United States Department of Labor
Employees' Compensation Appeals Board

D.F., Appellant	)	
and	)	**Docket No. 12-347**
	)	**Issued: June 18, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Ragan, MN, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 8, 2011 appellant filed a timely appeal from the Office of Workers' Compensation Programs' (OWCP) August 4, 2011 merit decision denying her occupational disease claim. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met her burden of proof to establish that she sustained a left foot injury causally related to factors of her federal employment.

On appeal, appellant contends that the most probable cause of her left foot condition was prolonged periods of walking and standing.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On May 5, 2011 appellant, a 54-year-old clerk, filed an occupational disease claim (Form CA-2) alleging injury to her left foot due to repetitive walking and pushing at work. She experienced pain in her toes and at the ball of her left foot, which was exacerbated by being on her feet for long periods of time. Appellant's symptoms included tingling, burning, numbness and shooting pain. Her position required standing and walking during most of her eight-hour shift, repetitive bending while lifting and pulling and pushing mail bins weighing up to 400 pounds.

Appellant submitted notes dated May 2, 2011 from Dr. Ralph Bovard, Board-certified in the field of preventive medicine, who diagnosed left foot and lower leg pain, which he indicated was "work related." Dr. Bovard stated, "At this point, there is no clear cause of her chronic foot pain."

The record contains a March 4, 2011 chart note from Dr. William Kuglar, a podiatrist, who diagnosed tarsal tunnel syndrome.

In a May 25, 2011 letter, OWCP informed appellant that the evidence submitted was insufficient to establish her claim. It requested additional details regarding the employment duties she believed caused or contributed to her claimed condition and a comprehensive medical report from a treating physician, which addressed symptoms, a definitive diagnosis and an opinion as to the cause of her diagnosed condition.

In a second report dated May 2, 2011, Dr. Bovard related a history that appellant's foot, ankle and lower left leg pain worsened during the previous year with increased weight bearing at work. X-rays showed no bony deformity or evidence of fracture. On examination, there was some tenderness on palpation over the undersurface of the left foot medially in the region of the first metatarsal phalangeal joint. Dr. Bovard stated that there was "some question of tarsal tunnel syndrome" and no clear cause of the foot pain, which left him "in a bit of a quandary." On May 12, 2011 he reiterated his diagnosis of left foot and lower leg pain, which he noted was "work related."

On January 31, 2011 Dr. Kuglar found no particular tenderness across the metatarsals, no palpable masses, limited plantar flexion at the second metatarsal phalangeal joint of the left foot and no pain or crepitus on range of motion. He indicated that appellant might be developing chronic capsulitis at the second metatarsal phalangeal joint.

In a narrative report dated March 4, 2011, Dr. Kuglar diagnosed possible tarsal tunnel syndrome. On examination, he noted adequate ankle and subtalar joint range of motion with no gross instability. There was no restriction of motion or crepitus at the metatarsal phalangeal joints. On standing and weight bearing there seemed to be some hyperactivity of the extensor muscles holding the toes in a dorsiflexed position. Dr. Kuglar was able to elicit some tenderness and symptoms of a positive Tinel's sign at the medial aspect of the left ankle, where the plantar nerves enter the plantar aspect of the foot, porta pedis. He was not able to localize any acute pathology that would correlate with appellant's symptoms.

In March 28, 2011 progress notes, Dr. Kuglar noted tenderness at the tarsal canal of the left foot. On April 8, 2011 he reiterated the diagnosis but noted that he could not specifically localize the left foot problem. Dr. Kuglar recommended a magnetic resonance imaging (MRI) scan.

In a March 16, 2011 report, Dr. Mario R. Quinones, a Board-certified neurologist, who stated that appellant had been experiencing a burning and stinging sensation on the ball of her left foot and numbness in the second toe. On examination, he found no specific tenderness in the medial malleolus in the area of the tarsal tunnel. Dr. Quinones stated:

> "Personally, I do not believe that she has the typical tarsal tunnel but it is quite possible that can give you only the burning feeling. This could be only local trauma of the plantar nerves distally due to decrease of fat pad on the foot, which I think is most likely the explanation because the pain is mainly when she has been standing for a long time on her feet so it is occupationally related. Unfortunately, the electromyogram is not [a] very sensitive or reliable test to rule in the tarsal tunnel because very frequently you might not obtain any motor nerve potentials on testing, which is the normal pupils, so only finding a complete normal test might rule out the diagnosis and in comparing with the other foot. At the end point I do not think we are going answer 100 percent the question."

In April 25, 2011 progress notes, Dr. Troy J. Boffeli, a podiatrist, diagnosed possible tarsal tunnel syndrome and chronic left foot and ankle pain. He noted appellant's statement that her employment activities involved standing all day and pushing heavy bins. A review of a recent MRI scan revealed no pathology consistent with nerve impingement. On examination, there was no evidence of a neuropathic breakdown. Dr. Boffeli opined that appellant might have some form of peripheral neuropathy.

The employing establishment controverted appellant's claim. It contended that appellant had a preexisting left foot condition that was not work related. The employing establishment submitted an April 21, 2010 report from Dr. Terence L. Vanderheiden, a podiatrist, who diagnosed juvenile osteochondrosis of the foot; enthesopathy of unspecified site; pain in the soft tissue of the limb; and hammer toe. Dr. Vanderheiden noted that for at least a year appellant had experienced a squishy feeling in the ball of her left foot, stinging, burning and pain in the lateral left foot and pain on the bottom of the left big toe. He stated that the etiology of her condition was unclear.

The record contains June 15, 2011 urgent care notes from Barbara Harris, a certified medical assistant, who diagnosed left foot and lower leg pain (work related). She stated that appellant had been engaged in repetitive work activity stressing her left foot and had worked on hard cement floors. On June 15, 2011 Rita W. Reed, M.D., diagnosed left foot pain and noted that appellant was under podiatric care. On examination she noted that appellant's left big toe stayed in fixed extension. The rest of the left foot was unremarkable.

In a July 6, 2011 report, Dr. Vanderheiden stated that appellant was suffering from chronic left foot pain, which she described as stinging, tingling and burning. X-rays revealed degenerative joint disease at the tarsal metatarsal joints and posterior calcaneal spurs. On

examination there was decreased active range of motion left second toe with plantar flexion. Palpable exostoses tarsometatarsal joints and laterally mild discomfort with palpation of the fifth metatarsal base on the left foot. With weight bearing, appellant had a higher arch bilaterally. Mild calcaneal varus and mild tibial varum, bilaterally, left greater than right. Dr. Vanderheiden diagnosed peroneal tendinitis of the left foot and ankle, possible early onset Freiberg's infraction second metatarsal left foot, cavus foot structure bilaterally, calcaneal varus bilaterally, tibial varum bilaterally and hammer toe (#2) left foot. The report contained a general information section describing the condition and possible causes of capsulitis/metatarsal injuries, which can occur due to repetitive stress and excessive force on the toe joints.

By decision dated August 4, 2011, OWCP denied appellant's claim on the grounds that the medical evidence of record did not establish that the claimed left foot condition was causally related to the established work-related events.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of establishing the essential elements of her claim, including the fact that an injury was sustained in the performance of duty as alleged[2] and that any disability and/or specific condition for which compensation is claimed is causally related to the employment injury.[3]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying the employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.[4] The medical evidence required to establish a causal relationship, generally, is rationalized medical opinion evidence, *i.e.*, medical evidence presenting a physician's well-reasoned opinion on how the established factor of employment caused or contributed to claimant's diagnosed condition. To be of probative value, the opinion of the physician must be based on a complete factual and medical background of the claimant, 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.[5]

An award of compensation may not be based on appellant's belief of causal relationship. Neither the mere fact that a disease or condition manifests itself during a period of employment,

[2] *Joseph W. Kripp*, 55 ECAB 121 (2003); *see also Leon Thomas*, 52 ECAB 202, 203 (2001). "When an employee claims that he sustained injury in the performance of duty he must submit sufficient evidence to establish that he experienced a specific event, incident or exposure occurring at the time, place and in the manner alleged. He must also establish that such event, incident or exposure caused an injury." *See also* 5 U.S.C. § 8101(5) ("injury" defined); 20 C.F.R. § 10.5(q) and (ee) (2002) ("Occupational disease or Illness" and "Traumatic injury" defined).

[3] *Dennis M. Mascarenas*, 49 ECAB 215, 217 (1997)

[4] *Michael R. Shaffer*, 55 ECAB 386 (2004). *See also Solomon Polen*, 51 ECAB 341, 343 (2000).

[5] *Leslie C. Moore*, 52 ECAB 132, 134 (2000); *see also Ern Reynolds*, 45 ECAB 690, 695 (1994).

nor the belief that the disease or condition was caused or aggravated by employment factors or incidents, is sufficient to establish a causal relationship.[6]

ANALYSIS

The medical evidence submitted by appellant is insufficient to establish that she sustained a left foot condition due to accepted employment activities as a mail clerk. Therefore, she has failed to meet her burden of proof.

On May 2, 2011 Dr. Bovard diagnosed left foot and lower leg pain, which he generally indicated was "work related." He provided examination findings and a history of injury based upon appellant's report. Dr. Bovard stated that there was some question of tarsal tunnel syndrome, but that there was no clear cause of the foot pain, which left him "in a bit of a quandary." On May 12, 2011 he reiterated his diagnosis of left foot and lower leg pain, which he noted was "work related." Dr. Bovard did not provide a firm medical diagnosis[7] or a definitive opinion on the cause of appellant's left foot condition. Therefore, his reports are of limited probative value.[8]

Reports from Dr. Kuglar are also insufficient to establish appellant's claim. On January 31, 2011 Dr. Kuglar provided examination findings and speculated that appellant might be developing chronic capsulitis at the second metatarsal phalangeal joint. Progress notes dated March 4 through April 8, 2011 contain objective findings and a diagnosis of possible tarsal tunnel syndrome. They do not contain any opinion on the cause of appellant's condition. Absent a definitive diagnosis or an opinion as to how appellant's claimed left foot condition was caused or aggravated by her employment, the reports are of diminished probative value.

Dr. Quinones provided examination findings and a history of injury. He opined that appellant did not have the typical tarsal tunnel symptoms and stated that due to the unreliability of the electromyogram, a definitive diagnosis was difficult to make. Dr. Quinones opined that appellant's condition was most likely occupationally related because her pain occurred mainly after standing for a long time on her feet. He did not provide a definitive diagnosis or an opinion adequately addressing the cause of appellant's condition. Accordingly, his report is insufficient to establish appellant's claim.

Dr. Boffeli diagnosed possible tarsal tunnel syndrome; chronic left foot and ankle pain failed to provide a definitive diagnosis.[9] Although he noted that appellant's employment activities involved standing all day and pushing heavy bins, he did not offer an opinion on the cause of her left foot condition. Dr. Boffeli did not explain the medical process through which

[6] *Phillip L. Barnes*, 55 ECAB 426 (2004); *see also Dennis M. Mascarenas*, *supra* note 3 at 218.

[7] The Board has held that pain is generally a symptom, rather than a firm medical diagnosis. *C.F.*, Docket No. 08-1102 (issued October 10, 2008).

[8] 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. *Dennis M. Mascarenas*, *supra* note 3.

[9] *See supra* note 7 (pain is a symptom, rather than a compensable medical diagnosis).

appellant's left foot condition resulted from her accepted work activities.[10] Therefore, his report is of limited probative value.

In an April 21, 2010 report, Dr. Vanderheiden diagnosed juvenile osteochondrosis of the foot; enthesopathy of unspecified site; pain in the soft tissue of the limb; and hammer toe. He noted a history that for at least a year appellant had experienced a squishy feeling in the ball of her left foot, stinging, burning and pain in the lateral left foot and pain on the bottom of the left big toe. Dr. Vanderheiden stated, however, that the etiology of appellant's condition was unclear. On July 6, 2011 he reviewed the results of x-rays, which revealed degenerative joint disease at the tarsal metatarsal joints and posterior calcaneal spurs. Dr. Vanderheiden provided examination findings and diagnosed peroneal tendinitis of the left foot and ankle, possible early onset Freiberg's infraction second metatarsal left foot, cavus foot structure bilaterally, calcaneal varus bilaterally, tibial varum bilaterally and hammer toe (#2) left foot. Although he provided general information regarding possible causes for appellant's condition he did not offer an opinion on the cause of her specific condition or explain how her work-related activities were competent to cause her claimed condition. Therefore, his reports are of diminished probative value.

In a June 15, 2011 report, Dr. Reed diagnosed left foot pain and provided examination findings. She did not, however, provide a definitive diagnosis, a complete medical or factual background or an opinion on the cause of appellant's condition. For these reasons, her report is insufficient to establish appellant's claim.

The record contains June 15, 2011 urgent care notes from Ms. Harris, a certified medical assistant, who diagnosed left foot and lower leg pain (work related). A certified medical assistant is not a physician as defined under FECA. Therefore, her report does not constitute probative medical evidence.[11]

The remaining medical evidence of record, including reports of MRI scans and x-rays that do not contain an opinion on the cause of appellant's claimed condition, are insufficient to establish appellant's claim.

Appellant expressed her belief that her alleged condition resulted from her employment duties. The Board has held, however, that the mere fact that a condition manifests itself during a period of employment does not raise an inference that there is a causal relationship between the two.[12] Neither the fact that the condition became apparent during a period of employment, nor the belief that the condition was caused or aggravated by employment factors or incidents, is

[10] *Willa M. Frazier*, 55 ECAB 379 (medical conclusions unsupported by rationale are of little probative value and are insufficient to establish causal relationship). *See also Calvin E. King, Jr.*, 51 ECAB 394 (2000); *see also Frederick E. Howard, Jr.*, 41 ECAB 843 (1990).

[11] A medical report may not be considered to be probative medical evidence if there is no indication that the person completing the report qualifies as "physician" as defined by FECA. Section 8101(2) of FECA provides as follows: "(2) 'physician' includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law." *See Merton J. Sills*, 39 ECAB 572, 575 (1988).

[12] *See Joe T. Williams*, 44 ECAB 518, 521 (1993).

sufficient to establish causal relationship.[13] Causal relationship must be substantiated by reasoned medical opinion evidence, which it is appellant's responsibility to submit. Therefore, appellant's belief that her condition was caused by the alleged work activities is not determinative.

OWCP advised appellant that it was her responsibility to provide a comprehensive medical report which described her symptoms, test results, diagnosis, treatment and the doctor's opinion, with medical reasons, on the cause of her condition. Appellant failed to do so. As there is no probative, rationalized medical evidence addressing how appellant's claimed condition was caused or aggravated by her employment, she has not met her burden of proof to establish that she sustained an occupational disease in the performance of duty causally related to factors of employment.[14]

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 has not met her burden of proof to establish that she sustained an injury in the performance of duty.

[13] *Id.*

[14] The Board notes that appellant submitted additional evidence after OWCP rendered its October 21, 2011 decision. The Board's jurisdiction is limited to reviewing the evidence that was before OWCP at the time of its final decision. Therefore, this additional evidence cannot be considered by the Board. 20 C.F.R. § 501.2(c); *Dennis E. Maddy*, 47 ECAB 259 (1995); *James C. Campbell*, 5 ECAB 35, 36 n.2 (1952).

ORDER

IT IS HEREBY ORDERED THAT the August 4, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 18, 2012
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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