

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

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T.F., Appellant)	
)	
and)	Docket No. 15-372
)	Issued: May 22, 2015
U.S. POSTAL SERVICE, POST OFFICE,)	
Tulsa, OK, Employer)	
_____)	

Appearances:
Allan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 8, 2014 appellant, through counsel, filed a timely appeal of the November 3, 2014 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 the case.

ISSUE

The issue is whether appellant has met her burden of proof to establish a traumatic injury in the performance of duty.

FACTUAL HISTORY

On January 18, 2013, appellant then a 53-year-old rural carrier, filed a Form CA-1, traumatic injury, alleging that on November 6, 2012, while pushing a gurney full of parcels she felt a sharp pain in her lower right knee. She stopped work on January 16, 2013.

¹ 5 U.S.C. §§ 8101-8193.

Appellant submitted a January 7, 2013 report from Dr. Ronald S. LaButti, an osteopath, who noted that she had a traumatic onset of left knee pain on November 6, 2012 while walking into the employing establishment. Dr. LaButti noted positive findings on examination of an antalgic gait, small joint effusion of the left lower extremity, and medial joint line pain. He noted x-rays of the left knee revealed medial subchondral fracture along the periphery of the medial tibial plateau with some joint space loss of the patellofemoral joint on the left. Dr. LaButti diagnosed acute traumatic onset of the left knee pain related to a fracture of the periphery of the medial tibial plateau and patellofemoral osteoarthritis. On January 16, 2013 he diagnosed acute atraumatic left knee pain ongoing for two months related to a subchondral insufficiency fracture of the medial tibial plateau with underlying osteochondral lesion. Dr. LaButti recommended double crutches nonweightbearing on the left lower extremity and returned appellant to sedentary work. A January 10, 2013 left knee magnetic resonance imaging (MRI) scan revealed destabilizing radial tear of the posterior root of the medial meniscus with loss of circumferential hoop containment of the meniscus, subchondral insufficient fracture with osteonecrosis, medial collateral ligament bursitis, bicompartamental arthrosis, advanced chondral loss of the anterior medial tibial plateau and patella, and moderate knee effusion with synovitis and plica.

By letter dated February 1, 2013, OWCP advised appellant of the type of evidence needed to establish her claim, particularly requesting that she submit a physician's reasoned opinion addressing the relationship of her claimed condition and specific employment factors. It also requested the employing establishment to provide comments from a knowledgeable supervisor on the accuracy of her statements and provide witness statements from those who witnessed the injury or had immediate knowledge of the injury.

In a February 12, 2013 statement, appellant noted that she was pushing a gurney to her casing area and her knee "popped." She noted finishing her mail route while in pain and stopping for a knee brace while on her route. Appellant indicated that she did not seek medical treatment because she believed that her left knee would resolve but it did not. She noted that her supervisor informed her that there was no time limit for filing a claim. Appellant submitted November 30, 2012 emergency room reports, which noted her treatment for a left foot injury. She reported dropping a 30-pound metal object directly on her foot. An x-ray of the left foot was negative. Dr. Daniel Feinberg, a Board-certified emergency room physician, diagnosed crush injury of the foot. In a January 24, 2013 duty status report, Dr. LaButti diagnosed left knee pain and noted that appellant could return to work on January 7, 2013 to a full-time sedentary position.

Also submitted were reports from Dr. LaButti. In a January 25, 2013 attending physician's report, Dr. LaButti diagnosed subchondral insufficiency fracture of medial tibial (osteochondral lesion). He checked a box "yes" that appellant's condition was caused or aggravated by an employment activity. Dr. LaButti returned appellant to a sedentary position. On February 2, 2013 he noted that she could return to work with temporary restrictions and recommended physical therapy. In a February 11, 2013 report, Dr. LaButti treated appellant for left knee pain which began on November 6, 2012 while she was walking into the employing establishment. He noted findings on examination and diagnosed exacerbation of patellofemoral osteoarthritis and insufficiency fracture of the medial tibial plateau with an underlying osteochondral lesion. Dr. LaButti returned appellant to work with restrictions. In a February 18, 2013 report, he diagnosed exacerbation of patellofemoral osteoarthritis and insufficiency fracture

of the medial tibial plateau with an underlying osteochondral lesion. Dr. LaButti noted that based on appellant's history she had an asymptomatic left knee until November 6, 2012 when she walked into the employing establishment. He noted that his opinion and diagnoses were based on her history, a physical examination, and radiographic findings.

In a March 8, 2013 decision, OWCP denied the claim as the evidence was insufficient to establish the events occurred as described.

On April 2, 2013 appellant requested a review of the written record. She submitted a March 13, 2013 report from Dr. LaButti who summarized her injury and history of treatment. Dr. LaButti noted that appellant presented only 50 percent improved and continued to have pain in the medial aspect of the left knee and could not fully extend her knee. He noted findings on examination with x-rays revealing progression of the osteochondral injury to the medial tibial plateau, sclerosis, patellofemoral osteophytes, and patellofemoral joint space loss. Dr. LaButti diagnosed left knee pain related to osteochondral injury to the medial tibial plateau and osteoarthritis of the patellofemoral, and medial joint compartment. In a March 18, 2013 report, he noted that appellant had a work-related injury while walking into her place of employment. Dr. LaButti diagnosed medial tibial plateau fracture with underlying osteochondral injury. He diagnosed a work-related left knee injury, which occurred on November 6, 2012 osteochondral injury of the medial tibial plateau and medial femoral condyle and exacerbation of preexisting osteoarthritis of the patellofemoral joint. Dr. LaButti noted that given the changes on the MRI scan and appellant's failure to progress or improve over six months following her injury he recommended a total left knee replacement.

In a March 18, 2013 note, Dr. LaButti provided clarification of the history of her left sided knee pain. He noted initially dictating that appellant had onset of knee pain while walking into her place of work. However, upon obtaining further history from appellant, Dr. LaButti noted that she was actually at work when injured. On April 1, 2013 he diagnosed traumatic osteochondritis desiccans with underlying osteonecrosis of the medial tibial plateau and bicompartamental osteoarthritis. Dr. LaButti noted worsening progression of the osteochondral injury and avascular necrosis. He diagnosed traumatic osteochondritis dissecans and worsening avascular necrosis of the medial femoral condyle of the left knee and recommended a left knee replacement due to severe disabling pain with daily living activities.

On April 9, 2013 Dr. LaButti performed a left total knee arthroplasty, partial lateral patellectomy, reduction osteotomy of the proximal tibia, and diagnosed end stage osteoarthritis of the left knee. A March 13, 2013 left knee MRI scan revealed interval development of a very small subchondral fracture central to posterior weight bearing medial femoral condyle, stable full thickness radial tear of the posterior root attachment of the medial meniscus with mild subluxation of the medial meniscus, stable grade 2 cartilage loss, no ligament tear, and stable grade four chondromalacia of the medial patellar facette.

On March 11, 2013 appellant's supervisor, Julie Minyard, noted that, on November 6, 2013, appellant reported that during the morning her knee popped and she was having pain. Ms. Minyard noted that at that time and on subsequent occasions appellant indicated that she did not want to file a claim, but one month later, her physician noted that it was probably work related, and she wished to file a claim.

In a decision dated July 24, 2013, an OWCP hearing representative affirmed as modified the March 8, 2013 decision. She found that the gurney pushing incident was established, but denied the claim because the medical evidence was insufficient to establish causal relationship.

On June 3, 2014 appellant, through counsel, requested reconsideration. She submitted a December 11, 2013 report from Dr. M. Stephen Wilson, a Board-certified orthopedist, who noted on November 6, 2012 that she was pushing a gurney of parcels and felt a left knee popping sensation. Dr. Wilson noted that appellant was treated by Dr. LaButti and underwent a total left knee replacement on April 9, 2013. He noted normal range of motion, weakness against resistance with flexion and extension, mild laxity was exhibited on stressing the medial collateral ligaments, tenderness to palpation over the medial, and lateral joint lines. Dr. Wilson opined that appellant sustained an injury on November 6, 2012 to her knee due to a work-related accident while employed as a letter carrier. He noted that she attempted to self-treat her symptoms without improvement, but her condition worsened. Dr. Wilson noted that by the time appellant presented to Dr. LaButti the fracture was minimally displaced and diagnostic studies revealed osteonecrosis caused by a stress fracture. He noted that she continued to weight bear and work which caused daily increased trauma which can result in altered blood supply to the bone and cause progressively worsening symptoms over the two months she attempted to self-treat. Dr. Wilson opined that the major cause of appellant's condition was the November 6, 2012 accident and she sustained an acute injury to her left knee, superimposed on some preexisting changes. He noted the fact that she did not seek immediate treatment more likely than not caused a progressive increase in her condition which then resulted in osteonecrosis, secondary collapse, resulting in a total knee replacement.

In a decision dated November 3, 2014, OWCP denied modification of the July 24, 2013 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA 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 of FECA, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed is causally related to the employment injury. These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or occupational disease.²

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether fact of injury has been established. There are two components involved in establishing fact of injury. 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. Second, the employee must submit medical evidence to establish that the employment incident caused a personal injury.³

² Gary J. Watling, 52 ECAB 357 (2001).

³ T.H., 59 ECAB 388 (2008).

Rationalized medical opinion evidence is generally 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 factors identified by the claimant.⁴

ANALYSIS

It is not disputed that, on November 6, 2012, appellant was pushing a gurney full of parcels to a casing area. It is also established that she has been diagnosed with left knee traumatic osteochondritis desiccans with underlying osteonecrosis of the medial tibial plateau and bicompartamental osteoarthritis. However, appellant has not submitted sufficient medical evidence to establish that her diagnosed conditions were caused or aggravated by this pushing incident.

Appellant submitted reports dated January 7 and February 11, 2013 from Dr. LaButti who noted that she had a traumatic onset of left knee pain on November 6, 2012 while walking into the employing establishment. Dr. LaButti noted findings and diagnosed an acute atraumatic onset of the left knee pain related to a fracture of the medial tibial plateau and also patellofemoral osteoarthritis as confirmed by x-rays. On February 11, 2013 he treated appellant for left knee pain which began on November 6, 2012 while she was walking into the employing establishment. Dr. LaButti diagnosed exacerbation of patellofemoral osteoarthritis and an insufficiency fracture of the medial tibial plateau with an underlying osteochondral lesion. In a February 18, 2013 report, he noted diagnoses and stated that, based on appellant's history, she had an asymptomatic left knee until November 6, 2012 when she walked into the employing establishment. However, Dr. LaButti's reports did not provide an accurate history of the November 6, 2012 injury to the extent that he indicated the injury occurred when she was walking into the employing establishment. This account differed from the history provided by appellant that she injured her knee at work pushing a gurney full of parcels to the casing area.⁵ Dr. LaButti also failed to provide a rationalized opinion explaining the causal relationship between appellant's left knee condition and her factors of employment.⁶ In a January 25, 2013 attending physician's report, he diagnosed a subchondral insufficiency fracture of the medial tibia and checked a box "yes" to indicate that the condition was employment related. However, the Board has held that an opinion on causal relationship which consists only of a physician checking a box "yes" regarding causal relationship is of little probative value. Without any explanation or rationale for the conclusion reached, such report is insufficient to establish causal relationship.⁷

⁴ *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

⁵ See *Frank Luis Rembisz*, 52 ECAB 147 (2000) (medical opinions based on an incomplete history or which are speculative or equivocal in character have little probative value).

⁶ See *Jimmie H. Duckett*, 52 ECAB 332 (2001); *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value).

⁷ *Lucrecia M. Nielson*, 41 ECAB 583, 594 (1991).

In a March 18, 2013 note, Dr. LaButti corrected his history of the injury and noted that initially he had reported that appellant had an onset of knee pain while walking into her place of employment; however, he clarified that she was actually at work and walking in her place of employment at the time of the onset of the injury. In a March 18, 2013 report, he diagnosed a work-related left knee injury which occurred on November 6, 2012. Dr. LaButti found an osteochondral injury of the medial tibial plateau and a medial femoral condyle and an exacerbation of preexisting osteoarthritis of the patellofemoral joint. Although he supported causal relationship, he did not provide sufficient medical rationale to explain his conclusion regarding the causal relationship. Dr. LaButti did not explain how “walking in [appellant’s] place of employment” would have caused or aggravate the diagnosed conditions or why the osteochondral injury of the medial tibial plateau and medial femoral condyle and exacerbation of preexisting osteoarthritis of the patellofemoral joint was not the result of nonwork-related factors.

A December 11, 2013 report from Dr. Wilson noted that on November 6, 2012 appellant was pushing a gurney of parcels and felt a popping sensation in her left knee. He diagnosed an injury on November 6, 2012 to her knee on that date due to a work-related accident. Dr. Wilson noted that appellant attempted to self-treat her symptoms without improvement. Appellant also continued to use the knee and to work which caused increased trauma and progressively worsening symptoms. Dr. Wilson opined that the major cause of her condition was the acute injury to her left knee, superimposed on some preexisting changes. He noted that the fact that appellant did not seek immediate medical treatment more likely than not caused a progressive worsening of her condition which then resulted in osteonecrosis, secondary collapse, and a total knee replacement. Although Dr. Wilson supported causal relationship, he did not provide sufficient medical rationale explaining the basis of his conclusion opinion. He did not explain how pushing a gurney of parcels would have caused or aggravated the diagnosed conditions. Rather, Dr. Wilson did not clarify how preexisting changes of the left knee and lack of immediate medical treatment interacted with the November 6, 2012 incident to cause her condition and the need for a total knee replacement.

Appellant submitted a November 30, 2012 emergency room report from Dr. Feinberg who noted her treatment for a left foot injury. She reported injuring her left foot at work when she dropped a 30-pound metal object directly on the foot. Dr. Feinberg noted an x-ray of the left foot was negative for fracture or dislocation and diagnosed crush injury of the foot. However, his report that appellant dropped a 30-pound metal object directly on the foot, differs from the history provided by her that she injured her knee pushing a gurney full of parcels to the casing area.⁸

The remainder of the medical evidence, including diagnostic test reports, fails to provide an opinion on the causal relationship between appellant’s job and her diagnosed left knee condition. For this reason, this evidence is insufficient to meet her burden of proof.⁹

⁸ See *supra* note 5.

⁹ *A.D.*, 58 ECAB 149 Docket No. 06-1183 (issued November 14, 2006) (medical evidence which does not offer any opinion regarding the cause of an employee’s condition is of limited probative value on the issue of causal relationship).

An award of compensation may not be based on surmise, conjecture, or speculation. Neither the fact that appellant's condition became apparent during a period of employment nor the belief that her condition was caused, precipitated, or aggravated by her employment is sufficient to establish causal relationship. Causal relationships must be established by rationalized medical opinion evidence.¹⁰ Appellant failed to submit such evidence, and OWCP therefore properly denied her claim for compensation.

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 did not meet her burden of proof to establish that her claimed conditions were causally related to her employment.

ORDER

IT IS HEREBY ORDERED THAT the November 3, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 22, 2015
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

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