United States Department of Labor
Employees' Compensation Appeals Board

T.L., Appellant	)	
and	)	**Docket No. 16-0687**
	)	**Issued: October 12, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Milwaukee, WI, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On February 23, 2016 appellant, through counsel, filed a timely appeal from the January 8, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (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 injury causally related to factors of his federal employment.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On December 23, 2014 appellant, then a 56-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that he sustained a right shoulder condition in the performance of duty. He noted starting a new postal delivery route in May 2014, which consisted of mostly apartment buildings "of which 250 must be loaded from the top." Appellant believed the motion of filling the mailboxes from above, along with 24 years of casing mail, and using his shoulders over his chest were the cause of the problems. He first became aware of the injury and its relation to his work on June 15, 2014. Appellant stopped work on December 17, 2014.

In a December 17, 2014 disability certificate, Dr. David E. Pryba, a Board-certified internist, advised that appellant was unable to work in any capacity due to shoulder injury and pain that resulted in significant disability.

In a December 22, 2014 report, Dr. Demetrios Douros, a Board-certified orthopedic surgeon, indicated that appellant could return to work with restrictions on lifting no more than three pounds with the right arm, no repetitive motions with the right arm, no overhead work with right arm, and light assist with left arm not to exceed three pounds.

By letter dated January 30, 2015, OWCP informed appellant of the type of evidence needed to support his claim and afforded him 30 days submit such evidence. It particularly requested that he have his physician provide an opinion, supported by a medical explanation, as to how work activities caused, or aggravated his claimed condition.

In December 17, 2014 treatment notes, Dr. Pryba noted that appellant complained of arthritis-type pain with the most troublesome areas in the right shoulder and as well as the left shoulder, knees, hips, and back. He advised that the pain was related to an injury "unclear as long [history] HX of 'low grade pain' and then increased after using posthole digger and working on car (on his job he is always also lifting shoulder above chest level to sort mail)." Dr. Pryba diagnosed shoulder joint pain and rotator cuff disorder. He continued treating appellant.

A December 18, 2014 right shoulder magnetic resonance imaging (MRI) scan report from Dr. Robert Rilling, a Board-certified diagnostic radiologist, noted no evidence of a rotator cuff tear. There was tendinosis, probably calcific, involving the supraspinatus and anterior fibers of the infraspinatus components of the rotator cuff, as well as degenerative acromioclavicular joint changes. A December 22, 2014 x-ray read by Dr. Sujan Fernando, a Board-certified diagnostic radiologist, revealed no fracture, mild glenohumeral joint degenerative changes, mild acromioclavicular joint arthrosis, and calcific tendinosis of the distal rotator cuff insertion.

Dr. Douros, in a December 22, 2014 progress note, advised that appellant was a letter carrier with a six-month history of right shoulder pain from sorting mail. Appellant described the activity of unloading mailboxes and sorting mail overhead as well as an overhand impingement-type motion to load mailboxes, which created and worsened pain. Dr. Douros advised that appellant related that he "never had trouble like this before." He indicated that appellant had no prior treatment. Dr. Douros noted that appellant liked to golf, but his condition

was affecting his golf game. He noted that appellant walked and biked as well. Dr. Douros advised that the pain was 10 out of 10 at its worst and could also be nonpainful at times. He related that appellant "feels that this is definitely related to his job, and from his description of his job, it sounds like that is something that is definitely a possibility." Dr. Douros examined appellant and found painful calcific right shoulder supraspinatus tendinitis with impingement.

On January 12, 2015 Dr. Douros noted that appellant was in for follow up of his right shoulder. He indicated that appellant hurt his shoulder about a month ago. Dr. Douros explained that appellant had some mild tendinosis and a little calcific tendinitis in his rotator cuff on MRI scan. He advised that appellant needed to try physical therapy before considering surgery. Dr. Douros continued to treat appellant and recommend physical therapy.

In a March 5, 2015 report, Dr. Ryan J. Kehoe, a Board-certified orthopedic surgeon, noted that appellant was seen for worsening right shoulder pain in the past couple of months. He indicated that there was "no specific antecedent trauma or injury, but he does quite a bit of repetitive right arm movements at work." Dr. Kehoe advised that the pain became quite debilitating in December 2014 and despite physical therapy appellant had not garnered much relief. He noted that MRI scan results revealed probable calcific tendinitis and acromioclavicular joint degenerative changes present with type 2 acromion and no rotator cuff tearing. Dr. Kehoe advised that his examination revealed shoulder range of motion fairly well maintained and diagnosed right shoulder impingement syndrome.

By decision dated March 26, 2015, OWCP denied appellant's claim. It found that the evidence did not establish a causal relationship between factors of federal employment and a diagnosed right shoulder condition. OWCP explained that the treating physicians did not provide supporting rationale or distinguish between work tasks and nonoccupational factors.

On April 16, 2015 counsel requested a telephonic hearing before an OWCP hearing representative, which was held on November 9, 2015. At the hearing, appellant described his duties as a letter carrier since 1990 that included delivering mail on a walking route. He explained that he initially delivered to big apartment buildings, sorted mail for about three hours per day, and delivered the balance of the day. Appellant also delivered mail to apartment mailbox banks, which involved reaching with his shoulder to place mail in slots up to seven feet off the floor. He explained that he made about 600 such deliveries daily. Appellant advised that he later changed in 1998 to a downtown route in Milwaukee, which also involved delivering mail to apartment buildings with large mail banks. He stated that he never had a right shoulder injury due to off-duty activity. Appellant pointed out his outside activities included playing golf in a league once per week. He also made minor repairs around the house and worked on his car from time to time. Appellant also noted that he used a posthole digger on one occasion in October 2014 to put up a light pole so his son could play outdoor hockey. He noted that he informed Dr. Pryba in December 2014 that his right arm bothered him due to work tasks and he also felt right arm pain at times when performing personal tasks.

In a March 25, 2015 report, Dr. Kehoe diagnosed calcific tendinitis on the right with acromioclavicular joint arthritis and advised that appellant was performing a calcific tendinitis evacuation, biceps tenotomy, and subacromial decompression. The right shoulder arthroscopic

surgery procedure was performed in March 30, 2015 by Dr. Kehoe. He continued to treat appellant and submit reports.

On April 24, 2015 Dr. Kehoe noted that appellant had recently undergone a right shoulder arthroscopy with subacromial decompression and distal clavicle excision, as well as an open biceps tenodesis for diagnosis of shoulder impingement, acromioclavicular joint arthritis, and superior labral tearing and biceps tendinitis. He explained that based upon his understanding of appellant's work over many years "[appellant] has been involved in repetitive lifting and reaching with the right arm; which would predispose him to chronic rotator cuff tendinitis with impingement, as well as acromioclavicular joint arthritis and additionally the increased likelihood of sustaining a superior labral tear." Dr. Kehoe opined that "[w]ith this in mind, [appellant's] right shoulder injuries in my opinion are more likely than not related to his repetitive work activities in a cumulative fashion." He advised that his opinion was within a reasonable degree of medical certainty based upon his treatment of appellant and a review of his medical history.

In a report of May 28, 2015, Dr. Kehoe released appellant to light-duty work effective June 8, 2015. OWCP also received physical therapy and physician assistant's notes.

By decision dated January 8, 2016, an OWCP hearing representative affirmed the March 26, 2015 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof 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 FECA, that the claim was timely filed within the applicable time limitation period of FECA, that an injury was sustained 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.[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]

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 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 causal relationship, generally, is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's

[3] *Joe D. Cameron*, 41 ECAB 153 (1989); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

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

rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[5]

ANALYSIS

Appellant alleged that he developed a right shoulder condition due to the repetitive work activities as a letter carrier. The evidence supports that he engaged in repetitive activities at work as part of his letter carrier duties. However, appellant submitted insufficient medical evidence to establish that his right shoulder condition was caused or aggravated by these activities or any other specific factors of his federal employment.

The evidence submitted by appellant includes December 17, 2014 reports from Dr. Pryba, who noted that appellant complained of arthritis-type pain in his right shoulder as well as other body joints. He indicated that appellant had a history of low grade pain that increased after a using posthole digger and working on his car. Dr. Pryba noted that appellant's job also involved lifting shoulder above chest level to sort mail. He diagnosed pain in the joint, shoulder region, rotator cuff disorder, and opined that appellant was unable to work. However, these reports are of limited probative value, as Dr. Pryba's report is equivocal and unclear. He attributes part of appellant's condition to activities outside work and also noted a history of prior shoulder pain without clearly explaining how the work activity caused or aggravated a right shoulder condition. The Board has held that unrationalized medical opinion is of limited probative value on causal relationship.[6]

On December 22, 2014 Dr. Douros advised that appellant was a letter carrier with a six-month history of right shoulder pain. He noted that appellant had pain from sorting the mail and noted appellant's description of work activities that created worsening pain. Dr. Douros advised that appellant related that he "never had trouble like this before." He related that appellant "feels that this is definitely related to his job, and from his description of his job, it sounds like that is something that is definitely a possibility." Dr. Douros diagnosed painful calcific tendinitis, supraspinatus, right shoulder with impingement and indicated that appellant could work with right arm restrictions. While he noted appellant's beliefs of causal relationship and opined that this was "definitely a possibility," Dr. Douros' opinion on causal relationship is, at best, couched in equivocal terms. Dr. Douros did not provide a reasoned opinion explaining why particular work activities caused or aggravated the diagnosed condition.[7] His opinion is of limited probative value.

[5] *Id.*

[6] *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).

[7] *Ricky S. Storms*, 52 ECAB 349 (2001) (while the opinion of a physician supporting causal relationship need not be one of absolute medical certainty, the opinion must not be speculative or equivocal; the opinion should be expressed in terms of a reasonable degree of medical certainty).

In a March 5, 2015 report, Dr. Kehoe noted that appellant was seen for worsening right shoulder pain in the past couple of months. He indicated that there was "no specific antecedent trauma or injury, but he does quite a bit of repetitive right arm movements at work." On April 24, 2015 Dr. Kehoe noted appellant's recent right shoulder surgery and explained that based upon his understanding of appellant's work over the last many years, "[appellant] has been involved in repetitive lifting and reaching with the right arm; which would predispose him to chronic rotator cuff tendinitis with impingement, as well as acromioclavicular joint arthritis and additionally the increased likelihood of sustaining a superior labral tear." He opined that "[w]ith this in mind, [appellant's] right shoulder injuries in my opinion are more likely than not related to his repetitive work activities in a cumulative fashion." Dr. Kehoe advised that his opinion was based upon his treatment of appellant and a review of his medical history. However, while he supported causal relationship, it is unclear how he arrived at this conclusion. Dr. Kehoe did not appear to be aware of appellant's outside activities such as using a posthole digger, which Dr. Pryba indicated caused increased shoulder pain in 2014, as well as golfing and working on his car.[8] He did not otherwise explain how he determined that work activities caused or aggravated his right shoulder condition. The need for medical rationale on causal relationship is particularly important as there appear to be nonwork factors that may have affected appellant's condition.

In a December 18, 2014 report, Dr. Rilling indicated that there was no rotator cuff tear. He did find tendinitis and evidence of degenerative changes acromioclavicular joint changes. In a December 22, 2014 x-ray read, Dr. Fernando revealed no fracture and mild glenohumeral joint changes. Neither diagnostic physician offered any rationale relative to causal relationship. As such their reports are of diminished probative value.

Other medical reports of record are of limited probative value as they do not address causal relationship.[9] OWCP also received notes from physical therapists and physician assistants. Health care providers such as nurses, acupuncturists, physician assistants, and physical therapists are not physicians under FECA. Thus, their opinions on causal relationship and have no probative medical value.[10]

Appellant has described his job duties with a degree of specificity relative to his over-the-shoulder work, including how he performs his job tasks daily in large apartment buildings. However, the medical evidence of record does not describe the pathophysiology nexus between his daily work duties and the medical relationship of his upper extremity complaints.

The Board has held that the mere fact that a condition manifests itself during a period of employment does not raise an inference that there is a causal relationship between the two.[11] Neither the fact that the condition became apparent during a period of employment nor the belief

[8] *See Leonard J. O'Keefe*, 14 ECAB 42, 48 (1962) (where the Board held that medical opinions based upon an incomplete history have little probative value).

[9] *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

[10] *Jane A. White*, 34 ECAB 515, 518 (1983). *See* 5 U.S.C. § 8101(2).

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

that the condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[12]

As there is no reasoned medical evidence explaining how appellant's employment duties caused or aggravated a medical condition involving his knees, he has not met his burden of proof in establishing that he sustained a medical condition causally related to factors of his employment.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish an injury causally related to factors of his federal employment.

ORDER

IT IS HEREBY ORDERED THAT the January 8, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 12, 2016
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

[12] *Id.*