United States Department of Labor
Employees' Compensation Appeals Board

C.K., Appellant	)	
and	)	**Docket No. 16-1623**
	)	**Issued: February 14, 2017**
DEPARTMENT OF VETERANS AFFAIRS, LOUIS STOKES CLEVELAND MEDICAL CENTER, Cleveland, OH, 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
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 9, 2016 appellant, through counsel, filed a timely appeal of a June 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.

[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.*

ISSUE

The issue is whether appellant has met her burden of proof to establish an occupational disease in the performance of duty.

FACTUAL HISTORY

On November 10, 2014, appellant then a 53-year-old part-time podiatrist, filed an occupational disease claim (Form CA-2) alleging that her work duties aggravated her previous nonwork-related right knee replacement. She became aware of her condition and realized it was causally related to her employment on March 17, 2014. Appellant did not stop work.

The employing establishment submitted a summary of a teleconference held on July 15, 2014, to assess appellant's reasonable accommodation request. A regional reasonable accommodations coordinator for the employing establishment, noted that the functional limitation of her knees limited her ability to arise from a seated position and potentially to ambulate longer distances. The employing establishment submitted a podiatric medicine privileges form dated November 19, 2014 in which appellant's work duties were described. An e-mail from Dr. Barbara A. Yeager, podiatry manager, dated December 4, 2014, noted appellant's work duties included rising from her desk and walking to the waiting room to notify her patients to report to the podiatry room, adjusting the podiatry chair for patients, removing and replacing shoes and socks of patients, sitting in a stool to provide treatment, obtaining instruments to work on the patient, standing to apply dressings, and walking to retrieve medication from the Pyxis machine.

Appellant was treated by Dr. Raymond Horwood, a Board-certified orthopedist, on November 20, 2014, for chronic knee pain postarthroplasty with significant limitations in walking, squatting, and stair climbing. Dr. Horwood indicated that she required accommodation because she was unable to perform the normal required physical demands of her job. In a November 20, 2014 work restriction note, he returned appellant to modified duty. In reports dated December 16 and 17, 2014, Dr. Horwood diagnosed persistent instability status post right knee replacement for degenerative joint disease. He noted that appellant had persistent and slowly increasing instability related to anterior cruciate insufficiency and hyperextension. Dr. Horwood indicated that she was able to perform the essential functions of her job as a podiatrist while adhering to restrictions documented on November 20, 2014. He noted that the restrictions were also based on a June 25, 2014 functional capacity evaluation (FCE). Dr. Horwood recommended that appellant avoid flexion and extension activity, sitting to standing position, and stair climbing. A June 25, 2014 FCE placed her in the sedentary physical demand level.

Appellant submitted an earlier treatment note from Dr. Bernard N. Stulberg, a Board-certified orthopedist, from September 26, 2014, for the right knee condition. Dr. Stulberg noted that her right knee condition was an existing problem and conservative management was unsuccessful. Appellant reported that her symptoms persisted and were directly related to her knee joint problems. She became more symptomatic with stairs, standing, and getting up from a seated position. Examination revealed antalgic gait to the right. The right knee had minimal patellofemoral crepitus and unstable ligament structures medially and with flexion. Dr. Stulberg

noted x-rays revealed a well-aligned right total knee replacement. He diagnosed persistent pain and findings suggestive of mid-flexion instability, cruciate-retaining knee implant, and status post right total knee replacement. Dr. Stulberg recommended bracing and strengthening.[3]

By letter dated January 7, 2015, OWCP advised appellant of the type of evidence needed to establish her claim, particularly requesting that she submit a physician's reasoned opinion addressing the relationship of her claimed condition to her specific employment factors. It also advised that the evidence was insufficient to establish that she actually experienced the employment factors alleged to have caused her injury.

Appellant submitted a January 15, 2015 physical capacities form from Dr. Stulberg who noted that she could work with temporary restrictions due to her right knee condition. In a report dated January 21, 2015, Dr. Stulberg sought authorization to proceed with follow-up surgery due to persistent pain following a total knee arthroplasty. He explained that appellant's posterior cruciate ligament was not functioning properly and, as a result, her left knee was unstable in mid-range positions which made it difficult for her to get up from a seated position, go down stairs, and do flexion and extension activities.

In a January 16, 2015 work capacity report, Dr. A.J. Cianflacco, a Board-certified orthopedist, treated appellant for a right shoulder condition. In a certificate of health care provider form dated January 22, 2015, he treated her in December 2014 for a rotator cuff tear of the dominant right shoulder. Dr. Cianflacco advised that appellant was unable to perform her clinical responsibilities as a podiatrist, but could return to work and perform administrative duties. In a February 17, 2015 report, he indicated that she could return to work with restrictions for her right shoulder.

In a decision dated February 19, 2015, OWCP denied appellant's claim as the evidence of record did not support that the injury or events occurred as alleged. It indicated that she had failed to respond to the January 7, 2015 development letter, which sought to clarify the specific work duties performed, which aggravated her condition, and how often she performed such activities.

On March 2, 2015 appellant requested an oral hearing before an OWCP hearing representative which was held on September 17, 2015. At the hearing, she indicated that her work duties included sitting, standing, getting on and off of a stool as she went from patient to patient, and performing minor surgeries. Appellant advised that she had a right total knee replacement on December 2, 2013.

Appellant also submitted medical evidence. Reports from Dr. Cianflacco dated December 10, 2014 to January 16, 2015 reflected treatment for a right shoulder rotator cuff tear, reiterated that she was unable to perform her clinical duties, and requested that she be

[3] On December 18, 2014 the employing establishment offered appellant a temporary modified assignment as a podiatrist effective November 20, 2014. It noted that the position was in accordance with the work restrictions provided by Dr. Horwood on November 20, 2014. On December 29, 2014 appellant declined the job offer and noted that she had sustained a new injury at work on December 2, 2014 secondary to repetitive stress placed on her right shoulder as she moved from a sitting to a standing position when treating patients,

temporarily reassigned to administrative duties. In a January 16, 2015 physical capacities form, Dr. Cianflacco again returned appellant to work with temporary restrictions.

Appellant submitted previous April 30 and May 14, 2014 medical reports from Dr. Horwood, which diagnosed recurrent pain post right knee replacement. Dr. Horwood noted that she had full weight bearing ambulation, no crepitus, effusion, erythema, and intact motor strength and sensation. Appellant had residual discomfort and symptoms from reflex sympathetic dystrophy (RSD). Her symptoms were worse when working in her clinic when sitting and standing while taking care of her patients. When appellant fully flexed, this caused and stimulated the RSD pain pattern. Right knee x-rays revealed the knee replacement to be well aligned, well seated, and of the appropriate size. Dr. Horwood diagnosed osteoarthritis of the right lower leg and ankylosis of the joint in the lower leg.

In reports dated May 21 and June 9, 2014, Dr. Horwood noted that appellant had undergone a right total knee arthroplasty and had ongoing significant pain that limited her ability to carry out her job. Appellant reported significant difficulty with prolonged sitting at low levels, stair climbing, and prolonged standing. Dr. Horwood noted that her impairment was due to the pain in her knee, difficulty sitting, prolonged standing, pushing, and pulling. In a July 16, 2014 report, appellant reported having a difficult time while at work as she had to get up and down. Dr. Horwood recommended that she take time off work. In an October 31, 2014 report, he noted that appellant was 11 months status post knee arthroplasty, but continued to have significant problems with her knees, including stair climbing and flexion activities and hyperextension sensation. Dr. Horwood diagnosed osteoarthritis.

Appellant also submitted a report from by Dr. Elizabeth Mease, a Board-certified physiatrist, dated November 7, 2014. Dr. Mease noted that appellant's history was significant for right knee arthroscopic posterior lateral meniscectomy in 1988, a right knee total arthroplasty in 2013, and a right knee manipulation in February 2014. Appellant reported returning to work on March 17, 2014 and repetitively sitting and standing during the day causing increased right knee pain. Dr. Mease indicated that appellant wore a double hinged knee brace to prevent instability in the right knee, otherwise her knee would buckle. She noted findings of an anterior scar on the right knee and mild effusion with moderate warmth. Dr. Mease diagnosed right knee pain aggravated by repetitive up and down and ambulating activities, in addition to chronic right knee inflammation which could be related, in part, to a failed right knee implant. She opined that repetitive use of the right knee was contributing to exacerbation of inflammation of the right knee. Dr. Mease recommended sedentary duties until appellant's symptoms resolved and opined that she likely required repeat surgery for a failed knee implant. In a report dated January 6, 2015, she provided a history of appellant's treatment for right shoulder and right knee conditions. Dr. Mease diagnosed right shoulder supraspinatus tendinitis and partial tear, and opined that the partial tear was causally related to the employment incident on December 2, 2014.

A right shoulder magnetic resonance imaging scan dated December 13, 2014 revealed supraspinatus tendinosis with partial tear, mild glenohumeral osteoarthritis, and subdeltoid bursitis.

In a December 8, 2015 decision, an OWCP hearing representative affirmed the February 19, 2015 decision.

On March 11, 2016 appellant requested reconsideration. She submitted an undated statement from Dr. Stulberg who indicated that the initial knee arthroplasty was properly positioned, but she developed increasing instability that required revision of a portion of the knee arthroplasty on May 1, 2014. Dr. Stulberg opined that it was probable that appellant's work activities contributed to her progressive instability requiring revision arthroplasty.

In a February 3, 2016 report, Dr. Horwood noted evaluating appellant on December 3, 2013 for right knee pain caused by a sports-related injury to her right knee in the 1980's. He noted x-ray's revealed severe degenerative arthritis of the right knee and recalled that on December 2, 2013 she underwent a total knee arthroplasty. Dr. Horwood indicated that postoperative stiffness with limited range of motion was noted and appellant underwent a manipulation of the knee on February 12, 2014. He opined that due to her employment duties over the past years she had significant exacerbation of her prior condition, including post-traumatic degenerative arthritis of the right knee due to her employment demands, which resulted in the need for the knee arthroplasty at a young age and the subsequent manipulation.

In a decision dated June 8, 2016, OWCP denied modification of the December 8, 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. When an employee claims that he or she sustained an injury in the performance of duty, he or she must submit sufficient evidence to establish a specific event, incident, or exposure occurring at the time, place, and in the manner alleged. Appellant must also establish that such event, incident, or exposure caused an injury.[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.[5] To establish fact of injury in 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.[6]

An employee's statement that an injury occurred at a given time and in a given manner is of great probative value and will stand unless refuted by strong or persuasive evidence.[7] Moreover, an injury does not have to be confirmed by eyewitnesses. The employee's statement,

[4] *See Walter D. Morehead*, 31 ECAB 188, 194 (1979) (occupational disease or illness); *Max Haber*, 19 ECAB 243, 247 (1967) (traumatic injury). *See generally John J. Carlone*, 41 ECAB 354 (1989); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[5] *S.P.*, 59 ECAB 184, 188 (2007).

[6] *R.R.*, Docket No. 08-2010 (issued April 3, 2009); *Roy L. Humphrey*, 57 ECAB 238, 241 (2005).

[7] *R.T.*, Docket No. 08-0408 (issued December 16, 2008); *Gregory J. Reser*, 57 ECAB 277 (2005).

however, must be consistent with the surrounding facts and circumstances and her subsequent course of action. An employee has not met her burden of proof to establish the occurrence of an injury when there are such inconsistencies in the evidence as to cast serious doubt upon the validity of the claim. Circumstances such as late notification of injury, lack of confirmation of injury, continuing to work without apparent difficulty following the alleged injury, and failure to obtain medical treatment may, if otherwise unexplained, cast doubt on an employee's statement in determining whether a *prima facie* case has been established.[8]

The medical evidence required to establish causal relationship is generally rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's 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.[9]

ANALYSIS

OWCP denied appellant's claim because she failed to establish the employment factors as alleged. In the present case, the evidence of record supports that appellant's duties as a podiatrist involved repetitively sitting, standing, and ambulating while performing her work duties. There is no dispute that she was actually doing the job of a podiatrist during the period in which she alleges an injury. Specifically, a December 4, 2014 statement from Dr. Yeager, podiatry manager, noted that appellant's work duties included repetitively rising from her desk and walking to the waiting room to notify her patients to report to the podiatry room, adjusting the podiatry chair for patients, removing and replacing shoes and socks of patients, sitting on a stool to provide treatment, obtaining instruments to work on patients, standing to apply dressings, and walking to retrieve medication from the Pyxis machine. Also, at her September 17, 2015 hearing, appellant indicated that her work duties included sitting, standing, and getting on and off of a stool as she went from patient to patient. The Board finds that the evidence is undisputed that her work duties included repetitively sitting, standing, and ambulating.

The Board finds that there is no medical evidence of record which establishes that the accepted repetitive work duties of appellant's federal employment caused or aggravated her claimed conditions.

Appellant submitted reports from dated April 30 to May 14, 2014. Dr. Horwood noted that she had residual discomfort and symptoms from RSD status post right knee replacement on February 12, 2014. He diagnosed osteoarthritis of the lower leg and ankyloses of the joint in the lower leg. Dr. Horwood indicated that appellant's symptoms were worse when she worked in her clinic and was up and down taking care of patients, which was possibly due to hitting full flexion and causing irritation which stimulated an RSD pain pattern. In reports dated May 21

[8] *Betty J. Smith*, 54 ECAB 174 (2002).

[9] *Solomon Polen*, 51 ECAB 341 (2000).

and December 17, 2014, Dr. Horwood noted that she had experienced chronic knee pain postarthroplasty and reported significant difficulty with prolonged sitting at low levels, stair climbing, and prolonged standing, pushing, and pulling which has plagued her ability to carry out her job. He noted that appellant's impairment was due to the pain in her knee, difficulty sitting, and prolonged standing. In a February 3, 2016 report, Dr. Horwood opined that based on her employment duties over the past years, she developed significant exacerbation of her prior condition and post-traumatic degenerative arthritis of the right knee, which resulted in the need for the knee arthroplasty at a young age and subsequent manipulation. The Board finds that, although he supported causal relationship, he did not provide medical rationale explaining the basis of his conclusory opinion that appellant's osteoarthritis of the lower leg, ankyloses of the joint, and RSD were due to the factors of employment.[10] Dr. Horwood did not explain the process by which prolonged sitting, standing, and ambulating caused or aggravated the diagnosed conditions.[11] Therefore, these reports are insufficient to meet appellant's burden of proof.

An undated report from Dr. Stulberg noted that appellant developed increasing instability of her knee status post right knee arthroplasty. Dr. Stulberg opined that was it probable that her work activities contributed to her progressive instability requiring revision arthroplasty. The Board notes that his report provides some support for causal relationship, but is insufficient to establish the claimed conditions are causally related to his employment duties. Dr. Stulberg's report, at best, provides speculative support for causal relationship as he noted that it was "probable" that appellant's work duties contributed to her right knee instability and additional surgery.[12] He provided no medical reasoning explaining how the particular workplace conditions caused or aggravated the diagnosed conditions. Other reports from Dr. Stulberg are insufficient to establish the claim as he did not specifically address whether appellant's employment activities had caused or aggravated a diagnosed medical condition.[13]

The report from Dr. Mease dated November 7, 2014 diagnosed right knee pain aggravated by repetitive up and down activities, ambulating, chronic inflammation of the right knee, and unstable right knee implant. Dr. Mease reported repetitive sitting and standing during the day and the physician opined that repetitive use of the right knee was contributing to exacerbation or inflammation of the right knee. Although Dr. Mease provides some support for causal relationship, the medical report is of limited probative value because it contains a conclusion regarding causal relationship which is unsupported by medical rationale.[14] She did

[10] *See T.M.*, Docket No. 08-0975 (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).

[11] *Id.*

[12] *See D.D.*, 57 ECAB 734 (2006) (medical opinions that are speculative or equivocal in character are of diminished probative value).

[13] *S.E.*, Docket No. 08-2214 (issued May 6, 2009) (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] *See supra* note 10.

not explain the process by which particular work activities would cause or aggravate a diagnosed medical condition.

The remainder of the medical evidence is of limited probative value as it fails to provide an opinion on the causal relationship between appellant's employment factors and her diagnosed conditions.[15] For these reasons, this evidence is insufficient to meet her burden of proof.

On appeal, counsel disagrees with OWCP's denial of appellant's claim for compensation and asserts that she submitted sufficient evidence to establish her claim. As noted above, the medical evidence of record establishes a medical condition, but does not establish that her diagnosed conditions are causally related to her 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 did not meet her burden of proof to establish an occupational disease in the performance of duty.

[15] *See supra* note 13.

ORDER

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

Issued: February 14, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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