United States Department of Labor
Employees' Compensation Appeals Board

S.A., Appellant	)	
and	)	**Docket No. 16-1128**
	)	**Issued: November 24, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Denver, CO, Employer	)	

Appearances:
John S. Evangelisti, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On May 6, 2016 appellant, through counsel, filed a timely appeal from a November 30, 2015 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 to consider the merits of this case.

ISSUE

The issue is whether appellant has met her burden of proof to establish an occupational disease causally related to factors of her 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 July 1, 2014 appellant then a 54-year-old supervisor, filed an occupational disease claim (Form CA-2) alleging that she developed left plantar fasciitis, right soleus rupture, and right ankle tendinitis as a result of prolonged walking, bending, and squatting required in her job. She first became aware of her condition on January 15, 2013 and realized that it was causally related to her federal employment on March 11, 2014. Appellant was last exposed to the conditions alleged to have caused her illness on March 11, 2013. She was terminated on June 4, 2013.[3]

In an undated statement, appellant indicated that a Dr. Anthony Valenti, a podiatrist, had performed right foot surgery 10 years prior. She noted that Dr. Valenti had diagnosed heel spur and plantar fasciitis and indicated that it was caused by prolonged standing and walking at work. On March 11, 2013 appellant reported stepping onto a sidewalk with her right foot and felt a pop and extreme right leg pain. She also attributed right hip pain to her work.

On July 18, 2014 OWCP advised appellant of the type of evidence needed to establish her claim, particularly a physician's reasoned opinion addressing the relationship between her claimed condition and specific work factors.

Appellant was treated by Dr. Valenti on January 15, 2013 for a one-month history of left heel pain. Dr. Valenti noted pain on palpation of the central band of the plantar fascia at the insertion to the calcaneus on the left foot. He noted that x-rays revealed significant medial spurring and he diagnosed left heel spur and plantar fasci. Dr. Valenti injected the left foot with lidocaine and applied a low dye strapping. On February 21, 2013 he again treated appellant for left heel pain. Dr. Valenti noted her plantar fasciitis was a direct result of standing on her feet at work for an extended period. He advised that appellant was currently in a removable cast and returned her to sedentary work. In reports dated March 7 and 28, and April 10, 2013, appellant presented for follow up of plantar fasciitis of the left foot. She had pain on palpation of the central band of the plantar fascia. Dr. Valenti noted a possible oblique fracture to the base of the fifth metatarsal. He advised an injection and orthotics.

On March 11, 2013 appellant complained of a pop associated with the right leg just distal to the knee which occurred while walking through a parking lot. Dr. Valenti found appellant disabled from work for one week. On May 22, 2013 he treated her for a previous right soleus rupture. Dr. Valenti noted pain on palpation of the central band of the left plantar fascia and diagnosed plantar fasci and tendinitis.

On June 5, July 3, and August 23, 2013 appellant continued treatment for left foot plantar fasciitis. He reported improvement, but was unable to tolerate walking. Dr. Valenti diagnosed plantar fasci and tendinitis. On July 26, 2013 appellant performed a left plantar fasciotomy. In reports dated August 9 and 23, and September 6 and 27, 2013, Dr. Valenti noted that appellant

[3] On May 15, 2013 appellant filed a traumatic injury claim under OWCP File No. xxxxxx537 alleging that on March 11, 2013 she felt something snap in her right leg while stepping up to a sidewalk. By decision dated July 2, 2013, OWCP denied the claim as causal relationship had not been established. By decision dated July 29, 2014, it denied modification of the July 2, 2013 decision.

reported slow postsurgical improvement. He noted findings of pain on palpation of the medial band of the plantar fascia which appeared to be a retracted area of the tendon. Dr. Valenti diagnosed plantar fasci and tendinitis. January 16 and February 11, March 4, and June 6, 2014 reports related that appellant had pain and swelling associated with the plantar medial aspect of the left ankle. Dr. Valenti noted findings and diagnosed plantar fasci and tendinitis. Dr. Valenti again administered an injection of lidocaine and applied a low dye strapping to her left foot. He indicated that he had no new treatment options and he opined that appellant could have multiple sclerosis.

On March 19, 2013 Dr. Cydney West, an osteopath, saw appellant for right hip pain. Appellant reported having low grade hip pain two years ago on the outside of the leg. She noted undergoing a prior iliotibial band surgery. Dr. West noted findings of right hip tenderness and pain over the lateral upper leg on palpation. She diagnosed hip pain and band friction syndrome. Dr. West recommended physical therapy.[4]

In a January 28, 2014 report, Dr. Jennifer O. Kubista, a Board-certified family practitioner, treated appellant for right knee pain. She noted laxity in the bilateral anterior cruciate ligaments. Dr. Kubista diagnosed knee pain, overuse injury, and arthritis. She referred appellant to an orthopedist.

On March 6, 2014 appellant was treated by Dr. Douglas Redosh, a Board-certified neurologist to whom she was referred by Dr. Valenti, for left foot pain. She reported rupturing her soleus muscle on the right side after being placed in a cast for left foot pain fracturing a left metatarsal bone and having had a plantar fasciotomy on July 1, 2013. Dr. Redosh noted findings of a mildly obese female, decreased sensation to pinprick in a patchy fashion below the left knee, decreased vibration sense in the left toe, and antalgic gait. He noted an electromyogram (EMG) was normal and diagnosed left leg pain. On April 3, 2014 appellant reported significant left foot pain. Dr. Redosh noted that a cervical spine magnetic resonance imaging (MRI) scan showed early cervical spondylosis at C5-6 and a thoracic spine MRI scan was normal.[5] He noted pain in both legs with an antalgic gait. Dr. Redosh noted diagnostic testing failed to reveal any abnormalities to explain her symptoms and diagnosed likely neuropathic pain. He recommended a brain MRI scan to rule out any infectious, autoimmune, compressive etiologies of myelopathy, including multiple sclerosis.

On June 26, 2014 appellant was treated by Dr. Jack L. Rook, a Board-certified physiatrist, for bilateral foot, right calf, and right hip pain. Dr. Rook noted that appellant's work required prolonged walking, standing, and pushing and pulling mail containers. Appellant had an antalgic gait as well as exquisite tenderness of the right greater trochanteric bursa. She also had severe tenderness of the plantar fascia, left and right Achilles bursa and tendon, and soleus muscle/posterior calf on the right side. Dr. Rook diagnosed greater trochanteric bursitis, status post rupture of the right soleus muscle with chronic myofascial pain, pain related to scar tissue formation, bilateral Achilles tendinitis and bursitis, bilateral plantar fasciitis, and strain of the metatarsal phalangeal joints of the great toe, second toe, and third toe on the right. He opined

[4] The record indicates that appellant underwent physical therapy from March 14 to April 4, 2013.

[5] An April 10, 2014 cervical spine MRI scan revealed early cervical spondylosis at C5-6.

that, based upon appellant's history and a review of her medical records, she had developed an occupational disease involving her right hip approximately nine years earlier, an occupational disease involving her left foot in December 2013, and an acute occupational injury of her right calf on March 11, 2013. Dr. Rook noted that appellant was wearing a left leg surgical boot and had to excessively contract the right calf muscles to get her left leg over the curb to enter her workplace and ruptured her right soleus muscle. He believed the soleus rupture was an acute injury that was related to the left foot injury. Dr. Rook opined that appellant's right great toe pain and right hip pain probably resulted from altered weight bearing, and that all of her current right leg problems were indirectly related to the left foot occupational disease.

For the right hip condition, Dr. Rook noted that appellant first had right hip pain at work performing job duties which included prolonged standing, and pushing and pulling of heavy mail containers. He indicated that the right hip condition was aggravated because of the alteration of appellant's gait which required her to bear most of her weight on her right leg. The altered weight-bearing resulted in excessive contraction of thigh musculature, repetitive irritation of that structure and inflammation with the severe pain. For the left plantar fasciitis, appellant first noted pain on the bottom of her left foot while she was at work engaging in prolonged standing and walking which progressively worsened as the holiday season progressed. Dr. Rook indicated that plantar fasciitis occurs when the longitudinal arch collapses causing stretching of the ligamentous tissue which can lead to inflammation along the fascia at the metatarsal heads and the heel. Appellant's job required standing on a hard floor all day long, walking on a hard floor, carrying heavy boxes while walking on a hard floor and forcefully pushing and pulling heavy objects. Dr. Rook opined that it is more than likely that the plantar fasciitis in her left foot was caused by the activities required of her job. He found that the right soleus muscle ruptured while contracting in an effort to raise appellant's body over the curb, and to allow her left foot (which had on a surgical boot) to clear the curb. The excessive contraction then precipitated the muscle rupture. Dr. Rook further opined that the right foot condition developed because of the increased weight bearing of her right leg to compensate for the painful left plantar fasciitis condition. He indicated that prolonged weight-bearing activities required in appellant's job contributed to the development of plantar fasciitis, Achilles bursitis, and tendinitis on the right side. Dr. Rook found that appellant had no traumatic events outside of work.

In a January 30, 2015 decision, OWCP denied appellant's claim finding that she had failed to establish that her claimed medical condition was causally related to the established work factors.

On February 15, 2015 appellant requested an oral hearing which was held on September 17, 2015. She also submitted additional medical evidence.

Appellant was treated by Dr. Redosh on March 7 and April 3, 2014 for left foot pain. Dr. Redosh restated appellant's history and diagnosed left lower extremity pain, likely neuropathic pain. On August 4, 2014 he noted her EMG was normal and her recent cervical and thoracic spine MRI scans did not show abnormalities to explain her symptoms. Dr. Redosh diagnosed idiopathic painful neuropathy in her left foot and recommended that appellant continue on her current medical regimen.

Appellant was seen by Dr. Valenti on July 11, July 28, and August 14, and December 9, 2014 for a swollen right foot. Right foot x-rays revealed excellent osseous fixation position. Dr. Valenti diagnosed right second metatarsal fracture, ganglion cyst, plantar fasci, and tendinitis and placed appellant in a removable cast. On December 31, 2014 he saw appellant in follow up for a stress fracture of the left second metatarsal. Dr. Valenti diagnosed metatarsal fracture, ganglion cyst, plantar fasciitis, and tendinitis. On January 21, February 11, and June 10, 2015, he reiterated appellant's diagnoses and recommended she continue to transition back to regular shoes and avoid overuse of the right foot. On June 23, 2015 Dr. Valenti treated appellant in follow up for neuritis of the right second digit. Appellant reported total relief from an injection on June 10, 2015. Dr. Valenti diagnosed neuritis, arthritis of the joint, metatarsal fracture, ganglion cyst, plantar fasciitis, and tendinitis and discharged appellant from his care. On August 19, 2015 he noted treating her since December 2012 for foot pain. Dr. Valenti initiated a change in appellant's medications to control her neuropathic pain.

Appellant was treated by Dr. Brian D. Shannon, a Board-certified orthopedist, on April 23 and May 7, 2014, for right hip pain. Dr. Shannon noted that appellant had a trochanteric bursa excised eight years prior. He noted point tenderness over the greater trochanter, pain with resisted hip abduction, and intact sensation. Dr. Shannon indicated that the trochanteric bursitis was refractory to physical therapy and he recommended a corticosteroid injection. On July 2 and August 1, 2014 he noted that appellant had significant hip pain that was refractory to conservative measures and recommended surgery.[6] On August 12, 2014 Dr. Shannon performed a right hip trochanteric bursa excision and diagnosed right hip trochanteric bursitis. On August 20, 2014 he treated appellant in follow up and noted that appellant was doing well and ambulating without assistive devices. Dr. Shannon noted mild swelling, no erythema, and a healed incision. He recommended that appellant advance her activities as tolerated.

Appellant submitted a March 5, 2015 report from Dr. Rook, who reviewed his June 26, 2014 evaluation. Dr. Rook opined that, based upon reasonable medical probability, appellant's right hip condition, left plantar fasciitis, and right soleus muscle rupture were work-related conditions. On April 27, 2015 he reiterated that her diagnosed conditions were employment related.

Appellant also provided treatment records from a physician assistant who diagnosed neuropathy and major depressive disorder.

In a decision dated November 30, 2015, an OWCP hearing representative affirmed the January 3, 2015 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[7] has the burden of proof to establish the essential elements of his or her claim. When an employee claims an injury in the performance of

[6] A July 30, 2014 right hip MRI scan revealed no acute or focal abnormality and possible surgical repair of the gluteus medius syndrome at the right hip.

[7] *Supra* note 2.

duty, the employee must submit sufficient evidence to establish that he experienced a specific event, incident or exposure occurring at the time, place, and in the manner alleged. The employee must also establish that such event, incident or exposure caused an injury.[8]

Whether an employee actually sustained an injury in the performance of duty begins with an analysis of whether fact of injury has been established.[9] 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.[10]

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 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.[11]

ANALYSIS

It is undisputed that appellant's duties as a supervisor included walking, bending, and squatting. However, she failed to submit sufficient medical evidence to establish that her diagnosed medical conditions were causally related to the specific accepted factors of her federal employment.

Appellant submitted a June 26, 2014 report from Dr. Rook who noted appellant's work duties and her examination findings. Dr. Rook opined that, based upon appellant's history and her medical records, she developed an occupational right hip condition nine years earlier, a left foot occupational disease in December 2013, and an acute occupational injury of her right calf on March 11, 2013. He noted that she was wearing a left leg surgical boot and had to excessively contract the right calf muscles to get her left leg over the curb to enter her workplace and ruptured her right soleus muscle. Dr. Rook believed the soleus rupture was an acute injury that was related to the left foot injury. He opined that all of the current problems with appellant's right lower extremity were indirectly related to the left foot occupational disease. Dr. Rook indicated that she first had right hip pain at the post office performing job duties which included

[8] *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).

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

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

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

prolonged standing and pushing and pulling of heavy containers. He noted that appellant first reported left foot pain while she was at work engaging in prolonged standing and walking which progressively worsened during the holiday season. Dr. Rook advised that plantar fasciitis occurs when the longitudinal arch collapses due to prolonged standing on a hard floor, being on one's feet all day long, walking on a hard floor, carrying heavy boxes while walking on a hard floor and forcefully pushing and pulling heavy objects. He opined that it was more than likely that the plantar fasciitis in her left foot was caused by the activities required of her job at the post office. Dr. Rook indicated that prolonged weight-bearing activities contributed to the development of plantar fasciitis, Achilles bursitis, and tendinitis on the right. On March 5, 2015 and April 27, 2015 he reiterated that appellant's conditions were employment related.

Although Dr. Rook supported causal relationship, he provided only general and speculative reasoning regarding how work factors caused the diagnosed conditions. He indicated that the left foot condition largely led to all of the other diagnosed conditions, but in doing so offered equivocal support for causal relationship noting that prolonged standing can lead to inflammation along the fascia at the metatarsal heads.[12] Dr. Rook also supported his conclusion on causal relationship of the diagnosed conditions by noting that appellant had no traumatic events outside of work. However, the Board has held that the fact that a condition manifests itself during a period of employment alone does not raise an inference that there is a causal relationship between the two.[13] Dr. Rook also did not have a complete understanding of appellant's history as he did not address other possible causes of appellant's condition as noted by other physicians.[14] Therefore, these reports are of limited probative value and insufficient to meet appellant's burden of proof.

Appellant submitted a February 21, 2013 report from Dr. Valenti who treated her for left heel pain. Dr. Valenti noted appellant's plantar fasciitis was a direct result of prolonged standing at work. He indicated that she was currently in a removable cast and required a sitting job. Although Dr. Valenti supported causal relationship, he did not provide medical rationale explaining the basis of his conclusory opinion regarding the causal relationship.[15] He did not explain the process by which standing for an extended period of time at work would cause or aggravate the diagnosed conditions. This report is thus insufficient to establish appellant's claim. Other reports from Dr. Valenti are also insufficient to establish the claim as he did not

[12] *See Leonard J. O'Keefe*, 14 ECAB 42, 48 (1962) (where the Board held that medical opinions based upon an incomplete history or which are speculative or equivocal in character have little probative value).

[13] *L.D.*, Docket No. 09-1503 (issued April 15, 2010).

[14] Dr. Valenti on June 6, 2014 indicated that he identified no new treatment options and opined that appellant could have multiple sclerosis. Dr. Redosh on March 6, 2014 suggested a brain MRI scan to rule out any infectious, autoimmune, compressive etiologies of myelopathy, including multiple sclerosis. *See supra* note 10.

[15] *See T.M.*, Docket No. 08-975 (issued February 6, 2009) (a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

provide an opinion on the causal relationship between appellant's work factors and her diagnosed conditions.[16]

Appellant submitted reports from Dr. Redosh dated March 6 to April 3, 2014, who treated her for left foot pain since 2012. Dr. Redosh noted that appellant was placed in a cast and ruptured her soleus muscle on the right side and fractured her metatarsal bone on the left foot. Appellant underwent a plantar fasciotomy in July 2013. On August 4, 2014 Dr. Redosh noted that diagnostic studies failed to show abnormalities to explain her symptoms. He diagnosed idiopathic painful neuropathy in her left foot and recommended appellant continue on current medical regimen. Dr. Redosh's reports are insufficient to establish the claim as he did not provide a history of injury[17] or specifically address whether the accepted work duties caused or aggravated a diagnosed medical condition.[18]

Similarly, reports from other physicians, such as Drs. West, Kubista, and Shannon, as well as reports of diagnostic testing, are of limited probative value and insufficient to establish the claim as these reports do not contain a physician's opinion specifically addressing whether appellant's work duties had caused or aggravated a diagnosed medical condition.[19]

Appellant also submitted reports from a physician assistant and a physical therapist. The Board has held that treatment notes signed by physician assistants or physical therapists have no probative value as these providers are not considered physicians under FECA.[20]

An award of compensation may not be based on surmise, conjecture, or speculation. Neither the fact that appellant's condition became apparent during a period of employment nor the belief that her condition was caused, precipitated, or aggravated by her employment is sufficient to establish causal relationship. Causal relationship must be established by rationalized medical opinion evidence.[21] Appellant failed to submit such evidence and OWCP therefore properly denied appellant's claim for compensation.

On appeal appellant, through counsel, disagrees with OWCP's decision denying her claim for compensation and noted that she submitted sufficient evidence to establish her claim. As noted above, the Board finds the medical evidence insufficient to establish that appellant's diagnosed conditions are causally related to her employment. Reports from her physicians failed

[16] *See 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).

[17] *Frank Luis Rembisz*, 52 ECAB 147 (2000).

[18] *See supra* note 16.

[19] *See id*.

[20] *See David P. Sawchuk*, 57 ECAB 316 (2006) (lay individuals such as physician assistants, nurses and physical therapists are not competent to render a medical opinion under the FECA); 5 U.S.C. § 8101(2) (this subsection defines a "physician" as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law).

[21] *See Dennis M. Mascarenas*, 49 ECAB 215 (1997).

to provide sufficient medical rationale explaining how appellant's injuries are causally related to particular employment factors.

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 causally related to factors of her federal employment.

ORDER

IT IS HEREBY ORDERED THAT the November 30, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 24, 2017
Washington, DC

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

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board