not see an isolated positive FISH test as being used to substantiate a diagnosis of babesiosis. Therefore, I would have some questions about the validity of his diagnosis of babesiosis."

Dr. stated "emphatically" that mycoplasma was related to the work injury as "it is uncommon to see mycoplasma lymphadenitis and unheard of to see this as transmitted by ticks. Mycoplasma is a ubiquitous pathogen which many people can be infected with during their time on earth."

He noted the subjective cognitive dysfunction and musculoskeletal complaints "and he does appear to be disabled by these complaints." He stated the claimant reported having problems concentrating "and therefore it seems that it would be a difficult for him to function in a typical work setting."

In answer to specific questions posed by the Office, Dr. stated the diagnoses of Bartonella, Babesia and Ehrlichia "are unclear. I note some inconsistencies with his Lyme disease diagnosis but note the diagnosis of Lyme disease. There is an entity of post-Lyme disease syndrome where patients have continued cognitive musculoskeletal symptoms and at times this is disabling." He stated this was under debate in the medical community as to how much Borrelia infection contributes to these problems. He stated that gastrointestinal and diarrheas are not thought to be symptoms of Lyme disease. "Whether his diarrhea, weight loss and anxiety are related to his Lyme disease or associated treatment or whether they are related to other disease conditions are unclear to me. In summary, then I think it is possible that a significant amount of his medical conditions are leading to his disability, but there are some unclear aspect as I detailed above."

He provided a diagnosis of post-Lyme syndrome "and it is quite possible this is accounting for much of his prolonged disability. Whether he has a separate medical condition such as fibromyalgia or chronic fatigue syndrome, or underlying depression would be speculation on my part and he may benefit from ongoing workups for these possibilities. He stated he takes "the patient's physical limitations at face value as he reports them to me. He notes extreme fatigue and problems getting out of bed. He notes joint aches and problems moving about. Based on that I would think that he is physically disabled and would have difficulty in doing manual labor. Whether this is absolutely due to persisting Lyme disease or whether there is another etiology for this is a little bit unclear to me. I am not a podiatrist or orthopedic surgeon and my opinion on this is based on the symptoms that he reports to me." He did not fill out the work restrictions form but stated, "Based on his report of problems concentrating and difficulties with activities as simple as reading a newspaper I do not think he is capable of working in a sedentary position." He again stated it was unclear if all the symptoms were due to a post-Lyme syndrome. He stated it is unclear as to whether the claimant might have additional conditions such as fibromyalgia, chronic fatigue syndrome, other undiagnosed

gastrointestinal ailments, or primary anxiety or depression. He recommended a medical workup to include psychiatric, neurological and GI specialists.

On May 15, 2009, Dr. stated he disagreed with the opinion of Dr. , the second opinion specialist. He stated Dr. findings were not conclusive with his findings relating to the "numerous tick-borne infections and co-infections of Lyme disease, Ehrlichiosis, bartonella and Mycoplasma fermentans, for which Mr. had a positive PCR." He disagreed with the suggestion of Whipple's Disease and stated that condition was "clearly not indicated by laboratory findings that document Mr. co-infections stemming from his initial tick-borne infections in 1992." He stated Whipple's disease could usually be cleared up by a course of antibiotics and the claimant had been off and on antibiotics for many years and if he had Whipple's Disease, "it would have been easily cleared up by now."

He stated the claimant was suffering from cognitive dysfunction, "resulting in his inability to read; CNS irritability resulting in left temporal headaches causing him to be markedly averse to light, nose and some odors; suffers from tinnitus; self-limiting intermittent pain in both hips; chronic numbness in the tips of his fingers and toes; experiences stabbing chest pain radiating to the extremities; tremors in both upper extremities; fasiculations in all large muscle groups; experiences stabbing rib and upper abdominal discomfort in both standing and sitting positions; experiences mononeuritis multiples; has considerable subcortical weakness and palsy; and frontal paracervical tightness and a history of Irritable Bowel Syndrome." He again stated the claimant was totally disabled.

On June 3, 2009, the District Office wrote to Dr. and requested clarification of his report. The Office noted that Dr. stated the claimant had no objective findings on examination and noted subjective complaints, "but nonetheless, you were taking his complaints at face value. You also recommended further evaluation, including a neurocognitive evaluation. Therefore, you are authorized to refer Mr. for psychological testing to assess his cognitive condition." The Office also authorized Dr. to refer the claimant to a physical medicine and rehabilitation specialist to "better assess his physical capacity and to perform a functional capacity evaluation as well."

On July 17, 2009, Dr. responded again stating it was "possible" the claimant had Lyme disease. He stated the claimant noted subjective symptoms of problems concentrating, problems reading, malaise, aches, and abdominal bloating. He stated he did not believe objective testing "can rule in or rule out the validity of these symptoms. I will defer to the Department of Labor on whether neurocognitive evaluation, psychiatric evaluation, or gastroenterology evaluation would be helpful in the disability issues here." He reiterated that the babesiosis diagnosis was reached through "unconventional means" with a negative blood smear at the time of diagnosis and no symptoms of acute babesiosis. Again, he stated the blood seriologies did not support ehrlichiosis and stated that the original Bartonella diagnosis was based on a non-FDA approved test and was also an unconventional means of diagnosing bartonellosis. He stated the mycoplasma

was not related to the tick bite due to the separation of time between exposure and infection as well as the frequency of mycoplasma in the environment. He stated that Dr. Jensen's statement that Whipple's disease was easily cleared by antibiotics is errant. "This is an infection that is well known to require an extended course of antibiotics and is prone to relapse if an inadequate course of antibiotics is given.

> "In summary then, drawing the causal link between the mycoplasma PCR result and the prior tick bite seems unlikely. The diagnosis of Bartonellosis was reached by unconventional means. The diagnosis of babesiosis was reached by unconventional means. I do not think he truly had ehrlichiosis. I refer to you my initial assessment.
>
> With regards to the Lyme Disease, I think an initial diagnosis of Lyme Disease was plausible. As pointed out by other physicians it would be somewhat odd to see Lyme Disease acquired in February in New Jersey, but theoretically possible."

Dr. responded to Dr. report (it is noted that Dr. refers to Dr. as "she" in his report; Dr. is male). Dr. stated Dr. made "multiple errors in her report" and did not provide supporting documentation for her opinion. He stated he is a Lyme disease expert and provided documentation from the Center for Disease Control to support his opinions. He stated the 1999 babesiosis test was positive for the FISH test "which is a sensitive test to Babesiosis." He stated the IgG test "is seen in recent infections and it is also seen with chronic infections, in fact it is sometimes the only band seen in chronic infections." He stated the claimant had tested positive for "Bb multiple times," through the years. He stated Dr. was incorrect in stating that the Babesiosis blood smear from January 16, 2008, was not FDA approved and is for research purposes only. He stated the CDC report "clearly states that blood smear is the way to diagnose Babesiosis." He also stated the CDC "clearly states Ehrlichiosis can be acquired in the Northeast and that it is possible to be transmitted by Ioxodes scapularis."

The Office then referred the claimant to Dr. , PhD., on December 7, 2009, for an evaluation. Dr. administered the MMPI test and noted that the prior psychological testing in 1999 did not include this test. Dr. diagnosed a major depressive disorder, single episode, severe, without psychotic features, and "rule out" dependent personality disorder. He stated the claimant developed a "great deal of psychological distress, depression and cognitive difficulty" after the initial examination. He stated he "cannot say with reasonable certainty that his major depression is causally related to such a work injury. Though I did not give a separate diagnosis of a cognitive disorder, it is clear that there have been memory and concentration impairments in the past, in the 1999 testing, and similar ones operating currently. Many of these difficulties could be related in part to his major depression, and some may be a common symptom of Lyme disease. There is no doubt that the health problems he has experienced over the years may have led to severe depression, though I cannot say with great certainty that this would be the main or only cause." He stated he is not able to perform the security guard

job any longer due to severe depression, difficulty concentrating, problems with memory and inability to tolerate stress."

The Functional Capacity Evaluation of January 5, 2010, stated the test results were valid but he is unable to work.

On February 24, 2010, the claimant advised the Office that he had been approved for OPM disability and Social Security disability benefits. He stated Dr. had relocated to Washington, D.C., from North Carolina and he requested authorization to travel to Philadelphia, Pennsylvania, for continuing treatment with a Dr. . On March 4, 2010, the Office denied the request for change of physicians, stating medical care could be obtained locally.

On March 22, 2010, the Office denied benefits for wage loss and disability beginning on November 9, 2007, finding that the medical evidence did not establish "the sequelae of a tick bite at work was the reason that you were unable to continue your limited duty job. You developed other conditions, whose relationship to the initial injury remain unclear; such as fibromyalgia, chronic fatigue, gastrointestinal problems and anxiety, that have not been accepted as injury-related." The claimant disagreed with this decision and requested an oral hearing before an OWCP Hearing Representative.

The hearing was held on August 23, 2010, in Jacksonville, Florida. The claimant did not appear for the hearing but was represented by his Attorney, Paul Felser. Mr. Felser argued that Dr. had confirmed the claimant suffers from post-Lyme disease and that "many, if not most, of his difficulties are consistent with those seen from Lyme disease syndrome and probably are connected to his Lyme Disease syndrome."[1] He stated Dr. opined that the cause of some of the other claimed conditions could be antibiotics. He stated if the claimant had residuals from the antibiotics, those residuals should be accepted. He stated that Dr. had taken the cognitive difficulties at face value and opined the claimant could not work.

Mr. Felser argued that the claimant's condition has continued to deteriorate over time. He attempted to continue to work but experienced a steady worsening of his condition. He cites Dr. Regan's report and noted that Dr. had not ruled out a relationship between the emotional issues and Lyme disease. He stated this is sufficient to accept depression.

He stated Dr. report was sufficient to establish total disability for this claimant, especially in combination with the reports of Dr.

The record was left open for thirty days to allow for receipt of additional evidence for consideration. A copy of the hearing transcript was sent to the Employing Agency for review and comment. There was no response from the Agency.

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[1] Hearing transcript, page 6.

Mr. Felser submitted a post-hearing brief reiterating his arguments. Also received were medical records, most of which have been previously submitted and considered. He did submit medical reports from Dr. , family physician. Dr. listed Lyme disease, ehrlichiosis, babesiosis, arthralgias, depression, abdominal pain, anxiety, and an abnormal brain SPECT as post-tick bite and from an on the job exposure. He stated the claimant still continues to suffer from symptoms related to a chronic infection and has depression and anxiety due to chronic pain and the stress of his compensation claim. He stated he could not work and his activities of daily living are affected by his chronic pain, anxiety, and depression.

I have carefully evaluated all the evidence in this claim and find that further medical development is indicated.

The issue is whether the claimant his/was disabled from his limited duty job effective November 9, 2007. The claimant has undergone many examinations by various physicians to determine a firm diagnosis and has many medical issues. His treating physicians relate Lyme disease, Bartonella, Babesia, Ehrlichiosis, Mycoplasma, as well as gastric, cognitive and emotional disorders to the initial tick bite and state he is unable to perform any work secondary to the employment conditions. The Office's second opinion specialist, Dr , noted residuals of Lyme disease but stated he could work a sedentary job.

Section 8123 (a) of the FECA provides that if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Office shall appoint a third physician who shall make an examination.[2] The Office then referred the claimant for a referee examination with Dr. , who is a professorial-level specialist in infectious diseases. Dr. acknowledged the claimant probably did have Lyme disease even though it was uncommon to see Lyme disease contracted in February in New Jersey. He stated it is plausible the claimant has a post-Lyme syndrome. He stated some post-Lyme patients develop musculoskeletal and cognitive problems and he was taking these complaints from the claimant at face value to support disability. He stated, however, it was "unclear" whether these complaints are due to post-Lyme or due to another cause. He recommended neurological, psychiatric, and GI work-ups. Dr. has stated it is his opinion that the claimant was never infected with Bartonella, Babesia, and Ehrlicia based on unconventional diagnostic means. He stated the mycoplasma infection was common in the environment and could not be related to a tick bite some 15 years prior. The Office found that Dr. report needed clarification due to a lack of objective findings and requested such clarification from him. In his response, the physician noted subjective difficulties of concentration and reading problems, malaise, aches, and abdominal bloating. He deferred to OWCP on referring the claimant for further specialist's examinations.

[2] *Richard L. Rhodes,* 50 ECAB __ (Docket No. 98-2346, issued February 23, 1999).

When a case is referred to an impartial medical specialist for the purpose of resolving a conflict in medical opinion evidence, the opinion of such specialist, if sufficiently well-rationalized and based on a proper medical background, must be given special weight.[3] While Mr. Felser has argued that Dr. report is sufficient to establish total disability, I find that this report is speculative and lacks sufficient rationale to support disability. Dr. has stated the evidence is sufficient to establish the claimant had Lyme disease and probably now has a post-Lyme syndrome. He stated, however, that disability was based on the cognitive and musculoskeletal problems which he could not say were from the employment injury or another medical condition. The Office wrote to him for clarification but his opinion remains speculative. When an impartial medical specialist's statement of clarification or elaboration is not forthcoming to the Office, of if the physician is unable to clarify or elaborate on the original report, of if the physician's report is vague, speculative or lacks rationale, the Office must refer the employee to another impartial specialist for a rationalized medical opinion on the point at issue.[4] I find that another referee evaluation is indicated in this case.

In addition, the Office referred the claimant to a psychologist, Dr. for a second opinion examination on the cognitive and emotional problems. Dr. was an inappropriate specialist for this claim. The Office should have referred the clamant to a psychiatrist or neuropsychiatrist for evaluation. Dr. report is also speculative on whether the diagnosed depression and any cognitive deficits are related to Lyme disease or other tick-borne illnesses.

In sum, this is a complex case involving many issues. I find that a multidisciplinary evaluation is indicated. The FECA *Procedure Manual*, Chapter 3-0500-4 (b) (5), states, "In very complex cases, defined as those where more than two conditions are involved and complications are contributing significantly to the clinical picture, a panel of physicians may be asked to examine the claimant and render a collective opinion. The services of such panels are most easily arranged through medical schools and hospitals, as these institutions employ specialists in many fields of medicine."

I find that referral to a medical school for professorial level evaluations are indicated in this case as a specialist of professorial rank carries extra weight.[5] Upon return of the file, the Office should update the Statement of Accepted Facts (SOAF) as necessary. The Office should then refer the claimant, along with the SOAF and the entire file, to a professorial level infectious disease specialist to coordinate the medical evaluations. The infectious disease specialist should perform the initial examination and determine if the claimant had Lyme disease and whether or not he still has residuals from the Lyme disease. In addition, he should opine whether the claimant has or had Bartonella, Babesia, Ehrlichia, and/or Mycoplasma and whether these conditions were from a work-related tick bite. He should provide the objective findings on examination, as well as a firm diagnosis and is authorized to perform diagnostic testing as necessary. The

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[3] *Louis G. Psyras*, 39 ECAB __ (1987).
[4] *Glen E. Shriner*, 53 ECAB ___ (Docket No. 00-816, issued October 12, 2001)
[5] FECA *Procedure Manual*, Chapter 3-0600-7 (1)

physician should comment on whether the claimant is or was able to continue working in the limited duty position on or after November 9, 2007, due to an employment-related medical condition. The specialist should provide detailed rationale for his or her opinion.

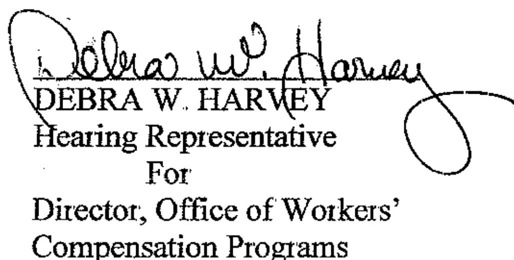
At that point, the infectious disease specialist should comment on neurological, cognitive, psychiatric, and/or GI conditions from which the clamant is suffering. He or she should also comment on the extensive use of antibiotics in treatment of this claimant. Should this physician opine for residuals from the original injury, he or she should refer the claimant to the appropriate specialist or specialists (GI, psychiatrist, neurologist, or any other specialist as he or she deems necessary)for further examination and/or testing to determine if any of these conditions is resultant from the tick bite, Lyme disease, or any other tick-bite related condition. These physicians should provide detailed reports supporting whether any diagnosed condition is employment-related or developed as a result of an employment-related condition. Objective findings, test results and firm diagnoses should be provided, along with rationale for all opinions rendered. The physicians should also comment on disability on or after the date of work stoppage and provide work restrictions if indicated.

After these reports have been received, and after any additional development deemed by the Office has been completed a *de novo* decision should be issued concerning the accepted conditions as well as the recurrence and disability on and after November 9, 2007.

Therefore, for the reasons set forth above, the decision of the District Office is hereby SET ASIDE and the file is REMANDED for action as described above.

DATED: NOV 17 2010

WASHINGTON, D.C.



DEBRA W. HARVEY
Hearing Representative
For
Director, Office of Workers' Compensation Programs