United States Department of Labor
Employees' Compensation Appeals Board

A.F., Appellant	)	
and	)	**Docket No. 14-1392**
	)	**Issued: October 21, 2014**
DEPARTMENT OF JUSTICE, BUREAU OF ALCOHOL, TOBACCO, FIREARMS & EXPLOSIVES, Washington, DC, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge

JURISDICTION

On June 2, 2014 appellant filed a timely appeal from a March 14, 2014 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 a traumatic injury in the performance of duty on February 28, 2013.

FACTUAL HISTORY

On March 5, 2013 appellant, then a 54-year-old management analyst, filed a traumatic injury claim (Form CA-1) alleging that she sustained a strained back, stiff neck, arm and

[1] 5 U.S.C. § 8101 *et seq.*

shoulder soreness, migraine headaches, pain in the right ear during a flight, and an unspecified left hip and left leg injury in the performance of duty on February 28, 2013. She explained that, while on a temporary-duty assignment at a Federal Law Enforcement Training Center on that date, she exited a vehicle while it was very windy, carrying a number of items including her laptop, coat and handouts for students, while also holding down her dress in the wind. Appellant's car door "blew open" and hit the car next to her. She turned and twisted to catch the door, which "pulled her back out" and caused her to feel a "popping" sensation in her back.

On March 4, 2013 Dr. Gregory Levickas, a Board-certified internist, assessed appellant with a migraine headache, ear pain and back pain, noting that all had improved. Appellant told Dr. Levickas that she had flown without eating to Georgia for a trip for work and began to develop a headache. She could feel pain in her right ear during the flight despite taking medication for the pain. Appellant then developed some pain in her right lower back and neck, for which she attended massage therapy, which granted some relief. Dr. Levickas noted that her ear pain was a recurrent condition whenever she flew. He noted an unremarkable examination of the extremities. In a disability certificate dated March 4, 2013, Dr. Levickas stated that appellant had been under his care on that date and could return to regular duties on March 6, 2013.

In a report dated May 14, 2013, Dr. Jonathan Dunn, a Board-certified orthopedic surgeon, assessed appellant with left hip greater trochanteric bursitis, thoracolumbar sprain/strain, bilateral shoulder strain that occurred after getting out her car at work, and preexisting lower back, left leg and bilateral shoulder symptoms. He noted that appellant told him that she was in Georgia to teach a training class when she exited a rental car, she twisted to grab the door of the car while holding her bag at the same time, and began to experience lower back, bilateral shoulder and neck pain. Appellant also reported that she developed a migraine headache at about the same time. Dr. Dunn noted that appellant had first seen Dr. Levickas on March 4, 2013. He reviewed a report of a magnetic resonance imaging (MRI) scan dated February 28, 2012, which found a partial bursal-sided rotator cuff tear. Dr. Dunn noted that appellant had a history of left hip, shoulder, and leg issues that began when she joined L.A. Fitness, noting that she once lifted weights and her shoulder pain developed, without ever resolving completely. Appellant's lower back pain and left leg pain worsened at that time, but Dr. Dunn noted that she had lower back pain over 20 years ago, with no recent lower back pain.

On examination, Dr. Dunn noted mild restriction of range of motion of appellant's cervical and thoracolumbar spine, moderate tenderness to palpation over the left greater trochanter, negative Neer's and Hawkins' tests, and no shoulder restriction of range of motion, instability, swelling, ecchymosis or erythema. He stated "It is my opinion within a reasonable degree of medical certainty that her lower back, left hip, left leg, and bilateral shoulder symptoms are directly and causally related to the work-related incident on [February 28, 2013] and represent a worsening of her preexisting pain in those areas." Dr. Dunn further noted, "Obviously, she has had symptoms in these areas in the past, but it seems to have worsened with this twisting injury at work; these are mostly soft tissue injuries, which I think would be expected to improve over the course of four to six weeks with appropriate therapy."

In a report dated May 20, 2013, Dr. Francisco A. Ward, Board-certified in physical medicine and rehabilitation, assessed appellant with lower back pain, shoulder pain, hip/pelvic pain, somatic/segmental dysfunction of the lumbar region, lesion of the medial nerve,

trochanteric bursitis of the left hip, shoulder impingement and bursitis of the right shoulder. He noted that appellant's most recent flare-up of symptoms occurred when she exited a car in Georgia while carrying a laptop bag in her right arm and handouts in her left hand, when a gust of wind swung the door open. Appellant tried to hold her dress down and twisted forcefully, when she felt something "pop" in her lower back. Dr. Ward stated that her shoulder condition was first noted years ago, and that she had been diagnosed with a partial tear of the right side. He stated that appellant did not recall an incident leading to a tear, so he suspected that it was degenerative in nature. Appellant's left shoulder pain was similar, but not as intense. Dr. Ward stated that her left hip discomfort was first noted in August 2012 without trauma. He noted an x-ray of her left hip was unremarkable. On examination, Dr. Ward noted good lumbar flexion and extension without tenderness over facet joints; atrophy of the left abductor pollicis brevis with slight weakness; a tender right subacromial bursa area and deltoid insertion in the humerus; mild positive Hawkins and Neer's tests on the right; and left hip tenderness over the greater trochanter. He recommended a subacromial steroid injection of the right shoulder; a fitness program with low-impact aerobics; and physical therapy of the shoulder and left hip.

On June 4, 2013 Dr. Ward performed a cortisone injection on appellant's right shoulder.

On June 6, 2013 appellant requested authorization for physical therapy of her left hip bursitis and lumbar sprain. On July 1, 2013 OWCP approved her request for authorization for an office visit and x-rays of her hip, pelvis and lumbar spine. Appellant continued to request authorization for physical therapy.

In a follow-up report dated June 11, 2013, Dr. Dunn stated that appellant reported no pain in her left hip laterally, and a moderate degree of pain in her lower back and shoulders, with the right shoulder more painful than the left. He examined her, noting mild restriction of the thoracolumbar region, a mildly positive Neer's test on the right, and tenderness to palpation grossly over the left greater trochanter. Dr. Dunn assessed appellant with a status post motor work-related injury on February 28, 2013 with left hip greater trochanteric bursitis, thoracolumbar sprain/strain, and bilateral shoulder sprain with preexisting lower back, left leg and bilateral shoulder symptoms.

In an August 26, 2013 letter, OWCP noted that appellant's case file had been reopened for consideration because her medical bills had exceeded $1,500.00. It notified her that she had not provided sufficient evidence to establish that she actually experienced the incident in question; that she was injured in the performance of duty; or that a physician had provided an opinion as to how the alleged incident had resulted in her diagnosed conditions. OWCP afforded appellant 30 days to submit additional evidence and to respond to its inquiries.

In a report dated February 5, 2013, Dr. Enzo Cosentino, a Board-certified otolaryngologist, noted that appellant has sensorineural hearing loss and that he recommended Afrin for an upcoming flight in an airplane along with a decongestant. He diagnosed appellant with chronic rhinitis with sinusitis and a history of fluid with previous myringotomies, a right-sided sensorineural "drop," asymmetric hearing loss, and a headache with probable sinusitis. An attached MRI scan of her right ear was normal. In an attached report dated March 4, 2013, Dr. Cosentino noted that appellant had come to the office for an emergency visit, and that she had returned from an airplane flight four days previously, at which time she had significant

difficulties with right ear pain, facial pain and congestion along with a headache during the flight. He diagnosed her with eustachian tube dysfunction secondary to a recent airplane flight and previous serous otitis media with fluid and myringotomies.

By letter dated September 4, 2013, Dr. Levickas noted that he had seen appellant on March 4, 2013 for a migraine headache, ear pain and back pain. He noted that appellant reported her symptoms began while traveling on a plane for work in Georgia. Appellant told him that the next three days were "the worst 3 days of my entire life." Dr. Levickas noted that she was seen by Dr. Cosentino and given Medrol and Levaquin. By the time appellant saw Dr. Levickas, her symptoms were improving. He noted her examination was unremarkable and that no further testing was performed. Dr. Levickas stated, "As far as I know she made a full recovery. I suspect that the flight triggered pressure trauma to her ear that then triggered a migraine. The back pain was likely triggered by the immobilization of the flight and the stress associated with the ear pain and headache."

In a narrative report dated September 24, 2013, Dr. Ward responded directly to the information requested by OWCP in its August 26, 2013 development letter. He noted that he had seen appellant on May 20, 2013 and on June 4, 2013. Dr. Ward stated that appellant's most recent flare-up of bilateral shoulder pain, left hip pain, lower back pain, and neck soreness occurred on February 28, 2013 when, while in Georgia, she exited a car while carrying a laptop bag in her right arm and hand-outs in her left arm. Wind swung the car door open and appellant twisted forcefully while trying to hold down her dress. On twisting, appellant felt something "pop" in her back. Dr. Ward noted that her shoulder condition was first noted years ago, and that she did not recall an incident leading to a tear, so that he suspected it was degenerative in nature. He stated that appellant's left hip discomfort was first noted in August 2012 without trauma. Dr. Ward stated his findings of lumbar lordosis, right shoulder bursitis and trochanteric bursitis of the left hip. He stated that it was his opinion within a reasonable degree of medical certainty that appellant's lower back, left hip, left leg, and bilateral shoulder symptoms were directly and causally related to the work-related incident on February 28, 2013 and represented a worsening of her preexisting pain in those areas.

On September 25, 2013 appellant responded to OWCP's inquiries. She stated that she was on a work trip to the Federal Law Enforcement Training Center in Brunswick, Georgia from February 27 through March 1, 2013. Appellant noted that her ear, nose, and throat specialist had advised her that prior to any airplane flight, she must take Sudafed and Afrin nasal spray the day before, the flight, the day of, the flight and the day after her flight. On the flight to Georgia, she felt pain and pressure in her right ear. Appellant noted several prior incidents of pain and hearing loss after airplane flights. She stated that her supervisors at work knew that she had this condition, but that she was still forced to fly and take these trips. Appellant noted that, after leaving the flight to Georgia, she readied her materials for work and did not eat until 6:30 p.m. to 7:00 p.m. During this time, her headache worsened. After a night during which appellant continued awakening due to the cold and noise from hotel maintenance in the next room, she ate breakfast. Her headache continued to worsen, and she left for her presentation at the Federal Law Enforcement Training Center at 11:30 a.m. When appellant exited her vehicle, it was windy, and she attempted to carry her purse, her laptop bag, her coat, and handouts. She attempted to hold her dress down in the wind and the car door blew open, hitting the car next to hers. Appellant turned to catch the door while still holding the items, when she "pulled her back

out" and felt a pop. She was able to give her presentation afterward, but the room was very hot. Appellant's head was "pounding severely" after the presentation was over and she felt nauseated. She requested an ice bag and after receiving it, returned to her hotel. Appellant's nausea and headache continued, and she felt too ill that evening to leave the hotel room. She began to feel pain in her neck, back, shoulders and left hip while recovering in her room from the headache. Appellant got a massage at Jacksonville Airport and at home. During the flight home, she was cramped between two large men. Appellant noted that she learned later that the area around the Federal Law Enforcement Training Center was experiencing a high pollen count at the time of her visit, and that this pollen could have caused her migraine. She noted that she waited until March 3, 2013 to report the injury because she was extremely ill, and that in fact she had reported the injury on March 2, 2013, the first day she felt well enough to enter her injury online. Appellant stated that she waited until May 14, 2013 to receive additional medical treatment because she had hoped her injuries would resolve by themselves with time, and because she had difficulty finding physicians that would accept federal workers' compensation. She stated that she had similar preexisting injuries of migraine headaches, a right ruptured eardrum, developing fluid and hearing loss after airplane flights for work, sinusitis, a right partial rotator cuff tear, lower back pain, neck pain, right arm pain from the shoulder, left hip pain and left leg pain.

On August 31, 2006 Dr. Cosentino stated that he believed appellant developed right-sided eustachian tube dysfunction from bronchitis and the fact that she was on an airplane. In a letter dated October 11, 2006, he stated that appellant returned to his office with improvement of her symptoms of otitis media and eustachian tube dysfunction. On March 5, 2007 Dr. Cosentino noted no recurrence of serous otitis media and a significant excoriation of the septum and the lateral wall on the left side with polypoid change of the right middle turbinate. On April 15, 2010 he noted that appellant presented with symptoms of sinusitis, which had been fairly significant after an airplane flight in early 2010. On examination, Dr. Cosentino noted severe crusting, significant mucopurulent discharge and a deflective septum to the left with a friable mucosa. In a letter dated May 18, 2010, he noted that appellant had no recurrence of nasal bleeding and that her mucosa was slowly reversing back to normal. On January 4, 2011 Dr. Cosentino noted that appellant visited his office for a follow-up on severe sinusitis and clogged ears. He noted that there was severe impaction of the ears and a recurrence of sinusitis. On October 4, 2011 Dr. Cosentino noted that appellant came to the office for an emergency visit regarding severe coughing, headache, post-nasal drip, nasal congestion and mucous. He noted that she had intermittent sinusitis. In a letter dated October 6, 2011, Dr. Cosentino noted a right serous otitis media. On November 9, 2011 he noted that appellant had a serous otitis media, acute otitis media with rupture, conductive hearing loss, eustachian tube dysfunction and external otitis. In a report dated January 4, 2012, Dr. Levickas assessed appellant with shoulder pain, ear pain and coronary atherosclerosis.

By decision dated September 26, 2013, OWCP denied appellant's claim. It found that she had not established a diagnosed condition related to the incident of February 28, 2013; that her injuries were related to duties of her federal employment; and that she had not submitted a well-reasoned physician's opinion on causal relationship.

On October 7, 2013 appellant requested a review of the written record before the Branch of Hearings and Review.

In a follow-up report from Dr. Dunn dated September 24, 2013, he assessed her with a status post work-related injury on February 28, 2013 with left hip greater trochanteric bursitis, thoracolumbar sprain/strain, right shoulder strain, and a history of preexisting lower back, left leg and bilateral shoulder symptoms. He recommended a brief course of physical therapy.

In a follow-up report from Dr. Ward dated September 24, 2013, he assessed her with right shoulder bursitis, which had been improved on her last visit *via* a subacromial bursa injection; trochanteric bursitis; and intermittent radicular discomfort into the left calf, with no nerve tension signs. On examination, he noted the same results as in his examination of May 20, 2013.

By decision dated March 14, 2014, the hearing representative determined that appellant had established the factual components of fact of injury, and that she was in the performance of duty while on travel status on February 28, 2013. However, he affirmed OWCP's decision dated September 26, 2013, finding that appellant had not established a causal relationship between the alleged factors of employment on February 28, 2013 and her diagnosed conditions. The hearing representative noted that the opinions of Drs. Dunn, Levickas and Ward were not supported by objective findings.

LEGAL PRECEDENT

An employee seeking benefits under FECA[2] 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 and/or specific condition for which compensation is claimed are causally related to the employment injury.[3] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated on a traumatic injury or an occupational disease.[4]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty it must first be determined whether a fact of injury has been established.[5] 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.[6] 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.[7]

[2] 5 U.S.C. § 8101 *et seq.*

[3] *C.S.*, Docket No. 08-1585 (issued March 3, 2009); *Bonnie A. Contreras*, 57 ECAB 364, 366 (2006).

[4] *S.P.*, 59 ECAB 184, 188 (2007); *Joe D. Cameron*, 41 ECAB 153, 157 (1989).

[5] *B.F.*, Docket No. 09-60 (issued March 17, 2009); *Bonnie A. Contreras*, *supra* note 3.

[6] *D.B.*, 58 ECAB 464, 466 (2007); *David Apgar*, 57 ECAB 137, 140 (2005).

[7] *C.B.*, Docket No. 08-1583 (issued December 9, 2008); *D.G.*, 59 ECAB 734, 737 (2008); *Bonnie A. Contreras*, *supra* note 3.

While on temporary-duty assignment, an employee is covered by FECA 24 hours a day with respect to any injury that results from activities incidental to the temporary assignment. The fact that an employee was on a special mission or in travel status during the time the condition manifested itself does not raise an inference that the condition was causally related to the incidents of employment.[8]

The claimant has the burden of establishing by the weight of reliable, probative and substantial evidence that the condition for which compensation is sought is causally related to a specific employment incident or to specific conditions of employment.[9] An award of compensation may not be based on appellant's belief of causal relationship. Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish a causal relationship.[10]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[11] Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is a causal relationship between the employee's diagnosed condition and compensable employment factors.[12] The opinion of the physician must be based on a complete factual and medical background of the employee, 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 employee.[13]

ANALYSIS

The Board finds that appellant has not established that she sustained an injury causally related to factors of her employment while on temporary duty status on February 28, 2013.

On March 5, 2013 appellant filed a traumatic injury claim alleging that she sustained a strained back, stiff neck, arm and shoulder soreness, migraine headaches, pain in the right ear during a flight, and an unspecified left hip and left leg injury in the performance of duty on February 28, 2013. In a later statement, she clarified that the pain to her right ear during a flight to Georgia while on travel status triggered a migraine headache, and that the next morning, while still in travel status, she twisted her back when exiting a car at the Federal Law Enforcement Training Center. In its March 14, 2014 decision, OWCP accepted that appellant had established the factual component of fact of injury, and that her incidents occurred within the performance of

[8] *See Rene Bonnin*, 38 ECAB 193 (1986).

[9] *Roma A. Mortenson-Kindschi*, 57 ECAB 418, 428 n.37 (2006); *Katherine J. Friday*, 47 ECAB 591, 594 (1996).

[10] *P.K.*, Docket No. 08-2551 (issued June 2, 2009); *Dennis M. Mascarenas*, 49 ECAB 215, 218 (1997).

[11] *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).

[12] *J.J.*, Docket No. 09-27 (issued February 10, 2009); *Michael S. Mina*, 57 ECAB 379, 384 (2006).

[13] *I.J.*, 59 ECAB 408, 415 (2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

duty. The Board finds that the medical evidence of record is not sufficient to discharge appellant's burden of proof to establish that her alleged conditions were causally related to factors of her federal employment.

In a report dated May 14, 2013, Dr. Dunn assessed appellant with left hip greater trochanteric bursitis, thoracolumbar sprain/strain, bilateral shoulder strain that occurred after getting out her car at work, and preexisting lower back, left leg and bilateral shoulder symptoms. On examination, he noted mild restriction of range of motion of appellant's cervical and thoracolumbar spine, moderate tenderness to palpation over the left greater trochanter, negative Neer's and Hawkins' tests, and no shoulder restriction of range of motion, instability, swelling, ecchymosis or erythema. Dr. Dunn stated "It is my opinion within a reasonable degree of medical certainty that her lower back, left hip, left leg, and bilateral shoulder symptoms are directly and causally related to the work-related incident on [February 28, 2013] and represent a worsening of her preexisting pain in those areas." He further noted, "Obviously, she has had symptoms in these areas in the past, but it seems to have worsened with this twisting injury at work; these are mostly soft tissue injuries, which I think would be expected to improve over the course of four to six weeks with appropriate therapy." In a follow-up report dated June 11, 2013, Dr. Dunn examined her, noting mild restriction of the thoracolumbar region, a mildly positive Neer's test on the right and tenderness to palpation grossly over the left greater trochanter. He assessed her with a status post motor work-related injury on February 28, 2013 with left hip greater trochanteric bursitis, thoracolumbar sprain/strain, and bilateral shoulder sprain with preexisting lower back, left leg and bilateral shoulder symptoms.

Dr. Dunn's reports are deficient in several respects. There are no objective findings with regard to any leg conditions. Dr. Dunn's opinion on causal relationship refers to symptoms rather than diagnosed conditions. The report containing his opinion on causal relationship for a shoulder condition contains no positive objective findings supporting the existence of such a condition, though his later report found a positive Neer's test. With regard to appellant's claimed neck, arm, right ear, left leg, and headache conditions, there are no objective findings to support causation or the aggravation of preexisting conditions. Dr. Dunn found a negative Spurling's sign in his May 14, 2013 report and no physician diagnosed a neck condition. Moreover, his reports lack a thorough biomechanical explanation of how appellant's alleged injuries occurred or were aggravated on February 28, 2013. Thus, Dr. Dunn's reports are insufficient to meet appellant's burden of proof to establish a causal relationship between her condition and the incident of February 28, 2013, supported by proper medical rationale.[14] Neither the fact that appellant's claimed conditions became apparent during a period of employment, nor the belief that they were aggravated by her employment is sufficient to establish causal relationship.[15]

On May 20, 2013 Dr. Ward assessed appellant with segmental dysfunction of the lumbar region, lesion of the medial nerve, trochanteric bursitis of the left hip, shoulder impingement and bursitis of the right shoulder. On examination, he noted good lumbar flexion and extension without tenderness over facet joints; atrophy of the left abductor pollicis brevis with slight

[14] *See K.W.*, Docket No. 10-98 (issued September 10, 2010).

[15] *See D.I.*, 59 ECAB 158 (2007).

weakness; a tender right subacromial bursa area and deltoid insertion in the humerus; mild positive Hawkins and Neer's tests on the right; and left hip tenderness over the greater trochanter. In a narrative report dated September 24, 2013, Dr. Ward noted his findings of lumbar lordosis, right shoulder bursitis and trochanteric bursitis of the left hip. He stated that it was his opinion within a reasonable degree of medical certainty that her lower back, left hip, left leg, and bilateral shoulder symptoms were directly and causally related to the work-related incident on February 28, 2013 and represented a worsening of her preexisting pain in those areas. Dr. Ward's opinion, like Dr. Dunn's, is not sufficient to meet appellant's burden of proof to establish causal relationship. It is not fully rationalized, as it lacks a thorough physiological explanation of how the incident of February 28, 2013, in particular, aggravated appellant's conditions of the thoracolumbar region, shoulder and back. Dr. Ward refers to symptoms rather than diagnosed conditions, as causally related to the events of February 28, 2013.

Appellant was diagnosed by a migraine by Dr. Levickas in his March 4, 2013 report. In a letter dated September 4, 2013, Dr. Levickas stated, "I suspect that the flight triggered pressure trauma to her ear that then triggered a migraine. The back pain was likely triggered by the immobilization of the flight and the stress associated with the ear pain and headache." However, there were no objective findings supporting the aggravation of a migraine condition. Similarly, the existence of appellant's right ear condition is supported by the reports of Dr. Cosentino from 2006 through 2012; however, the aggravation of a right ear condition on February 28, 2013, in particular, is not supported by any objective findings. There were no objective findings in any reports to support a left leg condition. The opinion of a physician supporting causal relationship must be based on a complete factual and medical background of the employee, 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 employee.[16]

The Board finds that the medical evidence of record lacks supporting medical rationale to establish appellant's claimed conditions, as there is a deficiency of objective medical evidence to support causation or aggravation of these conditions on February 28, 2013. Hence, appellant has not met her burden of proof to establish a causal relationship between her claimed back, neck, arm, ear, leg, and headache conditions and the incidents of February 28, 2013, and has not submitted sufficient evidence with regard to these conditions to require OWCP to undertake further development.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision.[17]

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that she sustained an injury on February 28, 2013.

[16] *Supra* note 13.

[17] *See* 5 U.S.C. § 8128(a); 20 C.F.R. §§ 10.605-10.607.

ORDER

IT IS HEREBY ORDERED THAT the March 14, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 21, 2014
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board