

aggravated by his employment on August 23, 2009. Appellant explained that he did not file his notice of occupational disease claim within 30 days because of management failure. He stopped work on April 12, 2010. In a supplemental statement, appellant reported that in April 2009 he began to feel pain in his left ankle whenever he put pressure and weight on it. The pain was initially minimal, but increased by June 23, 2009. Appellant opined that the continued and repeated activities of a postal carrier, which included walking on uneven cement pavement, going up and down stairs to deliver mail and getting off and on the two-ton postal vehicle aggravated his left ankle.

In a June 29, 2009 report, Dr. Joyce A. Tarbet, an orthopedic surgeon, noted that appellant was initially seen in her office for a previous back problem but now complained of pain in his left ankle for the past two to three months, primarily in the medial aspect. Appellant denied any recent trauma, but noted discomfort with weightbearing and walking. Upon examination, his ankle was not swollen, nontender over the medial malleolus and throughout the tibiotalar joint, had normal sensation throughout the left foot and ankle and had normal inversion of the heel with a heel raise. Dr. Tarbet noted that appellant had mild pes planus bilaterally. X-rays of the left ankle showed no fractures, dislocations and swelling. A 2009 electromyogram (EMG) nerve conduction test revealed no lumbar radiculopathy with minimal findings of a left tarsal tunnel syndrome. Dr. Tarbet concluded that appellant had posterior tibial tendinitis and bilateral pes planus. She recommended medial arch support.

In a November 5, 2009 report, Dr. Tarbet noted that appellant was a mail carrier and that his left ankle pain was aggravated by walking. Appellant had worn shoe inserts since his last examination, but they did not help. Dr. Tarbet reviewed his history and conducted an examination. She observed tenderness of the tibialis posterior and deltoid ligament and normal dorsi and plantar flexion but no erythema, swelling or warmth. Dr. Tarbet diagnosed tibialis tendinitis of the left ankle.

In a May 10, 2010 report, Dr. Thomas M. Smith, a Board-certified orthopedic surgeon, noted appellant's complaints of left ankle pain for the past nine months. Appellant used crutches and had not tried to walk without the boot. Dr. Smith reviewed appellant's history and noted that a May 10, 2010 x-ray showed no dislocation or fracture, well-preserved joint spaces and normal alignment. Upon examination, he observed a slight irregularity on lateral film midportion of tibial plafond. Dr. Smith diagnosed ankle and foot pain.

In an April 6, 2010 left ankle magnetic resonance imaging (MRI) report, Dr. Wayne Nagamine, a Board-certified diagnostic radiologist, observed an ill-defined cortical/subcortical area of T1 hypointensity and T2 hyperintensity involving the medial aspect of the tibial plafond extending into the adjacent portion of the medial malleolus. He also noted slight cortical irregularity involving the tibial plafond without gross articular collapse, but no unstable osteochondral fragment or other marrow edema. Dr. Nagamine's impression was that appellant sustained minimal posterior tibial tenosynovitis and cortical/subcortical edema in the medial aspect of the tibial plafond.

On June 4, 2010 OWCP advised appellant that the evidence submitted was insufficient to support his claim and requested additional information. It asked for a comprehensive medical report, which included results of examinations and tests, a diagnosis, treatment provided,

description of symptoms and a physician's opinion, based on medical rationale, explaining how exposure or activities in his federal employment contributed to his condition.

In a July 2, 2010 statement, appellant informed OWCP that Dr. Tarbet was no longer employed at his facility and that Dr. Smith would not provide a physician's opinion because he had been Dr. Tarbet's patient. He resubmitted the April 6, 2010 MRI scan report.

In a June 3, 2010 MRI scan report, Dr. Kathleen Bhatt, a Board-certified diagnostic radiologist, observed a half circle shaped lesion at the posterior medial aspect of the tibial plafond and a physiologic amount of fluid within the ankle mortise joint. Appellant's Achilles tendon, lateral peroneal tendons, anterior extensor tendons and medial flexor tendons were all intact. Dr. Bhatt identified no significant interval change in the subchondral bone marrow edema and subtle cortical irregularity at the posterior medial aspect of the tibial plafond. She stated that it may be secondary to developing degenerative change, possibly related to prior osteochondral injury.

By decision dated July 30, 2010, OWCP denied appellant's claim finding insufficient medical evidence to establish that his left foot or ankle condition was causally related to his employment activities.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his claim by the weight of the reliable, probative and substantial evidence² including that he sustained an injury in the performance of duty and that any specific condition or disability for work for which he claims compensation is causally related to that employment injury.³ In an occupational disease claim, appellant's burden requires submission of the following: (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 employee.⁴

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.⁵ 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

² *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

³ *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989); *M.M.*, Docket No. 08-1510 (issued November 25, 2010).

⁴ *R.H.*, 59 ECAB 382 (2008); *Ernest St. Pierre*, 51 ECAB 623 (2000); *D.U.*, Docket No. 10-144 (issued July 27, 2010).

⁵ *D.I.*, 59 ECAB 158 (2007); *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *W.D.*, Docket No. 09-658 (issued October 22, 2009).

specified employment factors or incident.⁶ 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.⁷ The mere fact that work activities may produce symptoms revelatory of an underlying condition does not raise an inference of an employment relation. Such a relationship must be shown by rationalized medical evidence of a causal relation based upon a specific and accurate history of employment conditions which are alleged to have caused or exacerbated a disabling condition.⁸

ANALYSIS

The Board finds that appellant failed to meet his burden of proof to establish that he sustained left tendinitis causally related to his employment activities. The record supports that his job as a city carrier required repetitive walking and climbing stairs to deliver mail; but the Board finds insufficient medical evidence that establishes that he sustained tibial tendinitis as a result of his employment activities.

Appellant submitted medical reports from Dr. Tarbet, who treated him for left ankle pain that was aggravated with walking. Dr. Tarbet reviewed his history and noted that he was a mail carrier. She conducted an examination and did not observe any swelling or tenderness over the medial malleolus and throughout the tibiotalar joint. X-rays did not reveal any fractures, dislocations and swelling and EMG results revealed minimal findings of left tarsal tunnel syndrome. Dr. Tarbet diagnosed posterior tibial tendinitis and recommended medial arch support. She did not, however, provide any opinion regarding the cause of appellant's diagnosed ankle condition. While Dr. Tarbet noted that he was a mail carrier, she did not explain how his activities as a mail carrier caused or contributed to the diagnosed condition. The Board has found that medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.⁹ Similarly, Dr. Nagamine's and Dr. Bhatt's MRI scan reports also do not contain any opinion on the cause of appellant's ankle condition. Thus, these reports are insufficient to establish his claim.

In a May 10, 2010 medical report, Dr. Smith examined appellant for complaints of left knee pain and noted a slight irregularity on lateral film mid portion of tibial plafond. He diagnosed ankle and foot pain. This report does not contain a diagnosed condition nor opinion on causal relationship. Thus, it is also insufficient to establish appellant's claim.

On appeal, appellant alleges that his original treating physician left the practice and his current physician was unable to locate her or her files and would not provide an opinion on causation. As noted, however, the employee has the burden of proof to establish the essential

⁶ *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

⁷ *B.B.*, 59 ECAB 234 (2007); *D.S.*, Docket No. 09-860 (issued November 2, 2009).

⁸ *Patricia J. Bolleter*, 40 ECAB 373 (1988).

⁹ *R.E.*, Docket No. 10-679 (issued November 16, 2010); *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

elements of his claim, which includes probative medical evidence establishing causal relationship. The record does not contain probative medical opinion evidence discussing how appellant's tibial tendinitis was caused by factors of his employment. Thus, appellant has not met his burden of proof to establish that he sustained tibial tendinitis as a result of his employment.

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 his burden of proof to establish that he sustained tibial tendinitis in the performance of duty.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 30, 2010 is affirmed.

Issued: August 10, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board