United States Department of Labor
Employees' Compensation Appeals Board

C.L., Appellant	)	
and	)	**Docket No. 14-05**
	)	**Issued: May 5, 2014**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION, New Orleans, LA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 3, 2013 appellant filed a timely appeal from a September 11, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP) denying his traumatic injury claim. 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.

ISSUE

The issue is whether appellant met his burden of proof to establish that he sustained a traumatic injury in the performance of duty on March 5, 2012.

FACTUAL HISTORY

This case was previously before the Board. By decision dated September 4, 2013, the Board set aside OWCP's September 17, 2012 decision to find that appellant established that the

[1] 5 U.S.C. § 8101 *et seq.*

March 5, 2012 incident occurred in time, place and manner alleged.[2] It remanded the case for OWCP to evaluate the medical evidence. The findings of fact and conclusions of law from the prior decision are hereby incorporated by reference.

Appellant submitted a March 5, 2012 urgent care report from a nurse at the Veterans Affairs (VA) Hospital who noted that he fell and suffered facial and oral trauma. The report advised that he ambulated with a limp and his right foot stuck on the tile flooring.

In a March 5, 2012 diagnostic report, Dr. Gordon R. Schally, a Board-certified diagnostic radiologist, reported that a computerized tomography (CT) scan of the brain revealed no acute intracranial abnormalities and mild cerebral and cerebellar atrophy with findings most suggestive of mild chronic microvascular ischemic change. X-rays of the face revealed no fracture or other acute abnormalities with moderate amounts of dental work noted.

In a March 5, 2012 diagnostic report, Dr. Marna J. Eissa, a Board-certified diagnostic radiologist, reported that a mandible report revealed no displaced mandible fracture. She recommended a dedicated facial bone CT scan due to suspicion of small fracture. Dr. Eissa noted no upper teeth were missing.

In a March 5, 2012 urgent care report, Dr. Vernon E. Chee, Board-certified in internal medicine, reported that appellant presented to urgent care after he fell. Appellant recalled walking in the hallway, then his left leg "gave out," causing him to fall forward and strike his face on the floor. He thought he lost consciousness, was dizzy and stayed on the floor for about 10 minutes. Appellant reported a history of muscle weakness and numbness in the left lower extremity, which sometimes caused him to trip while walking. A CT scan of the brain showed no acute intracranial abnormalities and x-rays revealed no fractures. Dr. Chee diagnosed trauma to the face, mouth and teeth, noting that appellant had several loose teeth. After returning from radiology, appellant was missing tooth 8 and part of 7 and 10. Dr. Chee reported that appellant sneezed and the tooth flew out. He noted that the other teeth were loose but remained in place and the bleeding had slowed. Dr. Chee reported that appellant could resume work on March 12, 2012 and referred him to VA Dental Clinic.

In a March 5, 2012 report, Dr. Georgia K. McDonald, a dentist, reported that appellant presented to the dental clinic for an emergency visit after he fell on the job. Appellant was last seen three years ago by another dentist for a dental extraction for decay. Recently, a tooth on the upper right had "fallen out on its own" and the extraction socket was still healing in the position of tooth 4. Dr. McDonald noted a medical history of osteoarthritis, particularly in the left leg. Appellant stated that he sometimes had difficulty walking when his leg got stiff.

On clinical examination, Dr. McDonald a noted fracture of tooth 9 with partial exfoliation, a crack on the root of tooth 10 probable and probable fracture of right porcelain fused to metal bridge on the upper right. Examination and clinical evaluation of radiographs demonstrated chronic generalized advanced periodontitis with poor demonstrated homecare of

[2] Docket No. 13-917 (issued September 4, 2013). The Board notes that appellant established that he suffered a fall on the morning of March 5, 2012. The Board found that the factual evidence of record was insufficient to establish that his fall was idiopathic.

the teeth in need of restorative repair. Mobility of the upper and lower anterior teeth could not be definitively determined to have been caused by the fall. Dr. McDonald noted that the mobility could be anatomic and pathologic in nature due to the 80 to 90 present horizontal bone loss and attachment loss on those teeth. She reported fractured facial aspects and a loose bridge from number tooth 8 to 6. Dr. McDonald also noted a residual root tip on tooth 9, which was probably a result of fracture from the fall. Appellant stated that he just "spit the tooth out" and could not find it. Radiographs showed periapical infection on tooth 14 and 8, which would have been there before today. Dr. McDonald also noted semilunar lip laceration approximately 3/4 of an inch. She recommended that tooth 6, 8, 9 and the 10 residual root tip be removed for suture of oral/facial wounds and lacerations.[3]

The employing establishment issued appellant a properly completed Form CA-16, authorization for examination, dated March 6, 2012. Appellant was authorized to visit Dr. James A. Campo, a dentist, at Campo Dentistry.

By decision dated September 11, 2013, OWCP denied appellant's claim on the grounds that the evidence was insufficient to establish that the March 5, 2012 employment incident caused his injuries. It noted that the reports of Dr. McDonald and Dr. Chee failed to explain how the conditions they diagnosed were caused by his fall on March 5, 2012.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of establishing the essential elements of his or her claim, including the fact that the individual is an "employee of the United States" within the meaning of FECA; that the claim was filed within the applicable time limitation; that an injury was sustained while in the performance of duty as alleged and that any disability or specific condition for which compensation is claimed are causally related to the employment injury.[4] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated on a traumatic injury or occupational disease.[5]

In order to determine whether an employee actually sustained an injury in the performance of duty, OWCP begins with an analysis of whether fact of injury has been established. Generally, fact of injury consists of two components which must be considered in conjunction with one another. The first component to be established is that the employee actually experienced the employment incident which is alleged to have occurred.[6] The second component is whether the employment incident caused a personal injury and generally can be established only by medical evidence.

To establish a causal relationship between the condition, as well as any attendant disability claimed and the employment event or incident, the employee must submit rationalized

[3] This report was also signed by Dr. Shemika L. Sample, a dentist.

[4] *Gary J. Watling*, 52 ECAB 278 (2001); *Elaine Pendleton*, 40 ECAB 1143, 1154 (1989).

[5] *Michael E. Smith*, 50 ECAB 313 (1999).

[6] *Elaine Pendleton*, *supra* note 4.

medical opinion evidence based on a complete factual and medical background, supporting such a causal relationship.[7] The opinion of the physician must be based on a complete factual and medical background of the claimant, 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 identified by the claimant. This medical opinion must include an accurate history of the employee's employment injury and must explain how the condition is related to the injury. The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.[8]

ANALYSIS

Appellant established that the March 5, 2012 incident occurred as alleged when he fell at work. OWCP denied his claim on the grounds that it lacked sufficient medical evidence to support that his injuries were medically related to the March 5, 2012 employment incident. The Board finds that appellant did not submit sufficient medical evidence to support that he sustained an injury causally related to the March 5, 2012 employment incident.[9]

In a March 5, 2012 diagnostic report, Dr. Schally reported that a CT scan of the brain revealed no acute intracranial abnormalities and mild cerebral and cerebellar atrophy with findings most suggestive of mild chronic microvascular ischemic change. X-rays of the face revealed no fracture or other acute abnormalities. In a March 5, 2012 diagnostic report, Dr. Eissa reported that a mandible report revealed no displaced mandible fracture. While the reports of Dr. Schally and Dr. Eissa provide imaging results from diagnostic tests, the physicians did not provide any opinion on causal relationship to the accepted incident. These diagnostic studies are not sufficient to establish appellant's claim.

In a March 5, 2012 report, Dr. Chee stated that appellant presented to urgent care after he fell. Appellant was walking in a hallway when his left leg "gave out," causing him to fall forward and strike his face on the floor. A CT scan of the brain showed no acute intracranial abnormalities and x-rays revealed no fractures. Dr. Chee diagnosed trauma to the face, mouth and teeth, noting that appellant had several loose teeth. After returning from radiology, appellant was missing tooth 8 and part of tooth 7 and 10. He reported that he sneezed and the tooth flew out. Dr. Chee noted that the other teeth were loose but remained in place and the bleeding had slowed. The Board finds that his report is not sufficient to establish appellant's claim. Dr. Chee failed to provide any opinion regarding the cause of appellant's condition. This renders his report of limited probative value.[10]

In a March 5, 2012 report, Dr. McDonald reported that appellant presented to the dental clinic for an emergency visit after he fell on the job. Appellant was last seen three years prior by

[7] *See* 20 C.F.R. § 10.110(a); *John M. Tornello*, 35 ECAB 234 (1983).

[8] *James Mack*, 43 ECAB 321 (1991).

[9] *See Robert Broome*, 55 ECAB 339 (2004).

[10] *S.W.*, Docket No. 08-2538 (issued May 21, 2009).

another dentist for a dental extraction for decay. On examination Dr. McDonald noted a fracture of tooth 9 with partial exfoliation, crack on root of tooth 10 probable and probable fracture of right porcelain fused to metal bridge on the upper right. Examination and clinical evaluation of radiographs demonstrated chronic generalized advanced periodontitis with poor demonstrated homecare of the teeth in need of restorative repair. Mobility of the upper and lower anterior teeth could not be definitively determined to have been caused by the fall. Dr. McDonald noted that the mobility could be anatomic and pathologic in nature due to the 80 to 90 present horizontal bone loss and attachment loss on those teeth. She reported fractured facial aspects and loose bridge from number tooth 8 to 6. Dr. McDonald also noted residual root tip on tooth 9, which was probably a result of fracture from the fall. Appellant stated that he just "spit the tooth out" and could not find it. Radiographs showed periapical infection on tooth 14 and 8, which would have been there before today. Dr. McDonald also noted semilunar lip laceration approximately 3/4 of an inch. She recommended that tooth 6, 8, 9 and 10 residual root tip be removed and diagnosed suture of oral/facial wounds and lacerations.

The Board notes that, while Dr. McDonald diagnosed of oral/facial wounds, fractured facial aspects, fracture of teeth, crack of teeth root, loose bridges, residual root tips, missing teeth and a semilunar lip laceration approximately 3/4 of an inch, she did not adequately address how the findings on examination were caused or contributed to by appellant's fall at work. Dr. McDonald noted advanced periodontitis with poor demonstrated homecare of the teeth in need of restorative repair. Mobility of the upper and lower anterior teeth could not be definitively determined to have been caused by the fall, which could be anatomic and pathologic in nature due to the 80 to 90 present horizontal bone loss and attachment loss on those teeth. Dr. McDonald's opinion is whether appellant's dental and facial injuries were caused or aggravated by the March 5, 2012 work incident is therefore speculative in nature.[11]

To be of probative value, a physician's opinion on causal relationship should be one of reasonable medical certainty.[12] Dr. McDonald's statement fails to provide a definitive opinion that the findings on examination were caused by the March 5, 2012 incident. Medical reports without adequate rationale on causal relationship are of diminished probative value and do not meet an employee's burden of proof.[13] The opinion of a physician supporting causal relationship must rest on a complete factual and medical background supported by affirmative evidence, address the specific factual and medical evidence of record and provide medical rationale explaining the relationship between the diagnosed condition and the established incident or factor of employment.[14] Without medical reasoning explaining how March 5, 2012 employment incident caused or contributed to his dental, facial and oral trauma, her report is insufficient to meet his burden of proof.[15]

[11] *See Michael R. Shaffer*, 55 ECAB 339 (2004).

[12] *See Beverly R. Jones*, 55 ECAB 411 (2004).

[13] *Ceferino L. Gonzales*, 32 ECAB 1591 (1981).

[14] *See Lee R. Haywood*, 48 ECAB 145 (1996).

[15] *C.B.*, Docket No. 08-1583 (issued December 9, 2008).

The March 5, 2012 urgent care reports from the VA Hospital nurses are also insufficient to establish appellant's claim. A nurse is not a physician as defined under FECA and their reports are of no probative value.[16]

In the instant case, appellant has established that the March 5, 2012 incident occurred as alleged. The record, however, is without rationalized medical evidence on the causal relationship between the accepted March 5, 2012 employment incident and his diagnosed conditions. Thus, appellant has failed to establish his claim.[17]

The Board notes that where, as in this case, an employing establishment properly executes a Form CA-16, which authorizes medical treatment as a result of an employee's claim for an employment-related injury, the CA-16 form creates a contractual obligation, which does not involve the employee directly, to pay for the cost of the examination or treatment regardless of the action taken on the claim.[18] The period for which treatment is authorized by a CA-16 form is limited to 60 days from the date of issuance, unless terminated earlier by OWCP.[19] Although OWCP adjudicated appellant's claim of injury, it did not address the issue of reimbursement pursuant to this CA-16 form. The record is silent as to whether OWCP paid for the cost of his examination or treatment for the period noted on the form.

The regulations provide that in unusual or emergency circumstances OWCP may approve payment for medical expenses incurred otherwise than as authorized in section 10.303. It may approve payment for medical expenses incurred even if a CA-16 form authorizing medical treatment and expenses has not been issued and the claim is subsequently denied; payment in such situations must be determined on a case-by-case basis.[20] In this case, appellant was transported to the emergency room for examination immediately after the employment incident. The employing establishment provided appellant with a CA-16 form within a week of the employment incident. In denying appellant's claim for a traumatic injury, OWCP did not address whether emergency circumstances or unusual circumstances were present or whether this was a situation in which reimbursement of medical expenses was appropriate.[21] It is required to exercise its discretion to determine whether medical care has been authorized or whether unauthorized medical care involved emergency or unusual circumstances.[22] The circumstances of the case warrant additional development of this issue. The case shall be remanded to OWCP

[16] 5 U.S.C. § 8102(2) of FECA provides as follows: "(2) 'physician' includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law."

[17] *C.P.*, Docket No. 13-831 (issued July 12, 2013).

[18] *See Tracy P. Spillane*, 54 ECAB 608 (2003).

[19] *See* 20 C.F.R. § 10.300(c).

[20] *Id.* at 10.304.

[21] *P.S.*, Docket No. 10-1560 (issued June 23, 2011).

[22] *Michael L. Malone*, 46 ECAB 957 (1995). *See Herbert J. Hazard*, 40 ECAB 973 (1989).

for further development consistent with this decision of the Board, followed by an appropriate decision.[23]

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that his diagnosed facial and oral conditions are causally related to the March 5, 2012 employment incident, as alleged. The case will be returned to OWCP for consideration of whether appellant's medical expenses related to his treatment from the March 5, 2012 incident should be reimbursed.

ORDER

IT IS HEREBY ORDERED THAT the September 11, 2013 decision of the Office of Workers' Compensation Programs is affirmed. The case is remanded for further development consistent with this decision of the Board.

Issued: May 5, 2014
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

[23] *A.F.*, Docket No. 13-520 (issued May 17, 2013).