United States Department of Labor
Employees' Compensation Appeals Board

R.D., Appellant	)	
and	)	**Docket No. 13-1854**
	)	**Issued: December 23, 2013**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Beckley, WV, 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
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge

JURISDICTION

On August 6, 2013 appellant filed a timely appeal from a March 29, 2013 merit decision and a July 15, 2013 nonmerit 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.

ISSUES

The issues are: (1) whether appellant met his burden of proof to establish an injury in the performance of duty on July 24, 2012; and (2) whether OWCP properly denied his request for an oral hearing as untimely.

FACTUAL HISTORY

On August 17, 2012 appellant, then a 60-year-old maintenance mechanic leader, filed a traumatic injury claim (Form CA-1) alleging that on July 24, 2012 he sustained contusions of the

[1] 5 U.S.C. § 8101 *et seq.*

head, back, leg and arm when he fell in a stairwell at the employing establishment. He notified his supervisor on August 17, 2012.

In a record of diagnostic testing dated December 21, 2012, Dr. Enrico Cappiello, a Board-certified radiologist, performed a magnetic resonance imaging (MRI) scan examination of appellant's right knee. He noted that the knee exhibited an extensive horizontal tear of the medial meniscus at the base of the posterior horn extending through the body into the anterior horn of the medial meniscus. Dr. Cappiello also noted a small joint effusion in association with a very small synovial recess behind the posterior aspect of the medial tibial plateau.

By letter dated January 17, 2013, Dr. Zahir noted that on July 24, 2012, appellant fell down the steps at the employing establishment and injured his right knee. He noted that appellant wore braces on his legs due to plantar fasciitis. Dr. Zahir also noted that appellant had a history of dizziness, hypertension, stomach ulcer and depression. He stated that the MRI scan examination performed by Dr. Cappiello revealed evidence of a complex medial meniscus tear of the right knee. Dr. Zahir reported his clinical impression of internal derangement and torn medial meniscus of the right knee, cervical spinal canal stenosis, hypertension, stomach ulcer and depression. He recommended that appellant have an arthroscopic surgery, a synovectomy, meniscetomy and chondroplasty if indicated. In a note dated January 17, 2013, Dr. Syed A. Zahir, a Board-certified orthopedic surgeon, stated that appellant had been examined in his office on that date. He recommended that appellant take six weeks off from work, to return on March 5, 2013.

By letter dated February 15, 2013, OWCP informed appellant that the evidence of record was insufficient to support his claim. It afforded him 30 days to submit additional evidence and respond to its inquiries.

By letter dated February 25, 2013, appellant stated that on the morning of July 24, 2012 he started his shift at 7:00 a.m. Appellant began to make his usual rounds, going from the first floor of the employing establishment to the basement. He stated that he remembered starting to walk down stairwell five and grabbing the handrail, but that the next thing he knew, he was lying on his back on the landing between two floors and he was in pain. Appellant estimated that he fell down at least three steps, and noted that there was no one else in the stairwell. When he rose, he was aware of pain in his lower back, buttocks, right knee, right elbow and the middle digit of his right hand. His right elbow was skinned and bleeding. When appellant picked himself up, he continued his work assignment. Later, appellant told, a coworker, about the incident, and became aware that his back was hurting to a greater extent than before. At the coworker's insistence, appellant decided that the best thing to do was to go to the emergency room. He explained the incident to his supervisor, who gave him a slip to go to the emergency room. The emergency room staff ran tests and took x-rays of appellant's lower back, right knee, head and neck and right hand. Appellant was in the emergency room for approximately six hours, after which he was admitted overnight for observation. He was discharged the next day with orders for more tests and excused from work for the next two days. Appellant noted that he currently had some back pain, but that the pain in his right knee had gotten progressively worse, despite the use of pain medication, a knee brace and a cane. He stated that, prior to the fall, he did not have knee pain, and that the injury to his right knee was the direct result of his fall down the stairwell. Appellant reported that he was not sure what caused him to fall, but that he had some dizziness in the past, thought to be caused by his blood pressure. He asserted that he was

not aware of any hazard or special condition that caused or contributed to his fall. In a narrative statement dated February 25, 2013, the supervisor confirmed that appellant reported on the morning of July 24, 2012 that he had fallen down steps in stairwell five. Appellant told his supervisor that he was in a lot of pain in his knees, hands and head. The supervisor completed a sick call slip for him to go to the Employee Health division, and appellant was admitted the same day for treatment at the employing establishment.

In a narrative statement dated February 25, 2013, appellant's coworker stated that when appellant arrived at work on July 24, 2012, he told him that he was in pain. Appellant advised that he had fallen down stairwell five in the main building at the employing establishment. The coworker walked appellant to the emergency room and stayed with him until his wife arrived.

In a record of diagnostic testing dated July 30, 2012, Dr. Rajendra Valiveti, a radiologist, performed an MRI scan evaluation of appellant's cervical spine. He noted a predisposition to spinal stenosis, a tiny central subligamentous disc at C5-6 that produced a borderline spinal stenonsis with the sagittal diameter of the spinal canal reduced to approximately nine millimeters, and severe narrowing of the left neural foramen at C6-7 due to Luschka joint disease. Dr. Valiveti stated his impression of mild-to-moderate degenerative changes of the cervical spine.

In progress notes dated July 30, 2012, Dr. Valiveti reviewed the results of x-ray examinations performed on July 24, 2012, the date of injury. On examination of appellant's right hand, he noted no fracture or bony subluxation, and minimal to mild degenerative changes at the distal interphalangeal joints. On examination of the lumbar spine, Dr. Valiveti noted no fractures, disc space narrowing, and minimal osteophyte formation. On examination of the thoracic spine, he noted no fractures and mild degenerative changes. On examination of the right knee, Dr. Valiveti noted no fracture or bony subluxation, an intact knee joint space and minimal degenerative changes at the patellofemoral joint. In the same medical records, there appears an unsigned review of the results of an echocardiogram performed on July 26, 2012, in which a person noted under the heading of clinical history that appellant had a syncopal episode with dizziness.

In a record of diagnostic testing dated December 22, 2012, Dr. Ben Paxton, a Board-certified radiologist, reviewed the results of x-rays of appellant's knees performed on December 21, 2012. He stated his findings of no acute fracture or dislocation, no joint effusion and minimal bilateral medial compartment joint space narrowing.

In progress notes dated December 27, 2012, Dr. John E. Traynham, a Board-certified orthopedic surgeon, reviewed the results of an MRI scan evaluation of appellant's right knee. He stated his impression of a complex medial meniscus tear of the right knee with a posterior meniscal cyst. Dr. Traynham noted that most of appellant's symptoms were related to degenerative meniscal changes and the cyst. He injected appellant's knee with Kenalog to relieve pain.

By decision dated March 29, 2013, OWCP denied appellant's claim, finding that the evidence of record failed to establish that appellant was in the performance of duty. It stated that his fall was idiopathic, because appellant and Dr. Zahir's January 17, 2013 report noted prior dizzy spells.

On May 29, 2013 appellant requested an oral telephonic hearing before an OWCP hearing representative.

By decision dated July 15, 2013, OWCP denied appellant's request for an oral hearing as untimely.

LEGAL PRECEDENT -- ISSUE 1

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 is causally related to the employment injury.[2] These are the essential elements of every compensation claim regardless of whether the claim is predicated on a traumatic injury or an occupational disease.[3]

A traumatic injury is defined as a condition of the body caused by a specific event or incident, or series of events or incidents, within a single workday or shift.[4] 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.[5] The second component is whether the employment incident caused a personal injury and generally can be established only by medical evidence.

It is a well-settled principle of workers compensation law and the Board has so held, that an injury resulting from an idiopathic fall -- where a personal, nonoccupational pathology causes an employee to collapse and to suffer injury upon striking the immediate supporting surface and there is no intervention or contribution by any hazard or special condition of employment -- is not within coverage of FECA.[6] Such an injury does not arise out of a risk connected with the employment and is, therefore, not compensable. The Board has made equally clear, the fact that the cause of a particular fall cannot be ascertained or that the reason it occurred cannot be explained, does not establish that it was due to an idiopathic condition.

The question of causal relationship in such cases is a medical one and must be resolved by medical evidence.[7] This follows from the general rule that an injury occurring on the industrial premises during working hours is compensable unless the injury is established to be

[2] *Gary J. Watling*, 52 ECAB 278, 279 (2001); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[3] *Michael E. Smith*, 50 ECAB 313, 315 (1999).

[4] 20 C.F.R. § 10.5(ee).

[5] *See Elaine Pendleton*, *supra* note 2.

[6] *See Carol A. Lyles*, 57 ECAB 265, 268 (2005).

[7] *Y.J.*, Docket No. 08-1167 (issued October 7, 2008); *A.D.*, 58 ECAB 149, 155-56 (2006); *D'Wayne Avila*, 57 ECAB 642, 649 (2006).

within an exception to such general rule.[8] If the record does not establish that the particular fall was due to an idiopathic condition, it must be considered as merely an unexplained fall, one which is distinguishable from a fall in which it is definitely proved that a physical condition preexisted and caused the fall.[9]

ANALYSIS -- ISSUE 1

The Board finds that appellant's fall on July 24, 2012 occurred in the performance of duty. If the cause of a particular fall cannot be ascertained, the fall is then considered an unexplained fall.[10] To properly apply the idiopathic fall exception to the premises rule, there must be two elements present: a fall resulting from a personal, nonoccupational pathology and no contribution from employment.[11] OWCP has the burden to present medical evidence showing the existence of a personal nonoccupational pathology; the mere fact that an employee has a preexisting medical condition, without supporting medical rationale, is not sufficient to establish that a fall is idiopathic.[12]

The medical evidence in this case does not clearly establish that appellant's fall was idiopathic. While appellant indicated in his letter dated February 25, 2013 that he had a history of dizziness thought to be caused by blood pressure, he also indicated that he was not aware of any special conditions that caused his fall, and noted on his CA-1 claim form that the cause of his injury was unknown. The medical evidence regarding appellant's condition causing dizziness is scant. By letter dated January 17, 2013, Dr. Zahir noted that appellant had a history of dizziness, hypertension, stomach ulcer and depression. In an unsigned review of the results of an echocardiogram performed on July 26, 2012, a person noted under the heading of clinical history that appellant had a syncopal episode with dizziness.

Unsigned medical reports are of no probative value when their authorship cannot be determined, as it cannot be discerned whether a physician signed the reports.[13] Therefore, the review of the results of an echocardiogram performed on July 26, 2012 has no probative value.

While the opinion of a physician supporting causal relationship need not be one of absolute medical certainty, the opinion must not be speculative or equivocal. The opinion should be expressed in terms of a reasonable degree of medical certainty.[14] As there is no conclusive evidence regarding the cause of the July 24, 2012 fall, it must be considered an unexplained fall

[8] *N.P.*, Docket No. 08-1202 (issued May 8, 2009); *Dora J. Ward*, 43 ECAB 767, 769 (1992); *Fay Leiter*, 35 ECAB 176, 182 (1983).

[9] *John R. Black*, 49 ECAB 624, 626 (1998); *Judy Bryant*, 40 ECAB 207, 213 (1988); *Martha G. List*, 26 ECAB 200, 204-05 (1974).

[10] *See Martha G. List*, *supra* note 9.

[11] *N.P.*, *supra* note 8.

[12] *See Steven S. Saleh*, 55 ECAB 169, 172-73 (2003).

[13] *See Merton J. Sills*, 39 ECAB 572, 575 (1988).

[14] *Ricky S. Storms*, 52 ECAB 349, 352 (2001).

that occurred in the performance of duty.[15] The case must therefore be remanded to OWCP to determine the nature and extent of any injury or disability that resulted from the fall. After such further development deemed necessary, OWCP shall issue an appropriate decision.

In light of the Board's findings regarding Issue 1, Issue 2 is rendered moot.[16]

CONCLUSION

The Board finds that appellant's July 24, 2012 fall at work was an unexplained fall and therefore occurred within the performance of duty.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 29, 2013 is set aside and the case is remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: December 23, 2013
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

[15] *Steven S. Saleh*, *supra* note 12.

[16] *See P.Y.*, Docket No. 11-937 (issued August 28, 2012).