United States Department of Labor
Employees' Compensation Appeals Board

C.M., Appellant	)	
and	)	**Docket No. 18-1516**
	)	**Issued: May 8, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Topeka, KS, Employer	)	

Appearances:
Brett E. Blumstein, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 3, 2018 appellant, through counsel, filed a timely appeal from a May 17, 2018 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 a medical condition causally related to the accepted factors of her federal employment.

FACTUAL HISTORY

On June 6, 2017 appellant, then a 58-year-old retired sales/distribution clerk, filed an occupational disease claim (Form CA-2) alleging that she developed shoulder, knee, and feet conditions while working in various positions as a clerk and city mail carrier due to factors of her federal employment. She noted that she first became aware of her claimed conditions on February 27, 2015 and first related them to her federal employment on November 28, 2016. Appellant retired from the employing establishment on February 27, 2015.

In an undated narrative statement, appellant described the duties she performed in the various positions she held during her approximate 30 years of federal employment, noting that they were repetitive in nature. She described her duties as a letter sorting machine (LSM) clerk/floor clerk, city carrier, distribution clerk, and window clerk.[3]

In a February 9, 2017 report, Dr. John W. Ellis, a Board-certified family practitioner, noted that on November 28, 2016 he had initially examined appellant and had obtained a history of injury. He documented her work as a city carrier and a mail clerk and reported that such work required a lot of gripping, lifting, sorting, and casing of mail and repetitive work with her hands. Dr. Ellis noted that appellant's city carrier work also involved sorting and delivering mail with a lot of rapid, repetitive movements of her hands and that because she was stationed in the downtown area she dealt with a heavy amount of mail. He reported that she last worked on February 27, 2015. Dr. Ellis noted that appellant's shoulder and knee pain began in the early 2000's and, in 1990, she had pain in the arch and in the ball of both feet. He also reported a history of her employment-related injuries under previous claims, reviewed medical records, and presented examination findings. Dr. Ellis diagnosed traumatic arthritis of both shoulders, tendinitis of both shoulders, traumatic arthritis of both knees, and flattening arch of both feet, which he opined that were employment related. He explained that appellant's employment, which required a lot of standing and walking on concrete, caused repetitive strains on the muscles and tendons in the joints and arch of her feet which caused the arches to fall. Dr. Ellis explained that standing and carrying a bag as well as climbing stairs and steps while carrying a bag placed additional abnormal stresses on her knees and on the cartilage and ligaments of her knees and caused traumatic arthritis, tendinitis, and chondromalacia in both knees. He also explained that casing and delivering mail caused repetitive strains of the shoulder muscles and ligaments which caused traumatic arthritis and tendinitis in the shoulders.

[3] Appellant alleged that her duties included keying letter mail on a LSM, casing mail, sitting on a stool, reaching over her head continuously to insert mail into the letter case, standing on a hard cement floor, bending, lifting up to 70 pounds, loading a truck, pushing equipment, carrying trays of mail, delivering mail, walking 10 miles per day, carrying a satchel weighing 30 to 40 pounds, walking on uneven terrain in all types of weather, and walking up and down stairs.

In a development letter dated July 7, 2017, OWCP noted that Dr. Ellis had not explained how appellant's specific employment activities caused, contributed to, or aggravated her medical conditions. It advised her of the type of factual and medical evidence needed to establish her claim and provided a questionnaire for her completion. OWCP afforded appellant 30 days to submit the necessary evidence. It also requested additional information from the employing establishment.

In response, appellant submitted factual and medical evidence, including a response to the provided questionnaire. In her July 31, 2017 statement, she noted that she first learned that her knee, shoulder, and foot conditions were work related from Dr. Ellis' consultation. Appellant described her activities outside of work prior to and after her retirement.[4] In another statement, she provided her work history from February 1985 to 2014, her prior employment injuries, the treatments she received, and her current symptoms. The record reflects that appellant worked limited duty with restrictions intermittently[5] from 2004 until her retirement on February 27, 2015.[6]

Appellant submitted diagnostic reports. A March 31, 2009 x-ray of her right foot revealed no acute process. A September 11, 2010 right knee x-ray showed no acute fracture or dislocation. A June 2, 2011 ultrasound of appellant's bilateral lower extremities was predominately normal. An August 23, 2011 right knee x-ray and a June 3, 2016 left knee x-ray revealed minimal/mild osteoarthritis. A September 27, 2011 magnetic resonance imaging (MRI) scan report of right knee showed no evidence of meniscal, cruciate, or collateral ligament tear, chondromalacia with small cartilaginous defect, and distal femoral chondromalacia.

OWCP received medical evidence dating from 2007 to 2016. In a May 15, 2007 report, Dr. Joseph G. Sankoorikal, a Board-certified physiatrist, diagnosed tendinitis and opined that repetitious-type activities and heavy lifting "seem to be aggravating the symptoms."

In an April 2, 2009 report, Dr. Christopher Brodine, a podiatrist, discussed treatment options for compression of neuroma of fourth interspace right and arthralgia right fourth metatarsocuneilform joint. He injected the fourth interspace right for neuroma on April 17, 2009.

In a September 17, 2010 report, Dr. Aileen C. McCarthy, a Board-certified internist, noted that appellant was seen in the emergency room with acute knee pain. She assessed prepatellar, suprapatella bursitis "most likely," and that appellant could have tendinitis. In a September 21, 2011 report, Dr. McCarthy indicated that the x-rays were consistent with some arthritis of the knee.

[4] Appellant indicated that after she retired from the employing establishment she began work at Topeka Independent Living Resource Center, 30 hours a week, where she cared for clients by driving to appointments, performing housekeeping and laundry chores, as well as assisting clients with feeding, bathing, dressing, grooming, and mobility transfers.

[5] Appellant submitted copies of work restrictions, return to work reports, offers of modified assignments and requests for light-duty work due to her carpal tunnel syndrome.

[6] Under OWCP File No. xxxxxx599, appellant has an April 26, 2004 work injury accepted for left hamstring strain. Under OWCP File No. xxxxxx083, she has an occupational disease claim accepted for bilateral carpal tunnel syndrome and bilateral synovitis and tenosynovitis. Under OWCP File No. xxxxxx617, appellant has an accepted condition for bilateral carpal tunnel syndrome and right cubital tunnel syndrome.

In a September 27, 2010 report, Dr. J. Douglas Gardner, Board-certified in rheumatology and internal medicine, reported that appellant's right knee started to hurt approximately two weeks prior with no history of trauma or injury. He assessed right knee pain with no clear cut abnormalities. Dr. Gardner noted that it was possible that appellant could have had prepatellar bursitis or tendinitis, but that there were no clinical findings that allowed for a more firm diagnosis.

In a May 17, 2011 report, Dr. Gardner noted that approximately three weeks prior appellant had turned to the left at work and felt popping and pain in her left knee. He provided an assessment of knee pain and possible small meniscal tear. Dr. Gardner noted that appellant's right knee pain from the previous fall had resolved. In an August 23, 2011 report, he indicated that she had right knee pain and swelling since the prior Sunday. Dr. Gardner diagnosed right knee effusion and pain, unknown etiology. He noted that appellant had twisted her left knee earlier that year and that those symptoms had resolved. In an August 29, 2011 report, Dr. Gardner assessed right knee pain and swelling of unclear cause. In his September 21, 2011 report, he provided an assessment of right knee pain. Dr. Gardner noted that an x-ray was consistent with some arthritis. In an October 9, 2012 report, he indicated that appellant had recurrent right knee pain and swelling. Dr. Gardner diagnosed recurrent right knee pain and effusion likely related to underlying osteoarthritis and hip pain likely bursitis.

In an October 14, 2012 emergency room report, Dr. P. Marcus Bassett, an emergency medicine specialist, noted that appellant had right knee pain, with no injury reported, and swelling that started two weeks ago with increased pain that day. No diagnosis was provided.

In a December 22, 2014 duty status report (Form CA-17), a neurologist with an illegible signature, diagnosed bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome.

In a June 3, 2016 report, Dr. Gardner noted that appellant had left knee pain for the prior one to two weeks with no injury. An assessment of left knee pain, unspecified chronicity, with radiographic evidence of left knee mild osteoarthritis was provided.

In an October 17, 2016 report, Dr. McCarthy diagnosed appellant with acute pain of the right shoulder. Other active problems included degenerative joint disease of the lower leg and osteoarthritis.

In an August 24, 2017 report, Dr. Ellis noted that he initially saw appellant on November 28, 2016 and that he had provided additional medical rationale in a February 9, 2017 report.[7] With regard to the shoulders, he noted that appellant's many years of working as a city carrier required her to carry a bag and she had to use both shoulders, which put abnormal additional stresses on the muscles and ligaments of her shoulders. Dr. Ellis noted that her work also required a lot of repetitive pulling and pushing and reaching above shoulder height, which caused the muscles and tendons in her shoulders to become hypertrophied. He related that tendinitis in appellant's shoulders developed into traumatic arthritis with continued overuse once the muscles and tendons were hypertrophied in the shoulder ligaments. With regards to the knees, Dr. Ellis noted that her prolonged years of standing put extra additional stressors on the cartilage of the femurs and tibias of both knees, which caused a more rapid degeneration of the cartilage. The loss

[7] This report is not of record.

of cartilage in the knees caused abnormal joint space in the knees, which caused abnormal movement of the knees, which caused subsequent traumatic arthritis in the bones of the knees. Dr. Ellis also opined that prolonged standing caused abnormal additional stresses on the muscles and tendons in the arch of appellant's feet and the joints of bones in her ankles and feet, which caused flattening of the arches.

In a second August 24, 2017 report, Dr. Ellis indicated that, after about 10 years of working at the employing establishment, appellant began to notice pain in the lower back. He diagnosed muscle tendon unit strain of the lumbar spine, arthritis of the lumbar spine, and bilateral S1 spinal nerve impingement. Dr. Ellis opined that appellant's prolonged standing and working caused abnormal increased pressures on the lower lumbar discs. He explained that her prolonged lifting of boxes, in front of the body and then put into hampers or vehicles, put leverage on the upper arms and increased pressure and abnormal stresses on the iliolumbar and sacroiliac ligaments of the lumbar spine.

On September 14, 2017 OWCP received an occupational disease claim (Form CA-2) dated September 5, 2017 in which appellant alleged that her federal duties caused or aggravated her back condition.

By decision dated December 6, 2017, OWCP denied appellant's occupational disease claim. It found that there was no rationalized medical evidence sufficient to establish that the diagnosed medical conditions were causally related to the accepted employment factors.

On January 10, 2018 OWCP received appellant's request for a review of the written record before an OWCP hearing representative, postmarked January 5, 2018.

Additional evidence included discharge instructions dated April 3, 2009 and emergency room encounter summaries dated September 27, 2011, January 10 and October 14, 2012, and April 25 and May 1, 2013.

By decision dated May 17, 2018, an OWCP hearing representative affirmed the December 6, 2017 decision. The hearing representative found that the medical evidence of record was insufficient to establish causal relationship between the diagnosed medical conditions and the accepted factors of appellant's federal employment.

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 of FECA, that the claim was timely filed within the applicable time limitation period of FECA,[8] that an injury was sustained in the performance of duty as alleged, and that any disability or medical condition for which compensation is claimed is causally related

[8] *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

to the employment 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]

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.[11]

The medical evidence required to establish causal relationship is rationalized medical opinion evidence.[12] 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.[13]

ANALYSIS

The Board finds that this case is not in posture for decision.

Appellant submitted reports by Dr. Ellis in support of his claim. In his February 9 and August 24, 2017 reports, Dr. Ellis noted appellant's employment history, her employment-related injuries under previous claims, reviewed medical records, and presented examination findings. He diagnosed traumatic arthritis of both shoulders, tendinitis of both shoulders, traumatic arthritis of both knees, flattening arch of both feet, muscle tendon unit strain of the lumbar spine, arthritis of the lumbar spine, and bilateral S1 spinal nerve impingement, all of which he attributed to her employment duties.

In his February 9, 2017 report, Dr. Ellis explained that appellant's employment, which required a lot of standing and walking on concrete, caused repetitive strains on the muscles and tendons in the joints and the arch of her feet which caused the arches to fall. He further explained that standing and carrying a bag as well as climbing stairs and steps while carrying a bag placed

[9] *J.M.*, Docket No. 17-0284 (issued February 7, 2018); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[10] *S.C.*, Docket No. 18-1242 (issued March 13, 2019); *K.M.*, Docket No. 15-1660 (issued September 16, 2016); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

[11] *C.D.*, Docket No. 17-2011 (issued November 6, 2018); *Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996).

[12] *M.B.*, Docket No. 17-1999 (issued November 13, 2018).

[13] *M.L.*, Docket No. 18-1605 (issued February 26, 2019).

additional abnormal stresses on her knees and on the cartilage and ligaments of her knees and caused traumatic arthritis, tendinitis, and chondromalacia in both knees. Dr. Ellis also explained that casing and delivering mail caused repetitive strains of the shoulder muscles and ligaments which caused traumatic arthritis and tendinitis in the shoulders.

In his August 24, 2017 report, Dr. Ellis explained that appellant's many years of working as a city carrier required her to carry a bag and she had to use both shoulders, which put abnormal additional stresses on the muscles and ligaments of her shoulders. He noted that her work also required a lot of repetitive pulling and pushing and reaching above shoulder height, which caused the muscles and tendons in her shoulders to become hypertrophied. Dr. Ellis related that tendinitis in appellant's shoulders developed into traumatic arthritis due to continued overuse once the muscles and tendons had hypertrophied in the shoulder ligaments. With regard to the knees, he noted that her prolonged years of standing put extra additional stressors on the cartilage of the femurs and tibias of both knees, which caused a more rapid degeneration of the cartilage. The loss of cartilage in the knees caused abnormal joint space in the knees, which resulted in abnormal movement of the knees, which caused subsequent traumatic arthritis in the bones of the knees. Dr. Ellis also opined that prolonged standing caused abnormal additional stresses on the muscles and tendons in the arch of appellant's feet and the joints of bones in her ankles and feet, which caused flattening of the arches. He also addressed her lumbar condition. Dr. Ellis opined that appellant's prolonged standing and working caused abnormal increased pressures on the lower lumbar discs of her spine. He explained that her prolonged lifting of boxes, in front of the body and then put into hampers or vehicles, put leverage on the upper arms and increased pressure and abnormal stresses on the iliolumbar and sacroiliac ligaments of the lumbar spine.

The Board finds that Dr. Ellis provided an affirmative opinion on causal relationship which describes the mechanism of injury, findings upon examination, and explained how the accepted factors of employment produced mechanical forces which caused appellant's diagnosed medical conditions. The Board finds that his opinion, while not sufficiently rationalized to meet her burden of proof, is sufficient, given the absence of opposing medical evidence, to require further development of the case record.[14]

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. The claimant has the burden to of proof establish entitlement to compensation. However, OWCP shares responsibility in the development of the evidence to see that justice is done.[15]

On remand, OWCP should refer appellant to an appropriate specialist, along with the case record and a statement of accepted facts for an evaluation and rationalized medical opinion regarding whether her diagnosed conditions were caused or aggravated by the accepted factors of her federal employment. After such further development of the case record as deemed necessary, OWCP shall issue a *de novo* decision.

[14] *S.S.*, Docket No. 17-0332 (issued June 26, 2018). *See also John J. Carlone*, 41 ECAB 354 (1898); *Horace Langhorne*, 29 ECAB 820 (1978).

[15] *C.M.*, Docket No. 17-1977 (issued January 29, 2019); *William J. Cantrell*, 34 ECAB 1223 (1983).

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the May 17, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with the decision of the Board.

Issued: May 8, 2019
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