United States Department of Labor
Employees' Compensation Appeals Board

D.S., Appellant	)	
and	)	**Docket No. 21-1080**
	)	**Issued: October 18, 2022**
U.S. POSTAL SERVICE, POST OFFICE, Elmer, NJ, Employer	)	

Appearances:
Anthony S. Arenas, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On July 1, 2021 appellant, through her representative, filed a timely appeal from an April 6, 2021 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 her burden of proof to establish a medical condition causally related to the accepted August 4, 2015 employment incident.

FACTUAL HISTORY

On August 19, 2015 appellant, then a 56-year-old customer service supervisor, filed a traumatic injury claim (Form CA-1) alleging that on August 4, 2015, she was walking to her desk when an oversized parcel slid and hit her foot, causing her to fall and hit her right arm on a chair while in the performance of duty. She alleged injuries to her lower back and to her right arm, hip, leg, and foot.

In a September 2, 2015 report and return to work note, Dr. Garo Avetian, an osteopathic physician specializing in internal medicine, indicated that appellant was evaluated for injuries sustained in a work-related incident on August 4, 2015. He recounted that appellant was walking at work when a large package slid, hit her foot, and caused her to fall over. Dr. Avetian noted that appellant complained of severe pain from her low back down to her hip, leg, and foot on the right side. On examination of appellant's thoracic and lumbar areas of the spine, he observed limited range of motion and pain with flexion and extension and positive straight leg raise testing on the left with pain. Dr. Avetian diagnosed thoracic and lumbar sprains, possible lumbar radiculopathy, and right hip, right elbow, and right calf and foot sprains. He opined that appellant's injuries were a direct result of her August 4, 2015 work-related accident.

Dr. Avetian completed duty status reports (Forms CA-17) dated September 2 through October 7, 2015 and an attending physician's report (Form CA-20) dated September 9, 2015. He noted a date of injury of August 4, 2015 and diagnoses of thoracic and lumbar sprains, and upper arm joint pain. Dr. Avetian checked a box marked "Yes" indicating that the condition was caused or aggravated by the described employment activity. He indicated that appellant could return to modified-duty work on November 30, 2015 and noted specific restrictions.

Appellant submitted an unsigned authorization for examination and/or treatment (Form CA-16). In Part B of the Form CA-16, Dr. Avetian reported that a large parcel struck appellant's left ankle and she fell down.

In letters dated September 10 and October 20, 2015, the employing establishment controverted appellant's claim. It noted that she did not report the alleged August 4, 2015 injury until 15 days later and did not seek medical attention until September. The employing establishment also contended that appellant did not properly complete paperwork. It further alleged that when she was on annual leave from March 23 through April 4, 2015 she had an off-duty back injury. The employing establishment submitted work excuse notes dated April 1 and 2 and May 6, 2015.

In a September 30, 2015 report, Dr. Avetian described the August 4, 2015 employment incident. He provided examination findings and diagnosed thoracic sprain, lumbar sprain, possible lumbar radiculopathy, right hip sprain, right elbow sprain, and right calf and foot pain. Dr. Avetian

recommended a lumbar MRI scan because he felt that appellant's current symptoms were a direct result of the August 4, 2015 work incident.

OWCP also received an August 11, 2015 note by Kristin LeBeau, a nonphysician clinician, who indicated that appellant was treated in their clinic for a serious medical condition and could return to work on August 15, 2015 with strict medical restrictions.

In a development letter dated November 10, 2015, OWCP informed appellant of the deficiencies of her claim. It advised her of the type of factual and medical evidence necessary to establish her claim and attached a questionnaire for her completion. OWCP afforded appellant 30 days to submit the requested evidence.

In a November 20, 2015 letter, W.M., a Postmaster, asserted that appellant had not established a new traumatic injury claim. She indicated that appellant did not report the incident according to standard operating procedure and contended that appellant had the custodian write a statement as if she had witnessed the alleged August 4, 2015 incident. OWCP received an employing establishment routing slip signed by appellant who described the August 4, 2015 incident. It also received a handwritten statement dated November 20, 2015 by an individual with an illegible signature who indicated that she did not see appellant fall down.

On November 30, 2015 appellant responded to OWCP's development questionnaire. She described the August 4, 2015 work incident and explained her delay in seeking a medical condition. Appellant reported that she had a previous slip and fall injury on February 21, 2015.

Appellant submitted a November 5, 2015 lumbar spine magnetic resonance imaging (MRI) scan, which revealed lumbar spondylosis, L2-3, L3-4, and L5-S1 disc desiccation with annular disc bulge, L3-4 central annular tear, L4-5 annular disc bulge effacing the thecal sac, and mild-to-moderate foraminal stenosis at multiple levels.

In a December 7, 2015 report, Dr. Avetian indicated that on February 21, 2015 appellant had suffered a slip and fall incident at work. He noted that her injury had resolved and she was able to return to work on June 15, 2015. Dr. Avetian reported that upon review of the latest lumbar MRI scan results, he could state with certainty that appellant's injuries and symptoms were related to the August 4, 2015 work incident. He explained that comparing appellant's previous MRI scan with the new one, it clearly showed foraminal stenosis at multiple levels that was not present before. Dr. Avetian reported that when the parcel slid off a cart and caused appellant to fall down, "this trauma caused her inflammation to her low back with tissues thickening, compressing the nerve roots and spinal cord and as a result spinal stenosis."

In a December 1, 2015 report, Dr. David Gigliotti, an osteopathic physician specializing in family medicine, recounted that appellant was previously treated for a February 21, 2015 slip and fall injury at work. He explained that on August 4, 2015 appellant sustained another work-related injury and was seen in his office on August 11, 2015.

By decision dated December 18, 2015, OWCP accepted that the August 4, 2015 incident occurred as alleged and that medical conditions had been diagnosed; however, it denied her claim finding that she had failed to establish causal relationship between the accepted employment incident and the diagnosed conditions.

On June 15, 2016 appellant requested reconsideration and submitted medical evidence.

Appellant submitted several diagnostic reports dated March 1, 2016. A right shoulder MRI scan revealed acromioclavicular degenerative joint disease and partial-thickness anterior insertional supraspinatus tear. A right knee MRI scan demonstrated meniscal tear of the medial and lateral compartments and degenerative changes. A right elbow MRI scan showed probable partial thickness tear of the humeral attachment of the radial collateral ligament. A right hip MRI scan revealed T2 hyperintensity at the right gluteal/trochanteric insertion consistent with tendinitis/tendinosis or mild partial tear. A right wrist MRI scan showed no abnormality or significant anatomic findings.

An April 13, 2016 upper extremity electromyography and nerve conduction velocity (EMG/NCV) study demonstrated lumbar radiculopathy affecting the L4 and L5 root levels bilaterally, right tibial motor neuropathy, and bilateral prolonged H reflex, suggestive of bilateral S1 radiculopathy.

In an undated report, Dr. Bradley Bodner, an osteopathic physician specializing in physical medicine and rehabilitation, noted a date of injury of August 4, 2015. He reported examination findings of reduced range of motion of the cervical and lumbar spines and diagnosed persistent post-traumatic cervicalgia and lumbago, lumbar radiculopathy, lumbar intervertebral disc displacement, and right elbow injury and possible ulnar nerve injury.

In a June 6, 2016 narrative report, Dr. Gerald M. Vernon, an osteopathic physician specializing in family medicine, described appellant's February 21, 2015 slip and fall injury and return to work on June 15, 2015. He recounted that on August 4, 2015 appellant was walking towards her desk when a large package struck her on the left side, causing her to fall down on her right side. Dr. Vernon noted that upon impact on the ground appellant injured her right shoulder, arm, elbow, wrist, and right knee. On examination of appellant's lumbar spine, he reported decreased range of motion and direct tenderness over the L4-5 and L5-S1 interspaces. Examination of appellant's bilateral hips showed good internal and external rotation and positive abduction test. Dr. Vernon indicated that examination of appellant's right knee revealed tenderness over the lateral and medial joint line and positive patella grind. Examination of appellant's right shoulder demonstrated tenderness over the apex of the shoulder and anterior and interior of the acromioclavicular (AC) joint. On examination of appellant's right elbow, Dr. Vernon observed tenderness over the medial epicondyle and pain with localized tenderness on resisted pronation and positive Tinel's sign over the elbow. He diagnosed reaggravation of prior lumbar spine injury, post-traumatic lumbar radiculopathy at L4 and L5, post-traumatic right tibial neuropathy, post-traumatic bilateral S1 radiculopathy, post-traumatic tendinopathy of the right gluteal/trochanteric insertion, post-traumatic partial thickness tear of the anterior insertional supraspinatus tear, post-traumatic horizontal tear of the anterior horn and tear of lateral meniscus of the right knee, post-traumatic partial thickness tear of the humeral attachment of the radial collateral ligament in the right wrist, and post-traumatic sprain/strain of the right wrist.

Dr. Vernon explained that appellant's February 21, 2015 work-related incident resulted in lumbar spine injuries. He noted that she underwent treatment for approximately four months and returned to work on June 15, 2015. Dr. Vernon recounted that on August 4, 2015 appellant suffered another work-related injury, which caused a permanent aggravation of her previous

lumbar condition and "a new direct causation of her right hip, knee, shoulder, elbow, and wrist." He noted that diagnostic and clinical findings were consistent with the way that the right side of appellant's body struck the floor when she fell.

By decision dated September 13, 2016 decision, OWCP denied modification of the December 18, 2015 decision.

On August 3, 2017 appellant, through counsel, requested reconsideration and submitted medical evidence.

In a July 7, 2017 addendum report, Dr. Vernon indicated that he had reviewed appellant's description of the August 4, 2015 incident. He reported that the description of the August 4, 2015 incident was consistent with the objective findings and injuries sustained by appellant.

By decision dated November 1, 2017, OWCP denied modification of the September 13, 2016 decision.

On October 31, 2018 appellant, through her then-counsel, requested reconsideration and submitted medical evidence.

In an October 29, 2018 addendum report, Dr. Vernon indicated that he had reviewed all of appellant's medical records, including her imaging studies, and opined that her right shoulder, right hip, pelvis area, and right knee injuries were a direct result of the August 4, 2015 work injury. He reported: "[t]his mechanism of injury is consistent with someone that has been struck on one side and has fallen to the outside and puts her arm or hand out, that is the typical type of injury that you would see when falling to the side, using your arm to stabilize the fall with the transmission of injury right up through hand, wrist, elbow, and shoulder and also injuring the right side of her pelvis and her right knee."

OWCP also received a December 17, 2015 report by Dr. Vernon. He described the February 21, 2015 and August 4, 2015 fall injuries at work. Dr. Vernon provided examination findings and diagnosed lumbosacral sprain, lumbar disc syndrome, possible lumbar facet syndrome, sprain of the right SI joint, IT band syndrome, right trochanteric bursitis, right shoulder sprain, right knee sprain, right cubital tunnel syndrome, right carpal tunnel syndrome, and right pronator syndrome. He concluded that "[t]he mechanism of injury sustained on [August 4, 2015] is consistent with her injuries and ongoing pain syndrome with the intensity and character of her pain being much worse following the second accident."

By decision dated February 28, 2019, OWCP denied modification of the November 1, 2017 decision.

On February 26, 2020 appellant, through her then-representative, requested reconsideration.

Appellant submitted an April 20, 2015 lumbar spine MRI scan, which showed loss of height and signal at L2-3 and L5-S1, preserved vertebral body heights, and Schmori's nodes seen at the inferior L1, superior L3, and opposing L3-4 endplates.

In a February 19, 2020 report, Dr. Mark A. Seldes, a Board-certified family medicine specialist, described that on August 4, 2015 a large, oversized parcel fell down and struck appellant on her left foot and ankle, causing her to fall down hard on the right side hitting her right hip, right leg, right knee, right foot, right shoulder, right arm, right hand, and lumbar spine. He noted that she had a previous slip-and-fall injury at work on February 21, 2015 and had returned to work with restrictions on June 15, 2015. Dr. Seldes discussed the medical treatment that appellant received and her diagnostic studies. He recounted her current complaints of daily pain, difficulty performing her activities of daily living, and difficulty staying asleep.

Upon examination of appellant's bilateral shoulders, Dr. Seldes observed tenderness to palpation over the anterolateral and posterior aspects and positive Neer's and Hawkins tests. Examination of appellant's right elbow revealed tenderness to palpation over the lateral and medial aspects and limited range of motion. Dr. Seldes reported that examination of appellant's lumbar spine revealed tenderness to palpation lateral to the midline in the dorsal lumbar spine area and over the bilateral sacroiliac joints. Examination of appellant's right hip showed tenderness to palpation over the anterolateral aspect of the right hip joint and examination of the right knee revealed tenderness to palpation over the lateral and medial joint line and limited range of motion. Dr. Seldes diagnosed lumbar radiculopathy, right shoulder rotator cuff tear, right trochanteric bursitis, right knee medial meniscus tear, right knee lateral meniscal tear, and right elbow radial collateral ligament tear. He opined that appellant suffered a work-related injury on August 4, 2015 when she was struck by a parcel at work.

A lumbar x-ray examination report dated July 14, 2016, showed moderate scoliosis, disc space narrowing at the L3-4 level, and degenerative changes at the L3-4 level.

By decision dated April 1, 2020, OWCP denied modification of the February 28, 2019 decision.

On June 11, 2020 appellant, through her then-representative, requested reconsideration.

In a May 19, 2020 report, Dr. Seldes noted his disagreement with the April 1, 2020 denial decision. He recounted his previous examination findings and appellant's diagnostic studies. Dr. Seldes reported: "it is my opinion with clinical evaluation, diagnostic review, history and evaluation of the patient directly that it is with reasonable medical certainty that this patient suffered a work-related injury on [August 4, 2015] when she was struck by a parcel at work in her left ankle and foot and knocked down on the right side of her body."

By decision dated September 4, 2020, OWCP denied modification of the April 1, 2020 decision.

On March 24, 2021 appellant, through her then-representative, requested reconsideration.

In a December 28, 2020 report, Dr. Seldes described the February 21 and August 4, 2015 fall injuries at work and the medical treatment that appellant received. He compared appellant's April 17, 2015 and November 5, 2015 lumbar spine MRI scans. Dr. Seldes indicated that appellant had a preexisting injury on February 21, 2015, which eventually resolved so that appellant could return to work. He opined that the subsequent August 4, 2015 injury aggravated her underlying injuries on February 21, 2015. Dr. Seldes requested that OWCP accept appellant's claim for

lumbar radiculopathy, right shoulder rotator cuff tear, right trochanteric bursitis, right knee meniscal tear, right knee lateral meniscal tear, and right elbow radial collateral ligament tear.

By decision dated April 6, 2021, OWCP denied modification of the September 4, 2020 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 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]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, OWCP must first determine whether fact of injury has been established.[7] There are two components involved in establishing fact of injury. First, the employee must submit sufficient evidence to establish that he or she actually experienced the employment incident at the time, place, and in the manner alleged.[8] Second, the employee must submit evidence, in the form of probative medical evidence, to establish that the employment incident caused a personal injury.[9]

To establish causal relationship between the condition, as well as any attendant disability claimed and the employment event or incident, the employee must submit rationalized medical opinion evidence.[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

[3] *Id*.

[4] *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *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); *K.M.*, Docket No. 15-1660 (issued September 16, 2016); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

[7] *D.B.*, Docket No. 18-1348 (issued January 4, 2019); *S.P.*, 59 ECAB 184 (2007).

[8] *D.S.*, Docket No. 17-1422 (issued November 9, 2017); *Bonnie A. Contreras*, 57 ECAB 364 (2006).

[9] *B.M.*, Docket No. 17-0796 (issued July 5, 2018); *David Apgar*, 57 ECAB 137 (2005); *John J. Carlone*, 41 ECAB 354 (1989).

[10] *See S.A.*, Docket No. 18-0399 (issued October 16, 2018); *see also Robert G. Morris*, 48 ECAB 238 (1996).

the specific employment factor(s) identified by the employee.[11] The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[12]

ANALYSIS

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

Appellant submitted reports by Dr. Vernon dated December 17, 2015 through June 6, 2016. Dr. Vernon noted that appellant's February 21, 2015 slip and fall injury and recounted that on August 4, 2015 a large package struck appellant on the left side, causing her to fall down on her right side. He noted that upon impact on the ground appellant injured her right shoulder, arm, elbow, wrist, and right knee. Dr. Vernon provided examination findings and diagnosed reaggravation of prior lumbar spine injury, post-traumatic lumbar radiculopathy at L4 and L5, post-traumatic right tibial neuropathy, post-traumatic bilateral S1 radiculopathy, post-traumatic tendinopathy of the right gluteal/trochanteric insertion, post-traumatic partial thickness tear, post-traumatic horizontal tear of the anterior horn and tear of lateral meniscus of the right knee, post-traumatic partial thickness tear of the humeral attachment of the radial collateral ligament in the right wrist, and post-traumatic sprain/strain of the right wrist. He opined that on August 4, 2015 appellant sustained a permanent aggravation of her previous lumbar condition and new right hip, knee, shoulder, elbow, and wrist conditions. Dr. Vernon reported that the mechanism of injury is consistent with someone that has been struck on one side and has fallen to the outside and puts her arm or hand out, that is the typical type of injury that you would see when falling to the side, using your arm to stabilize the fall with the transmission of injury right up through hand, wrist, elbow, and shoulder and also injuring the right side of her pelvis and her right knee.

The Board finds that, while the reports of Dr. Vernon are not fully rationalized, he provided a pathophysiological explanation with regard to causal relationship. Thus, further development is required.[13]

[11] *M.V.*, Docket No. 18-0884 (issued December 28, 2018); *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[12] *James Mack*, 43 ECAB 321 (1991).

[13]. *M.R.*, Docket No. 20-0101 (issued September 14, 2021); *N.K.*, Docket No. 20-1634 (issued September 10, 2021); *Richard E. Simpson*, 55 ECAB 490, 500 (2004); *John J. Carlone, supra* note 9.

It is well established that proceedings under FECA are not adversarial in nature, and while appellant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[14] OWCP has an obligation to see that justice is done.[15]

The Board will, therefore, remand the case to OWCP for further development of the medical evidence regarding whether appellant sustained a medical condition causally related to the August 4, 2015 employment incident. On remand OWCP shall refer appellant, a statement of accepted facts, and the medical evidence of record to a physician in the appropriate field of medicine for a rationalized opinion on whether any of the diagnosed conditions are causally related to the accepted employment incident. If the physician opines that the diagnosed conditions are not causally related, he or she must explain with rationale how or why his or her opinion differs from that of Dr. Vernon. Following this and other further development as deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's claim.

CONCLUSION

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

[14] *See e.g., M.G.*, Docket No. 18-1310 (issued April 16, 2019); *Walter A. Fundinger, Jr.*, 37 ECAB 200, 204 (1985); *Dorothy L. Sidwell*, 36 ECAB 699, 707 (1985); *Michael Gallo*, 29 ECAB 159, 161 (1978); *William N. Saathoff*, 8 ECAB 769, 770-71 (1956).

[15] *See A.J.*, Docket No. 18-0905 (issued December 10, 2018); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983); *Gertrude E. Evans*, 26 ECAB 195 (1974).

ORDER

IT IS HEREBY ORDERED THAT the April 6, 2021 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.[16]

Issued: October 18, 2022
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board

[16] A completed Form CA-16 authorization may constitute a contract for payment of medical expenses to a medical facility or physician, when properly executed. The 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. *See* 20 C.F.R. § 10.300(c); *J.D.*, Docket No. 22-0286 (issued June 15, 2022); *V.S.*, Docket No. 20-1034 (issued November 25, 2020); *J.G.*, Docket No. 17-1062 (issued February 13, 2018); *Tracy P. Spillane*, 54 ECAB 608 (2003).