United States Department of Labor
Employees' Compensation Appeals Board

P.P., Appellant	)	
and	)	**Docket No. 19-1359**
	)	**Issued: April 30, 2020**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Washington, DC, Employer	)	

Appearances:
Brett E. Blumstein, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
CHRISTOPHER J. GODFREY, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On June 6, 2019 appellant, through counsel, filed a timely appeal from a May 14, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met his burden of proof to establish diagnosed conditions causally related to the accepted December 14, 2016 employment incident while performing high-risk employment duties.

FACTUAL HISTORY

On December 20, 2016 appellant, then a 48-year-old nurse, filed a traumatic injury claim (Form CA-1) alleging that on December 14, 2016 he injured his left index finger while in the performance of duty. He explained that a bloody needle stuck through his left index finger. On the reverse side of the claim form, the employing establishment indicated that appellant was injured in the performance of duty. It did not indicate whether he had stopped work.

In a February 8, 2018 development letter, OWCP advised appellant that the evidence of record was insufficient to establish his claim as he had not demonstrated that he experienced the incident or employment factor alleged to have caused injury. It noted the type of evidence necessary to establish his claim, including a comprehensive, narrative medical report from a qualified physician that included a diagnosis and an opinion, supported by medical rationale, addressing how the claimed employment incident caused or aggravated a medical condition. OWCP attached a questionnaire for appellant's completion. It afforded him 30 days to submit the necessary evidence. In the same letter, OWCP requested that the employing establishment provide appellant's treatment notes if he had been treated at an agency medical facility.

By decision dated March 12, 2018, OWCP denied appellant's traumatic injury claim finding that the evidence of record failed to establish that he was injured in the performance of duty, as alleged.

A December 14, 2016 memorandum from appellant's coworker, L.L., indicated that on that date she was acting as charge nurse in the emergency room when appellant let her know that while he was cleaning a bed in emergency room 5 he was stuck by a contaminated needle. She went to emergency room 5 with him and found that at the left edge of the bed there was an exposed butterfly needle attached to a vacutainer with its tubing filled with light red, fresh blood that was consistent with an arterial needle stick. L.L. observed two puncture marks on appellant's left index finger, and she told him to go to the handwashing station for decontamination. She then called a coworker to bring a red top blood tube and saline flush to collect the specimen, as she thought that if the blood had been in the tubing for hours it was probably clotted, however, the vacuum in the red top tube was able to collect the entire specimen. L.L. confirmed that the sample and the needle were bagged and labeled and given to a registered nurse at the employing establishment for safekeeping and processing. The coworker also collected a blood sample from appellant. Two attending physicians were informed about the incident and, together with L.L., initiated a needle stick protocol care plan. L.L. noted that she inquired about the unique identifier needed to appropriately identify the unknown specimen so that it could be accurately reported to the lab. After reviewing the daily patient log to identify possible sources of the blood and needle, she identified three possible patients. L.L. noted that appellant had indicated, however, that the needle could have been in the bed when it was in use in another room.

In a statement dated February 26, 2018, appellant noted that on the date of the incident he was admitted into the emergency department and provided with the needle stick protocol. Immediately after the incident, he consulted Dr. Andre Michalak, his primary care physician who specializes in internal medicine, who referred him to Dr. Jose Bordon, a Board-certified infectious disease specialist. Appellant attached a December 14, 2016 report of contact he made with the employing establishment in response to OWCP's request for details about his injury. He also noted in his statement that he had treated a patient in emergency room 5 for a wound check and dressing change, but no blood was drawn from the patient. Then, after the patient was discharged, he returned to emergency room 5 and began stripping the bed when he felt a sharp pain. When appellant pulled his hand back he saw a BD vacutainer push button which was not retracted, and its tubing was full of blood. He removed his glove and saw two puncture wounds through his left index finger. Appellant then washed his hands and informed the charge nurse L.L.

On October 26, 2018 appellant, through counsel, requested reconsideration. Counsel asserted that appellant's December 14, 2016 report of contact and L.L.'s December 14, 2016 memorandum both provided detailed statements of the events surrounding the needle stick incident. He attached new evidence including an October 2, 2018 medical report by Dr. John W. Ellis, a Board-certified family medicine specialist, which set forth the history of appellant's employment incident involving the needle stick. Counsel asserted that appellant had therefore established his claim.

In the October 2, 2018 medical report, Dr. Ellis indicated that appellant had previously been in good health and had never been diagnosed with human immunodeficiency virus (HIV) or Hepatitis C. He reported that on December 14, 2016 a needle had stuck through appellant's finger while he was at work. Appellant noted that in January or February 2017 he had experienced achiness and felt fatigued and tired. In February 2017, he was diagnosed with HIV and Hepatitis C. On February 4, 2018 appellant felt a burning sensation in his left thumb and fingers, and was diagnosed with cryoglobulinemia. An arteriogram revealed that his blood supply was cut off from his left four fingers and part of his left thumb all the way up to his left forearm. On February 7, 2018 appellant underwent a left forearm fasciotomy, left hand fasciotomy, and left upper extremity fasciotomy. On February 10, 2018 he had a left upper extremity partial disclosure and tensioning of the fasciotomy. On February 13, 2018 appellant underwent incision and drainage of his left arm incision and drainage and closure of the compartment syndrome. On March 9, 2018 he had his left gangrenous index, middle, ring, and small fingers and the tip of his left thumb amputated. Dr. Ellis diagnosed HIV, Hepatitis C, cryoglobulinemia, traumatic compartment syndrome of the left upper extremity, blood clots of the left upper extremity requiring fasciotomy with loss of fingertips in the dominant left upper extremity, acquired absence of left thumb and left fingers secondary to fasciotomy, and orthostatic hypotension. He opined that all of these diagnoses were caused by appellant's workplace needle stick. Dr. Ellis noted that after appellant's needle stick he went to the occupational health unit where he was found to be HIV and Hepatitis C negative, and then in February 2017 was diagnosed with HIV and Hepatitis C. He opined that the timeline of appellant's development of HIV and Hepatitis C was chronologically consistent with his specific workplace needle stick. Dr. Ellis also indicated that appellant was not a drug or needle user, and he opined that the infectious disease from the needle stick caused appellant's blood to clot. The clotting caused an embolus in the blood vessels of appellant's left upper arm, thumb, and digits and necessitated the above-noted surgeries. Dr. Ellis opined that appellant's viral load caused his autonomic response, which in turn caused his orthostatic hypotension.

By decision dated January 22, 2019, OWCP modified its March 12, 2018 decision finding that the evidence of record established that appellant was injured in the performance of duty, as alleged. However, the claim remained denied because the medical evidence submitted was insufficient to establish that his diagnosed conditions were causally related to the accepted December 14, 2016 event.

On April 3, 2019 appellant, through counsel, requested reconsideration.

A March 20, 2019 medical report by Dr. Ellis indicated that he reviewed medical records dated January 20, 2017 from Dr. Bordon, which noted that appellant was a new patient who was seen after his exposure to HIV. Appellant took a rapid HIV detection test which was nonreactive, and he was then advised to take a few more tests to confirm the status of his HIV exposure. Dr. Ellis also reviewed medical records dated January 27, 2017 from Dr. Bordon who indicated that appellant was diagnosed with exposure to a blood borne pathogen, an unspecified viral infection, and HIV exposure, and he was treated for HIV exposure. He reviewed a statement made by appellant on March 18, 2019 in which he stated that he had a partner, no prior drug use, no blood transfusions, and did not engage in high-risk sexual activity. Dr. Ellis furthered stated that he took rapid HIV tests on January 20 and 27, 2017, both of which came back negative. Appellant indicated that he tested positive for Hepatitis C and HIV in February 2017, approximately 60 days after he was struck by the needle. Dr. Ellis opined that it is medically reasonable to conclude that this specific chronology of initial negative results after the needle stick incident and then later positive results indicated that appellant developed HIV and Hepatitis C from occupational exposures at the employing establishment.

By decision dated May 14, 2019, OWCP denied modification of the January 22, 2019 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] has the burden of proof to establish 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 of FECA,[4] that an injury was sustained in the performance of duty as alleged, and that any disability or medical condition for which compensation is claimed is causally related to the employment injury.[5] These are the essential elements of each and every compensation claim, regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[6]

[3] *Id*.

[4] *J.P.*, Docket No. 19-0129 (issued April 26, 2019); *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *Joe D. Cameron*, 41 ECAB 153 (1989).

[5] *J.M.*, Docket No. 17-0284 (issued February 7, 2018); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[6] *R.R.*, Docket No. 19-0048 (issued April 25, 2019); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

To determine whether a federal employee has sustained a traumatic injury in the performance of duty it must first be determined whether fact of injury has been established.[7] 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.[8] Second, the employee must submit sufficient evidence to establish that the employment incident caused a personal injury.[9]

Rationalized medical opinion evidence is 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 incident.[10]

OWCP's procedures provide at Chapter 2.805.6 of the Federal (FECA) Procedure Manual as follows:

> "High-Risk Employment. Certain kinds of employment routinely present situations which may lead to infection by contact with animals, human blood, bodily secretions and other substances. Conditions such as (HIV) infection and [H]epatitis B more commonly represent a work hazard in health care facilities, correctional institutions and drug treatment centers, among others, than in [f]ederal workplaces as a whole….
>
> "The [claims examiner] CE can accept the claim for a physical injury where one exists while developing the claim for a more serious condition (*e.g.*, a puncture wound may be accepted while any claimed hepatitis is developed)."[11]

[7] *R.B.*, Docket No. 17-2014 (issued February 14, 2019); *B.F.*, Docket No. 09-0060 (issued March 17, 2009); *Bonnie A. Contreras*, 57 ECAB 364 (2006).

[8] *S.F.*, Docket No. 18-0296 (issued July 26, 2018); *D.B.*, 58 ECAB 464 (2007); *David Apgar*, 57 ECAB 137 (2005).

[9] *A.D.*, Docket No. 17-1855 (issued February 26, 2018); *C.B.*, Docket No. 08-1583 (issued December 9, 2008); *D.G.*, 59 ECAB 734 (2008); *Bonnie A. Contreras*, *supra* note 7.

[10] *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.6 (January 2013).

Regarding acceptance of the claim for the alleged disease, these procedures provide:

"(b) … the CE may accept the case if --

> (1) A known carrier is involved, and the claimant had neither a prior history of the disease nor exposure outside of employment; or
>
> (2) A prior test was negative and a physical injury (such as a sexual assault) has been accepted, even if a known carrier is not involved, if the claimant's occupation puts him or her at continuous risk for contracting the disease in question and factors unrelated to work have not been identified as a source of infection. If such factors are present, the CE must carefully consider the medical probability of infection both outside and within the sphere of employment, as well as the incubation period of the disease."[12]

The claimant bears the burden of proof to establish a claim for a consequential injury. As part of this burden, he or she must present rationalized medical opinion evidence, based on a complete factual and medical background, establishing causal relationship. The opinion must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship of the diagnosed condition and the specific employment factors or employment injury.[13]

In discussing the range of compensable consequences, once the primary injury is causally connected with the employment, the question is whether compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury. The rules that come into play are essentially based upon the concepts of direct and natural results and of the claimant's own conduct as an independent intervening cause. The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.[14]

ANALYSIS

The Board finds that appellant has met his burden of proof to establish his diagnosed conditions of HIV and Hepatitis C are causally related to the accepted December 14, 2016 employment incident while performing high-risk employment duties.

The Board initially finds that appellant's work as a nurse at the employing establishment routinely presented situations which placed him in contact with human blood, bodily secretions, and other potentially hazardous substances which OWCP and the Board have determined are

[12] *Id*.

[13] *K.W.*, Docket No. 18-0991 (issued December 11, 2018).

[14] *K.S.*, Docket No. 17-1583 (issued May 10, 2018); Arthur Larson & Lex K. Larson, *The Law of Workers' Compensation* § 3.05 (2014).

common contaminants in a high-risk employment position.[15] Such contact, including a needle stick contaminated with human blood as occurred here, was possible at the employing establishment in his position. Thus, appellant's position as a nurse is found to constitute high-risk employment.

Having established that appellant was employed in a high-risk position at the time of the needle stick, it must next be determined whether his claim should be accepted for diagnoses associated with high-risk employment under either of the two provisions in OWCP's aforementioned procedures. In support of his claim, he submitted an October 2, 2018 medical report by Dr. Ellis who indicated that after appellant's December 14, 2016 needle stick incident he went to the employing establishment's occupational health unit where he was tested and found to be HIV and Hepatitis C negative. Subsequently, in February 2017, appellant again underwent testing and was diagnosed as positive for HIV and Hepatitis C. No other factors outside of his employment have been identified as a potential source of infection. Dr. Ellis opined that the timeline of appellant's development of HIV and Hepatitis C is chronologically consistent with the specific accepted December 14, 2016 workplace needle stick. OWCP accepted that the needle stick occurred on December 14, 2016 and that upon initial testing he was negative, but in close proximity he was tested again and, within mere months following the incident, he tested positive. The Board finds that Dr. Ellis' opinion regarding the timeline of the development of the positive diagnostic testing, coupled with his high-risk occupation which put him at continuous risk for contracting the diseases in question and the lack of other factors likely to have been a source of infection, is sufficient to establish causal relationship for the conditions of HIV and Hepatitis C. The Board therefore finds that although the source of the blood from the butterfly needle that stuck appellant is unknown, appellant has satisfied all elements listed in Chapter 2.805.6(b)(2) of OWCP's procedure manual, and has therefore met his burden of proof to establish that the diagnosed conditions of HIV and Hepatitis C must be accepted as work related.

Regarding appellant's claim that his left upper extremity conditions were a consequence of the accepted injury, the Board finds that this case is not in posture for decision.

Dr. Ellis' October 2, 2018 medical report diagnosed additional conditions that he claimed were also caused by appellant's December 14, 2016 employment incident. In addition to HIV and Hepatitis C, he diagnosed cryoglobulinemia, traumatic compartment syndrome of the left upper extremity, blood clots of the left upper extremity, and orthostatic hypotension, and he opined that all of these diagnoses were caused by appellant's workplace needle stick. Dr. Ellis explained that the infectious diseases from the needle stick caused appellant's blood to clot which in turn caused an embolus in the blood vessels of appellant's left upper arm, thumb, and digits and necessitated the previously mentioned surgeries. He also opined that appellant's viral load caused his autonomic response, which in turn caused his orthostatic hypotension.

Proceedings under FECA are not adversarial in nature, and OWCP is not a disinterested arbiter.[16] The Board finds that while Dr. Ellis' October 2, 2018 report is insufficient to meet appellant's burden of proof regarding causal relationship of the additional the left upper extremity

[15] *Supra* note 12; *see also D.W., widower of T.M.*, Docket No. 14-0460 (issued February 11, 2016).

[16] *See B.B.*, Docket No. 18-1321 (issued April 5, 2019).

conditions, it raises an uncontroverted inference between his additional diagnosed conditions of cryoglobulinemia, traumatic compartment syndrome of the left upper extremity, blood clots of the left upper extremity, and orthostatic hypotension and his now accepted December 14, 2016 employment injury. Further development of appellant's claim is therefore required.

On remand OWCP shall prepare a statement of accepted facts and refer appellant to an appropriate Board-certified specialist for a second opinion examination and an evaluation regarding whether he sustained additional medical conditions due to or as a consequence of the accepted December 14, 2016 employment injury. Following such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that appellant has met his burden of proof to establish HIV and Hepatitis C as causally related to the accepted December 14, 2016 employment injury. The Board also finds that this case is not in posture for decision regarding the issue of whether appellant has met his burden of proof to establish additional conditions due to or as a consequence of his accepted December 14, 2016 employment injury.

ORDER

IT IS HEREBY ORDERED THAT the May 14, 2019 decision of the Office of Workers' Compensation Programs is reversed in part and set aside in part and the case is remanded for further action consistent with this decision of the Board.

Issued: April 30, 2020
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board