United States Department of Labor
Employees' Compensation Appeals Board

K.M., Appellant	)	
and	)	**Docket No. 15-0724**
	)	**Issued: August 25, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Wilmington, DE, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 2, 2015 appellant, through counsel, filed a timely appeal from a November 6, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 his burden of proof to establish an occupational disease in the performance of duty.

FACTUAL HISTORY

On September 24, 2011 appellant, then a 50-year-old mail carrier, alleged that he sustained a recurrence of disability due to his January 29, 2011 employment injury. OWCP developed his recurrence claim as a new occupational disease claim.

[1] 5 U.S.C. § 8101 *et seq.*

In a December 14, 2011 statement accompanying the claim, appellant advised that he had previously injured his left knee in a work injury on January 29, 2011. He had undergone a left knee arthroscopic surgery in April 2011, and after surgery he returned to work full time employment. Appellant continued to experience swelling and discomfort. He noted that in August 2011 he was assigned to a different location where his condition worsened. Appellant advised that on September 24, 2011 he began to experience nonstop discomfort and continuous swelling while delivering his postal route. When he returned to the original location a throbbing pain began after he pushed and unloaded a hamper.

In an October 3, 2011 statement, a manager of distribution operations for the employing establishment advised that appellant informed her that he sustained a recurrence of a prior work injury, but that he was disciplined for failing to timely report the accident and for working in an unsafe manner. She opined that the injury was the result of him not wanting to commute from his home in New Jersey and his inability to perform at a minimum standard. She further noted that appellant was observed walking inside and leaving the employing establishment with a normal gait and not showing signs of discomfort.

In an October 10, 2011 report, Dr. David Anapolle, a Board-certified orthopedic surgeon, advised that appellant complained of increased left knee pain after being transferred to a different office with increased activity. Appellant related that he was required to do a nine-hour route in eight hours. Dr. Anapolle advised that up until that time appellant was able to perform his regular duties without problem. On physical examination Dr. Anapolle found no deformity, atrophy, ecchymosis, swelling, crepitus, or effusion. He advised that there was medial joint line tenderness, full range of motion, normal gait, and 5/5 strength in all muscle groups tested. Dr. Anapolle assessed left knee pain. He advised that appellant was able to work modified duty with no repetitive bending, stooping, or kneeling, and standing restricted to 30 minutes to an hour.

In an October 19, 2011 report, Dr. Anapolle advised that appellant was still experiencing left knee pain. A left knee x-ray revealed mild degenerative changes medially and no acute abnormalities. Dr. Anapolle diagnosed degenerative joint disease with synovitis of the left knee. In an October 26, 2011 report, he advised that appellant had increased knee pain due to residuals of degenerative disease which could be symptomatic after the loss of meniscal tissue from injury and subsequent arthroscopic meniscectomy. Dr. Anapolle advised that there was no evidence of additional injury, but it was possible that appellant's activity level exceeded what his knee could tolerate.

On December 5, 2011 Dr. Anapolle advised that appellant had a functional capacity evaluation which revealed that appellant was at minimum function at the medium level of work. He noted that appellant engaged in "self-limiting" behavior in 33 percent of the tasks which exceeded the normal level and possibly suggested symptom magnification. Dr. Anapolle opined that further surgery or treatment would be of no additional benefit and suggested returning appellant to work with permanent restrictions.

In a July 9, 2012 report, Dr. Matthew Pepe, a Board-certified orthopedic surgeon, advised that appellant was experiencing medial-side pain of the left knee. On physical examination he noted no effusion, no trophic changes, good quad tone, full range of motion, and tenderness

diffusely over the medial joint line. Dr. Pepe advised that magnetic resonance imaging (MRI) scan revealed no abnormalities and assessed left knee pain with an unknown etiology. On October 12, 2012 he noted appellant's status and assessed left knee post-traumatic osteoarthritis. Dr. Pepe noted that appellant's prognosis was good and opined that he was able to work a modified schedule. In a November 9, 2012 report, he noted findings and stated that appellant was at maximum medical improvement. Dr. Pepe noted that he would see appellant on an as-needed basis.

By letter dated March 22, 2013, OWCP notified appellant that evidence was insufficient to establish the claim. Appellant was advised to complete a questionnaire establishing the factual element of his claim and notified of the type of medical evidence needed. No response was received.

By decision dated April 22, 2013, OWCP denied appellant's claim because evidence did not establish that the injury occurred as described.

In an April 12, 2013 statement, appellant advised that he returned to full duty on July 9, 2011 following his surgery. He noted that his route had high rise office buildings that sometimes required him to take the stairs. Appellant also noted that he had to stand on his toes to reach mailboxes and push hampers filled with mail. He advised that, in August 2011, he was transferred to a different employing establishment where his new route involved a lot of climbing stairs and walking up streets on an incline which placed pressure and stress on his knees. Appellant noted that prior to his injury he was criticized about the time it took him to complete his route and advised that he should finish earlier. He noted that on September 24, 2011 he began to experience pain, swelling, throbbing, and discomfort in his knee. In an April 15, 2013 statement, appellant reiterated assertions made in his earlier statement.

Appellant also provided an April 27, 2012 report from Dr. Pepe who advised that appellant began having knee pain after he slipped on ice and twisted his knee. Dr. Pepe noted that appellant initially improved following surgery. He advised that appellant's pain increased and that he reported swelling with standing, soreness, and burning. Dr. Pepe noted that appellant returned to work; however, appellant was currently out of work. On physical examination he noted well-healed arthroscopic portals, no effusion, tenderness over the medial greater than lateral patellar facets, normal glides, central patellar tracking, no patellar apprehension, tenderness over the inferior pole of the patella, negative pivot shift, negative anterior and posterior drawer, no rotator instability, stable varus and valgus stress, and tenderness over the medial joint line. Dr. Pepe advised that left knee x-rays revealed no abnormality. He assessed left knee pain status post arthroscopy. Appellant also submitted several reports that predated his current claim.

By letter dated May 3, 2013, appellant's counsel requested an oral hearing.

In a February 12, 2013 report, Dr. Joseph Mesa, a Board-certified orthopedic surgeon, advised that appellant began experiencing significant discomfort when he returned to work in July 2011. On examination he noted tenderness over the medial joint line, no effusion, range of motion from 0 to 130 degrees, and tenderness over the medial joint line. Dr. Mesa assessed

chronic anterior cruciate ligament sprain and some degenerative changes of the knee. He recommended a short course of physical therapy to return appellant back to work.

At the August 28, 2013 oral hearing, appellant advised that when he returned to work he was not 100 percent healed and that he was given a new route which contained many hills and which took an extra hour to complete. He also advised that he was instructed to work faster and his knee worsened as time progressed.

Dr. Mesa continued to submit status reports. In an October 8, 2013 report, he advised that appellant was still experiencing medial joint line pain and tenderness. Dr. Mesa noted that appellant potentially had an occult chondral injury which was not identified by the MRI scan so he recommended a repeat MRI scan with a higher Tesla magnet.

By decision dated December 18, 2013, an OWCP hearing representative affirmed the denial of appellant's claim. She found that he had established a factual basis for his claim, but stated that the medical evidence was insufficient to establish that employment factors caused a diagnosed condition.

Appellant continued to submit medical evidence. In an August 26, 2013 report, Dr. Mesa advised that appellant had returned to work full time following his 2011 surgery. He noted that appellant had significant ambulatory requirements in his job as a mail carrier and that on September 11, 2011 he began having extreme knee pain and swelling. While appellant had persistent pain in the knee, he noted that an MRI scan showed no significant lesion that would explain the cause of his chronic pain. Dr. Mesa agreed that appellant should be placed on permanent restrictions. He further noted that his current diagnosis was exacerbation of a previous condition with regard to his knee and possible occult medial chondral lesion. Dr. Mesa opined that appellant had been injured for over two years and still had persistent weakness.[2] In an April, 18, 2014 operative report, he advised that appellant underwent a left knee arthroscopy with partial medial meniscectomy, medial plica excision, and osteochondral plug seven millimeters to medial femoral condyle.

In a May 20, 2014 report, Dr. Mesa noted the history of the injury and appellant's treatment history. He advised that appellant had persistent pain that eventually rendered him unable to work. Dr. Mesa opined that appellant had an occupational disease in his left knee which never healed from the work-related meniscal tear and chondral lesion which was treated surgically. He asserted that appellant's return to work did not allow him to recover as well. Dr. Mesa opined that appellant's "knee injury is causally related to his activities at work and was exacerbated by the activities required of his job." He recommended that appellant stay off work so that he could undergo dedicated physical therapy.

By letter dated June 25, 2014, appellant's counsel requested reconsideration.

By decision dated November 6, 2014, OWCP affirmed the denial of appellant's occupational disease claim.

[2] An October 31, 2013, MRI scan of the left knee revealed a small stable osteochondral defect in the medial femoral condyle and a subtle horizontal tear through the posterior horn of the medial meniscus.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden to establish 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, 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.[3] 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.[4]

Whether an employee actually sustained an injury in the performance of duty begins with an analysis of whether fact of injury has been established. To establish 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.[5]

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 generally required to establish causal relationship. The opinion of the physician must be based on a complete factual and medical background, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[6] The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[7]

ANALYSIS

Appellant claimed that he sustained a left knee condition in the performance of duty. There is no dispute that his duties included climbing stairs, lifting, and reaching above his shoulders. However, the medical evidence is insufficient to establish that his medical condition was causally related to the accepted work factors.

In his August 26, 2013 report, Dr. Mesa advised that after surgery appellant had returned to work full time. He noted that appellant had significant ambulatory requirements of his job as a mail carrier. On September 11, 2011 appellant began having extreme pain and swelling of his

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

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

[5] *R.H.*, 59 ECAB 382 (2008); *Ernest St. Pierre*, 51 ECAB 623 (2000).

[6] *I.J.*, 59 ECAB 408 (2008); *see supra* note 4.

[7] *James Mack*, 43 ECAB 321 (1991).

knee. Although Dr. Mesa refers to the ambulatory requirements of appellant's job he did not explain how this caused or contributed to his diagnosed condition. He also incorrectly refers to the date of injury as September 11, 2011 as appellant stated that his increased symptoms began on September 24, 2011.[8] In his May 20, 2014 report, Dr. Mesa noted that after appellant returned to work he had persistent pain which eventually rendered him unable to work. He advised that appellant had never healed from the work-related meniscal tear and his return to work prevented him from recovering as well. Dr. Mesa opined that appellant's "knee injury is causally related to his activities at work and was exacerbated by the activities required of his job." He supports causal relationship, but he does not explain how particular work duties caused or contributed to appellant's condition. On February 12, 2013 Dr. Mesa advised that when he returned to work in July 2011 he began having significant discomfort. Although he references appellant's return to work, he failed to attribute his discomfort to any specific factors of his employment. The Board has held that a physician's opinion on causal relationship must address the specific factual and medical evidence of record and provide medical rationale explaining the relationship between the diagnosed condition and established factors of employment.[9] Dr. Mesa's reports failed to do so and are insufficient to discharge appellant's burden of proof.

In his October 10, 2011 report, Dr. Anapolle advised that appellant complained of left knee pain. He noted that appellant had increased pain that developed after he was transferred to another employing establishment with increased activity. Dr. Anapolle advised that up until that time appellant was able to perform his regular duties without problem. The Board has found that the mere fact that a condition manifests itself or is worsened during employment period does not raise an inference of causal relationship between the two.[10] Dr. Anapolle failed to specify the increased activity and failed to explain how this increased activity caused or contributed to appellant's condition. In an October 26, 2011 report, he advised that appellant had residual degenerative disc disease which could be symptomatic following the loss of meniscal tissue from injury and subsequent arthroscopic meniscectomy. Dr. Anapolle advised that there was no evidence of additional injury, but it was possible that appellant's activity level exceeded that which his knee could tolerate. He notes that it is possible that increased activity contributed to the condition; however, the Board has held that medical opinions which are speculative or equivocal are of diminished probative value.[11]

In an April 27, 2012 report, Dr. Pepe advised that appellant began experiencing knee pain after he slipped on ice and twisted his knee. He noted that appellant had surgery and that he had improved initially, but his pain subsequently had increased. Dr. Pepe referenced appellant's

[8] *See Vernon R. Stewart*, 5 ECAB 276, 280 (1953) (where the Board held that medical opinions based on histories that do not adequately reflect the basic facts are of little probative value in establishing a claim).

[9] *Lee R. Haywood*, 48 ECAB 145 (1996); *see also T.M.*, Docket No. 08-975 (issued February 6, 2009) (a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

[10] *Patricia Bolleter*, 40 ECAB 373 (1988).

[11] *See S.E.*, Docket No. 08-2214 (issued May 6, 2009) (finding that opinions such as the condition is probably related, most likely related or could be related are speculative and diminish the probative value of the medical opinion).

previous work-related injury without attributing his current condition to factors of his employment, as a result this report is insufficient to discharge his burden of proof.

Other medical reports are insufficient as they do not address causal relationship between appellant's work factors and his claimed left knee condition.[12]

Consequently, appellant has submitted insufficient medical evidence to establish his claim.

On appeal counsel argues that appellant established his claim or, in the alterative, that OWCP failed to adequately develop the medical evidence. The Board finds that the medical evidence did not include the necessary medical reasoning to meet his burden of proof.

Appellant may submit new evidence or argument as part of a formal 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 establish that he sustained an occupational disease caused by factors of his employment.

[12] *Jaja K. Asaramo*, 55 ECAB 200 (2004).

ORDER

IT IS HEREBY ORDERED THAT the November 6, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 25, 2015
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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