United States Department of Labor
Employees' Compensation Appeals Board

J.D., Appellant	)	
	)	**Docket Nos. 13-2120 &**
and	)	**14-33**
	)	**Issued: September 4, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Chadds Ford, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 16, 2013 appellant, through her attorney, filed a timely appeal from merit decisions of the Office of Workers' Compensation Programs' (OWCP) dated May 14, 2013 terminating her compensation benefits and March 27 and July 9, 2013 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.

ISSUES

The issues are: (1) whether OWCP properly terminated appellant's compensation benefits effective July 9, 2012 on the grounds that she no longer had any residuals or disability causally related to her accepted employment-related injury in OWCP File No. xxxxxx957; (2) whether appellant had any continuing employment-related residuals or disability after July 9, 2012 in OWCP File No. xxxxxx957; and (3) whether she established a left ankle injury causally related to factors of her federal employment in OWCP File No. xxxxxx886.

On appeal, counsel contended that appellant's claims under OWCP File Nos. xxxxxx957 and xxxxxx886 be consolidated as they were duplicate claims. He asserted that they have the

[1] 5 U.S.C. § 8101 *et seq.*

same date of awareness of the injury and factors of employment. Counsel further asserted that appellant filed the second claim because her work factors continued and she experienced pain and required additional surgery.

FACTUAL HISTORY

On January 8, 2010 appellant, then a 51-year-old regular rural carrier, filed an occupational disease claim (Form CA-2) under OWCP File No. xxxxxx957 alleging that she first became aware of her bilateral foot condition on January 1, 2007. She alleged that on September 6, 2009 she first realized that her condition was caused by her work duties, which included standing three to five hours a day and hopping out of a long-life vehicle (LLV) 30 times a day while delivering mail. Appellant's regular work schedule was from 7:30 a.m. to 3:30 p.m., Monday through Saturday.

By letter dated April 21, 2010, OWCP accepted appellant's claim for traumatic bilateral plantar fasciitis. It paid her total disability compensation benefits.

On May 28, 2010 appellant stopped work. On June 2, 2010 she returned to full-duty work. Appellant again stopped work on July 3, 2010. On August 17, 2010 she underwent authorized partial release of the medical band of the plantar fascia of the left foot. On November 18, 2010 appellant returned to part-time limited-duty work, four hours a day. Her work hours increased to seven hours every other day commencing January 6, 2011. On February 10, 2011 appellant began performing limited-duty work eight hours a day every other day.

By letter dated March 24, 2011, OWCP referred appellant, together with a statement of accepted facts and the medical record, to Dr. Robert A. Smith, a Board-certified orthopedic surgeon, for a second opinion to determine whether she had any employment-related residuals or disability. In an April 18, 2011 medical report, Dr. Smith diagnosed traumatic bilateral plantar fasciitis. He advised that, although appellant had pain in her feet, there were no objective test results to indicate that she had any ongoing plantar fascial problems and she had a good result from her left foot surgery. Dr. Smith concluded that appellant could continue performing full-time regular-duty work.

In an April 8, 2011 duty status report, Dr. Timothy Chen, a podiatrist, released appellant to return to full-time, full-duty work on that date. In reports dated May 18 and October 12, 2011, he diagnosed plantar fasciitis.

An unsigned report dated February 22, 2012 contained the printed name of Dr. Andre O. Williams, a Board-certified anesthesiologist. The report noted appellant's left ankle pain and provided essentially normal findings on physical examination with the exception of definite soft swelling along the tendon sheath inferior to the lateral mallalus which was only mildly tender to palpation.

In a March 26, 2012 report, Dr. Scott M. Reich, a podiatrist, stated that on February 10, 2012 appellant presented with bilateral left greater than right ankle pain. Appellant reported to Dr. Reich that her condition was caused by her mail carrier job which required her to

continuously hop in and out of a truck. She further reported that the continuous physical aspects of her job exacerbated these symptoms. Dr. Reich noted that appellant currently presented with significant pain on palpation along her peroneal tendon, left greater than the right. He advised that a magnetic resonance imaging (MRI) scan showed tendinosis of the peroneus longus tendon with peritendinosis of the common peroneus tendon sheath of the left ankle. Dr. Reich recommended peroneal tendon debridement and repair. He concluded that the surgery would prevent appellant from working approximately six to eight weeks since she had physical work activities.

By letter dated April 9, 2012, OWCP referred appellant, along with a statement of accepted facts and a list of questions, to Dr. Steven J. Valentino, a Board-certified orthopedic surgeon, for another second opinion.[2] The statement of accepted facts and list of questions noted the accepted condition of bilateral plantar fasciitis. Dr. Valentino was asked to address whether appellant continued to have residuals of this employment-related condition and to determine her work restrictions.

In an April 17, 2012 report, Dr. Valentino reviewed a history of the accepted employment-related bilateral foot condition, and appellant's medical treatment and work capacity. He also reviewed her medical records which included a February 13, 2012 MRI scan of the left ankle that showed tendinosis in the common peroneal tendon sheath without a tear, stress about the anterior aspect of the calcaneus and a normal image of the plantar fascia. Dr. Valentino noted appellant's complaint of heel pain, worse on the left than on the right. On examination, he reported that she was able to walk normally. Appellant could heel/toe and squat and return without postural difficulty. She had a well-healed small scar consistent with her surgery and Dr. Valentino's review of her records. On examination of the spine, Dr. Valentino reported full range of motion with all motion segments. Classic modified Spurling's maneuvers, sitting spine, straight leg raising and prone stretch sitting were negative. On neurologic examination, Dr. Valentino found intact deep tendon reflexes, normal motor and sensory examinations, and no pathologic reflexes. On examination of the hips, knees, ankles and feet he found full range of motion. A Faber test was negative. On examination of the knees and ankles, Dr. Valentino found no synovitis, effusion or internal derangement. There was no tenderness with palpation of the peroneal tendon. Dr. Valentino reported a normal plantar examination as there was no tenderness over the incision site which was well healed and no abnormal findings on stretching of the plantar fascia bilaterally. The ankle had good stability and intact medial deltoid and lateral ligaments. An anterior drawers' sign and stress testing were negative. Dr. Valentino diagnosed resolved plantar fasciitis. Upon his extensive evaluation and review of records, he agreed with the treatment of appellant's work-related plantar fasciitis, including her surgery which resolved her plantar fasciitis symptoms. He advised that MRI scan findings of peroneal tendinosis were not related to either the work-related plantar fasciitis injury or resolved bilateral plantar fasciitis. Dr. Valentino opined that given this finding was not present early on and that appellant's work-related bilateral plantar fasciitis had completely resolved, she had no complaints compatible with residuals of the condition. He concluded that she could perform full-time, full-duty work with no restrictions. Dr. Valentino further concluded that treatment related to appellant's peroneal tendinitis was not related to her work injury or work duties.

[2] In a May 5, 2011 e-mail, OWCP advised an OWCP nurse that it was trying to obtain appellant's release to full-duty, full-time work.

In a May 14, 2012 report, Dr. Frank B. Sarlo, a Board-certified physiatrist, stated that the results of electromyogram and nerve conduction studies (EMG/NCS) were normal.

On May 30, 2012 OWCP issued a notice of proposed termination of appellant's wage-loss compensation and medical benefits based on Dr. Valentino's medical opinion. Appellant was advised that she had 30 days to submit additional evidence in response to the proposed termination.

In a May 25, 2012 note, Dr. Reich advised that appellant could return to full-duty work as of May 21, 2012. He noted that she was tentatively scheduled to undergo left ankle surgery. In an attending physician's report (Form CA-20) dated June 8, 2012, he diagnosed left peroneal tendinitis. Dr. Reich indicated with a checkmark that the diagnosed condition was caused or aggravated by an employment activity. He again noted appellant's scheduled surgery and advised that she would be totally disabled from June 27 to August 27, 2012. She could resume work on August 27, 2012.

On June 12, 2012 appellant filed a Form CA-2 and an undated narrative statement under OWCP File No. xxxxxx886. She first became aware of her peritendinosis on January 1, 2007. Appellant alleged that on September 6, 2009 she realized that her condition was caused or aggravated by essentially the same accepted factors of employment under OWCP File No. xxxxxx957. The record in OWCP File No. xxxxxx957 contained copies of Dr. Reich's March 26, 2012 report, Dr. Valentino's April 17, 2012 report and hospital records regarding the June 27, 2012 left ankle surgery.

Hospital records indicate that on June 27, 2012 appellant was scheduled to undergo debridement of the peroneal tendon with exploration and topaz of the left foot.

In a July 9, 2012 decision, under OWCP File No. xxxxxx957, OWCP terminated appellant's wage-loss compensation and medical benefits effective that date. It found that the medical evidence submitted was insufficient to outweigh the weight accorded to Dr. Valentino's opinion.

By letter dated July 11, 2012, under OWCP File No. xxxxxx886, OWCP advised appellant that the evidence submitted was insufficient to establish her June 12, 2012 claim. It requested additional factual and medical evidence. OWCP also requested additional factual and medical evidence from the employing establishment regarding appellant's allegations, a description of the physical requirements for her rural carrier position and her treatment at its medical facility.

By letter dated April 10, 2013, appellant, through her attorney, requested reconsideration of the July 9, 2012 decision contending that an accompanying March 14, 2013 report from Dr. D. Scot Malay, a podiatrist, was supportive of her claim of residuals. Counsel requested that OWCP combine File Nos. xxxxxx957 and xxxxxx886 into one claim as they were duplicative and both cited January 1, 2007 as the date of awareness of the injury and September 6, 2009 as the date she related her condition to work. Appellant filed the second claim because the work factors continued and she had pain and was scheduled to undergo additional surgery.

In the March 14, 2013 report, Dr. Malay obtained a history of the work-related bilateral foot condition and appellant's medical treatment. He stated that as a mail carrier she had to stand

and walk up to 10 hours a day. Appellant rated her pain as 5 to 7 on a 10-point scale. On physical examination, Dr. Malay reported normal findings. On neurological examination, he reported essentially normal findings with the exception of a faintly present bilateral Tinel's sign posterior to the medial malleolus at the tibial nerve to percussion which radiated to the sole but not fully to the toes and without proximal radiation. Appellant's stance and gait displayed a smooth, comfortable and self-selected cadence without early heel off and with normal appearing propulsion bilaterally with the exception of flexor stabilization digital contractures (hammering of the toes). In the open kinetic chain, the digits were fully relocating with push-up loading of the metatarsus bilaterally. Appellant reported pain in her tarsal tunnel and metatarsal ball in stance. Palpation and moderate deep pressure revealed tenderness in both tarsal tunnels and there was palpable and boggy edema localized to the peroneal tendon sheath as it coursed posterior and distal to the lateral malleolus only in the left leg and ankle.

Dr. Malay assessed bilateral tarsal tunnel syndrome and metatarsalgia. He advised that appellant's peroneal tendinitis appeared to be quiescent as it had evidently responded to therapy. Appellant did not have complex regional pain syndrome (CRPS), reflex sympathetic dystrophy (RSDS), (CRPS Type I) or causalgia (CRPS Type II) as she readily allowed examination and manipulation of her feet, showed no gross evidence of vasomotor instability (despite cigarette smoking) and did not display allodynia (pain due to nonnoxious stimuli) or hyperpathia (pain out of proportion to a stimulus) in either foot. Moreover, appellant did not appear to have rheumatoid arthritis or any other systemic arthropathy of an inflammatory nature even though a blood test displayed a low level rheumatoid factor.

Dr. Malay suspected that this could be aggravating to appellant's pedal and ankle conditions as it may have contributed to a low level of inflammation in her connective tissues (tendons, ligaments, bones and joints) that were slow to heal as compared to an individual without the presence of this autoantibody. He stated that cigarette smoking byproducts were also known to upregulate certain proinflammatory cytokines in patients with the rheumatoid factor present in their serum which could contribute to appellant's foot and ankle pain. Furthermore, there was no objective evidence of tremor or muscle spasm during examination. Dr. Malay advised that appellant's current pain and disability were the result of years of prolonged weight-bearing work requirements, in particular long hours carrying mail and performing other standing work duties. The hyperpronating mechanics of her feet led to the development of chronic plantar fasciitis, followed by compensatory peroneal tendinitis as the peroneal tendon attempted to plantarflex the first ray to resist the progressive valgus deformation. Despite focal therapies aimed at resisting the hyperpronation-induced pes valgoplanus deformation (hindfoot pronation leading to flattening of her pedal arch), including foot orthoses and physical therapy, alteration of activities, anti-inflammatory and analgesic medications, and surgery, every time appellant resumed her weight-bearing duties she relapsed into the same foot and ankle pain, which was indicative of an inability of her tissues to stand up to the demands of her job despite her efforts to carry them out. Dr. Malay stated that the duration of time dedicated to recovery following her surgical treatments was appropriate since six weeks was typically enough time for soft tissue healing and the gradual resumption of physical activities. He concluded that appellant should satisfactorily improve within 6 to 12 more months of supportive therapy and sedentary duties that did not require more than one hour of continuous weight-bearing activity.

In an undated report, Dr. Chen provided a history of his treatment of the accepted employment injury and appellant's medical treatment and work capacity. He advised that she

was currently able to work full time, five days a week with Monday and Sunday off for rest. The days off restriction would allow appellant's foot and heel to recover. Appellant still required chronic pain control medication. Dr. Chen advised that the symptoms related to her heel would be recurrent and episodic in nature. From time to time, appellant would require time and days off as needed due to her level of discomfort. Resting her foot periodically was important to reduce pain and inflammation, thereby preventing her acute symptoms from progressing and lingering.

In a July 19, 2012 report, Dr. Damian M. Andrisani, a Board-certified orthopedic surgeon, obtained a history of appellant's bilateral lower extremities conditions. On physical examination, he reported essentially normal findings with the exception of pain over the anterior border of the tibia. Dr. Andrisani reviewed x-rays of the knees and legs which were normal. He noted that a May 11, 2012 bone scan demonstrated no abnormalities consistent with CRPS, but there was a suggestion of degenerative changes of the proximal tibula and fibular articulation. Dr. Andrisani further noted that the May 14, 2012 EMG/NCS were negative for any abnormalities of bilateral lower extremities. He diagnosed bilateral lower extremity leg pain and stated that appellant was three weeks status post left ankle surgery. Dr. Andrisani advised that the pain about the anterior aspect of her leg may be secondary to compensation of chronic peroneal tendinosis. He did not expect any improvement for at least several months following appellant's surgery.

An unsigned report dated July 27, 2012 contained the printed name of "Dr. Williams." It stated that since appellant's last visit on May 4, 2012 she had undergone surgery at the lateral malleolus on the left. Three to four weeks since the surgery she had made an excellent recovery and was satisfied with the outcome. Appellant continued to experience burning pain in the soles of both feet which she believed was due to ongoing plantar fasciitis.

In a September 6, 2012 decision, under OWCP File No. xxxxxx886, OWCP denied appellant's occupational disease claim. It found that Dr. Andrisani's report was insufficient to establish that her current left ankle condition was causally related to her prior claim or that her regular carrier position caused peroneal tendinitis of the left ankle. OWCP further noted that Dr. Valentino's report found no causal relationship between appellant's accepted condition and peroneal tendinitis for which she underwent surgery on June 27, 2012 and her employment. On September 24, 2012 appellant requested an oral hearing before an OWCP hearing representative.

By letter dated March 3, 2013, appellant's attorney, again requested that OWCP combine appellant's claims under File Nos. xxxxxx957 and xxxxxx886.

In a March 27, 2013 decision, under OWCP File No. xxxxxx886, an OWCP hearing representative affirmed the September 6, 2012 decision. He found that OWCP properly adjudicated the claim as a new occupational disease. The factual and medical evidence supported the filing of a new occupational disease claim based on appellant's renewed exposure to previously injurious work factors. The hearing representative found that she failed to submit rationalized medical evidence sufficient to establish that her left peroneal tendon condition was causally related to the established employment factors. In an April 10, 2013 letter, appellant's attorney requested reconsideration and submitted Dr. Malay's March 14, 2013 report.

In an April 11, 2013 letter, OWCP denied appellant's request to combine File Nos. xxxxxx957 and xxxxxx886. It noted that this request was previously addressed by the hearing representative's March 27, 2013 decision under File No. xxxxxx886. The hearing representative stated that the factual and medical evidence supported that a new claim for an occupational condition should be filed based upon appellant's renewed exposure to potentially injurious work factors. He also stated that the claim under File No. xxxxxx957 was accepted for traumatic bilateral plantar fasciitis while the claim under File No. xxxxxx886 sought compensation for left peroneal tendon.

In a May 14, 2013 decision, OWCP denied modification of its termination decision. It found that the medical evidence submitted was insufficient to outweigh the weight accorded to Dr. Valentino's April 17, 2012 report.

In a July 9, 2013 decision, under OWCP File No. xxxxxx886, OWCP denied modification of the March 27, 2013 decision. It found that Dr. Malay's report did not provide a sufficiently rationalized medical opinion based on an accurate factual background and objective test results to support his physical examination findings.

LEGAL PRECEDENT -- ISSUE 1

The United States shall pay compensation for the disability of an employee resulting from personal injury sustained while in the performance of duty.[3] Once OWCP accepts a claim, it has the burden of proof to justify termination or modification of compensation benefits.[4] After it has determined that an employee has disability causally related to federal employment, OWCP may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.[5]

ANALYSIS – ISSUE 1

The Board finds that OWCP met its burden of proof to terminate appellant's wage-loss compensation and medical benefits as of July 9, 2012. OWCP accepted that appellant sustained traumatic bilateral plantar fasciitis while in the performance of duty. As of February 10, 2011, appellant worked in a limited-duty position eight hours a day every other day. OWCP obtained a second opinion from Dr. Smith, a Board-certified orthopedic surgeon, who opined on April 18, 2011 that appellant had no residuals of her accepted traumatic bilateral plantar fasciitis and that she could continue to perform her regular full-time work duties.

OWCP found that another second opinion was necessary and referred appellant to Dr. Valentino to determine whether she could perform full-time, full-duty work with no restrictions. Dr. Valentino's April 17, 2012 report reviewed a history of the accepted employment injury and appellant's medical treatment which included her authorized August 2010 plantar surgery. He provided normal examination findings. Dr. Valentino found

[3] 5 U.S.C. § 8102(a).

[4] *Harold S. McGough*, 36 ECAB 332 (1984).

[5] *Jason C. Armstrong*, 40 ECAB 907 (1989).

that appellant could work normally and perform heel and toe squats and return without postural difficulty. He further found that she had a well-healed small scar consistent with her surgery and his review of her records. On examination of the spine, Dr. Valentino reported full range of motion and negative classic modified Spurling's maneuvers, sitting spine, straight leg raising and prone stretch sitting. On neurologic examination, he reported intact deep tendon reflexes, normal motor and sensory examination and no pathologic reflexes. Regarding the hips, knees, ankle and feet, Dr. Valentino found no synovitis, effusion or internal derangement or tenderness with palpation of the peroneal tendon. He also found that the ankle had good stability and intact medial deltoid and lateral ligaments. Dr. Valentino further found that a plantar examination revealed no tenderness over the incision site which was well healed and no abnormal findings on stretching of the plantar fascia bilaterally. He reported that an anterior drawer sign and stress testing were negative. Dr. Valentino diagnosed resolved plantar fasciitis.

Based upon his extensive evaluation and review of records, Dr. Valentino opined that surgery resolved appellant's work-related plantar fasciitis symptoms. While he found that an MRI scan revealed peroneal tendinosis, he opined that this condition was not related to the accepted plantar fasciitis or resolved plantar fasciitis and that any treatment for the diagnosed condition was not related to her work injury or work duties. Dr. Valentino explained that, since this finding was not present early on and appellant's work-related condition had completely resolved, she had no complaints compatible with residuals of the accepted condition. He concluded that she could perform full-time, full-duty work with no restrictions.

The Board finds that Dr. Valentino's report represents the weight of the medical evidence and that OWCP properly relied on his report in terminating appellant's wage-loss compensation and medical benefits for the accepted condition on July 9, 2012. Dr. Valentino's opinion is based on a proper factual and medical history as he reviewed the statements of accepted facts and appellant's prior medical treatment. He also related his comprehensive examination findings in support of his opinion that appellant no longer had any residuals or disability causally related to the accepted traumatic bilateral plantar fasciitis.

The remaining evidence submitted prior to the termination of compensation is insufficient to show that appellant had any remaining work-related residuals or disability. Dr. Chen's April 8, 2011 duty status report found that appellant could return to full-time, full-duty work on that date. His subsequent reports addressed her plantar fasciitis and pain in her left heel and peroneal brevis tendon and disability for work on certain dates. The Board has generally held that pain is a symptom, rather than a firm medical diagnosis.[6] Moreover, Dr. Chen did not provide any opinion addressing whether appellant's conditions and disability for work were causally related to the accepted employment injury. The Board has held 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.[7]

Dr. Reich's March 26, 2012 report noted that when appellant was seen on February 10, 2012 she reported that her job as a mail carrier which required her to continuously hop in and out

[6] *C.F.*, Docket No. 08-1102 (issued October 10, 2008).

[7] *See K.W.*, 59 ECAB 271 (2007); *A.D.*, 58 ECAB 149 (2006); *Jaja K. Asaramo*, 55 ECAB 200 (2004); *Michael E. Smith*, 50 ECAB 313 (1999).

of her truck caused and exacerbated her bilateral left greater than right ankle pain. He diagnosed her current condition as tendinosis of the peroneus longus tendon with peritendinosis of the common peroneus tendon sheath of the left ankle based on an MRI scan. Dr. Reich recommended surgery to treat the diagnosed condition and advised that appellant would be unable to work approximately six to eight weeks following surgery due to her physical work activities. He merely repeated the history of injury as reported by appellant without providing his own opinion on whether her condition was work related. Dr. Reich failed to provide a rationalized opinion regarding the causal relationship between her left ankle condition and the factors of employment believed to have caused or contributed to such condition.[8]

In a June 8, 2012 Form CA-20, Dr. Reich indicated with a checkmark that appellant's left peroneal tendinitis was caused or aggravated by an employment activity. He advised that she was scheduled to undergo left ankle surgery and would be totally disabled from June 27 to August 27, 2012. The Board has held that an opinion consisting of a physician's checkmark is of diminished probative value without any explanation or rationale for the conclusion reached.[9] Dr. Reich did not adequately explain how the diagnosed condition or total disability was caused or contributed to by the accepted employment-related injury. In a May 25, 2012 note, he found that appellant could return to full-duty work as of May 21, 2012. Dr. Reich did not provide an opinion of whether appellant's disability was related to the accepted work injury.

Neither Dr. Sarlo's EMG/NCS nor the hospital records related to appellant's June 27, 2012 left ankle surgery provided an opinion addressing whether she had any continuing residuals or disability due to the accepted work injury.[10]

The Board finds that Dr. Valentino's opinion that appellant had recovered from the employment injury represents the weight of the medical evidence and the additional medical evidence submitted is insufficient to create a conflict in opinion regarding whether she had continuing residuals or disability related to the accepted injury. Therefore, OWCP properly terminated appellant's compensation effective July 9, 2012 based on Dr. Valentine's opinion.

LEGAL PRECEDENT -- ISSUE 2

Once OWCP properly terminates appellant's compensation benefits, the burden shifts to appellant to establish that she has continuing disability after that date related to her accepted injury.[11] To establish a causal relationship between the condition as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence based on a complete medical and factual background, supporting such a causal

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

[9] *D.D.*, 57 ECAB 734 (2006); *Sedi L. Graham*, 57 ECAB 494 (2006).

[10] *See* cases cited, *supra* note 7.

[11] *See I.J.*, 59 ECAB 408 (2008); *Franklin D. Haislah*, *supra* note 8.

relationship.[12] Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[13]

ANALYSIS -- ISSUE 2

The Board finds that appellant has not established that she has any continuing residuals or disability causally related to her work-related traumatic bilateral plantar fasciitis after July 9, 2012.

After the termination of her wage-loss compensation and medical benefits on July 9, 2012, appellant submitted a March 14, 2013 report from Dr. Malay. He found that appellant's peroneal tendinitis appeared to be quiescent as it had responded to therapy. Dr. Malay further found that her bilateral tarsal tunnel syndrome, metatarsalgia and disability were causally related to factors of her employment. However, he did not find that appellant was disabled for work due to objective residuals of the accepted traumatic bilateral plantar fasciitis. Instead, Dr. Malay attributed her inability to work to bilateral tarsal tunnel syndrome and metatarsalgia, conditions not accepted as work related by OWCP. Further, he did not provide an opinion addressing whether appellant's resolved peroneal tendinitis resulted from the accepted employment injury.[14] Moreover, Dr. Malay's opinion on causal relationship is based on an inaccurate history of appellant's established work factors. He stated that her job as a mail carrier required her to, among other things, walk up to 10 hours a day to deliver mail. OWCP, however, accepted that appellant's work duties involved hopping out of a LLV 30 times a day to deliver mail. The Board notes that medical opinions must be based on a complete and accurate factual and medical background and medical opinions based on an incomplete or inaccurate history are of limited probative value.[15] While Dr. Malay provides an opinion on causal relationship, he relates appellant's injuries and disability to walking long hours, not driving and dismounting her LLV. For the stated reasons, the Board finds that his report is insufficient to meet appellant's burden of proof.

Dr. Andrisani's July 19, 2012 report found that appellant had bilateral lower extremity leg pain and that she was status post left ankle surgery. He advised that the pain about the anterior aspect of her leg may be secondary to compensation of chronic peroneal tendinosis. As stated, pain is not a compensable medical diagnosis.[16] Further, Dr. Andrisani did not provide any opinion addressing the causal relationship between appellant's bilateral leg condition and the established work factors.[17] The Board finds that his report is insufficient to establish appellant's burden of proof.

[12] *Id.*

[13] *See Paul Foster*, 56 ECAB 208 (2004); *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[14] *See* cases cited, *supra* note 7.

[15] *J.R.*, Docket No. 12-1099 (issued November 7, 2012); *Douglas M. McQuaid*, 52 ECAB 382 (2001).

[16] *C.F.*, *supra* note 6.

[17] *See* cases cited, *supra* note 7.

Dr. Chen's undated report provided a history of his treatment of the accepted employment injury and appellant's medical treatment and noted her left heel pain. He advised that she could work full time, five days a week with two days off for rest and to allow for recovery of her left foot and heel condition, but did not explain how her condition and inability to work her regular schedule of six days a week were causally related to the accepted work injury. The Board again notes that pain is not a compensable medical diagnosis.[18] Moreover, Dr. Chen's opinion that appellant would require time and days off work in the future due to her recurrent and episodic heel symptoms to prevent the progression and lingering of her acute symptoms of pain and inflammation is based on a fear of future injury. It is well established that the possibility of future injury or disability is not a basis for payment of compensation.[19] For the stated reasons, the Board finds that Dr. Chen's report is insufficient to satisfy appellant's burden of proof.

None of the reports submitted by appellant after the termination of benefits included a rationalized opinion regarding the causal relationship between her current foot condition and disability and her accepted work-related condition. Consequently, appellant did not establish that she had any employment-related residuals or disability after July 9, 2012.

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.

LEGAL PRECEDENT -- ISSUE 3 -- OWCP FILE NO. xxxxxx886

An employee seeking benefits under FECA[20] 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; that an injury was sustained while in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury.[21] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated on a traumatic injury or an occupational disease.[22]

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 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 employment factors identified by the claimant were the proximate cause of the condition for

[18] *See C.F.*, *supra* note 6.

[19] *I.J.*, *supra* note 11; *Gaeten F. Valenza*, 39 ECAB 1349, 1356 (1988).

[20] 5 U.S.C. §§ 8101-8193.

[21] *C.S.*, Docket No. 08-1585 (issued March 3, 2009); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[22] *S.P.*, 59 ECAB 184 (2007); *Victor J. Woodhams*, 41 ECAB 345 (1989); *Joe D. Cameron*, 41 ECAB 153 (1989).

which compensation is claimed or, stated differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant. The medical evidence required to establish a causal relationship is rationalized medical opinion evidence. The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable certainty, and must be supported by medial rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[23] Neither the fact that appellant's condition became apparent during a period of employment nor, his or her belief that the condition was caused by his or her employment is sufficient to establish a causal relationship.[24]

Proceedings under FECA are not adversarial in nature nor is OWCP a disinterested arbiter. While the claimant has the burden to establish his or her claim, OWCP also has a responsibility in the development of the evidence.[25]

ANALYSIS -- ISSUE 3 -- OWCP FILE NO. xxxxxx957

The Board finds that this case is not in posture for decision as to whether appellant sustained a left ankle peritendinosis causally related to her federal employment.

OWCP accepted appellant's factors of federal employment as a rural letter carrier. It denied her occupational disease claim for a left ankle injury, however, finding that the weight of the medical evidence rested with Dr. Valentino, OWCP's referral physician, who found that appellant's left ankle condition was not causally related to the accepted employment factors.

In the April 17, 2012 report, Dr. Valentino found that left ankle MRI scan findings of peroneal tendinosis were not related to either the work-related plantar fasciitis injury or resolved bilateral plantar fasciitis. He further found that appellant could perform full-duty work on a full-time basis with no restrictions and that any treatment for her peroneal tendinitis was not related to her work injury or duties. The Board notes that the statement of accepted facts and list of questions forwarded to Dr. Valentino in OWCP File No. xxxxxx957 addressed the accepted bilateral plantar fasciitis condition. He was asked to provide an opinion on whether appellant continued to have residuals of this employment-related injury and identify her work restrictions. In the claim under OWCP File No. xxxxxx886, OWCP did not ask Dr. Valentino to address whether appellant's peroneal tendinosis was causally related to her federal employment.[26] His report only noted that this condition was not causally related to the accepted bilateral plantar fasciitis injury for which appellant filed a claim on January 8, 2010 and the work duties claimed to have caused this accepted injury. Dr. Valentino did not provide any medical opinion addressing the causal relationship between appellant's peroneal tendinosis and the work duties she performed after her authorized August 17, 2010 left foot surgery, recovery and return to limited-duty work on February 10, 2011 through June 27, 2012, the date of her left ankle

[23] *I.J., supra* note 11; *Victor J. Woodhams, id.* at 351-52.

[24] *Kathryn Haggerty*, 45 ECAB 383, 389 (1994).

[25] *See Claudia A. Dixon*, 47 ECAB 168, 170 (1995).

[26] The Board notes the case record in OWCP File No. xxxxxx886 does not contain the statement of accepted facts and list of questions forwarded to Dr. Valentino in OWCP File No. xxxxxx957.

surgery. The Board finds, therefore, that Dr. Valentino's report is not dispositive on the issue of causal relationship.

Once OWCP undertakes development of the record it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[27] When it selects a physician for an opinion on causal relationship, it has an obligation to secure, if necessary, clarification of the physician's report and to have a proper evaluation made.[28] Because it referred appellant to a second opinion physician, it has the responsibility to obtain a report that will resolve the issue of whether her left ankle condition was caused by her federal employment.[29] Dr. Valentino did not provide a rationalized opinion on the cause of appellant's left ankle condition.

The case will be remanded to OWCP for further development of the medical evidence.[30] On remand, OWCP should prepare a new statement of accepted facts regarding appellant's claimed work exposure through June 2012 and refer her to a physician in the appropriate field of medicine for a rationalized opinion on the causal relationship between her diagnosed left ankle condition and her employment duties.[31] Following this and any other further development as it deems necessary, OWCP shall issue a *de novo* decision on appellant's occupational disease claim.[32]

Counsel requested before OWCP and on appeal consolidation of the instant claim under File No. xxxxxx957 and appellant's claim under File No. xxxxxx886 because they are duplicate claims due to the same date of awareness of the injury and factors of employment. Counsel further asserted that appellant filed the second claim because her work factors continued and she experienced pain and required more surgery. While OWCP procedures provide that cases should be doubled when a new injury case is reported for an employee who previously filed an injury claim for a similar condition or the same part of the body,[33] appellant has identified a different foot injury in File No. xxxxxx957. As noted, the Board has directed separate further development of the medical record in File No. xxxxxx957. While the claims may be substantially similar in some respects, they do not appear to be identical. For the stated reasons, the Board finds that counsel's arguments have not been established.

[27] *Phillip L. Barnes*, 55 ECAB 426, 441 (2004); *see also Virginia Richard (Lionel F. Richard)*, 53 ECAB 430, 433 (2002); *Dorothy L. Sidwell*, 36 ECAB 699, 707 (1985); *William J. Cantrell*, 34 ECAB 1233, 1237 (1993).

[28] *Alva L. Brothers, Jr.*, 32 ECAB 812 (1981).

[29] *See Ramon K. Farrin, Jr.*, 39 ECAB 736 (1988).

[30] *S.E.*, Docket 08-2243 (issued July 20, 2009).

[31] When a medical evaluation is made at its request, OWCP has the responsibility of obtaining a proper evaluation. *Leonard Gray*, 25 ECAB 147, 151 (1974).

[32] *See P.K.*, Docket No. 08-2551 (issued June 2, 2009); *see also Horace Langhorne*, 29 ECAB 820, 822 (1978).

[33] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *File Maintenance and Management*, Chapter 2.400.8(c)(1) (February 2000).

CONCLUSION

The Board finds that OWCP properly terminated appellant's compensation benefits effective July 9, 2012 on the grounds that she no longer had any residuals or disability causally related to her accepted employment-related injury. The Board further finds that appellant failed to establish that she had any continuing employment-related residuals or disability after July 9, 2012. Lastly, the Board finds that the case is not in posture for a decision as to whether appellant sustained a left ankle injury in the performance of duty.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' May 14, 2013 decision is affirmed and July 9 and March 27, 2013 decisions are set aside and the case is remanded for further consideration consistent with this decision.

Issued: September 4, 2014
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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