United States Department of Labor
Employees' Compensation Appeals Board

E.R., Appellant	)	
	)	
and	)	**Docket No. 18-0983**
	)	**Issued: October 15, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Pontiac, MI, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 13, 2018 appellant filed a timely appeal from a November 6, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has met his burden of proof to establish bilateral lower extremity conditions due to the accepted factors of his federal employment.

FACTUAL HISTORY

On March 1, 2017 appellant, then a 52-year-old supervisor of distribution operations, filed an occupational disease claim (Form CA-2) alleging that he sustained employment-related bilateral

[1] 5 U.S.C. § 8101 *et seq.*

tendinitis and osteoarthritis in both knees and plantar fasciitis in both feet.[2] He indicated that he first became aware of his claimed conditions on June 1, 1995 and first realized that it was caused or aggravated by his federal employment on August 1, 2014. Appellant stopped work on February 11, 2016.

Appellant submitted a March 19, 2015 report cosigned by Dr. Anna Gladstone and Dr. Braswell Deen, attending Board-certified family practitioners. Dr. Gladstone and Dr. Deen indicated that appellant presented on March 18, 2015 complaining of 10 years of knee pain, worse on the right. Appellant reported having been in the military more than 10 years ago and working for the employing establishment for more than 10 years, a job that required working long hours on cement floors.[3] Dr. Gladstone and Dr. Deen noted that appellant reported experiencing knee soreness which varied from the 5/10 level to the 8/10 level. The physicians provided a diagnosis of "osteoarthritis of knee."[4]

In a December 19, 2016 disability note, Dr. Jeffrey D. Shapiro, an attending Board-certified orthopedic surgeon, diagnosed "chondromalacia patella" and recommended modified work from December 19, 2016 onwards which allowed for a "sit/stand option" and restricted appellant from working on a concrete floor for more than four hours per work shift.

In a February 20, 2017 form report, Dr. Allison Davenport, a Department of Veterans Affairs resident physician, indicated that appellant reported having bilateral patellar tendon pain which started 20 years prior and grew progressively worse over time. She detailed physical examination findings for his knees, noting that the range of motion of both knees was full with his exhibiting pain during the testing. Appellant had 5/5 strength in both lower extremities and that there was no instability in either knee. Dr. Davenport diagnosed bilateral knee pain (right greater than left) and osteoarthritis with component of tendinitis.

In another February form report, Dr. Davenport indicated that appellant reported injuring his insoles during his military service and experiencing a period of improvement of his condition followed by a worsening of his condition in the last few years. She detailed physical examination findings for his feet, noting that he exhibited pain in both feet. Dr. Davenport diagnosed foot pain and plantar fasciitis of both feet.

In a March 24, 2017 development letter, OWCP requested that appellant submit additional evidence in support of his claim, including a physician's opinion supported by a medical explanation as to how the reported employment factors caused or aggravated a medical condition. It requested that he complete and return an attached questionnaire which posed various questions regarding the employment factors which he believed caused or aggravated his claimed condition. OWCP afforded appellant 30 days to submit a response.

[2] Appellant submitted a personnel document showing that he had worked at the employing establishment since June 1997.

[3] Appellant reported that eight years prior he underwent arthroscopy of his right knee which showed degenerative changes. The case record does not contain a report of such surgery.

[4] The report indicated that Dr. Gladstone administered a corticosteroid injection in each knee on May 18, 2015.

In a response dated April 17, 2017, appellant indicated that, while serving as a supervisor of plant operations, he worked for 10 hours per day on cement/concrete floors, 5 to 6 days per week. He noted that he dispatched trucks and supervised floor operations. Appellant advised that his problems began while he was in the military, but were aggravated while working at the employing establishment.

Appellant submitted an October 19, 2015 report from Dr. William Kesto, an attending Board-certified orthopedic surgeon, who indicated that appellant presented for a new patient visit. Dr. Kesto reported that he was a disabled U.S. Army veteran and had experienced pain in both his knees for 21 years. He reported the findings of the physical examination he conducted on October 19, 2015, noting that appellant had 5/5 strength and normal sensation in his lower extremities. Dr. Kesto discussed the diagnostic testing of appellant's knees and diagnosed bilateral knee pain and bilateral primary osteoarthritis of knee. He discussed various treatment options with appellant, including the use of anti-inflammatory medications and injection therapy.

Appellant periodically visited Dr. Kesto in order to receive corticosteroid injections in his knees, including instances on November 16, 23, 30, and December 7 and 14, 2015. Dr. Kesto continued to diagnose bilateral primary osteoarthritis of knee. On January 20, 2016 appellant reported to Dr. Kesto that he had been walking 8 to 10 hours per day and had experienced swelling in his right knee and pain in both knees. Dr. Kesto detailed physical examination findings from that date, and he diagnosed patellar tendinitis of the right knee, possible right lateral meniscus tear, and bilateral primary osteoarthritis of knee. He advised that he would obtain a magnetic resonance imaging (MRI) scan of appellant's right knee. The right knee MRI scan that Dr. Kesto obtained on January 27, 2016 contained an impression of chondral fissure along the medial aspect of the lateral patellar facet, small knee joint effusion, mild degenerative/reactive subchondral marrow edema of the proximal tibiofibular joint, mild tendinosis of the distal quadriceps tendon, minimal tendinosis of the proximal patellar tendon, and small Baker's cyst. The findings noted that no meniscal tears were identified and that the cruciate and collateral ligaments were intact without evidence of tear or sprain.[5]

In a March 16, 2017 report, Dr. Davenport indicated that she saw appellant on January 11 and February 13, 2017 for follow-up of ongoing pain in both knees and feet which he reported began during his military service and had been an intermittently present issue for him since. She noted that her review of previous office records "[did] not explicitly suggest otherwise." Dr. Davenport posited that appellant's osteoarthritis was diagnosed years after his military service because it takes many years for arthritis to manifest itself after prolonged damage to the joints. She felt that it was not likely that his plantar fasciitis was caused by his knee osteoarthritis. Dr. Davenport explained that plantar fasciitis was typically caused by strain placed on the plantar fascia from prolonged standing, walking, and running on hard surfaces and appellant had reported that his knee osteoarthritis and plantar fasciitis had been coexistent with neither condition preceding the other.

[5] During a March 9, 2017 visit, appellant reported to Dr. Kesto that on February 3, 2016 Dr. Shapiro had performed arthroscopy on his right knee. He further advised that his current right knee pain was worse than his presurgery right knee pain. Dr. Kesto diagnosed bilateral knee pain. The case record does not contain any surgery reports.

By decision dated June 5, 2017, OWCP denied appellant's claim for an employment-related bilateral foot condition. It accepted his employment factors as alleged, *i.e.*, standing and walking on cement/concrete surfaces for up to 10 hours per day, 5 to 6 days per week, but found that appellant failed to submit medical evidence sufficient to establish a diagnosed medical condition causally related to the accepted employment factors.

On August 11, 2017 appellant requested reconsideration of OWCP's June 5, 2017 decision.

In an August 7, 2017 statement, appellant indicated that his lower extremity medical condition was connected to his military service and started in June 1995, and he noted that he started working for the employing establishment in June 1997. He advised that for 18 of the 20 years he worked at the employing establishment he worked as a supervisor. Appellant indicated that in May 2014 he started working as a supervisor of plant operations, a job which required him to stand and walk on cement/concrete floors for 8 to 10 hours per week, 5 to 6 days per week. He asserted that his working on cement/concrete floors at the employing establishment aggravated the lower extremity condition he sustained during his military service.

Appellant submitted an August 3, 2017 report from Dr. Benjamin Nguyen, an attending Board-certified family practitioner, who indicated that appellant was under his care for chronic bilateral knee pain, bilateral foot numbness, bilateral patella tendinitis, and bilateral plantar fasciitis. Dr. Nguyen opined that these conditions "are being aggravated by his job." He recommended work restrictions of intermittent standing and walking for no more than two hours per work shift.

By decision dated November 6, 2017, OWCP denied modification of its June 5, 2017 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[6] 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 of FECA, that the claim was timely filed within the applicable time limitation period of FECA, that the 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.[7]

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

[6] *Supra* note 1.

[7] 5 U.S.C. § 8101(1); *B.B.*, 59 ECAB 234 (2007); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[8] *J.C.*, Docket No. 16-0057 (issued February 10, 2016); *E.A.*, 58 ECAB 677 (2007).

caused an injury.[9] 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.[10]

OWCP regulations define the term "[o]ccupational disease or illness" as a condition produced by the work environment over a period longer than a single workday or work shift.[11] To establish that an injury was sustained in the performance of duty in an occupational disease claim, an employee 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 diagnosed condition is causally related to the employment factors identified by the employee.[12]

The medical evidence required to establish causal relationship generally is rationalized medical opinion evidence.[13] The opinion of the physician must be based on a complete and accurate factual and medical background of the employee, 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 established employment factors.[14]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish bilateral lower extremity conditions due to factors of his federal employment.

Appellant claimed that his bilateral knee osteoarthritis and plantar fasciitis conditions, which he believed that he originally sustained during his military service, were aggravated by his work at the employing establishment.[15] OWCP accepted his employment factors as alleged, *i.e.*, standing and walking on cement/concrete surfaces for up to 10 hours per day, 5 to 6 days per week, but found that appellant failed to submit medical evidence sufficient to establish a diagnosed medical condition causally related to the accepted employment factors.

The Board finds that appellant has not submitted medical evidence sufficient to establish a diagnosed lower extremity medical condition causally related to the accepted employment factors.

---

[9] *Id.*

[10] *R.H.*, 59 ECAB 382 (2008); *Ellen L. Noble*, 55 ECAB 530 (2004).

[11] 20 C.F.R. § 10.5(q); *see also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Initial Development of Claims*, Chapter 2.800.2b (June 2011).

[12] *D.H.*, Docket No. 15-1876 (issued January 29, 2016); *D.I.*, 59 ECAB 158 (2007); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[13] *F.S.*, Docket No. 15-1052 (issued July 17, 2015); *Tomas Martinez*, 54 ECAB 623 (2003).

[14] *P.K.*, Docket No. 08-2551 (issued June 2, 2009); *John W. Montoya*, 54 ECAB 306 (2003).

[15] Appellant indicated that in May 2014 he started working as a supervisor of plant operations, a job which required him to stand and walk on cement/concrete floors for 8 to 10 hours per week, 5 to 6 days per week.

In a March 19, 2015 report, Dr. Gladstone and Dr. Deen indicated that appellant presented on March 18, 2015 complaining of 10 years of knee pain, worse on the right.[16] The physicians provided a diagnosis of "osteoarthritis of knee." In a December 19, 2016 report, Dr. Shapiro diagnosed "chondromalacia patella" and recommended modified work from December 19, 2016 onwards. The Board finds that these reports are of no probative value with respect to appellant's claim for employment-related lower extremity conditions because, although these physicians diagnosed lower extremity conditions, they did not provide an opinion that they were caused by employment factors. The Board has held that medical evidence which does not offer an opinion regarding the cause of an employee's condition is of no probative value on the issue of causal relationship.[17]

In a February 20, 2017 report, Dr. Davenport indicated that appellant reported having bilateral patellar tendon pain which started 20 years prior and grew progressively worse over time. She detailed physical examination findings for his knees, noting that he had full range of motion of both knees, 5/5 strength in both lower extremities, and no instability in either knee. Dr. Davenport diagnosed bilateral knee pain (right greater than left) and osteoarthritis with a component of tendinitis. In another February 20, 2017 report, she indicated that appellant reported injuring his insoles during his military service and experiencing a period of improvement of his condition followed by a worsening of his condition in the last few years. Dr. Davenport diagnosed foot pain and plantar fasciitis of both feet. The Board finds that these reports have no probative value with respect to establishing appellant's claim for employment-related lower extremity conditions because she did not provide an opinion that the diagnosed conditions were caused by employment factors. As noted above, medical evidence which does not offer an opinion regarding the cause of an employee's condition is of no probative value on the issue of causal relationship.[18]

In an October 19, 2015 report, Dr. Kesto noted that appellant reported that he had experienced pain in both his knees for 21 years. He discussed the diagnostic testing of appellant's knees and diagnosed bilateral knee pain and bilateral primary osteoarthritis of knee. Appellant periodically visited Dr. Kesto between November and December 2015 in order to receive corticosteroid injections in his knees and Dr. Kesto continued to diagnose bilateral primary osteoarthritis of knee. On January 20, 2016 Dr. Kesto diagnosed patellar tendinitis of the right knee, possible right lateral meniscus tear, and bilateral primary osteoarthritis of knee. On March 9, 2017 he diagnosed bilateral knee pain. These reports of Dr. Kesto also have no probative value with respect to the underlying issue of this case because he did not provide an opinion that the

[16] In this report, appellant noted having been in the military more than 10 years ago and working for the employing establishment for more than 10 years, a job that required working long hours on cement floors. In the factual statements he submitted with the present claim, he indicated that he had been working for the employing establishment since 1997 and that he had a postal job which required walking/standing on hard surfaces since 2014.

[17] *See Charles H. Tomaszewski*, 39 ECAB 461 (1988).

[18] *See id.* In a March 16, 2017 report, Dr. Davenport indicated that appellant reported that the problems with his knees and feet began during his military service and had been an intermittently present issue for him since. She felt that it was not likely that his plantar fasciitis was caused by his knee osteoarthritis because the two conditions were coexistent with neither condition preceding the other. This report also is of no probative value on the underlying issue of this case because Dr. Davenport did not provide an opinion that appellant's lower extremity conditions were related to his work.

diagnosed conditions were caused by the accepted employment factors. His reports are not supportive of appellant's claim because they do not provide a rationalized opinion on causal relationship.[19]

In an August 3, 2017 report, Dr. Nguyen indicated that appellant was under his care for chronic bilateral knee pain, bilateral foot numbness, bilateral patella tendinitis, and bilateral plantar fasciitis. He opined that these conditions "are being aggravated by his job." Dr. Nguyen recommended work restrictions of intermittent standing and walking for no more than two hours per work shift. Appellant's submission of this report does not establish his claim for employment-related lower extremity conditions because Dr. Nguyen's opinion on causal relationship is of limited probative value due to its lack of medical rationale. Dr. Nguyen did not provide any description of appellant's job or explain how his specific work duties could have aggravated the diagnosed conditions. Moreover, he did not provide any findings upon physical examination and diagnostic testing to support his opinion on causal relationship. The Board has held that a report is of limited probative value regarding causal relationship if it does not contain medical rationale explaining how an employment activity could have caused or aggravated a medical condition.[20] Dr. Nguyen's opinion on causal relationship is of limited probative value for the further reason that it is not based on a complete factual and medical history as he did not provide any description of appellant's longstanding lower extremity problems.[21]

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 bilateral lower extremity conditions due to factors of his federal employment.

[19] *See D.R.*, Docket No. 16-0528 (issued August 24, 2016) (finding that a report is of limited probative value regarding causal relationship if it does not contain medical rationale explaining the relationship between a given employment activity and a diagnosed medical condition).

[20] *See Y.D.*, Docket No. 16-1896 (issued February 10, 2017).

[21] *See supra* note 14. *See also E.R.*, Docket No. 15-1046 (issued November 12, 2015).

ORDER

IT IS HEREBY ORDERED THAT the November 6, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 15, 2018
Washington, DC

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

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

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