United States Department of Labor
Employees' Compensation Appeals Board

A.P., Appellant	)	
and	)	**Docket No. 14-221**
	)	**Issued: April 15, 2014**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION MEDICAL CENTER, Tuskegee, AL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 12, 2013 appellant, through her attorney, filed a timely appeal from the October 8, 2013 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.

ISSUE

The issue is whether appellant met her burden of proof to establish that she sustained a traumatic injury in the performance of duty on May 9, 2011.

FACTUAL HISTORY

On May 17, 2011 appellant, then a 55-year-old nurse, filed a traumatic injury claim alleging that on May 9, 2011 she felt a sharp jolt to her left finger and arm as she turned on a light switch. She stopped work on May 9, 2011.

[1] 5 U.S.C. § 8101 *et seq.*

On May 26, 2011 OWCP advised appellant of the additional factual and medical evidence needed to establish her claim.

In a May 9, 2011 incident report, the employing establishment noted that appellant went into a resident's room to turn the light switch on. It was broken and she received a shock on her right finger radiating up her right arm. An engineering safety official noted that "[e]ven if the light switch was broke the chance of being shocked by flipping a switch would be [slim]."

OWCP received several treatment notes from Dr. John B. Riser, a Board-certified neurologist and physiatrist. In a September 30, 2010 report, Dr. Riser advised that appellant was being treated for relapsing remitting multiple sclerosis (MS). He noted that she was relatively stable on medication for over 15 years but was having some difficulties with ataxia. In a May 9, 2011 treatment note, Dr. Riser obtained a history that appellant had experienced an electric shock to the left index finger that caused a dull pain. In a May 16, 2011 report, he noted that there was an electrical switch malfunction that shocked the left side of her hand and went up to her chest. Appellant felt more numbness on the left side and had trouble expressing herself. Dr. Riser noted that she did not have any recent febrile illness and continued to take Betaseron for immunomodulating treatment and Ampyra for ambulation. On examination, he noted mild bilateral internuclear ophthalmic plegia, cranial nerves 2 to 12 were otherwise intact, motor examination 5/5 throughout, reflexes brisk throughout, mild proprioceptive loss in the feet, patient has a broad-based gait but can ambulate with no assisted device. Dr. Riser reviewed a cranial magnetic resonance imaging (MRI) scan with and without contrast. He advised possible "Soul-Medrol post MRI scan if not internal improvement and recommended continuing the current medications." In a May 18, 2011 report, Dr. Riser noted treating appellant for MS for a number of years. He related that she had a recent on-the-job injury in which she was shocked by a light switch which exacerbated her condition. A cranial MRI scan on May 20, 2011 revealed dozens of MS defects throughout the midbrain, cerebellum and cerebrum and additional mild diffuse cerebral atrophy.

In a July 8, 2011 decision, OWCP denied appellant's claim. It found that the factual evidence did not support that the claimed event occurred as alleged.

In an August 1, 2011 report, Dr. Riser noted that appellant had MS which was exacerbated following the recent on-the-job incident. Appellant was unable to return to work because of persistent neurological defects. Dr. Riser saw her on August 4, 2011, and noted that she was unable to report to work as she had persistent balance issues and cognitive problems. In reports dated October 12 and December 1, 2011, he advised that appellant was frustrated by her residual neurological problems including difficulty with cognition and balance. Appellant ambulated with a rolling walker and had some problems with endurance, but did not have any recent falls or neurological deterioration.

On June 28, 2012 appellant's attorney requested reconsideration.[2]

[2] On January 11, 2012 appellant appealed to the Board. The Board issued an order on August 31, 2012 dismissing the appeal at her request. Docket No. 12-559.

In an April 11, 2012 report, Dr. Riser provided an update on appellant's neurological condition. Appellant had a recent exacerbation of MS and continued to have problems with balance and memory and could not return to work. Dr. Riser noted that her prognosis was guarded because of her persistent neurological defects despite treatment and physical therapy. On June 27, 2012 he explained that appellant was stable until she was subjected to a specific incident at work involving an electrical shock from a defective light switch. Following the incident, appellant had a significant worsening of her neurological symptoms and her disease despite aggressive treatment with steroids and other medications. Dr. Riser explained that she went from being ambulatory and independent and able to work as a nurse, to only be able to walk with the assistance of a rolling walker and was not able to return to gainful employment. He opined that the "exacerbation of [appellant's] disease appears to be permanent based on the lack of interval improvement over this period of time."

In a June 22, 2012 report, Dr. Michael L. Aitkens, a Board-certified internist, advised that appellant was a patient who was diagnosed with mitral valve prolapse, palpitations, hyperlipidemia, hypertension and MS. He noted that she was referred to him after she sustained an electrical shock while at work. Dr. Aitkens related that appellant had fatigue and weakness. He ordered physical therapy and aqua therapy and noted that she also had symptoms of restless legs syndrome.

On January 14, 2013 appellant's attorney requested reconsideration. In a January 25, 2012 letter, appellant stated that since May 9, 2011 she was off duty and continued to have exacerbation of her MS and was unable to work. In a January 20, 2012 letter, appellant described her injury. Photos of the light switch accompanied her letters. An October 8, 2010 MRI scan of the brain showed extensive bilateral T2 hyper intensities throughout the right and left cerebral hemispheres typical for MS.

In an October 19, 2012 report, Dr. Riser explained that appellant was stable until an incident at work in May 2011, when she sustained an electrical shock while entering a patient's room. He stated that this caused a "worsening of her neurological symptoms despite aggressive treatment. Dr. Riser indicated that appellant walked with a rolling walker and had problems with cognition, memory and balance. He advised that she was unable to return to work.

In a letter dated January 25, 2013, Lasiandra Smith, a workers' compensation specialist, controverted the claim. She noted that, when the incident occurred, the fire department was called and tape was placed over the area in question until the engineering department could take care of the matter.

By decision dated March 13, 2013, OWCP denied modification of the July 8, 2011 decision.

On March 28, 2013 counsel requested reconsideration. He contended that appellant submitted sufficient evidence to establish her claim. In a February 21, 2013 report, Dr. Riser noted that she was seen in follow up for secondary progressive prolapsing MS. He stated that appellant had an overall "continent function now and Lipitor with a rolling walker, but had problems with recurrent falls despite physical therapy efforts." Dr. Riser noted that she was concerned about the initial injury with a light switch which seemed to have accelerated her MS.

By decision dated May 14, 2013, OWCP modified the March 13, 2013 decision. It found that the light switch incident occurred as alleged. OWCP found that the medical evidence was not sufficient to establish that the light switch incident worsened appellant's preexisting MS.

On July 10, 2013 appellant's attorney requested reconsideration. He reiterated that appellant provided sufficient evidence to establish the claim. OWCP also received another statement from her describing her employment incident.

In a June 25, 2013 report, Dr. Riser noted that appellant was his patient for the past 20 years with relapsing remitting MS. Appellant was stable working full time as a nurse with minimal neurological problems until she was shocked by a defective light switch on May 9, 2011 at work. Following the incident, she had significant progression of her disease, including problems with her vision, thinking ability and balance such that she was unable to work in any capacity and required a rolling walker for ambulation. Dr. Riser explained that the cranial MRI scan subsequent to the injury did not show any significant changes. Due to appellant's abnormal baseline MRI scan, there often was no direct correlation between the clinical disease activity and MRI scan findings. Dr. Riser opined that "the shock caused by the light switch had a negative impact on her MS which has persisted to this day."

By decision dated October 8, 2013, OWCP denied modification of the May 14, 2013 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] 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 timely filed within the applicable time limitation period of FECA[4] and that an injury was sustained in the performance of duty.[5] These are the essential elements of each compensation claim, regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[6]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether the fact of injury has been established. There are two components involved in establishing the fact of injury. First, the employee must submit sufficient evidence to establish that he or she actually experienced the employment incident at the time, place and in the manner alleged.[7] In some traumatic injury cases, this component can be established by an employee's uncontroverted statement on the Form CA-1.[8]

[3] 5 U.S.C. §§ 8101-8193.

[4] *Joe D. Cameron*, 41 ECAB 153 (1989).

[5] *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[6] *Delores C. Ellyett*, 41 ECAB 992 (1990).

[7] *Julie B. Hawkins*, 38 ECAB 393, 396 (1987); *see* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Fact of Injury*, Chapter 2.803.2a (June 1995).

[8] *John J. Carlone*, 41 ECAB 354 (1989).

Second, the employee must submit sufficient evidence, generally only in the form of medical evidence, to establish that the employment incident caused a personal injury.[9]

Rationalized medical opinion evidence is generally required to establish causal relationship. The opinion of the physician must be based on a complete factual and medical background, 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.[10]

ANALYSIS

The Board finds that this case is not in posture for decision.

Appellant alleged that on May 9, 2011 she was shocked when she turned on a light switch. She felt a sharp jolt to her left finger and arm into her chest. OWCP accepted that the incident occurred as alleged.

The issue is whether the medical evidence is sufficient to establish that the employment incident caused an injury. The medical reports from Dr. Riser are generally supportive of appellant's claim. Dr. Riser stated that he had followed appellant for 20 years and found that the May 9, 2011 incident exacerbated her MS. On May 18, 2011 he noted that she was a patient of his for a number of years with relapsing MS and advised that she had a recent on-the-job injury in which she was shocked by an open light switch which caused an exacerbation of her preexisting condition. In an August 1, 2011 report, Dr. Riser noted that appellant had MS which was exacerbated by the May 9, 2011 incident. He advised that she was unable to return to work because of persistent neurological defects. In a June 27, 2012 report, Dr. Riser explained that "following the incident, [appellant] had significant worsening of her neurological symptoms and her disease despite aggressive treatment." He noted that she went from being ambulatory and independent in her employment as a nurse but was disabled for gainful employment and her condition was permanent. Dr. Riser advised that the electrical shock caused a worsening of appellant's neurological symptoms. After the incident, appellant had significant progression of her disease including problems with her vision, thinking ability and balance such that she was been unable to work in any capacity and required a rolling walker for ambulation. Dr. Riser opined that "the shock caused by the light switch had a negative impact on her MS which has persisted to this day." While none of these reports were completely rationalized, they were consistent in indicating that appellant sustained an employment-related exacerbation of her MS.

Proceedings under FECA are not adversarial in nature nor is OWCP a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.[11] While

[9] *See supra* note 8. For a definition of the term "traumatic injury," *see* 20 C.F.R. § 10.5(ee).

[10] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[11] *William J. Cantrell*, 34 ECAB 1223 (1983).

Dr. Riser did not provide sufficient rationale in his support of causal relationship, his reports raise an inference of causal relationship sufficient to require further development of the case.[12]

On remand, OWCP should refer appellant, the case record and a statement of accepted facts to an appropriate specialist for an evaluation and a rationalized medical opinion on whether the May 9, 2011 incident caused or contributed to her condition and disability for work. After such further development of the case record as OWCP deems necessary, a *de novo* decision shall be issued.

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the October 8, 2013 decision of the Office of Workers' Compensation Programs is set aside and remanded.

Issued: April 15, 2014
Washington, DC

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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

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

[12] *See supra note 8*; *Horace Langhorne*, 29 ECAB 820 (1978).