United States Department of Labor
Employees' Compensation Appeals Board

W.R., Appellant	)	
and	)	**Docket No. 11-170**
	)	**Issued: September 23, 2011**
U.S. POSTAL SERVICE, MAIN POST OFFICE, Little Rock, AR, Employer	)	

Appearances:
James W. Stanley Jr., Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 27, 2010 appellant filed a timely appeal from July 2 and September 2, 2010 decisions of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUES

The issues are: (1) whether appellant met his burden of proof to establish that he sustained an occupational disease in the performance of duty; and (2) whether OWCP properly denied appellant's request for reconsideration under 5 U.S.C. § 8128(a) without further merit review.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On November 30, 2009 appellant, then a 48-year-old customer services supervisor, filed an occupational disease claim. He alleged that he aggravated his preexisting degenerative knee joint disease and foot osteoarthritis due to walking and conducting route inspections for years. Appellant became aware of his condition on January 20, 2003 and realized its relationship to his employment on February 10, 2008. He stopped work on October 30, 2009.

Appellant detailed in an undated statement that he worked for the employing establishment since 1991. As a result of his job duties, namely walking on hard surfaces and performing route inspections, he experienced bilateral knee pain around 2003, which led to two right knee operations in 2003 and 2005 and a left knee operation in 2008. Appellant also developed severe right foot pain in late 2006 and early 2007 and was diagnosed with degenerative arthritis secondary to his injured knees. He notified his superiors about his condition, but continued to perform his duties. On October 21, 2009 appellant underwent left subtalar joint fusion surgery.

In an August 10, 2004 report from Dr. William S. Bowen, a Board-certified orthopedic surgeon, appellant complained of right posterior kneecap pain and added that his knee was previously scoped to repair a medial meniscus that he tore while in military service. On examination, Dr. Bowen observed healed arthroscopic portals, trace effusion, tenderness near the lateral joint line and significant crepitus around the lateral retinaculum. X-rays showed a large spur formation off the anterior patellar pole. Dr. Bowen diagnosed right patellofemoral osteoarthritis with a bone spur and synovitis. In an April 21, 2005 follow-up report, he recommended repeat arthroscopic surgery.[2]

An October 31, 2006 report from Dr. R. Alex Dellinger, a podiatrist, noted left plantar pain. Examination revealed pes planus and acute pain on palpation along the medial band of the plantar fascia. X-rays showed a possible prior medial sesamoid fracture, mild hallux valgus deformity and metatarsus adductus. Dr. Dellinger diagnosed plantar fasciitis. On November 14, 2006 he diagnosed neuritis after noting swelling and acute pain on palpation of the deep peroneal nerve. On February 14, 2007 appellant had pain in the dorsum of the left foot. Dr. Dellinger found slight tingling and pain on percussion over the dorsum at the base of the fourth metatarsal and about the fourth metatarsocuboid joint. In a December 18, 2007 note, he pointed out that appellant's symptoms became increasingly medial with dull pain on palpation around the first metatarsocuneiform joint. Radiological data showed early osteoarthritic change. Dr. Dellinger diagnosed first metatarsocuneiform joint osteoarthritis.[3]

On March 17, 2008 Dr. Bowen noted appellant's left knee pain and stated that his job required prolonged standing. He noted that appellant's weight had dropped from 380 to 320 pounds since he last saw him three years earlier. Appellant had left knee tenderness while x-rays

[2] Dr. Bowen's reports from July 5 and August 18, 2005 noted appellant's postoperative recovery and scheduled an August 22, 2005 return-to-work date.

[3] Appellant later complained of sharp left heel pain, which Dr. Dellinger diagnosed as plantar fasciitis in a June 24, 2008 note. A July 8, 2008 follow-up note stated that his symptoms significantly improved.

confirmed mild right knee tricompartmental arthritis. Dr. Bowen diagnosed left patellar chondromalacia. He added in an April 29, 2008 report that appellant had crepitus in the anterior aspect and medial compartment of the left knee and a possible meniscal tear. Appellant had a left knee arthroscopy on May 14, 2008. On June 30, 2008 Dr. Bowen related that appellant had a longstanding knee condition due to his military service and had surgeries on both knees. X-rays showed fairly significant bilateral knee osteoarthritis. Dr. Bowen opined that "an extensive amount" of appellant's left knee pain and symptoms were the "direct result of him having to bear the majority of his weight following his right knee surgery and injuries onto his left side which would certainly exacerbate any prearthritic type of condition."[4]

In a July 14, 2009 report from Dr. Dellinger, appellant complained of bilateral ankle and hindfoot pain, aches and soreness. Foot x-rays feet showed dorsal talar neck spurs and decreased subtalar joint space. Appellant had sharp pain on palpation of the bilateral lateral sinus tarsi and diminished range of motion of the bilateral subtalar joints. Dr. Dellinger diagnosed sinus tarsitis and osteoarthritis. He also assessed Morton's neuroma of the left foot in an August 18, 2009 report due to a positive Mulder's sign. In an August 21, 2009 report, Dr. David L. Harshfield, Jr., a Board-certified diagnostic radiologist, stated that a computerized tomography (CT) scan of the ankles showed moderate hypertrophy of the Achilles tendon, low-grade hypertrophic changes of the medial and lateral tendon groups, chronic ankle changes with traction-related ossification, and atherosclerotic calcification. On August 27, 2009 Dr. Dellinger noted that the CT scan confirmed osteoarthritic changes in the subtalar joint.

OWCP informed appellant in a December 15, 2009 letter about the evidence needed to establish his claim. Appellant submitted additional medical records and a response to an OWCP questionnaire regarding his job duties.

In a December 22, 2009 report, Dr. Dellinger diagnosed arthritis of the hindfeet and bilateral subtalar joints. He pointed out that appellant recently underwent left subtalar joint fusion surgery and was expected to have the same operation on his right foot in the future. Dr. Dellinger noted that appellant "admits to being on his feet a lot over the years for his job." He opined that this "certainly may have contributed to his current condition" and that he "may or may not develop further arthritis in other joints in the future, but is likely due to his current status and previous job requirements."

A January 5, 2010 report from Dr. Bowen noted that appellant sustained chronic bilateral knee and foot problems, both of which necessitated surgery. Dr. Bowen mentioned that appellant was required to stand or walk for most of the workday, but was unlikely to continue with his current duties based on his body mass index and lower-extremity orthopedic ailments.

In a February 8, 2010 decision, OWCP denied the claim, finding the medical evidence insufficient to establish that the accepted employment activity aggravated a diagnosed condition.

Appellant requested reconsideration on March 30, 2010. In a February 25, 2010 report, Dr. Bowen noted that appellant's job with the employing establishment "has always required significant standing and excessive amounts of walking." He opined: "His knees have both

[4] Appellant received injections from Dr. Bowen for his bilateral knee osteoarthritis and synovitis.

deteriorated over the years and I do believe this is a direct result of both his weight and his extensive amount of activity that his job requires. Certainly his work has been an aggravating condition in his knees and at his young age." Dr. Bowen stated that appellant would continue with conservative management but would likely need future knee replacement surgery.

Dr. Dellinger repeated in a March 29, 2010 note that appellant's arthritic foot condition was the direct result of both his weight and job activity, namely significant standing and excessive amounts of walking. Dr. Dellinger also noted that appellant's work had aggravated the condition of his feet.

On July 2, 2010 OWCP denied modification of the February 8, 2010 decision.

Appellant requested reconsideration on August 12, 2010 and submitted additional evidence. In an August 10, 2010 note, Dr. Dellinger related that appellant underwent a failed left subtalar joint fusion procedure on October 21, 2009 and required revisional surgery. He also reiterated that appellant walked and stood extensively at work, which "facilitated the development of his original arthritic condition." Dr. Dellinger's July 2, 2010 duty status report released appellant to full-time, modified duty.

On September 2, 2010 OWCP denied appellant's request for reconsideration on the basis that he did not present new evidence or legal contentions warranting further merit review.

LEGAL PRECEDENT -- ISSUE 1

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 timely filed within the applicable time limitation period, that an injury was sustained in the performance of duty as alleged and that any disabilities and/or specific conditions for which compensation is claimed are 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]

Whether an employee actually sustained an injury in the performance of duty begins with an analysis of whether fact of injury has been established.[7] To establish fact of injury in an occupational disease claim, an employee 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 employee.[8]

[5] *Elaine Pendleton*, 40 ECAB 1143 (1989).

[6] *Victor J. Woodhams*, 41 ECAB 345 (1989).

[7] *See S.P.*, 59 ECAB 184, 188 (2007).

[8] *See R.R.*, Docket No. 08-2010 (issued April 3, 2009); *Roy L. Humphrey*, 57 ECAB 238, 241 (2005).

Causal relationship is a medical issue and the evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is evidence which includes a physician's opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. 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.[9]

ANALYSIS -- ISSUE 1

The evidence supports that appellant's job duties involved prolonged walking and standing as well as repetitive bending and stooping. The record also contains several firm diagnoses, most notably bilateral knee, hindfoot and subtalar joint arthritis. Nonetheless, the medical evidence is insufficient to establish that the described employment factors aggravated a preexisting condition.

Dr. Bowen's reports from August 10, 2004 to February 25, 2010 documented appellant's persisting knee problems. He obtained a history of injury, noting that appellant previously sustained a torn right medial meniscus in the military and underwent numerous arthroscopies on both knees. Dr. Bowen diagnosed bilateral knee osteoarthritis. In a February 25, 2010 note, he concluded that appellant's employment, which entailed significant standing and excessive amounts of walking, directly contributed to his condition. However, Dr. Bowen's opinion is of little probative value because he failed to provide medical rationale explaining how standing, walking, bending or stooping pathophysiologically aggravated a preexisting injury.[10]

In medical records from October 31, 2006 to March 29, 2010, Dr. Dellinger noted left foot symptoms and eventually diagnosed bilateral hindfoot and subtalar joint arthritis based on physical examination and x-rays. He further noted that appellant underwent left subtalar joint fusion surgery and was expected to have the same operation on his right foot. Dr. Dellinger opined in a December 22, 2009 and March 29, 2010 reports that standing and walking on the job for many years directly aggravated his condition and that he developed arthritis as a direct result of both his weight and activity required in his job. His opinion, though, lacks fortifying medical rationale and has diminished probative value on the issue of causal relationship.[11]

Lastly, Dr. Harshfield's August 21, 2009 report is of limited probative weight since no opinion was given regarding the cause of appellant's condition.[12]

On appeal, appellant's counsel argues that Drs. Bowen and Dellinger's reports were sufficient to establish the occupational disease claim and that the burden shifted to OWCP to

[9] *I.J.*, 59 ECAB 408 (2008); *Woodhams*, *supra* note 6.

[10] *Joan R. Donovan*, 54 ECAB 615, 621 (2003); *Ern Reynolds*, 45 ECAB 690, 696 (1994).

[11] *See George Randolph Taylor*, 6 ECAB 986, 988 (1954).

[12] *J.F.*, Docket No. 09-1061 (issued November 17, 2009); *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

demonstrate that their opinions on causal relationship were inadequate.[13] As noted, the medical evidence did not pathophysiologically explain how appellant's employment factors aggravated a preexisting knee or foot condition. Moreover, appellant has the burden of establishing by the weight of reliable, probative and substantial evidence that his condition was caused adversely affected by his employment. As part of this burden, he must present rationalized medical opinion evidence, based on a complete factual and medical background, showing causal relation.[14] The absence of a known etiology for appellant's condition does not relieve him of this burden. In addition, the fact that the etiology is unknown or obscure does not shift the burden of proof to OWCP to disprove causal relation. Causal relation between the disabling disease and the employment must be established in each case by affirmative evidence.[15] In the absence of well-reasoned medical opinion explaining this relationship, appellant failed to meet his burden.[16]

LEGAL PRECEDENT -- ISSUE 2

To require OWCP to reopen a case for merit review under section 8128(a) of FECA,[17] OWCP regulations provide that the evidence or argument submitted by a claimant must either: (1) show that OWCP erroneously applied or interpreted a specific point of law; (2) advance a relevant legal argument not previously considered by OWCP; or (3) constitute relevant and pertinent new evidence not previously considered by OWCP.[18] Where the request for reconsideration fails to meet at least one of these standards, OWCP will deny the application for reconsideration without reopening the case for a review on the merits.[19]

ANALYSIS -- ISSUE 2

Appellant requested reconsideration and provided a July 2, 2010 duty status report and August 10, 2010 note from Dr. Dellinger. OWCP denied his request on the grounds that he did not present new evidence warranting further merit review. Appellant contends on appeal that OWCP failed to consider all the pertinent medical evidence.

Evidence submitted on reconsideration includes Dr. Dellinger's August 10, 2010 note. The Board finds that this treatment note constitutes relevant and pertinent new evidence not previously considered by OWCP as it addressed the underlying issue of OWCP's July 2, 2010 merit decision: whether appellant's employment factors aggravated a preexisting arthritic

[13] The Board notes that appellant's counsel makes several references to medical reports that are not part of the record.

[14] *Froilan Negron Marrero*, 33 ECAB 796 (1982).

[15] *See William D. Styron*, 32 ECAB 866 (1981).

[16] The Board points out that appellant submitted new evidence after issuance of the July 2, 2010 merit decision. However, the Board lacks jurisdiction to review evidence for the first time on appeal. 20 C.F.R. § 501.2(c)(1).

[17] 5 U.S.C. § 8128(a).

[18] *E.K.*, Docket No. 09-1827 (issued April 21, 2010). *See* 20 C.F.R. § 10.606(b)(2).

[19] *L.D.*, 59 ECAB 648 (2008). *See* 20 C.F.R. § 10.608(b).

condition. Therefore, OWCP was obligated to conduct a merit review of the claim when appellant submitted this evidence in support of his reconsideration request.[20] Reopening a claim for merit review does not require a claimant to submit all evidence which may be necessary to discharge his burden of proof.[21] If OWCP should determine that the new evidence submitted lacks probative value, it may deny modification of the prior decision, but only after the case has been reviewed on the merits.[22] Appellant's case shall be remanded to OWCP to conduct a merit review of the entire record. After such further development as is deemed necessary, OWCP shall issue an appropriate merit decision.

CONCLUSION

The Board finds that appellant did not establish that he sustained an occupational disease in the performance of duty. However, the Board finds that OWCP improperly denied appellant's request for reconsideration under 5 U.S.C. § 8128(a) without further merit review.

[20] OWCP improperly determined in the September 2, 2010 decision that Dr. Dellinger's August 10, 2010 note duplicated previously-considered evidence. Dr. Dellinger's first attempt to support causal relationship in a December 22, 2009 report vaguely stated that appellant's condition may have been due to "being on his feet a lot over the years for his job." Later, his March 29, 2010 note attributed appellant's injury to both his weight and his job activities at work, namely standing and walking. By comparison, the August 10, 2010 opinion not only specified the employment duties that contributed to appellant's condition, but also omitted any reference to his weight as a contributory factor. Thus, the August 10, 2010 treatment note addressed causal relationship in a different manner than the physician's previous reports.

[21] *See Kenneth R. Mroczkowski*, 40 ECAB 855 (1989); *Helen E. Tschantz*, 39 ECAB 1382 (1988).

[22] *See Dennis J. Lasanen*, 41 ECAB 933 (1990).

ORDER

IT IS HEREBY ORDERED THAT the July 2, 2010 decision of the Office of Workers' Compensation Programs is affirmed and the September 2, 2010 decision of OWCP is set aside and remanded for further action consistent with this decision.

Issued: September 23, 2011
Washington, DC

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

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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