

**United States Department of Labor
Employees' Compensation Appeals Board**

N.C., Appellant)

and)

DEPARTMENT OF HOMELAND SECURITY,)
FEDERAL AIR MARSHAL SERVICE,)
West Orange, NJ, Employer)

Docket No. 15-1900
Issued: March 7, 2016

Appearances:

Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:

CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On September 19, 2015 appellant, through counsel, filed a timely appeal of a September 11, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (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 has met his burden of proof to establish pulmonary embolism causally related to a June 9, 2014 employment incident.

On appeal counsel argues that the medical evidence is sufficient to establish the claim, or at least warrant further development of the evidence.

¹ 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On June 13, 2014 appellant, then a 45-year-old federal air marshal, filed a traumatic injury claim (Form CA-1) alleging that on June 9, 2014 he developed shortness of breath while on an assignment in Berlin, Germany. The employing establishment controverted the claim.

In a June 16, 2014 letter, OWCP informed appellant that the evidence of record was insufficient to establish his claim. Appellant was advised as to the medical and factual evidence required and he was afforded 30 days to provide the requested evidence.

Appellant thereafter submitted medical evidence in support of his claim.

A June 12, 2014 chest computerized tomographic angiography (CTA) revealed suspect bilateral pulmonary emboli with suggestion of mild right heart strain and subtle upper anterior lobe segment irregular one centimeter nodule, which could represent pneumonia, a mass, or focal atelectasis. Follow-up was recommended.

Dr. Patrick J. Alcasid, a Board-certified internist with subspecialties in critical care and pulmonary disease, reported on June 12, 2014 that appellant had been evaluated for pulmonary embolism. He reported that appellant was employed as an air marshal, that he had arrived from a long flight from Germany on Tuesday, and that he had some swelling in his lower extremity, which was normal for him after long flights. Appellant related that he subsequently had shortness of breath and dyspnea on exertion and ultimately went to a physician due to the progression of his symptoms. Physical examination findings were presented as well as results from a chest computerized axial tomography (CAT) scan, chest x-ray, and lower extremity Doppler test. The CAT scan revealed bilateral pulmonary embolism, the chest x-ray revealed no acute changes, and the lower extremity Doppler test showed no deep vein thrombosis (DVT). Dr. Alcasid diagnosed acute bilateral pulmonary emboli which he opined was likely associated with immobility/stasis as the patient is an air marshal and as there was no lower extremity DVT.

In a June 13, 2014 authorization for examination and treatment (Form CA-16), Larry Saez, an authorizing official, noted an injury date of June 9, 2014 and a diagnosis of pulmonary emboli. He approved treatment for the effects of the diagnosed condition.

A report from Ocean Medical Center dated June 13, 2014 provided physical examination findings and diagnoses of acute pulmonary embolism and left upper lobe one centimeter nodule versus atelectasis.² Dr. Jay A. Vida, a Board-certified internist, was identified as an attending physician and Dr. Emad Kamel, a Board-certified internist with subspecialties in critical care medicine, pulmonary disease, and sleep medicine, was identified as a consulting physician. Under history of injury, the report noted that appellant was seen at the emergency room following an abnormal CAT scan showing bilateral extensive pulmonary embolism. It noted that appellant was employed as an air marshal and that he experienced dyspnea on exertion, severe shortness of breath, and severe weakness shortly after a recent eight-hour plane trip from Germany. The report noted appellant's risk factor for pulmonary embolism as it is likely related to long travel trips as he works as an air marshal, but it did not rule out hypercoagulable state.

² The author of the report is unclear as it only identifies the initials "LMH."

Dr. Shannon Rittberg, a Board-certified osteopathic family practitioner, in a June 30, 2014 CA-20 form diagnosed pulmonary embolism by CTA and provided work restrictions. She checked a box marked “no” to the question of whether the diagnosed condition had been caused or aggravated by an employment activity.

In attending physician’s reports (Form CA-20) dated July 1 and 8, 2014, Dr. Dhiren Shah, Board-certified in critical care medicine, internal medicine, pulmonary disease, and sleep medicine, diagnosed pulmonary embolism based on review of a CTA and provided work restrictions. He noted that appellant was hospitalized for this condition from June 12 to 13, 2014. On the July 6, 2014 CA-20 form, Dr. Shah checked a box marked “no” to the question of whether the diagnosed condition had been caused or aggravated by an employment activity.

In a July 10, 2014 statement, appellant related that on June 9, 2014 while on an international mission he had difficulty breathing. On the day he arrived, while walking to a restaurant with coworkers, and on returning to the hotel, he experienced labored breathing. Initially, he stated that he attributed his condition to his allergies, but upon his return to the United States he saw his primary care physician as his condition had worsened. Based on a CAT scan appellant was diagnosed with extensive bilateral pulmonary emboli and his physician referred him to the hospital for further treatment.

By decision dated July 31, 2014, OWCP accepted that appellant was in the performance of duty while traveling on June 9, 2014 but denied his claim as it found he had failed to meet his burden of proof to establish that the diagnosed pulmonary embolism was caused or aggravated by work factors.

Dr. Gustavo de la Luz, a Board-certified internist with subspecialties in critical care and pulmonary disease, in an April 1, 2015 CA-20 form, noted an injury date of June 9, 2014 and diagnosis of pulmonary embolism and checked the box marked “no” to the question of whether the condition had been caused or aggravated by an employment activity. He reported that appellant was capable of performing light-duty work, but no air travel effective April 12, 2015.

In a letter dated June 23, 2015, appellant’s counsel requested reconsideration and submitted new medical evidence. The new medical evidence submitted with the request is set forth below.

In a June 12, 2014 Ocean Medical Center hospital admission report, Dr. Anna Dedona, a Board-certified internist, noted that appellant presented in the emergency room with symptoms of increased shortness of breath, at rest and on exertion, and CAT scan showed bilateral pulmonary emboli. Dr. Dedona noted that appellant was admitted to the hospital, started on medication and would undergo a pulmonary evaluation.

In a September 3, 2014 progress note, Dr. de la Luz noted that appellant was referred for the diagnosis of bilateral pulmonary emboli. He reported that his symptoms began with his air travel to Germany as part of his duty as an air marshal. Appellant related that his shortness of breath had been mildly present in May, but that his shortness of breath and symptoms worsened during his flight to Germany. Physical examination findings and objective test results were

provided. Dr. de la Luz diagnosed left upper lobe nodule, pulmonary embolism, and no deep vein thrombosis.

In a March 4, 2015 CA-20 form, Dr. de la Luz reported an injury date of June 9, 2014 and diagnosis of pulmonary embolism which he attributed to appellant's air travel employment duty. He released appellant to light-duty work with no air travel or immobilization on March 13, 2015.

In a March 6, 2015 progress note, Dr. de la Luz noted that appellant was seen for a routine follow-up for evaluation of his pulmonary embolus. He diagnosed pulmonary embolism and noted that the pulmonary disease currently appeared to be well controlled. Dr. de la Luz noted that appellant was not cleared to fly and that he had reservations about clearing appellant to return to his air marshal flying duties based on the unprovoked pulmonary embolism.

In a June 26, 2015 report, Dr. de la Luz provided a history of appellant's treatment and injury history. He noted that, following a prolonged transatlantic flight to the United States from Germany, appellant was hospitalized for a pulmonary embolism. Dr. de la Luz opined that appellant's prolonged air travel from Germany contributed to his pulmonary embolism, which he noted was "classically called unprovoked pulmonary embolism."

By decision dated September 11, 2015, OWCP denied modification of the prior decision, after merit review.

LEGAL PRECEDENT

An employee seeking benefits under FECA³ 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.⁴ 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.⁵

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.⁶ First, the employee must submit sufficient evidence to establish that he actually experienced the employment incident at the time, place, and in the manner alleged.⁷ Second, the employee must

³ 5 U.S.C. § 8101 *et seq.*

⁴ *C.S.*, Docket No. 08-1585 (issued March 3, 2009); *Bonnie A. Contreras*, 57 ECAB 364 (2006).

⁵ *S.P.*, 59 ECAB 184 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

⁶ *B.F.*, Docket No. 09-60 (issued March 17, 2009); *Bonnie A. Contreras*, *supra* note 4.

⁷ *D.B.*, 58 ECAB 464 (2007); *David Apgar*, 57 ECAB 137 (2005).

submit sufficient evidence, generally only in the form of medical evidence, to establish that the employment incident caused a personal injury.⁸

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.⁹ 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 the compensable employment factors.¹⁰ 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.¹¹

ANALYSIS

OWCP accepted that appellant was in the performance of duty while on a flight from Germany to the United States on June 9, 2014. However, the medical evidence is insufficient to establish that his pulmonary embolism was caused or aggravated by his flight on that date.

In reports and CA-20 forms, Dr. de la Luz diagnosed pulmonary embolism. In a March 4, 2015 CA-20 form, he noted an injury date of June 9, 2014 and attributed appellant's pulmonary embolism to his air travel required in his job as an air marshal. In a June 26, 2015 report, Dr. de la Luz noted that appellant had been hospitalized for a pulmonary embolism following prolonged air travel from Germany. He opined that this prolonged travel contributed to appellant's pulmonary embolism, which he explained was "classically called unprovoked pulmonary embolism." While Dr. de la Luz generally noted that appellant's prolonged air travel from Germany was the cause of appellant's pulmonary condition, he failed to explain how, in this specific case, the prolonged air travel on June 9, 2014 resulted in the diagnosed conditions.¹²

In reports dated June 12, 2014, Dr. Alcasid related that appellant's bilateral pulmonary embolism was likely a result of appellant's immobility/stasis due to appellant's air marshal job. His opinion was not expressed to a reasonable degree of medical certainty, but rather, is equivocal and speculative in nature. Dr. Alcasid's use of the term "likely" renders his opinion speculative in nature.¹³ He did not sufficiently explain the causal relationship between

⁸ *C.B.*, Docket No. 08-1583 (issued December 9, 2008); *D.G.*, 59 ECAB 734 (2008); *Bonnie A. Contreras*, *supra* note 4.

⁹ *Y.J.*, Docket No. 08-1167 (issued October 7, 2008); *A.D.*, 58 ECAB 149 (2006); *D'Wayne Avila*, 57 ECAB 642 (2006).

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

¹¹ *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

¹² *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

¹³ *L.R. (E.R.)*, 58 ECAB 369 (2007); *D.D.* 57 ECAB 734 (2006); *M.W.*, 57 ECAB 710 (2006); *Cecilia M. Corley*, 56 ECAB 662 (2005).

appellant's diagnosed condition and the prolonged air travel on June 9, 2014. Therefore, Dr. Alcasid's report is of diminished probative value.

The Board notes that the remaining evidence of record, which includes a June 12, 2014 hospital admission report by Dr. Dedona, CA-20 forms from Drs. Rittberg and Shah diagnosing pulmonary embolism, and a hospital report dated June 13, 2014 by Drs. Vida and Kamel, are also insufficient to support appellant's burden.

Dr. Dedona's hospital admission report is of limited probative value on the relevant issue of the present case as it does not contain an opinion on causal relationship.¹⁴ The reports from Drs. Rittberg and Shah are also insufficient to support appellant's claim as they negated causation when they both checked "no" on a CA-20 form to the question of whether the diagnosed condition was employment related.

While Drs. Kamel and Vida, in their hospital report, noted that long travel trips are considered a risk factor for pulmonary embolism, they also concluded that hypercoagulable state could not be ruled out as the cause of the diagnosed condition. The report from Drs. Kamel and Vida is again speculative as it offered no definitive opinion as to the cause of the diagnosed pulmonary embolism, it is also insufficient to support appellant's claim.¹⁵ There is no probative, rationalized medical evidence explaining how appellant's diagnosed bilateral pulmonary emboli were caused or aggravated by the June 9, 2014 incident. Thus, appellant has not met his burden of proof in establishing that his diagnosed condition was causally related to his federal employment.

The Board notes that the record contains a June 13, 2014 CA-16 form noting a June 9, 2014 injury date and signed by Mr. Saez authorizing medical treatment. Ordinarily, where the employing establishment authorizes treatment of a job-related injury by providing the employee a properly executed CA-16 form,¹⁶ OWCP is under contractual obligation to pay for the medical care provided.¹⁷ The Board finds that upon return of the case record, this matter should be addressed.

On appeal counsel argues that the medical evidence is sufficient to establish appellant's claim, or at least warrant further development. As discussed above, the medical evidence submitted by appellant was insufficient to establish his claim. As detailed above, the record currently before the Board is devoid of any medical opinion, which is supported by sufficient rationale, explaining how the diagnosed pulmonary condition had been caused by appellant's air travel on June 9, 2014.

¹⁴ *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *Jaja K. Asaramo*, 55 ECAB 200 (2004); *Michael E. Smith*, 50 ECAB 313 (1990).

¹⁵ *Cecilia M. Corley*, *supra* note 13.

¹⁶ *See Val D. Wynn*, 40 ECAB 666 (1989); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Authorizing Examination and Treatment*, Chapter 3.300.3(a)(3) (February 2012).

¹⁷ 5 U.S.C. § 8103; 20 C.F.R. § 10.304. *See L.B.*, Docket No. 10-469 (issued June 2, 2010); *see also* Federal (FECA) Procedure Manual, *id.*

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.

CONCLUSION

The Board finds that appellant has not met his burden to establish that his pulmonary embolism had been caused or aggravated by the June 9, 2014 incident.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 11, 2015 is affirmed.

Issued: March 7, 2016
Washington, DC

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

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board