United States Department of Labor
Employees' Compensation Appeals Board

L.B., Appellant	)	
and	)	**Docket No. 13-1640**
	)	**Issued: March 21, 2014**
DEPARTMENT OF THE ARMY,	)	
Fort Bragg, NC, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 1, 2013 appellant, through her attorney, filed a timely appeal from a May 30, 2013 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's collapse at work and cardiac arrest on October 16, 2010 was in the performance of duty within the meaning of FECA; and (2) whether appellant met her burden of proof to establish that she sustained a stress-related condition causally related to her federal employment.

On appeal, appellant's attorney asserts that, as her job duties as a dispatcher are inherently stressful, she has established a compensable factor of employment and therefore the case must be remanded to OWCP to address the medical evidence of record.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On October 17, 2012 a traumatic injury claim was filed on appellant's behalf. The claim form indicated that appellant, then a 43-year-old public safety dispatcher, fell from her chair and went into cardiac arrest on October 16, 2012. She was taken to the Womack Army Medical Center (WAMC).[2] Appellant stopped work that day.

By letter dated November 6, 2012, OWCP informed appellant of the type of evidence needed to support her claim. In a November 21, 2012 statement, she indicated that her memory of the events of that day were unclear. Appellant described her job duties, stating that she received administrative and 911 calls that included giving instructions to people experiencing medical emergencies and that the volume of calls varied from day to day.

A number of witness statements were submitted by coworkers. Curtis M. Forte indicated that at 10:04 a.m. on October 16, 2012 he observed appellant returning to her seat when she fell, hit her head and was unconscious and unresponsive. He related that the emergency medical service (EMS) was called and that Christine Ansell began cardiopulmonary resuscitation (CPR) and rescue breathing and applied a defibrillator until EMS arrived and took over. Mr. Forte indicated that appellant was transported to WAMC. Jack C. Marshall indicated that he observed her collapse to the ground as she was walking from the break room and described the efforts made by personnel until EMS arrived. Pretto R. Scott indicated that he did not see appellant fall but heard a "thump" when she fell to the floor. He stated that she appeared to be unconscious and unresponsive. Mr. Scott indicated that he notified EMS and described the care given until EMS arrived. Clydean S. Matthews also described the efforts to revive appellant. Ms. Ansell stated that she heard the thump when appellant fell and described the medical efforts she and others made until EMS arrived. Deborah Holfelder, dispatch supervisor, also heard a loud thud and saw appellant on the floor and coworkers assisting her. She stated that she knew that appellant was in cardiac arrest before transport to WAMC.

An OWCP Form CA-16, authorization for examination, dated October 17, 2012, indicated that appellant was authorized to receive office and/or hospital treatment as medically necessary for the effects of the injury.

Appellant provided the WAMC emergency room report dated October 16, 2012, in which Dr. Rebecca A. Calhoun, Board-certified in emergency medicine, described a history that a coworker heard a thump and found appellant unresponsive; CPR was administered; EMS was called and appellant was transported to the WAMC emergency room. Dr. Calhoun provided examination findings and described emergency care. She indicated that appellant was admitted and diagnosed cardiac arrest. In a history and physical report, Dr. David C. Deblasio, a Board-certified internist, described a history that appellant fell out of her chair with a subsequent cardiac arrest. He noted that the family reported that, one month prior to admission at WAMC, she had gastric bypass surgery at Cape Fear Valley Medical Center and that she had multiple complications thereafter. Dr. Deblasio stated that, three days after appellant's initial discharge following the procedure, she passed out and was hospitalized for three days and that, two days after being discharged the second time, she was readmitted for complaints of hematemesis and

[2] The claim was filed on appellant's behalf by Victoria Post, Chief, Integrated Incident Management Center.

was then hospitalized for seven days, received six units of blood and was found to have a gastric ulcer. He indicated that since that time she had multiple episodes of emesis with decreased appetite. Studies done at WAMC included an unremarkable computerized tomography (CT) study of the brain. A CT study of the abdomen and pelvis demonstrated status post gastric bypass and diverticulosis without evidence of diverticulitis. Electrocardiogram (EKG) demonstrated a prolonged QT interval. In a discharge summary Dr. Hillary Thomas, Board-certified in emergency medicine, repeated appellant's medical history. She described appellant's hospital course at WAMC and indicated that discharge diagnoses were cardiac arrest, ventricular tachycardia and ventricular fibrillation. Appellant was stabilized at WAMC and on the evening of October 17, 2012 she was transferred to University of North Carolina Health Care (UNCHC) in Chapel Hill, NC, for definitive evaluation of coronary anatomy and etiology of cardiac arrhythmias.

Hospital records from UNCHC include an October 18, 2012 history and physical note in which Dr. Timothy C. Nichols, Board-certified in internal medicine, cardiovascular disease and interventional cardiology, described a history that appellant fell out of her chair at work and was found to be in cardiac arrest; that coworkers administered CPR and that appellant was transported to WAMC. Dr. Nichols also noted that she had a gastric bypass performed five weeks previously and described the complicated postoperative period and indicated that she had continued to struggle with abdominal pain and nausea since that time. He noted an additional past medical history including diabetes mellitus, hypertension, hyperlipidemia and depression. Dr. Nichols performed physical examination and diagnosed unspecified hyperlipidemia, uncontrolled diabetes and ventricular fibrillation.

In a consultation note dated October 18, 2012, Dr. John Mounsey, a Board-certified internist, indicated that, based on appellant's telemetry, she had long QT syndrome that was the underlying etiology of her recent sudden cardiac arrest.[3] He advised that this could be an acquired long QT related to her recent gastric bypass but this was not clear. Dr. Mounsey advised that she needed an eventual implant of a dual chamber cardioverter-defibrillator (ICD) for secondary prevention of sudden cardiac death. He indicated that appellant should be evaluated for an underlying cardiac disorder with a magnetic resonance imaging (MRI) scan study, coronary angiography, genetic screening and counseling.

An echocardiography study on October 18, 2012 was technically difficult and demonstrated left ventricular abnormalities. Cardiac catheterization on October 22, 2012 demonstrated nonobstructive coronary artery disease. On October 23, 2012 an ICD was implanted.

Appellant was discharged from UNCHC on October 25, 2012. In the discharge summary, Dr. Nichols described her hospital course, including that an ICD was implanted. He noted that her QT interval was significantly prolonged on EKG at admission and discharge, which was possibly secondary to medications or a genetic syndrome and stated that genetic test

[3] Long QT syndrome is defined as prolongation of the QT interval combined with torsades de pointes and manifest as several different forms; it may be acquired, usually due to metabolic or cardiac abnormality or to drug administration or congenital, occurring either with deafness or without. It may lead to serious arrhythmia and sudden cardiac death. *Dorland's Illustrated Medical Dictionary*, at 1823 (30th ed. 2003).

results were pending. Discharge diagnoses included ventricular fibrillation with arrest, unspecified hyperlipidemia, diabetes mellitus and hypertension.

In a November 16, 2012 report, Dr. Ross Simpson, Board-certified in internal medicine, cardiovascular disease and clinical cardiac electrophysiology, and Dr. John Rommel, a Board-certified internist, noted that appellant was seen in follow up. Examination findings were provided and the physicians diagnosed a long QT with cardiac arrest and hypertension. They indicated that they were waiting for results of the genotype of appellant's QT anomaly.

On November 23, 2012 appellant reported that she had been diagnosed with vertigo since the October 16, 2012 incident.

In a November 29, 2012 report, Dr. Robert M. Gabel, Board-certified in occupational medicine and a consultant at WAMC, controverted the claim. He indicated that he had reviewed appellant's medical records and statements from her and coworkers regarding the October 16, 2012 incident. Dr. Gabel maintained that there was no work exposure that caused or precipitated the incident. He indicated that appellant had an acute onset of ventricular tachycardia, torsades de pointes and/or ventricular fibrillation at work, noting that she had two significant risk factors for this potentially fatal cardiac dysrhythmia: low serum potassium, possibly from her medication and/or protracted vomiting over a couple of weeks and a history of a prolonged QT interval on her EKG studies. Dr. Gabel concluded that her cardiac irregularity, fall and cardiac arrest had no causal relationship under FECA.

By decision dated December 14, 2012, OWCP denied the claim on the grounds that fact of injury was not established. Appellant, through her attorney, timely requested a hearing.

In a January 23, 2013 report, Dr. Gabel indicated that he had examined appellant regarding her request to return to full duty. He indicated that she had a genetic marker for prolonged QT and a low threshold for cardiac arrhythmias and that she had returned to modified duty on January 11, 2013. Dr. Gabel advised that appellant could work without restrictions.

On February 15, 2013 Dr. Rommel advised that appellant had been seeking care at UNCHC for treatment of a genetic condition prolonging part of her EKG, which placed her at increased risk for dangerous arrhythmias. He opined that there was evidence that this condition could be triggered by stress and being startled. Dr. Rommel noted that appellant had a defibrillator implanted and that she was taking medication to help protect her heart.

At the hearing, held on March 13, 2013, appellant's attorney admitted that appellant had a genetic anomaly, long QT syndrome but, as maintained by Dr. Rommel, this could be triggered by stress and therefore her job duties caused the cardiac arrest. Appellant testified that her job duties as a dispatcher were stressful, noting that there were problems with a new computer system and that there had been an increased number of suicides at Fort Bragg. She indicated that morale was low due to staffing issues and that her QT syndrome was diagnosed after the October 16, 2012 incident.

In a March 27, 2013 report, Dr. Rajesh K. Khurana, Board-certified in family medicine, noted a history that on October 16, 2012 appellant collapsed to the ground in cardiac arrest while walking from the break room at work which led to hospitalization. He indicated that she had a

defibrillator and had been having left shoulder pain since the injury. In correspondence dated May 20, 2013, Edward M. Lemanski, chief of FECA division at the employing establishment, maintained that there was no mention of appellant having left shoulder pain in any physicians' reports until Dr. Khurana's March 27, 2013 note.

By decision dated May 30, 2013, an OWCP hearing representative modified appellant's traumatic injury claim to an occupational disease claim. She found that appellant's fall on October 16, 2012 was not caused by a factor of employment but was the result of a nonoccupational illness and was thus idiopathic. The hearing representative noted that appellant was not at her workstation at the time of her collapse and concluded that, as she did not establish a compensable factor of employment, she did not establish that she sustained a stress-related condition in the performance of duty. She affirmed the December 14, 2012 decision.

LEGAL PRECEDENT -- ISSUE 1

It is a general rule that where an injury arises in the course of employment, occurs within the period of employment, at a place where the employee reasonably may be and takes place while the employee is fulfilling his or her duties or is engaged in doing something incidental thereto, the injury is compensable unless it is established to be within an exception to the general rule. One of the exceptions to the general rule is an idiopathic fall.[4]

It is a well-settled principle of workers' compensation law 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. Such an injury does not arise out of a risk connected with the employment and is therefore not compensable. However, 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. 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.[5] 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 the employment.[6] OWCP has the burden of proof to submit medical evidence showing the existence of a personal, nonoccupational pathology if it chooses to make a finding that a given fall is idiopathic in nature. The fact that the cause of a particular fall cannot be determined does not establish that it was due to an idiopathic condition and if the record does not establish a particular fall was due to an idiopathic condition, it must be considered as merely an unexplained fall, which is covered under FECA.[7]

[4] *Roger Williams*, 52 ECAB 468 (2001).

[5] *M.M.*, Docket No. 08-1510 (issued November 25, 2008).

[6] *N.P.*, Docket No. 08-1202 (issued May 8, 2009).

[7] *Jennifer Atkerson*, 55 ECAB 317 (2004).

ANALYSIS -- ISSUE 1

The Board finds that appellant's October 16, 2012 fall at work and subsequent cardiac arrest were not in the performance of duty. Appellant's attorney admitted at the hearing that appellant had a genetic anomaly, long QT syndrome. This is supported by reports dated January 25 and February 15, 2013 in which Drs. Gabel and Rommel reported that appellant had genetic markers for prolonged QT. On October 18, 2012 Dr. Mounsey advised that, based on her telemetry, the long QT syndrome was the underlying etiology in appellant's recent sudden cardiac arrest.

While Dr. Rommel stated that, sudden cardiac arrest could be triggered by stress and being startled, his opinion was couched in equivocal terms and he did not describe appellant's job duties or indicate that stress caused her cardiac arrest on October 16, 2012. While the medical opinion of a physician supporting causal relationship does not have to reduce the cause or etiology of a disease or condition to an absolute certainty, neither can such opinion be speculative or equivocal. The opinion of a physician supporting causal relationship must be one of reasonable medical certainty that the condition for which compensation is claimed is causally related to federal employment and such relationship must be supported with affirmative evidence, explained by medical rationale and be based upon a complete and accurate medical and factual background of the claimant.[8] Dr. Rommel's opinion is of insufficient probative value to establish that work-related stress on October 16, 2012 caused appellant's collapse.

Moreover, as reported by Drs. Deblasio, Nichols and Gabel, appellant had a second significant risk factor in that she had recently had gastric bypass surgery with a complicated postoperative course and had recently returned to work prior to the October 16, 2012 incident. There is no probative medical evidence in the record that she fell due to unexplained reasons or due to a medical condition that was caused or aggravated by employment factors.[9]

The Board has recognized that, although a fall is idiopathic, an injury resulting from an idiopathic fall is compensable if "some job circumstance of working condition intervenes in contributing to the incident or injury, for example, the employee falls onto, into or from an instrumentality of the employment" or where, instead of falling directly to the floor on which he has been standing, the employee strikes a part of his body against a wall, a piece of equipment, furniture or machinery or some like object.[10] A claimant has the burden of establishing that he or she struck an object connected with the employment during the course of the idiopathic collapse.[11] In the present case, the record does not support that appellant struck any object on her way to the floor or that an employment hazard contributed in any way. While the claim form and history provided by Dr. Deblasio indicated that she fell out of her chair during the October 16, 2012 incident, this is not in agreement with the witness statements. Both Mr. Forte and Mr. Marshall indicated that appellant fell to the ground while walking, returning to her seat.

[8] *Patricia J. Glenn*, 53 ECAB 159 (2001).

[9] *See Y.C.*, Docket No. 07-513 (issued August 6, 2007).

[10] *Margaret Cravello*, 54 ECAB 498 (2003).

[11] *Id*.

There is no indication that she struck anything while falling. Appellant's fall on October 16, 2012 is considered idiopathic and therefore noncompensable.[12]

The Board, however, 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.[13] The period for which treatment is authorized by a Form CA-16 is limited to 60 days from the date of issuance, unless terminated earlier by OWCP.[14] The record is silent as to whether OWCP paid for the cost of appellant's examination or treatment for the period noted on the form.

LEGAL PRECEDENT -- ISSUE 2

To establish her claim that she sustained a stress-related condition in the performance of duty, appellant must submit the following: (1) medical evidence establishing that she has a stress-related disorder; (2) factual evidence identifying employment factors or incidents alleged to have caused or contributed to her condition; and (3) rationalized medical opinion evidence establishing that the identified compensable employment factors are causally related to her stress-related condition.[15]

Workers' compensation law does not apply to each and every injury or illness that is somehow related to an employee's employment. In the case of *Lillian Cutler*,[16] the Board explained that there are distinctions as to the type of employment situations giving rise to a compensable emotional condition arising under FECA. There are situations where an injury or illness has some connection with the employment but nevertheless does not come within coverage under FECA.[17] When an employee experiences emotional stress in carrying out his or her employment duties and the medical evidence establishes that the disability resulted from an emotional reaction to such situation, the disability is generally regarded as due to an injury arising out of and in the course of employment. This is true when the employee's disability results from his or her emotional reaction to a special assignment or other requirement imposed by the employing establishment or by the nature of the work.[18] A claimant must support his or

[12] *Roger Williams, supra* note 4. As to appellant's assertion that she had vertigo since the fall, there is no medical evidence of record that diagnosed this condition and she did not allege that she injured her right shoulder in the fall, as identified by Dr. Khurana on March 27, 2013, more than five months after the October 16, 2012 collapse and cardiac arrest.

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

[14] *See* 20 C.F.R. § 10.300(c).

[15] *Leslie C. Moore*, 52 ECAB 132 (2000).

[16] 28 ECAB 125 (1976).

[17] *See Robert W. Johns*, 51 ECAB 137 (1999).

[18] *Lillian Cutler, supra* note 16.

her allegations with probative and reliable evidence. Personal perceptions alone are insufficient to establish an employment-related emotional condition.[19]

ANALYSIS -- ISSUE 2

The Board also finds that appellant did not establish that she sustained a stress-related condition in the performance of duty. Appellant asserted at the March 13, 2013 hearing that there had been problems with the computer system and staffing issues. Allegations alone by a claimant are insufficient to establish a factual basis for a stress-related claim but rather must be corroborated by the evidence.[20] Appellant submitted no witness statements or other corroboration of these specific allegations.

Appellant also asserted at the hearing and on appeal that her regular duties as a dispatcher, which are inherently stressful, caused stress. As a dispatcher, her job duties include interacting with the public in emergency and stressful situations. Under the principles set forth in *Cutler*, described above, this would be a compensable factor of employment.[21] There is, however, no medical evidence to support that this compensable employment factor caused any medical condition.

To be of probative medical value, a physician's opinion regarding the cause of an emotional condition must relate the condition to the specific incidents or conditions of employment accepted as factors of employment, must be based on a complete and accurate factual history and must contain adequate medical rationale in support of the conclusions.[22] The only medical report of record that discussed the relationship of stress was Dr. Rommel's February 15, 2013 report. As discussed above, this report is equivocal and of insufficient probative value to establish that appellant sustained a stress-related condition caused by her job. Dr. Rommel did not discuss any specific job duties or relate his supposition to anything specific. There is no additional medical evidence of record that discusses appellant's job duties.

The Board therefore concludes that, contrary to appellant's assertion on appeal, she has not provided any probative medical evidence to show that her regular job duties caused stress such that further development of the medical record is warranted.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

[19] *Roger Williams, supra* note 4.

[20] *M.D.*, 59 ECAB 211 (2007).

[21] *See Peter J. Smith*, 48 ECAB 453 (1997); *Lillian Cutler*, *supra* note 16.

[22] *Mary J. Ruddy*, 49 ECAB 545 (1998).

CONCLUSION

The Board finds that appellant did not sustain an injury in the performance of duty on October 16, 2012 and that she did not establish that she sustained a stress-related condition due to the accepted employment factor.

ORDER

IT IS HEREBY ORDERED THAT the May 30, 2013 decision of the Office of Workers' Compensation Programs is affirmed as modified.

Issued: March 21, 2014
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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