United States Department of Labor
Employees' Compensation Appeals Board

D.H., Appellant	)	
and	)	**Docket No. 19-0633**
	)	**Issued: January 8, 2020**
DEPARTMENT OF AGRICULTURE, ANIMAL & PLANT HEALTH INSPECTION SERVICE, Raleigh, NC, Employer	)	

Appearances:
Daniel F. Read, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 30, 2019 appellant, through counsel, filed a timely appeal from a January 8, 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.[3]

[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.*

[3] The Board notes that following the January 8, 2019 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met his burden of proof to establish that his left foot necrotizing fasciitis was causally related to the accepted factors of his federal employment.

FACTUAL HISTORY

On May 16, 2018 appellant, then a 50-year-old biological science technician, filed an occupational disease claim (Form CA-2) alleging that he contracted necrotizing fasciitis (flesh eating bacteria) as a result of factors of his federal employment including working in contaminated water. He indicated that he first became aware of his condition and that it resulted from factors of his federal employment on May 1, 2018. Appellant stopped work on May 4, 2018.

In a May 16, 2018 development letter, OWCP informed appellant that the evidence of record was insufficient to establish his claim. It advised him of the factual and medical evidence necessary to support his claim and also provided a questionnaire for completion. OWCP afforded appellant 30 days to respond.

In a separate development letter of even date, OWCP requested additional information from the employing establishment regarding appellant's employment duties and whether it concurred with his allegations.

Appellant responded to OWCP's development letter in a statement dated June 6, 2018. He explained that he worked in eight different counties, in different beaver swamps. Appellant believed that he had been exposed to necrotizing fasciitis sometime in April or May 2018. He noticed that his left foot was a little red and puffy on May 1, 2018. Appellant reported that he worked alone and that he had never experienced anything like this before.

Appellant submitted emergency room records dated May 6, 2018 by Dr. Mark Worthen, a Board-certified family physician. He recounted that about two weeks prior appellant had developed redness in his left foot, which began to creep up his leg. Appellant indicated that he simultaneously experienced a sudden gush of foul-smelling fluid mixed with blood from the lateral aspect of his foot and between the fourth and fifth metatarsals so he sought treatment in the emergency room. Dr. Worthen noted that appellant had a history of diabetes mellitus and hypertension. He also related that appellant worked in murky water and that occasionally the murky water leaked into appellant's boot and soaked his foot. Upon examination of appellant's left foot, Dr. Worthen observed an ulcer on his left lateral foot near the metaphalangeal (MP) joint and a deep ulcer between the fourth and fifth toes. He also noted redness and induration of the skin extending to just below the knee. Dr. Worthen diagnosed diabetic ulcer of the midfoot and worsening cellulitis and abscess of the left leg. He related that a May 6, 2018 left foot x-ray revealed subcutaneous emphysema in the forefoot, worrisome for necrotizing infection. Dr. Worthen referred appellant to another hospital with a higher level of care.

A May 7, 2018 left foot computerized tomography (CT) scan showed extensive soft tissue emphysema, more than would be expected given the open wounds, necrotizing fasciitis/ gangrene/phlegnon with anaerobic organism in the differential, and generalized subcutaneous soft tissue edema.

OWCP also received hospital records dated May 8 to 14, 2018. In a May 8, 2018 admission report, Dr. Dwan Varner, a Board-certified internist, noted that appellant worked in murky swamp waters and that the water often leaked into his boot soaking his foot. Appellant reported that two weeks prior, he had noticed redness in his left foot that traveled up to his left leg. Dr. Varner recounted a history of diabetes mellitus and hypertension. Upon physical examination of appellant's left foot, he observed erythema, swelling, and drainage between the fourth and fifth toes. Dr. Varner assessed "diabetic ulcer of midfoot associated with diabetes mellitus due to underlying condition, with necrosis of muscle [and] necrotizing fasciitis." He recommended surgical intervention. In a May 14, 2018 discharge summary report, Dr. Varner noted discharge diagnoses of necrotizing fasciitis, cellulitis of the left lower leg, diabetic ulcer of midfoot associated with diabetes mellitus due to underlying condition, with necrosis of muscle and necrotizing fasciitis, diabetes mellitus, and hypertension.

In a May 8, 2018 operative report, Dr. Lawrence N. Larabee, a Board-certified orthopedic surgeon, noted a preoperative diagnosis of necrotizing fasciitis of the left foot lateral side and plantar aspect. He reported appellant's employment history working in the swamps and medical history of uncontrolled diabetes. Dr. Larabee noted that appellant underwent emergency surgery, which resulted in left midfoot amputation to include the third, fourth, and fifth toes and left midfoot debridement.

In a June 18, 2018 work status note, Dr. Jamie Udwadia, a Board-certified physiatrist, noted that appellant was to remain out of work.

By decision dated July 26, 2018, OWCP denied appellant's occupational disease claim. It accepted that appellant worked in water as part of his employment duties and that he had a diagnosis of necrotizing fasciitis, but denied his claim finding that the medical evidence of record was insufficient to establish causal relationship between his diagnosed medical condition and the accepted employment factors.

On October 17, 2018 appellant, through counsel, requested reconsideration. Counsel noted that appellant's final discharge diagnosis from the hospital was for necrotizing fasciitis and that appellant had described how he worked in filthy water and had a blister on his foot. He argued that Dr. Larabee provided a positive opinion that it was "highly probable" that given the nature of appellant's work, he contracted the infection at work. Counsel further contended that appellant only had to prove that his work factors contributed in any way to his condition in order to establish a workers' compensation claim.

In an accompanying statement, appellant explained that he worked with all the soil and water offices in nine counties. He related that he trapped beavers and removed beaver dams. Appellant asserted that he worked in different types of water and swamps where there was trash, dead deer carcasses, and other dead animals in the water. He explained that water would get into his boot through holes from briers, sticker bushes, and beaver sticks and that sometimes water would go over his waders into his boots. Appellant noted that he only went into the water when working for the employing establishment. He acknowledged that it was difficult to know where he caught necrotizing fasciitis, but he thought that he got this problem when he had a blister on his left foot in the spring of 2018. Appellant indicated that his blister broke, which left the skin a little raw, and then it got wet in the swamp.

In a May 29, 2018 progress note, Dr. Udwadia indicated that he treated appellant for left foot full-thickness open wound. He reviewed appellant's history of injury and noted that he underwent a partial amputation of the left foot and debridement. Dr. Udwadia reported appellant's active diagnoses as necrotizing fasciitis, diabetic ulcer of midfoot associated with diabetes mellitus due to underlying condition with necrosis of muscle, diabetic neuropathy, and diabetes mellitus.

In an October 11, 2018 letter, Dr. Larabee related a history of diabetes mellitus 2 and a work history of spending a lot of time in murky and unclear water. He noted that appellant first presented in the emergency room on May 6, 2018 after noticing redness in his left foot for the prior two weeks and heavy bleeding and pus that morning. Dr. Larabee reported that on May 8, 2018 he performed a debridement and partial amputation of appellant's left foot, to include amputation of appellant's fifth, fourth, and third toes. He noted that the pre and postoperative diagnosis was necrotizing fasciitis of the left foot. Dr. Larabee explained that necrotizing fasciitis was tissue death caused by bacterial infection. He indicated that bacteria typically entered the body through a cut or scrape. Dr. Larabee related that appellant had callouses on his feet, which were common in diabetics with neuropathy, and that appellant was probably predisposed to skin breakage and infection due to his diabetes. He further opined that appellant's work "greatly increased his risk of developing bacterial infections." Dr. Larabee noted that appellant's feet remained wet for extended periods of time, which promoted bacteria growth, and that he worked in contaminated and unhealthy water for extended periods of time. He also explained that considering appellant's broken blister in the spring of 2018 and working with water inside his boots, it was "highly probable" that this infection was contracted while working in unclean water with wet feet.

Appellant submitted progress notes by Teddle Gore, a family nurse practitioner, dated August 19, 2016 to April 25, 2017. She recounted appellant's treatment for type 2 diabetes mellitus with diabetic polyneuropathy and hypertension.

By decision dated January 8, 2019, OWCP denied modification of the July 26, 2018 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[4] 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,[5] 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

[4] *Supra* note 2.

[5] *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

employment injury.[6] 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.[7]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.[8]

Causal relationship is a medical issue, and the medical evidence required to establish causal relationship is rationalized medical opinion evidence.[9] 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 specific employment factors identified by the employee.[10]

In any case where a preexisting condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation, acceleration or precipitation, the physician must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.[11]

ANALYSIS

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

In support of his claim appellant submitted numerous medical reports relating to a left lower extremity condition which developed in April or May 2018. Those medical reports provide consistent diagnoses relating to the left lower extremity and indicate that appellant described employment duties requiring working in an environment causing his lower extremities to frequently become wet with water containing bacteria and other contaminants.

Included in the medical reports submitted were reports from Dr. Larabee, who consistently opined that appellant's necrotizing fasciitis was due to his employment exposures to wet environments containing bacteria while working as a biological science technician. Dr. Larabee explained that necrotizing fasciitis was tissue death caused by bacterial infection and he indicated that bacteria typically entered the body through a cut or scrape. He explained that due to his

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

[7] *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).

[8] *S.C.*, Docket No. 18-1242 (issued March 13, 2019); *R.H.*, 59 ECAB 382 (2008).

[9] *A.M.*, Docket No. 18-1748 (issued April 24, 2019); *T.H.*, 59 ECAB 388, 393 (2008); *Robert G. Morris*, 48 ECAB 238 (1996).

[10] *M.V.*, Docket No. 18-0884 (issued December 28, 2018); *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013).

diabetic neuropathy appellant had callouses on his feet. Dr. Larabee therefore noted that appellant was probably predisposed to skin breakage and infection due to his diabetic condition. He opined that appellant's work had greatly increased his risk of developing bacterial infections. Dr. Larabee further opined that appellant's feet remained wet for extended periods of time while working, which promoted bacteria growth, and that he worked in contaminated and unhealthy water for extended periods of time. He explained that, considering appellant's broken blister in the spring of 2018 and working with pond water inside his boots, it was highly probable that this infection was contracted while working in unclean water with wet feet.

Accordingly, the Board finds that Dr. Larabee provided an affirmative and rationalized opinion on causal relationship. Dr. Larabee identified employment factors which appellant consistently claimed had precipitated his necrotizing fasciitis, identified physical findings upon examination and treatment, and provided a rationalized opinion citing to the facts of the case. Thus, the Board finds that Dr. Larabee's opinion is sufficient to require further development of the record.[12]

It is well established that, proceedings under FECA are not adversarial in nature, and that while appellant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[13] OWCP has an obligation to see that justice is done.[14]

On remand OWCP shall refer appellant, a statement of accepted facts, and the medical evidence of record to an appropriate Board-certified physician. The chosen physician shall provide a rationalized opinion addressing whether the diagnosed left lower extremity conditions are causally related to the accepted factors of appellant's federal employment. If the physician opines that the diagnosed conditions are not causally related, he or she must provide rationale explaining the opinion. Following this and any other further development as deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim.

CONCLUSION

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

[12] *J.J.*, Docket No. 19-0789 (issued November 22, 2019); *J.G.*, Docket No. 17-1062 (issued February 13, 2018); *A.F.*, Docket No. 15-1687 (issued June 9, 2016). *See also John J. Carlone*, 41 ECAB 354 (1989); *Horace Langhorne*, 29 ECAB 820 (1978).

[13] *A.P.*, Docket No. 17-0813 (issued January 3, 2018); *Jimmy A. Hammons*, 51 ECAB 219, 223 (1999); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[14] *R.B.*, Docket No. 18-0162 (issued July 24, 2019); *K.P.*, Docket No. 18-0041 (issued May 24, 2019).

ORDER

IT IS HEREBY ORDERED THAT the January 8, 2019 merit 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.

Issued: January 8, 2020
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board