

field office along the Jersey shore following Hurricane Sandy. On the morning of January 2, 2013, appellant had just mailed some work-related parcels at a local postal facility when she tripped and fell on the adjacent walkway. On her Form CA-1, she identified her injuries as bruises and scrapes on the left side of her face, forehead, below the left eye, and above her lip. Appellant also reported bruises and scrapes on both hands. A colleague who was waiting for appellant outside of the postal facility reported having observed her facial injuries. Appellant told her coworker that she fell. Later that morning, she sought treatment at a local hospital emergency department. Dr. Rosalia C. Riguerra, a Board-certified internist, diagnosed multiple superficial abrasions to the face, right hand, left hand, and left knee. She also diagnosed right and left knee contusions.

According to appellant, the employing establishment terminated her services effective February 15, 2013.²

OWCP initially denied appellant's claim, but subsequently accepted that she sustained multiple superficial abrasions to her face, hands, and left knee, as well as contusions to both knees as a result of her January 2, 2013 work-related fall.

Appellant later complained of headache, dizziness, and earache. She claimed to have had a knot on her forehead after she fell and hit the pavement. A February 28, 2013 brain computerized tomography (CT) scan was negative. Appellant also complained of left and right knee pain. Her bilateral knee magnetic resonance imaging (MRI) scans dated March 18, 2013 were both negative.

On April 15, 2013 Dr. Michael A. Cerruti, a Board-certified orthopedic surgeon, diagnosed bilateral knee sprain and contusion. He referred appellant for physical therapy (PT). OWCP also received appellant's April 22, 2013 initial PT evaluation conducted by Lisa Definis, a licensed physical therapist.

Dr. Jason K. Chang, a Board-certified internist, examined appellant on May 6, 2013 and diagnosed right leg cellulitis. He noted that she had fallen in New Jersey in January and sustained a mild upper leg scratch just below her right knee. Appellant subsequently developed a rash with small bumps then blisters, and was treated at an urgent care facility in early March 2013. Dr. Chang noted that at the time she was given an oral antibiotic and a cream, which seemed to have initially resolved the problem. However, the condition recurred, and on March 26, 2013 appellant was seen at the U.C. Davis emergency department where she was treated for eczema/dermatitis versus psoriasis. Her treatment consisted of hydrocortisone cream and Clindamycin, an oral antibiotic. Since then the infection seemed to subside, but Dr. Chang noted residual hyperpigmentation of the skin just below appellant's knee. The patch area measured approximately 4 x 7 centimeters. Appellant indicated that she attended a cardiopulmonary resuscitation (CPR) class yesterday (May 5, 2013) and was bent over on her knees and legs. She reported developing small blisters on her right upper leg just below the knee. Some of the blisters had opened with serious drainage. Appellant also reported redness, swelling, and some discomfort to the area. Dr. Chang ordered a wound culture and x-rays of the

² After returning home to California, appellant worked for a real estate brokerage firm and as a substitute teacher.

right tibia/fibula. He also prescribed Clindamycin, and advised appellant to follow-up with her primary care physician in five to seven days.

The May 6, 2013 right tibia/fibula x-ray showed presumed old post-traumatic changes of the medial malleolus (ankle), and was otherwise unremarkable.

On May 9, 2013 Dr. Chang advised appellant that the wound culture revealed Staph as the primary cause of her infection. He further advised that this condition should be treated with Clindamycin.

In a May 13, 2013 follow-up examination, Dr. John T. Hosoume diagnosed cellulitis and abscess of the right anterior tibia.³ He prescribed Clindamycin. Appellant's symptoms had gradually improved over the past week and her right tibia cellulitis was noted to be "resolving." Dr. Hosoume saw appellant again on August 15, 2013 and released her to resume full duties without restrictions.

In a September 5, 2013 report, Dr. Cerruti noted that early in the year appellant tripped on an uneven walkway and fell, landing on both knees. He further noted that she developed a secondary infection with cellulitis over the anterior aspect of the right tibia just below the tibial tubercle. Dr. Cerruti indicated that when he initially saw appellant on April 15, 2013, it was three months post injury and the skin in the cellulitic area showed some discoloration and darkening, but the infection did not appear to extend deeply. At that time, there was no drainage or oozing. Dr. Cerruti also noted that appellant's March 18, 2013 bilateral knee MRI scans showed intact menisci. His initial diagnosis was sprain/contusion of the right knee with cellulitis over the right tibial tubercle. Appellant's treatment included PT and quad strengthening. On follow-up examination, Dr. Cerruti reported slow improvement. Appellant's right knee range of motion was full and the cellulitic area on the right proximal leg appeared to be healing. Dr. Cerruti advised her to complete the full six weeks of PT. When appellant returned for follow-up on May 23, 2013, he noted that appellant still had some pain around the right knee and there was a change in the cellulitic area with some blisters popping up. Dr. Cerruti indicated that she reported that a culture revealed Staph and she had been prescribed Clindamycin. His May 23, 2013 examination revealed hypertrophic pigmentation and discoloration around the knee with a small eschar inferiorly about eight millimeters in greatest dimension. Dr. Cerruti also noted mild diffuse swelling of the whole lower extremity, with no pitting edema. Tests for deep venous thrombosis were negative. Dr. Cerruti again diagnosed contusion/sprain right knee slowly resolving and history of blistering and cellulitis right leg. He noted that, since the May 23, 2013 examination, appellant's condition had improved. Appellant apparently went on a trip and did some sunbathing, which seemed to help her right leg. Dr. Cerruti noted that she presently complained of some mild pain and stiffness in the right knee and also in the right hip region.

Appellant's September 5, 2013 physical examination revealed full range of motion in both the right knee and right hip. Dr. Cerruti noted there was ligamentous laxity and her McMurray's test was negative. There were no other signs of significant problems. Dr. Cerruti also reported that appellant's neurovascular status was intact in both lower extremities.

³ Dr. Chang previously advised appellant to follow-up with Dr. Hosoume, who is a Board-certified internist.

Additionally, he noted that the area of skin where the cellulitis once appeared seemed to now be healed. Lastly, Dr. Cerruti indicated that there was still some mild swelling in the right leg as compared to appellant's left leg.

Dr. Cerruti diagnosed contusion/sprain right knee with secondary cellulitis, healed. He noted that there was still some mild residual right knee pain and stiffness, which he thought was perhaps due to early degenerative joint disease rather than a significant internal derangement. Dr. Cerruti did not plan further diagnostic tests or surgery. His only recommendation was a follow-up visit in three months.

In a September 25, 2014 decision, OWCP's Branch of Hearings and Review accepted that appellant sustained multiple superficial abrasions to her face, hands, and left knee, as well as contusions to both knees. The acceptance was based on Dr. Riguerra's January 2, 2013 diagnosis. However, the hearing representative did not accept appellant's claimed headache, earache, and right knee/leg cellulitis.

LEGAL PRECEDENT

A claimant seeking benefits under FECA has the burden of establishing the essential elements of her claim by the weight of the reliable, probative, and substantial evidence, including that an injury was sustained in the performance of duty as alleged and that any specific condition or disability claimed is causally related to the employment injury.⁴

To determine if an employee sustained a traumatic 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 that must be considered in conjunction with one another. The first component is whether the employee actually experienced the employment incident that allegedly occurred.⁵ The second component is whether the employment incident caused a personal injury.⁶ An employee may establish that an injury occurred in the performance of duty as alleged, but fail to establish that the disability or specific condition for which compensation is being claimed is causally related to the injury.⁷

⁴ 20 C.F.R. § 10.115(e), (f) (2014); see *Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996).

⁵ *Elaine Pendleton*, 40 ECAB 1143 (1989).

⁶ *John J. Carlone*, 41 ECAB 354 (1989). Causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue. See *Robert G. Morris*, 48 ECAB 238 (1996). A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factor(s) must be based on a complete factual and medical background. *Victor J. Woodhams*, 41 ECAB 345, 352 (1989). Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty, and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factor(s). *Id.*

⁷ *Shirley A. Temple*, 48 ECAB 404, 407 (1997).

ANALYSIS

OWCP accepted that appellant sustained multiple superficial abrasions to her face, hands, and left knee, as well as contusions to both knees. However, appellant also claims to have developed a secondary skin infection (cellulitis) on her right anterior tibia just below the knee. She also claimed post-traumatic headache and earache. Where 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.⁸

Appellant's February 28, 2013 brain CT scan is the only medical evidence ostensibly relevant to her claimed headache and/or earache. She indicated that she had a knot on her forehead from the January 2, 2013 fall, and the February 28, 2013 radiologist's report noted a history of headaches and dizziness due to trauma. However, the brain CT scan was negative.

Although appellant complained of headache and earache, which she believed were employment related, the current medical evidence does not support such a finding. Her personal belief that the work-related fall was responsible for her claimed headache and/or earache is insufficient, by itself, to establish causal relationship.⁹

Regarding appellant's right leg cellulitis, the Board notes that when Dr. Riguerra examined her on January 2, 2013, she warned of the possibility of infection and prescribed Bactroban, a topical antibiotic. At the time, Dr. Riguerra's only right knee diagnosis was contusion. Based on the current record, the first medical evidence of right leg cellulitis postdates appellant's accepted injury by approximately four months. Although appellant reported having been treated for a rash in March 2013, she did not provide OWCP the relevant medical records.

After the January 2, 2013 emergency department treatment records, the next medical evidence regarding appellant's right knee was her March 18, 2013 MRI scan, which was negative and did not otherwise address whether she had cellulitis. Dr. Cerruti's April 15, 2013 PT referral also did not address whether appellant had cellulitis. At that time, he diagnosed bilateral knee sprain and contusion. Similarly, Ms. Definis' April 22, 2013 initial PT evaluation noted evidence of anterior knee contusion/ecchymosis, but did not mention any evidence or history of infection.¹⁰

Dr. Chang's May 6, 2013 treatment notes were the first of record to include a diagnosis of right leg cellulitis. At the time, appellant complained of a right leg infection and reported having fallen in January in New Jersey. She described her injury as a mild upper leg scratch just

⁸ *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004).

⁹ 20 C.F.R. § 10.115(e); *Phillip L. Barnes*, 55 ECAB 426, 440 (2004).

¹⁰ Certain healthcare providers such as physician assistants, nurse practitioners, physical therapists and social workers are not considered "physician[s]" as defined under FECA. 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t). As such, their opinions will not suffice for purposes of establishing entitlement to FECA benefits. *K.W.*, 59 ECAB 271, 279 (2007); *David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006). A report from a physician assistant or certified nurse practitioner will be considered medical evidence if countersigned by a qualified physician. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3a(1) (January 2013).

below the right knee. Although the reported history included reference to treatment appellant received in March 2013 for a rash and eczema/dermatitis/psoriasis, the prior treatment records were not made part of the record. When Dr. Chang examined appellant on May 6, 2013, she reported having participated in a CPR class the previous day where she was bent over on her knees. He diagnosed cellulitis of the right leg and prescribed an antibiotic. The comment section of the report included a notation of chronic atopic dermatitis with superimposed re-infection. Dr. Chang requested a wound culture and x-rays of appellant's right tibia/fibula. He also advised that she follow-up with her primary care physician in five to seven days. Dr. Chang subsequently informed appellant that the skin culture revealed Staph infection, which should be treated with an antibiotic. The May 6, 2013 x-ray revealed a previous right ankle injury, but was otherwise unremarkable. Dr. Chang did not specifically attribute appellant's right leg cellulitis to her January 2013 fall.

Dr. Hosoume examined appellant on May 13, 2013 and diagnosed cellulitis and abscess of the right anterior tibia. However, he did not address the cause of the cellulitis and abscess.

In his September 5, 2013 report, Dr. Cerruti noted that earlier in the year, appellant tripped and fell, landing on both knees and she developed a secondary infection with cellulitis over the anterior aspect of the right tibia just below the tibial tubercle. He explained that he initially examined appellant three months postinjury, and at the time the skin in the cellulosic area showed some discoloration and darkening, but the infection did not appear to extend deeply. Also, there was no drainage or oozing at that time. Dr. Cerruti indicated that he initially diagnosed sprain/contusion of the right knee with cellulitis over the right tibial tubercle. The Board notes that the records submitted with respect to Dr. Cerruti's April 15, 2013 examination appear to be incomplete. The record before OWCP included Dr. Cerruti's April 15, 2013 referral for physical therapy, which did not mention cellulitis. Dr. Cerruti saw appellant again on May 23, 2013; however, those treatment records are also absent from the record. When he reexamined appellant on September 5, 2013, he diagnosed contusion/sprain right knee with secondary cellulitis, healed.

According to Dr. Cerruti, appellant's cellulitis was secondary to the right knee contusion/sprain she sustained earlier in 2013. He first examined appellant three months after her injury. Dr. Cerruti offered no explanation of how appellant's right knee contusion developed into cellulitis. Moreover, he did not explain how he was able to relate appellant's skin infection to a fall that occurred some three months prior to his initial examination. A physician's opinion on causal relationship must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factor(s).¹¹ Dr. Cerruti merely concluded without explanation that appellant "developed a secondary infection with cellulitis...."

The Board finds that the medical evidence of record fails to establish that appellant's claimed headache, earache, and right knee/leg cellulitis are causally related to her January 2, 2013 work-related fall. Accordingly, OWCP properly declined to accept these additional medical conditions.

¹¹ *Victor J. Woodhams, supra* note 6.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision.¹²

CONCLUSION

Appellant failed to establish that her claimed right knee/leg cellulitis are causally related to her January 2, 2013 employment injury.

ORDER

IT IS HEREBY ORDERED THAT the September 25, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 10, 2015
Washington, DC

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

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

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

¹² 5 U.S.C. § 8128(a); 20 C.F.R. §§ 10.605-10.607.