United States Department of Labor
Employees' Compensation Appeals Board

P.O., Appellant	)	
and	)	**Docket No. 14-1675**
	)	**Issued: December 3, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Honolulu, HI, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 21, 2014 appellant filed a timely appeal from a January 24, 2014 merit decision and a July 16, 2014 nonmerit 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.[2]

ISSUES

The issues are: (1) whether appellant has established that her claim should be expanded to include additional right hip conditions due to the June 26, 1997 employment injury; and

[1] 5 U.S.C. § 8101 *et seq.*

[2] Under the Board's *Rules of Procedure*, an appeal must be filed within 180 days from the date of issuance of an OWCP decision. An appeal is considered filed upon receipt by the Clerk of the Appellate Boards. *See* 20 C.F.R. § 501.3(e)(f). One hundred and eighty days from January 24, 2014, the date of OWCP's last merit decision, was July 23, 2014. Since using July 28, 2014, the date the appeal was received by the Clerk of the Appellate Boards, would result in the loss of appeal rights, the date of the postmark is considered the date of filing. The date of the U.S. Postal Service postmark is July 21, 2014, rendering the appeal timely filed. *See* 20 C.F.R. § 501.3(f)(1).

(2) whether OWCP properly denied appellant's request for further merit review under 5 U.S.C. § 8128(a).

FACTUAL HISTORY

This matter has previously been before the Board on appeal. On June 26, 1997 appellant, then a 38-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that, on that same date, she was delivering mail in heavy rain when she slipped and fell forward, twisting her left foot and back as she fell. She sought emergency medical treatment that same date at Straub Clinic and Hospital. OWCP accepted the claim for left foot and low back strain.

Appellant initially sought treatment with Dr. Robert Sussman, Board-certified in family and occupational medicine. She was also treated at Portner Orthopedics and Rehabilitation Clinic by Dr. Elva Pearson, Board-certified in physical medicine and rehabilitation. Appellant missed work intermittently from June 28 to September 2, 1997 when she returned to full duty. On July 29, 1998 she stopped work and received wage-loss compensation. Appellant subsequently returned to work, but intermittently was removed from work.

In a June 26, 1997 urgent care report, Dr. Florante Deleon, Board-certified in family medicine, noted complaints of left foot pain and pain in the lower back/tailbone after a fall at work. He noted that appellant complained of low back pain spreading into the upper back. Dr. Deleon noted that x-rays of the left foot and lumbosacral spine were normal and he diagnosed left foot and lumbosacral sprain.

On July 5, 1997 Dr. Pearson reported that appellant complained of central lumbar spine pain with some radiation into the right buttock and thigh. Physical examination revealed hip range of motion was full and pain free.

In an August 6, 1997 report, Dr. Bernard Portner, Board-certified in physical medicine and rehabilitation, reported that an x-ray of the bilateral sacroiliac (SI) joints revealed some small degenerative osteophytosis in the inferior right SI joint.

By report dated August 6, 1997, Dr. Pearson diagnosed right SI joint dysfunction, noting that physical examination revealed the right SI joint was positive to anterior provocation as well as posterior palpation. In an August 25, 1997 report, she noted that appellant underwent an SI joint injection. Appellant noted significant improvement and Dr. Pearson released her to full duty on September 10, 1997. She returned for treatment on March 9, 1998.

On October 18, 1998 appellant was referred to Dr. Ramon Bagby, a Board-certified orthopedic surgeon, for a second opinion examination regarding the nature and extent of her injuries. In his November 20, 1998 report, Dr. Bagby reported that appellant complained of right buttock pain and walked with an altered gait. He noted that x-rays at the time revealed a questionable spondylolisthesis, which could not be substantiated on a lumbar spine magnetic resonance imaging (MRI) scan. Upon physical examination Dr. Bagby noted range of motion of the hip, knee, and ankle joints were within normal limits. He opined that appellant's current subjective complaints were the result of lumbar deconditioning and obesity rather than a specific injury on June 27, 1997.

A notice of proposed termination of compensation letter was sent to appellant on March 24, 1999 informing her that, based upon the second opinion report of Dr. Bagby, the medical evidence no longer supported her claim that she had any disability related to her work injury of June 26, 1997. She was notified of the evidence needed to support her claim and was afforded 30 days to submit the information.

By decision dated April 26, 1999, OWCP terminated appellant's wage-loss compensation benefits as she had not submitted the necessary documentation in support of her claim. Appellant thereafter requested a hearing before the Branch of Hearings and Review. The hearing was held on April 25, 2000. During the hearing, appellant testified that her hip began to hurt after she returned to work when she climbed stairs. She noted that she was told by physicians that her back pain was due to SI strain. Appellant also testified that she had fractured her tail bone in July 1999. By decision dated July 24, 2000, an OWCP hearing representative denied modification of the prior decision, finding that she had not established continuing disability causally related to the accepted injury.

Appellant submitted additional medical reports from her treating physicians who opined that she continued to suffer from injuries relating to the June 26, 1997 employment incident. She also continued to request reconsideration by letters dated August 22 and 23 and October 14, 2000 and July 21, 2001. On August 29, 2002 OWCP denied appellant's request for reconsideration without a merit review finding that her application did not contain any new and relevant evidence or argument.

On April 7, 2003 the Board remanded this case to OWCP for consideration of the merits of appellant's claim. The Board found that appellant had submitted additional medical evidence at the time she filed her request for reconsideration with OWCP and that the reports she submitted, including reports from Dr. Portner, were new and relevant to her claim that she remained disabled due to her work injury. The case was therefore remanded for merit review of the new and relevant medical evidence then of record.

By decision dated October 8, 2003, OWCP found that appellant continued to suffer from residuals of her June 26, 1997 work injury. It expanded the claim to include lumbar strain, SI joint dysfunction, and consequential major depression with consequential chronic pain syndrome.

On August 2, 2005 appellant was referred to Dr. Thomas Grollman, a Board-certified orthopedic surgeon, for a second opinion examination regarding the nature and extent of her injuries. In an August 22, 2005 medical report, Dr. Grollman documented a history of the employment incident, reviewed prior medical and diagnostic reports, and provided findings on physical examination. He diagnosed status post lumbosacral strain without evidence of lumbar radiculopathy with persisting chronic pain symptoms and history of left foot sprain resolved with no residuals. Dr. Grollman speculated possible early right hip arthritis due to complaints of pain, though he also noted that appellant's hip range of motion was satisfactory. He recommended further x-rays of the right hip and pelvis to determine if any arthritic process or degenerative changes existed. Dr. Grollman further noted that appellant had complaints of continued low back pain, but the MRI scan was essentially negative with no significant disc herniation and that there was no evidence of any lumbar radiculopathy. He opined that she was likely never totally

disabled except for the first couple of weeks after the original injury and could resume light-duty work.

Dr. Gary Okamura, a Board-certified orthopedic surgeon, noted following a March 28, 2007 evaluation that appellant had right hip arthritis. His July 24, 2007 evaluation revealed right hip strain with osteoarthritis. On June 11, 2007 Dr. Hayato Mori, Board-certified in orthoscopic surgery, recommended that appellant consider the option of a hip arthroscopy to treat her pain, but he did not believe that she was a good surgical candidate for a joint replacement.

In a medical report dated April 21, 2008, Dr. D. Scott McCaffrey, Board-certified in emergency medicine, noted that appellant sustained an injury in 1997 in the course of her duties as a letter carrier when she slipped and fell on wet grass while delivering mail, during which time she landed with a high amount of force on her buttocks causing compression injuries of the spinal column as well as an injury to the right hip. He diagnosed multiple conditions including severe acute and chronic right hip sprain with possible occult femoral neck fracture and persistent osteoarthritis with osteophyte formation. Dr. McCaffrey summarized and reviewed prior diagnostic reports. He noted that a June 26, 1997 x-ray of the lumbar spine revealed bilateral pars defects at L4-5 with spondylosis, a July 30, 1999 bone scan revealed findings consistent with a distal sacral fracture, a May 22, 2000 computerized tomography (CT) scan of the sacrum revealed osteoarthritis of both SI joints and mild bony encroachment upon the left L5-S1 neural foramen, and a February 15, 2007 CT scan of the right hip revealed degenerative spurring at the hip joint and a questionable small chip fracture of the spur at the anterior acetabulum. Dr. McCaffrey further noted that Dr. Portner's August 6, 1997 evaluation noted small osteophytosis inferior right SI joint. Pertaining to appellant's right hip injury, he opined that appellant experienced either an occult fracture and/or chip type fracture compression injury and would benefit from arthroscopic removal of that fragment and/or total hip replacement. Dr. McCaffrey noted that the mechanism of her fall, along with multiple specialists and imaging reports noting trauma, developed a firm nexus with the industrial injury to a high degree of medical probability.

In a June 18, 2008 addendum report, Dr. McCaffrey related that appellant had documented hip complaints which were noted by some practitioners early in her recovery. He noted that he and other physicians thought her lumbar injury was the primary etiology of her pain and impairment, which has since been clarified. Appellant's persistent impairment and pain, which included significantly altered gait and limitations on sitting or standing for prolonged periods, required hip arthroscopic intervention. Dr. McCaffrey noted that she recently received an intra-articular hip injection which provided her significant but temporary relief, providing objective clinical proof that she had been suffering from a post-traumatic hip disorder.

By report dated December 8, 2008, Dr. McCaffrey requested authorization for arthroscopic hip surgery as appellant's hip disorder appeared to be her primary impairment and pain source.

On February 26, 2009 appellant wrote to OWCP and requested that a determination be made on her request for authorization for hip surgery. Due to the delay in the process she resubmitted the medical reports of Dr. McCaffrey which set forth her alleged need for arthroscopic hip surgery.

The record indicates that appellant continued to treat with Dr. McCaffrey through 2010 and 2011, and he documented her continuing right hip complaints and need for arthroscopic surgery.

In a March 25, 2011 report, Dr. McCaffrey noted that appellant had cardinal signs of hip dysfunction including range of motion loss in the hip joint as well as myofascial tenderness of the muscles surrounding the hip itself. He noted that the case had been complicated by failure in the early stages to appreciate the level of her hip injury as it related to other regional trauma, most notably a lumbar disc derangement at L4-5 and L5-S1, which was causing a referred pain in the right buttock, right leg, and pain around the hip region thereby delaying definitive diagnosis through symptom masking. Dr. McCaffrey reported that appellant's limping and complaints of right hip pain, which were never documented, prevented her from getting treatment of the hip. He referenced the report of Dr. Jeffrey Lee, a Board-certified orthopedic surgeon, which noted that August 1997 pelvic radiographs were notable for narrowing of the lateral aspect of the right hip joint with lateral acetabular osteophyte. Such structural post-traumatic pathology was confirmed subsequently in the February 2007 CT scan of the hip.

By report dated December 14, 2011, Dr. Linda J. Rowan, a Board-certified physiatrist specializing in physical medicine and rehabilitation, noted that appellant was referred to her for an evaluation of her 1997 work injuries. She provided a history of the June 26, 1997 employment incident and diagnosed right hip pain with records documenting post-traumatic osteoarthritis and osteophyte impingement syndrome, acute lumbosacral spine sprain, L4-5 and L5-S1 disc derangement and facet arthrosis, and T9 compression fracture with multilevel disc derangement. Dr. Rowan found that she did not have all medical records to verify these diagnoses, but noted right hip discomfort and an obviously antalgic gait on physical examination.

On February 15, 2012 OWCP referred appellant and the case file to Dr. Tetsuto Numata, a Board-certified orthopedic surgeon, for a second opinion medical examination to establish the diagnosis of her right hip condition and the nature and extent of her disability. Dr. Numata's letterhead notes that he is affiliated with Brewer Consulting Services, Inc.

In an April 19, 2012 medical report consisting of 44 pages, Dr. Numata reported that on June 26, 1997 appellant was walking on grass to deliver mail when her left foot slid, causing her to fall forward and twist her left leg and back as she fell down. He provided a detailed review and summary of her prior medical reports and diagnostic studies, including additional reports that she provided to him. Dr. Numata noted that appellant complained of continued right hip, right groin, and right thigh pain and provided findings on examination. He reported that the medical documentation of record supported the accepted OWCP conditions listed in the statement of accepted facts dated December 14, 2011 of left foot sprain, sprain of SI joint, sciatica, contusion of right hip, and recurrent major depression. Dr. Numata noted that the work-related left foot sprain and sciatica had resolved, but there remained residual symptoms of low back pain from the sprain of the SI joint. With respect to the contusion of the right hip, he reported that there was no evidence of its existence in the medical record and no current evidence of its existence.

Dr. Numata provided an additional diagnosis of right hip osteoarthritis, a condition which had not been accepted by OWCP. He opined that, based on review of the medical records,

appellant's right hip osteoarthritis likely preexisted the work injury and became symptomatic due to the natural progression of the disease rather than due to the specific effects of the work injury at issue. Dr. Numata's report summarized the findings of the August 6, 1997 pelvic x-ray. He noted that the medical records clearly documented that the initial injury complaints were located in the lower back, right leg, and left foot with no complaints about the right hip or groin. Dr. Numata referenced Dr. Pearson's July 5, 1997 report, eight days following the traumatic incident, which noted hip range of motion was full and pain free. Dr. Pearson's report further indicated that testing and examination revealed that appellant's pain was located over the right SI joint, which made sense given the mechanism of injury where she fell on her buttocks. This diagnosis was further supported by the significant improvement appellant noted after her injection which allowed her to return to work on September 2, 1997, and where she did not follow up with Dr. Pearson until March 9, 1998. Dr. Numata further noted that Dr. Bagby's November 20, 1998 second opinion report noted that her range of motion of the hip, knee, and ankle joints were within normal limits. He opined that issues pertaining to the right hip did not arise until December 17, 1998, nearly a year and a half later, when Dr. Pearson noted pain on mobilization of the right hip in a capsular pattern and diagnosed right hip capsulitis. Dr. Numata noted conflicting findings between Dr. Bagby's November 20, 1998 report, which noted normal right hip examination, and Dr. Pearson's December 17, 1998 report, which documented pain on mobilization of the right hip noting that the physicians examined appellant just 27 days apart. He further noted that Dr. Pearson never noted complaints of right groin pain.

Dr. Numata opined that very subtle findings of right hip osteoarthritis may have been developing by the end of 1998 as a result of natural progression. He noted that more than one and a half years of time had elapsed since the work-related incident, creating too long of a time period for the symptoms in the right hip/groin area to have been directly caused by the work injury at issue. Dr. Numata further noted that the mechanism of the injury was not of sufficient magnitude to have caused physical damage to the internal structure of the right hip and was not severe enough to cause symptomatic osteoarthritis of the hip to develop within one and a half years of time, where none had existed before. He noted that physical examination findings and symptoms recorded by the treating physicians developed too long a time after the injury to opine that the work injury had aggravated the preexisting condition of osteoarthritis to bring the symptoms to the surface. Dr. Numata concluded that appellant's osteoarthritis was caused by the natural progression of her preexisting right hip condition and not due to the June 26, 1997 work-related incident.

By decision dated June 5, 2012, OWCP denied appellant's claim to include right hip osteoarthritis as an accepted condition finding that the medical evidence of record failed to establish that it was causally related to the July 26, 1997 employment incident. It noted that the weight of the medical evidence rested with Dr. Numata, the second opinion physician, who opined that her preexisting right hip osteoarthritis was caused by the natural progression of the condition and not a result of the work-related incident.

On June 29, 2012 appellant requested an oral hearing before the Branch of Hearings and Review. Prior to the hearing she submitted additional medical notes of Dr. Rowan. In a note dated May 29, 2012, Dr. Rowan noted that she exhibited an antalgic gait, diminished right lower extremity internal rotation, and an impression of right hip pain, and osteoarthritis. A hearing was held on October 22, 2012 where appellant testified that her right hip arthritis was injury related

and not caused by a preexisting condition. She further argued that the reports of Dr. Rowan and Dr. McCaffrey established her claim.

Following the hearing appellant submitted additional medical and diagnostic records from 1997 to present, as well as copies of records previously on file. She submitted Orthopedic Clinic progress notes dated July 11 to 23, 1997. A July 23, 1997 note documented right hip tenderness. However, none of these progress notes contained a legible physician's signature. The additional medical records appellant submitted prior to the oral hearing are set forth below.

In an October 29, 1997 report, Dr. Peter Balkin, a Board-certified diagnostic radiologist, related that appellant's pelvic x-ray was essentially normal. He reported that an incidental note was made of a bony spur seen arising from the region of the right mid pelvis. Dr. Balkin opined that this was probably a normal variation related to prior trauma and could also represent calcification of one of the ligaments which was also a normal variation. He noted that this was of no clinical significance.

On May 25, 1999 Dr. Michael C. Ling, Board-certified in internal medicine, reported that a bone scan of the pelvis and hips revealed normal findings.

In a May 28, 1999 medical report, Dr. Alan Oki, a treating physician, noted that appellant struck her coccyx during a work-related fall and complained of back and right hip pain. He diagnosed chronic low back and right hip pain which he opined was related to chronic psoas and iliacus myofascitis.

By report dated September 15, 1999, Dr. Cedric Akau, Board-certified in physical medicine and rehabilitation, related that appellant sustained a work-related injury on June 26, 1997 when she sprained her left foot and back. He noted that he did not have access to all of her prior medical reports and provided review of the reports that were provided to him. Dr. Akau noted x-rays of the pelvic region in August 1997 revealed sclerosis at the right SI joint and what appeared to be a four centimeter, calcific density spur off the spine of the ischium. This spur was unchanged in characteristic when compared to an x-ray taken in May 1999. The May 1999 x-ray also showed sclerosis of the right SI joint more than the left and the bony spicule seen previously. Dr. Akau diagnosed right low back pain, which he opined initially started as a SI joint strain, but had developed into chronic pain syndrome.

In a July 23, 2004 medical report, Dr. Melvin Yea, a treating physician, noted complaints of right hip and buttock pain. Neurologic examination did not reveal evidence of lumbar radiculopathy and multiple MRI scans failed to show significant nerve root compression. Dr. Yea speculated whether appellant's pain could be caused by a hip injury.

On September 9, 2005 Dr. John L. Cieply, a Board-certified diagnostic radiologist, reported that appellant's MRI scan of her right hip revealed normal findings. He noted that specific views of the SI joints failed to demonstrate evidence of joint space widening, effusion, or bone edema to suggest inflammation. Dr. Cieply further noted that the pelvic soft tissues were unremarkable.

In a March 28, 2007 medical report, Dr. Okamura noted that x-rays of the pelvis and lateral of the right hip revealed mild-to-moderate arthritis with some bone spurs along the acetabulum and sclerosis along the acetabulum. He diagnosed right hip arthritis.

On June 11, 2007 Dr. Mori recommended hip arthroscopy to treat appellant's pain, noting that she was a good surgical candidate to treat appellant's pain.

Dr. Lee reported on July 24, 2007 that an August 1997 pelvic radiograph was notable for narrowing of the lateral aspect of the right hip joint with lateral acetabular osteophyte which was confirmed by a CT scan in February 2007. He diagnosed right hip strain and osteoarthritis and opined that appellant's pain was probably attributable to a combination of chronic musculo ligamentous strain and arthritis of the lateral aspect of the hip.

In a September 4, 2012 medical report, Dr. Jeffrey Kimo Harpstrite, a Board-certified orthopedic surgeon, provided findings on physical examination and diagnosed moderate degenerative arthritis bilateral hips, right worse than left. He noted that appellant presented with chronic right hip pain and a mild limp. Dr. Harpstrite recommended nonoperative treatment, but noted hip replacement surgery will likely be needed in the future. He recommended that appellant continue conservative treatment at this point until she has worsening of her arthritis and then hip replacement surgery could then be necessary.

On October 24, 2012 Dr. Rowan reported that appellant had sought treatment with her since December 14, 2011. She described the employment incident noting that appellant slipped on a rainy day causing her to abruptly hit the ground on the right buttock twisting her body. Appellant recalled discomfort in her low back and right hip area. Dr. Rowan reviewed prior medical and diagnostic reports. She noted that appellant had multiple diagnostics, most of which did not show significant problems in the hips specifically. Pelvic x-rays in 1997 were normal, an undated MRI scan of the hip from the late 1990's/early 2000 was normal, and a 2005 MRI scan also revealed normal. A 2007 CT scan of the hip noted degenerative spurring at the hip joint with questionable small chip fracture of the spur at the anterior acetabulum and a slightly decreased joint space of the upper hip joint area. A May 30, 2007 x-ray of the hip documented linear lucency, but no joint space narrowing or erosions. Dr. Rowan noted that Dr. Harpstrite diagnosed moderate degenerative arthritis of bilateral hips. She diagnosed low back pain related to degenerative changes, a T9 compression fracture, and facet arthrosis.

In a November 5, 2012 medical report, Dr. Patrick Murray, a Board-certified orthopedic surgeon, confirmed by written statement that he initially evaluated appellant on July 11, 2007 and diagnosed early symptomatic arthritis to the hip following a problem with her back subsequent to a fall some 10 years earlier.

By decision dated December 10, 2012, the Branch of Hearings and Review affirmed OWCP's June 5, 2012 decision finding that the evidence of record failed to establish that her right hip osteoarthritis was caused by the June 26, 1997 employment incident. The hearing representative noted that the weight of the medical evidence remained with Dr. Numata serving as the second opinion physician as he offered an opinion based on an accurate history, examination findings, and a detailed review of the diagnostic tests and physicians' reports of record. The hearing representative further noted that the record did not contain any medical

record supportive of a causal relationship between appellant's accepted work injury and her claimed hip condition.

On December 4, 2013 appellant requested reconsideration of the December 10, 2012 decision. She made allegations including fraud, conspiracy, abuse of power, and gross negligence, arguing that the medical staff who evaluated her on June 26, 1997 failed to document and ignored her numerous right hip complaints. Appellant further argued that Dr. Numata did not review numerous medical reports and did not have an accurate history of injury, stating that she was initially misdiagnosed with low back strain. In support of her claim, she submitted medical reports previously of record as well as a November 15, 2013 medical report of Dr. Rowan who noted that review of a June 16, 1999 medical report from Straub Clinic and Hospital indicated that appellant had a long-standing history of right hip and low back pain which was related to a 1997 work injury. Dr. Rowan noted that appellant had complained of significant right hip pain, which made it difficult for her to walk, causing her to walk with a limp. She opined that appellant's prior medical reports documented post-traumatic arthritis and osteophyte impingement syndrome.

By decision dated January 24, 2014, OWCP affirmed the December 10, 2012 decision finding that the evidence of record failed to establish that appellant's right hip osteoarthritis was caused by the June 26, 1997 employment incident. It noted that the medical reports submitted were insufficient to overcome the weight of the medical evidence provided to Dr. Numata's report. OWCP further noted that appellant's allegations of conspiracy, abuse of power, abuse toward injured workers, and gross negligence were not relevant to the issue at hand which required medical evidence to establish causation.

On April 1, 2014 appellant requested reconsideration of OWCP's decision. She provided a statement which repeated prior arguments and allegations made, including fraudulent and falsified medical records, errors in the facts, fraud by OWCP for failing to review all of the medical reports, and insufficiency in Dr. Numata's report. The only medical evidence submitted in support of appellant's request for consideration was a handwritten clinic note from Dr. Rowan which clearly does not contain an opinion as to the cause of the claimant's hip condition.

By decision dated July 16, 2014, OWCP denied appellant's request for reconsideration finding that she neither raised substantive legal questions nor included new and relevant evidence.

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 filed within the applicable time limitation; that an injury was sustained while in the performance of duty as alleged and that any disability or specific condition for which compensation is claimed is causally related to the

employment injury.[3] These are the essential elements of every compensation claim regardless of whether the claim is predicated on a traumatic injury or an occupational disease.[4]

To establish a causal relationship between the condition, as well as any attendant disability claimed and the employment event or incident, the employee must submit rationalized medical opinion evidence based on a complete factual and medical background, supporting such a causal relationship.[5] The opinion of the physician 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. This medical opinion must include an accurate history of the employee's employment injury and must explain how the condition is related to the injury. 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.[6]

ANALYSIS -- ISSUE 1

OWCP accepted appellant's claim for left foot sprain, low back sprain, SI region sprain not otherwise classified, sciatica, SI ligament sprain, major depression recurrent episode, and right hip contusion. By decision dated January 24, 2014, it denied her request to expand her claim to include her additional right hip conditions. The issue on appeal is whether appellant has established that her right hip osteoarthritis is causally related to the accepted June 26, 1997 employment incident. The Board finds that she has failed to meet her burden of proof.[7]

In its January 24, 2014 decision, OWCP determined that the weight of the medical evidence rested with Dr. Numata, a Board-certified orthopedic surgeon serving as the second opinion physician. The Board finds that his well-rationalized report, which was based upon a proper factual and medical background, represents the weight of the medical evidence and establishes that appellant's right hip osteoarthritis was not caused by the June 26, 1997 employment incident.[8]

In his April 19, 2012 medical report, Dr. Numata opined that appellant's preexisting right hip osteoarthritis was caused by the natural progression of the condition and was not a result of the June 26, 1997 employment incident. He provided a detailed history of injury, findings on physical examination, and review and summary of her prior medical reports and diagnostic studies, including those she provided to him. Dr. Numata noted that there was no evidence of the accepted right hip contusion in the medical record as the records clearly documented that the initial injury complaints were located in the lower back, right leg, and left foot with no

[3] *Gary J. Watling*, 52 ECAB 278 (2001); *Elaine Pendleton*, 40 ECAB 1143, 1154 (1989).

[4] *Michael E. Smith*, 50 ECAB 313 (1999).

[5] *See* 20 C.F.R. § 10.110(a); *John M. Tornello*, 35 ECAB 234 (1983).

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

[7] *P.B.*, Docket No. 13-951 (issued September 10, 2013).

[8] *Y.M.*, Docket No. 14-1050, 14-1193 (issued December 24, 2014).

complaints about the right hip or groin. He further noted that there was no current evidence of existence right hip contusion. Dr. Numata diagnosed right hip osteoarthritis, a condition not accepted by OWCP, explaining that the condition likely preexisted the work injury and became symptomatic due to the natural progression of the disease rather than due to the specific effects of the work injury at issue.

The Board has carefully reviewed the opinion of Dr. Numata and finds that it has reliability, probative value, and a convincing quality with respect to its conclusions regarding the issue presented on appeal.[9] Dr. Numata's opinion is based on a proper factual and medical history and he thoroughly reviewed the factual and medical history by accurately summarizing the relevant medical evidence.[10] As noted, he provided medical rationale for his opinion by explaining that the medical records clearly documented that the initial injury complaints were located in the lower back, right leg, and left foot with no complaints pertaining to the right hip or groin. Dr. Numata referenced Dr. Pearson's July 5, 1997 report, eight days following the traumatic incident, which noted hip range of motion was full and pain free. Dr. Pearson's report further indicated that testing and examination revealed that appellant's pain was located over the right SI joint, which made sense given the mechanism of injury when she fell on her buttocks. This diagnosis was further supported by the significant improvement appellant noted after her initial injection, allowing her to return to work on September 2, 1997 with no follow up with Dr. Pearson until March 9, 1998. Dr. Numata further explained that the mechanism of the injury was not of sufficient magnitude to have caused physical damage to the internal structure of the right hip. Moreover, it was not severe enough to cause symptomatic osteoarthritis of the hip to develop within one and a half years of time, where none had existed before. Dr. Numata provided support for this assertion documenting that issues pertaining to the right hip did not arise until December 17, 1998 when Dr. Pearson noted pain on mobilization in a capsular pattern and diagnosed right hip capsulitis. There were also no documented reports of right groin pain contained in the record. Dr. Numata further noted that Dr. Pearson's findings were contradicted by Dr. Bagby's November 20, 1998 evaluation the month before which noted a normal right hip examination.

Dr. Numata provided support for his arguments and addressed prior medical reports and diagnostic studies.[11] He specifically addressed the findings of the August 6, 1997 pelvic x-ray, yet maintained that appellant's right hip osteoarthritis was not caused or aggravated by the June 26, 2007 employment incident. Dr. Numata opined that she had a preexisting degenerative right hip condition, which was unaltered by the June 26, 1997 injury, explaining that very subtle findings of right hip osteoarthritis may have been developing by the end of 1998 as a result of natural progression. Thus, his opinion is entitled to special weight and establishes that appellant's right hip osteoarthritis was not caused by the June 26, 1997 employment incident.[12]

[9] *See R.W.*, Docket No. 12-375 (issued October 28, 2013).

[10] *See Melvina Jackson*, 38 ECAB 443 (1987).

[11] *See G.P.*, Docket No. 14-395 (issued June 5, 2014).

[12] *A.H.*, Docket No. 13-266 (issued October 24, 2013) (the reports of appellant's attending physicians were insufficient to establish a recurrence of disability. OWCP relied on the report of the second opinion physician in denying appellant's claim).

Subsequent to Dr. Numata's April 19, 2012 report, appellant submitted various medical reports, many of which were previously of record, in support of her claim.

In medical reports dated December 14, 2011 to November 15, 2013, Dr. Rowan reported that appellant sustained a work-related injury on June 26, 1997 when she slipped and fell, causing her to abruptly hit the ground. She reported that review of a June 16, 1999 medical report from Straub Clinic and Hospital indicated that appellant had a long-standing history of right hip and low back pain which was related to a 1997 work injury. Dr. Rowan noted that appellant had complained of significant right hip pain which caused her to walk with a limp. She stated that appellant's prior medical reports documented post-traumatic arthritis and osteophyte impingement syndrome.

The Board finds that the opinion of Dr. Rowan is not well rationalized.[13] Dr. Rowan first treated appellant on December 14, 2011 more than 14 years after the employment incident. She noted a diagnosis of post-traumatic arthritis and osteophyte impingement syndrome based on review of appellant's medical record. However, Dr. Rowan failed to give any opinion regarding the cause of appellant's condition and only generally noted that a June 16, 1999 medical report from Straub Clinic and Hospital indicated a long-standing history of right hip and low back pain which was related to a 1997 work injury. She further noted that pelvic x-rays in 1997 were normal, the MRI scan of the hip in the late 1990's/early 2000 was normal, and a 2005 MRI scan also revealed normal. Based on her review of the diagnostic studies, Dr. Rowan did not dispute that appellant's right hip showed normal findings subsequent to the employment incident until a 2007 CT scan of the hip. This does not provide support for a long-standing history of right hip pain stemming from a 1997 work-related incident. Moreover, 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.[14] Without medical reasoning explaining how the June 26, 1997 employment incident caused or contributed to appellant's right hip osteoarthritis, Dr. Rowan's reports are insufficient to meet appellant's burden of proof.[15]

In medical reports dated April 21, 2008 to March 25, 2011, Dr. McCaffrey reported that appellant sustained an injury in 1997 in the course of her duties as a letter carrier when she slipped and fell on wet grass while delivering mail, during which time she landed with a high amount of force on her buttocks causing compression injuries of the spinal column as well as an injury to the right hip. He diagnosed multiple conditions including severe acute and chronic right hip sprain with possible occult femoral neck fracture and persistent osteoarthritis with osteophyte formation. Dr. McCaffrey summarized and reviewed prior diagnostic reports and opined that appellant experienced either an occult fracture and/or chip type fracture compression injury. He opined that her documented hip complaints were related to her workplace fall as the mechanism of the fall correlated with the development of trauma as confirmed by prior medical reports and diagnostic findings.

[13] *C.B.*, Docket No. 08-1583 (issued December 9, 2008).

[14] *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

[15] As this report does not provide a clear opinion on the causal relationship between appellant's diagnosed condition and the employment incident, it cannot meet her burden of proof. *D.H.*, Docket No. 13-1085 (issued September 18, 2013).

The Board finds that the opinion of Dr. McCaffrey is not well rationalized and is insufficient to overcome the weight of the medical evidence afforded to Dr. Numata.[16] Dr. McCaffrey noted that the case had been complicated by failure in the early stages to appreciate the level of appellant's hip injury as it related to other regional trauma, most notably a lumbar disc derangement at L4-5 and L5-S1, which was causing a referred pain in the right buttock and right leg pain around the hip region, thereby delaying definitive diagnosis through symptom masking. He reported that her limping and complaints of right hip pain, which were never documented, prevented her from getting treatment of the hip. Dr. McCaffrey failed, however, to explain why appellant exhibited no physical findings of a hip condition and had findings of full range of motion. He noted that a 2008 intra-articular hip injection provided her significant but temporary relief, and referenced this as objective clinical proof that she had been suffering from a post-traumatic hip disorder. However, the reports of Dr. Pearson and Dr. Portner, dating back to the initial injury in 1997 and 1998, reflect that injections to the SI joint provided appellant significant relief. Moreover, treatment to the SI joint following the June 26, 1997 employment incident was verified by subjective complaints, physical examination, and objective clinical findings. Relief from an intra-articular hip injection more than 11 years after the initial employment incident is not probative medical evidence of a work-related post-traumatic hip disorder. Furthermore, an August 1997 pelvic radiograph which noted some small degenerative osteophytosis in the inferior right sacroiliac joint also does not rise to the level of probative medical evidence supporting a finding of causal relationship as expressed by Dr. McCaffrey.[17]

Dr. McCaffrey's opinion on causation is further deficient as he failed to explain why appellant's right hip complaints were not caused by a preexisting degenerative arthritic condition. His report provided no discussion regarding whether preexisting osteoarthritis had progressed beyond what might be expected from the natural progression of that condition.[18] A well-rationalized opinion is particularly warranted when there is a history of a preexisting condition.[19] Dr. McCaffrey's statement on causation fails to provide a sufficient explanation as to the mechanism of injury and did not adequately explain how the June 26, 1997 employment incident would cause or aggravate her preexisting right hip osteoarthritis. Medical reports without adequate rationale on causal relationship are of diminished probative value and do not meet an employee's burden of proof.[20] The opinion of a physician supporting causal relationship must rest on a complete factual and medical background supported by affirmative evidence, address the specific factual and medical evidence of record, and provide medical rationale

[16] *See generally Floyd Stilley*, Docket No. 02-2016 (issued February 19, 2003) (the claimant's attending physician based his opinion on an inaccurate history, while OWCP referral physician based his opinion on a thorough review of the factual and medical evidence of record, an accurate history of injury, and the results of objective testing. The Board held that the weight of the medical opinion rested with OWCP's referral physician).

[17] *See K.P.*, Docket No. 14-1330 (issued October 17, 2014).

[18] *R.E.*, Docket No. 14-868 (issued September 24, 2014).

[19] The Board has held that an opinion that a condition is causally related because the employee was asymptomatic before the injury is insufficient, without adequate rationale, to establish causal relationship. *T.M.*, Docket No. 08-975 (issued February 6, 2009); *Michael S. Mina*, 57 ECAB 379 (2006).

[20] *Ceferino L. Gonzales*, 32 ECAB 1591 (1981).

explaining the relationship between the diagnosed condition and the established incident or factor of employment.[21] Without explaining how physiologically the movements involved in the employment incident caused or contributed to the diagnosed conditions, Dr. McCaffrey's opinion is of limited probative value and insufficient to meet appellant's burden of proof.[22]

Appellant argues that a July 23, 1997 orthopedic clinic progress note, which references right hip tenderness, establishes proof of a work-related right hip injury. As previously discussed, the Board notes that the report does not contain a legible signature establishing that it was signed by a physician.[23] Moreover, the report is an isolated report of a symptom without a diagnosis of a verifiable medical condition in the hip.

Appellant further references Dr. Portner's August 6, 1997 pelvic x-ray as evidence of a work-related right hip injury. This diagnostic report is also insufficient to establish that her right hip osteoarthritis was caused or aggravated by the employment incident as the physician only noted small degenerative osteophytosis in the inferior right SI joint and made no findings pertaining to the right hip.[24] Additionally, Dr. Balkin's October 29, 1997 report is of no probative value as he noted that a pelvic x-ray revealed a possible bony spur arising from the region of the right mid pelvis, which he opined was of no clinical significance.[25]

Dr. Lee's July 24, 2007 report noted that the August 1997 pelvic radiograph was notable for narrowing of the lateral aspect of the right hip joint with lateral acetabular osteophyte, which was confirmed by a February 2007 CT scan. However, he failed to explain how the findings of the August 1997 pelvic x-ray, which both Dr. Ragby and Dr. Grollman found to be insufficient evidence of a definitive right hip condition, established that osteoarthritis seen on a February 2007 right hip CT scan confirmed the existence or aggravation of this condition dating back 10 years to the injury in 1997. Dr. Lee diagnosed right hip strain and osteoarthritis and opined that appellant's pain was probably attributable to a combination of chronic musculo ligamentous strain and arthritis of the lateral aspect of the hip. His opinion is of limited probative value as he failed to give any definitive, rationalized medical opinion regarding the cause of her injury.[26]

The Board notes that appellant's argument that Dr. Numata did not thoroughly review the medical record is without merit. Dr. Numata's report provided detailed review of her prior medical reports including those provided to him by her. While Dr. Numata did not summarize every report in the record, this does not mean that these reports were not reviewed. There is no

[21] *See Lee R. Haywood*, 48 ECAB 145 (1996).

[22] *See L.M.*, Docket No. 14-973 (issued August 25, 2014); *R.G.*, Docket No. 14-113 (issued April 25, 2014); *K.M.*, Docket No. 13-1459 (issued December 5, 2013); *A.J.*, Docket No. 12-548 (issued November 16, 2012).

[23] A report that is unsigned or bears an illegible signature and lacks proper identification cannot be considered probative medical evidence. *Thomas L. Agee*, 56 ECAB 465 (2005); *Richard F. Williams*, 55 ECAB 343 (2004).

[24] *D.U.*, Docket No. 14-1670 (issued December 15, 2014).

[25] *Id.*

[26] *D.K.*, 59 ECAB 141 (2007).

requirement that an examining physician must list every medical report reviewed.[27] Medical reports should contain dates of examination or treatment, clinical history, detailed description of physical findings, results of x-ray or laboratory tests, diagnosis, prognosis, description of impairment if any, specific limitations for work, clinical course of treatment, a reasoned opinion on causal relationship, and a detailed description of the employee's work tolerance limitations in any case where the issue is the claimant's ability to return to work.[28] The record reveals that OWCP sent appellant's medical records to Dr. Numata at the time of the referral and his report establishes that he reviewed the medical record provided in reaching his conclusions.[29]

The remaining medical evidence of record is insufficient to establish appellant's claim as the physicians failed to provide a rationalized opinion that her right hip osteoarthritis was caused by the June 26, 1997 employment incident.[30]

On appeal, appellant argues that at the very least a conflict has been created between Dr. Numata, serving as the second opinion physician and her attending physicians. When two physicians give reasoned but differing opinions concerning causal relationship and one physician's opinion is based on an inaccurate or incomplete factual or medical background, the opinion based on an accurate factual or medical history typically has more probative value.[31] For the reasons noted above, the opinions of Dr. Rowan and Dr. McCaffrey were not fully rationalized to create a conflict in the case. Dr. Numata provided a well-reasoned medical opinion based on a complete medical background using both subjective and objective findings.[32] Therefore, his opinion was properly afforded the weight of the evidence.

Appellant's belief that the June 26, 1997 employment incident caused her medical problem is not in question. But that belief, however, sincerely held, does not constitute the medical evidence necessary to establish causal relationship. Because appellant has failed to submit a well-rationalized medical report establishing that her right hip osteoarthritis was caused or aggravated by the June 27, 1997 employment incident, she has failed to meet her burden of proof.[33]

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[27] *S.N.*, Docket No. 12-123 (issued June 12, 2012).

[28] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.3(c)(3) (July 2011).

[29] *Id*.

[30] *S.M.*, Docket No. 14-1056 (issued August 22, 2014).

[31] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.6(a)(1) (September 2010).

[32] A well-reasoned medical opinion should also be consistent with the findings upon examination. Findings may be noted during physical examination, laboratory testing, and diagnostic procedures. Sufficient objective data (findings on examination, test results) should be included in the report to support the medical conclusions. *Id.* at Chapter 2.810.6(a)(2).

[33] *See generally Michael Hughes*, 52 ECAB 387 (2001); *Howard Y. Miyashiro*, 43 ECAB 1101, 1115 (1992); *Dorothy Sidwell*, 41 ECAB 857 (1990).

Appellant may submit additional evidence, together with a written request for reconsideration, to OWCP within one year of the Board's merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.606 and 10.607.

LEGAL PRECEDENT -- ISSUE 2

To require OWCP to reopen a case for merit review under FECA section 8128(a), OWCP regulations provide that the evidence or argument submitted by a claimant must: (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.[34] Section 10.608(b) of OWCP regulations provide that when an application for reconsideration does not meet at least one of the three requirements enumerated under section 10.606(b)(3), OWCP will deny the application for reconsideration without reopening the case for a review on the merits.[35]

ANALYSIS -- ISSUE 2

The Board finds that the refusal of OWCP to reopen appellant's case for further consideration of the merits of her claim, pursuant to 5 U.S.C. § 8128(a), did not constitute an abuse of discretion.

The issue presented on appeal is whether appellant met any of the requirements of 20 C.F.R. § 10.606(b)(3), requiring OWCP to reopen the case for review of the merits of the claim. In her November 19, 2013 application for reconsideration, appellant did not show that OWCP erroneously applied or interpreted a specific point of law. She did not advance a new and relevant legal argument. Appellant's arguments were the same as those set forth in her June 29, 2012 and December 4, 2013 requests for reconsideration, arguing, *inter alia*, fraud, conspiracy, abuse of power, and negligence. The Board has held that material which is duplicative of that already contained in the case record does not constitute a basis for reopening a case.[36] Furthermore, where the legal argument presented has no basis in fact or precedent, OWCP is not required to reopen the case for merit review.[37]

Appellant also argued that Dr. Numata did not review numerous medical reports and did not have an accurate history of injury, stating that she was initially misdiagnosed with low back strain. As previously noted, there is no requirement that an examining physician must list every medical report reviewed.[38] Appellant further asserts that OWCP did not review all of her medical records. The Board notes that OWCP's June 5 and December 10, 2012, and January 24, 2014 decisions discussed the documents submitted to the record on reconsideration.[39] Moreover,

[34] *D.K.*, 59 ECAB 141 (2007).

[35] *K.H.*, 59 ECAB 495 (2008).

[36] *J.B.*, Docket No. 14-1164 (issued November 20, 2014). *See Kenneth R. Mroczkowski*, 40 ECAB 855 (1989).

[37] *B.J.*, Docket No. 14-1028 (issued September 17, 2014). *See also Norman W. Hanson*, 40 ECAB 1160 (1989).

[38] *Supra* note 29.

[39] *Supra* note 43.

OWCP is not required to list every piece of evidence in the record.[40] There is no basis to conclude that OWCP failed to consider the documents submitted. Moreover, OWCP is not required to list every piece of evidence in the record.

The Board notes that the underlying issue in this case was whether appellant's right hip osteoarthritis was caused or aggravated by the June 26, 1997 employment incident. That is a medical issue which must be addressed by relevant medical evidence.[41] Appellant, however, failed to submit new and relevant medical evidence in support of her claim.

The only medical evidence received was a June 24, 2014 clinic note from Dr. Rowan which did not provide a diagnosis or opinion that appellant's right hip osteoarthritis was caused by the June 26, 1997 employment incident. Appellant failed to provide detailed medical rationale from a physician to explain and support the medical opinion that her diagnosed right hip osteoarthritis was caused by the June 26, 1997 employment incident.[42] The Board has held that the submission of evidence which does not address the particular issue involved does not constitute a basis for reopening a case.[43] A claimant may obtain a merit review of an OWCP decision by submitting new and relevant evidence. In this case, while appellant submitted new evidence, it was not relevant in addressing causal relationship.[44]

The Board accordingly finds that appellant did not meet any of the requirements of 20 C.F.R. § 10.606(b)(3). Appellant did not show that OWCP erroneously applied or interpreted a specific point of law, advance a relevant legal argument not previously considered by OWCP, or constitute relevant and pertinent evidence not previously considered. Pursuant to 20 C.F.R. § 10.608, OWCP properly denied merit review.

On appeal, appellant asserts that she was denied due process because her claim was denied merit review, the Board notes that this argument would be related to a constitutional question. The Supreme Court has held that constitutional questions are unsuited to resolution in administrative hearing procedures.[45] As the Board is an administrative body, it does not have jurisdiction to review a constitutional claim such as that made by appellant.[46] The federal courts retain jurisdiction over decisions under FECA where there is a charge of a violation of a clear statutory mandate or there is a constitutional due process claim.[47] The Board notes that

[40] *C.f. K.L.*, Docket No. 14-1218 (issued October 24, 2014).

[41] *See Bobbie F. Cowart,* 55 ECAB 746 (2004).

[42] *See George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of little probative value).

[43] *Jimmy O. Gilmore*, 37 ECAB 257 (1985); *Edward Matthew Diekemper*, 31 ECAB 224 (1979).

[44] *M.C.*, Docket No. 14-21 (issued March 11, 2014); *M.H.*, Docket No. 13-2051 (issued February 21, 2014).

[45] *See Johnson v. Robinson*, 415 U.S. 361 (1974) and cases cited therein.

[46] *See Robert F. Stone*, 57 ECAB 292 (2005); *Diana L. Smith*, 56 ECAB 524 (2005); *Vittorio Pittelli*, 49 ECAB 181 (1997).

[47] *See Andrew Fullman*, 57 ECAB 574 (2006).

appellant's claim was denied because she did not provide any medical evidence to establish that she suffered a right hip injury causally related to the accepted June 26, 1997 employment incident. This argument does not show that OWCP abused its discretion by refusing to reopen appellant's case for further consideration of the merits of her claim, pursuant to 5 U.S.C. § 8128(a).[48]

CONCLUSION

The Board finds that appellant did not meet her burden of proof to establish that her right hip osteoarthritis was caused by the June 26, 1997 employment incident. The Board also finds that OWCP properly denied her request for reconsideration without a merit review.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs decisions dated July 16 and January 24, 2014 are affirmed.[49]

Issued: December 3, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

[48] *G.B.*, Docket No. 13-1260 (issued December 2, 2013).

[49] James A. Haynes, Alternate Judge, participated in the original decision but was no longer a member of the Board effective November 16, 2015.