United States Department of Labor
Employees' Compensation Appeals Board

M.A., Appellant	)	
and	)	**Docket No. 19-1551**
	)	**Issued: April 30, 2020**
U.S. POSTAL SERVICE, POST OFFICE, Phoenix, AZ, 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:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 15, 2019 appellant filed a timely appeal from a May 13, 2019 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 met her burden of proof to establish a medical condition causally related to the accepted October 9, 2015 employment incident.

FACTUAL HISTORY

On October 9, 2015 appellant, then a 58-year-old mail handler, filed a traumatic injury claim (Form CA-1) alleging that on that date she tripped over a bar that was left sticking out and sustained bilateral knee contusions while in the performance of duty. On the reverse side of the claim form, the employing establishment indicated that appellant was injured in the performance of duty. It noted, however, that its knowledge of the facts disagreed with the statements of appellant and it was therefore controverting the claim.

In an October 9, 2015 personal narrative statement, appellant stated that she tripped on a bar and landed on her knees and her left arm. She indicated that she experienced pain in her knees, upper legs, left elbow, and left shoulder.

With her statement, appellant submitted medical evidence. An unsigned October 9, 2015 physician's work activity status report noted that appellant was seen by Dr. Rutvik Patel, a family medicine specialist on that date. Appellant was provided a written prescription for medication and restricted from physical activity until her next follow-up visit. An October 9, 2015 attending physician's report (Form CA-20) containing an illegible signature indicated that appellant recounted that, while at work, she tripped over a bar and injured her knees, right leg, right ankle, left elbow, and left shoulder. Appellant related that she had a previous ankle/foot injury. The report noted a diagnosis with bilateral knee contusions. The report related that appellant's conditions were caused or aggravated by the employment activity described. Appellant was treated with ice, a brace, and pain medication, and the report indicated that she was not able to resume work. An October 9, 2015 duty status report (Form CA-17) also containing an illegible signature indicated that appellant fell, which caused knee pain, left shoulder pain, and left elbow pain. The report contained a diagnosis of bilateral knee contusions and a left shoulder contusion, and indicated that appellant could not return to work.[3]

In an October 10, 2015 letter, the employing establishment controverted appellant's claim contending that she did not sustain an injury in the performance of duty, as alleged, and had not established a causal relationship between her diagnosed conditions and the alleged employment incident. In another October 10, 2015 letter, it alleged that she had preexisting left elbow, left shoulder, and left forearm contusions which had been accepted by OWCP.[4]

[3] Appellant also submitted an October 9, 2015 form wherein she indicated that on that date she tripped and fell face-down, injuring both of her knees, her right ankle, and her left elbow. It also indicated that she experienced pain in her shoulder.

[4] Appellant has a prior claim for a December 16, 2011 traumatic injury accepted under OWCP File No. xxxxxx892, for contusion of left elbow and forearm and disorder of bursae and tendons in the left shoulder region. The claims have not been administratively combined.

An October 11, 2015 medical report signed by Dr. Le Vu, an urgent care medicine specialist, indicated that appellant presented with pain in the anterior and lateral areas of her left shoulder which radiated into her arm, pain in the olecranon area of her left elbow, pain in the anterior area of both of her knees, and right foot/toe pain. Exacerbating factors included shoulder movement and arm elevation. A physical examination revealed a limited range of motion and tenderness in the deltoid and anterior left shoulder, tenderness in the olecranon bursa of the left elbow, swelling and diffuse tenderness of the anterior area of the knees, and tenderness in the medial longitudinal arch of the right foot. X-rays were negative for fractures in the left shoulder, elbow, and knees. Dr. Vu diagnosed appellant with pain in her right foot, left elbow, both knees, and acute left shoulder pain. She noted that a fall from tripping caused appellant's injury. Dr. Vu provided activity restrictions for appellant and noted that she should return for a follow up.

In an October 21, 2015 development letter, OWCP informed appellant that the documentation received to date was insufficient to support her claim for FECA benefits. It advised her of the type of factual and medical evidence necessary to establish her claim and attached a questionnaire for her completion. OWCP afforded appellant 30 days to submit the necessary evidence.

In a separate letter dated October 21, 2015, OWCP requested that the employing establishment provide additional information concerning appellant's claim. It noted that in absence of a full reply from the employing establishment, it may accept her allegations as factual. OWCP afforded the employing establishment 30 days to submit the requested information.

A revised October 9, 2015 traumatic injury claim (Form CA-1) submitted by appellant repeated the date and cause of her injury and noted that in addition to bruising both knees, she bruised her left elbow, left shoulder, left arm, right thigh, and right hip. Appellant also noted that she slammed her right foot sideways into a cement floor. An October 9, 2015 employee accident notification sheet from appellant's supervisor detailed appellant's workplace fall that day.

An October 9, 2015 medical report by Dr. Patel indicated that appellant presented with left shoulder pain and bilateral anterior knee pain which radiated up and down her right leg. Appellant stated that while she was at work she tripped on a bar and fell face-down, injuring both of her knees, her right leg, her right ankle, and her left elbow. She was wearing a right ankle brace, which she noted was from a 2008 work injury, and she stated that she was awaiting surgery for a collapsed arch. Appellant indicated that she had difficulty moving her left shoulder and arm, that her pain was worse with movement, and that her overall pain was moderate to severe. A physical examination of her left shoulder revealed a limited and painful range of motion and tenderness in the acromioclavicular joint and the anterior part of the shoulder. Appellant's left elbow was tender in the olecranon bursa, and she experienced pain upon flexion and extension. Her left knee appeared swollen and bruised. It was tender in the anterior and painful upon flexion and extension. Its strength was 4/5 and it was positive for the patellofemoral apprehension test and equivocal for the medial and lateral McMurray tests. Appellant's right knee was also swollen and tender in the anterior. It had full range of motion that was painful upon flexion. Preliminary radiology interpretations of x-rays of appellant's knees, left shoulder, and left elbow indicated a possible avulsion fracture of the distal clavicle or acromion in the left shoulder and no fractures in the left elbow or either knee. Appellant was diagnosed with acute shoulder pain, left elbow and bilateral anterior knee pain, and a closed fracture of the distal clavicle. Dr. Patel indicated that her fall

caused her "injury." He provided appellant with a cane, gait training, an orthopedic specialist referral, and pain medication.

An October 15, 2015 medical report by Dr. Michael Steingart, a Board-certified orthopedic surgeon, indicated that appellant presented with pain in her left shoulder, left elbow, left hip, right foot, right ankle, and both knees. Appellant recounted that she fell while at work, injuring her left shoulder, left elbow, left hip, right ankle, right foot and both knees. She stated that when she fell she first hit her left elbow and slammed her right foot, and that her pain was moderate to severe and aggravated by movement. Appellant had trouble walking, standing, grasping, lifting her arm, and bearing weight. She was wearing a left knee brace, a right ankle u-splint, and a left shoulder sling. Appellant also experienced tingling and numbness in both feet due to neuromas prior to her fall, and she mentioned a prior right ankle injury which caused her arch to collapse. Dr. Steingart reviewed appellant's medical records and conducted a physical examination, which revealed left elbow tenderness in the olecranon, a flat pronated right foot, and pain upon palpation in the right lateral IT band and bursal tendon region laterally. A physical examination of appellant's left shoulder revealed an effusion in the right anterior area, pain upon palpation of the anterior area, painful range of motion in the extremes, 4/5 strength secondary to pain, and pain in the acromioclavicular joint. A physical examination of appellant's left knee revealed bruising medial and interior to the patella and tenderness into the patella and the medial collateral ligament region. X-rays of appellant's left and right knees were negative, and an x-ray of her left shoulder revealed a possible distal clavicle fracture. Dr. Steingart diagnosed pain in appellant's left shoulder, left elbow, left hip, left foot, right leg, right ankle, and both knees.

An October 15, 2015 letter from Dr. Steingart indicated that appellant could not return to work until November 15, 2015. An October 19, 2015 letter from him indicated that appellant could return to work for full-time modified duty, and he listed appellant's work restrictions. On October 27, 2015 Dr. Steingart prescribed physical therapy. An October 16, 2015 letter from the employing establishment continued to controvert appellant's claim.

An October 27, 2015 follow-up medical report by Dr. Steingart repeated his previous diagnoses, aspirated her knee, and provided a knee injection.

In an October 28, 2015 personal narrative statement, appellant provided additional details about her claimed October 9, 2015 work injury. In a November 9, 2015 response to OWCP's questionnaire, she indicated that she had a prior left shoulder injury from 2011 that was aggravated by her workplace fall. In a November 10, 2015 letter, appellant indicated that she provided requested information to OWCP.

By decision dated November 24, 2015, OWCP denied appellant's traumatic injury claim, finding that the evidence of record was insufficient to establish a diagnosed condition in connection with the accepted October 9, 2015 employment incident. It concluded, therefore, that the requirements had not been met to establish an injury as defined by FECA.

On August 9, 2016 appellant requested reconsideration and submitted additional evidence.

A December 23, 2015 magnetic resonance imaging (MRI) scan of appellant's left shoulder interpreted by Dr. Marc Weinstein, a Board-certified radiologist, revealed severe subscapularis

tendinosis with intermediate to high grade partial-thickness articular-sided tearing distally, an adjacent high grade partial tear through the biceps tendon, moderate-to-severe infraspinatus tendinosis with articular-sided fraying, moderate supraspinatus tendinosis without tear, moderate osteoarthritis of the acromioclavicular joint, type 2 or 3 acromion, lateral down-sloping of the acromion, and mild osteoarthritis of the glenohumeral joint with fraying.

A February 22, 2016 MRI scan of appellant's right foot interpreted by Dr. Andrew Collins, a radiology specialist, revealed a suggestion of an overlying full-thickness cartilage loss, a marrow signal alteration body of calcaneus, a multilocular ganglion cyst sinus Tarsi region, and tenosynovitis of the flexor hallucis longus tendon with a small amount of fluid in the tendon sheath. Plantar fascia thickening with adjacent soft tissue swelling and prior sprains of the anterior talofibular ligament and the calcanofibular ligament were additionally noted.

By decision dated August 15, 2016, OWCP modified its prior decision, finding that the evidence of record was sufficient to establish that a medical condition was diagnosed in connection with the October 9, 2015 accepted employment incident. However, it continued to deny appellant's claim, as the evidence of record was insufficient to establish a causal relationship between her diagnosed conditions and the accepted October 9, 2015 employment incident.

OWCP subsequently received additional medical evidence. In a September 6, 2016 letter, Dr. Steingart stated that appellant's injuries "were caused as a factor" of her job and "not to nonexistent preexisting conditions." He also indicated that she should remain on light duty. Dr. Steingart provided the dates and summaries of his examinations and treatments of appellant through July 29, 2016. He indicated that she continued to complain of pain, and he noted that an MRI scan of her left shoulder revealed multiple cuff tears. Dr. Steingart also indicated that the right side of appellant's foot had a chronic tear, and that an MRI scan of her left knee revealed a medial meniscus tear. He diagnosed a nontraumatic right tibialis posterior tendon tear, posterior tibialis tendon insufficiency, right ankle chondromalacia, left bicep tendinitis, left shoulder rotator cuff disorder, and a medial meniscus tear of the left knee.

A March 2, 2017 medical report signed by Dr. Robert Berghoff, a Board-certified orthopedic surgeon, indicated that appellant complained of left knee and left shoulder pain. Appellant recounted her October 9, 2015 workplace fall and stated that she had no prior knee pain. A physical examination revealed tenderness over the acromioclavicular joint and pain with cross arm abduction and the Hawkins and Neer tests. A stiff-legged gait on the left and medial joint line tenderness in the left knee were also noted. Dr. Berghoff reviewed a December 23, 2015 MRI scan of appellant's left shoulder, which he indicated revealed acromioclavicular arthritis, tendinosis of the subscapularis with some partial thickness tearing, a partial tear of the biceps tendon, tendinosis of the supraspinatus tendon, and mild degenerative changes in the glenohumeral joint. He also reviewed a February 29, 2016 MRI scan of appellant's left knee, which he noted revealed a medial meniscus tear and chondral loss in the central area of the medial compartment.

An April 11, 2017 medical report by Dr. Berghoff indicated that appellant complained of constant and aching right knee pain. Appellant related that she had intermittent episodes of right knee pain since her October 9, 2015 work injury and that she was having trouble walking and driving. A physical examination of her right knee revealed medial joint line tenderness.

Dr. Berghoff reviewed March 2, 2017 x-rays of both of appellant's knees and indicated that they revealed normal results.

On May 13, 2019 OWCP denied modification of its August 15, 2016 decision, finding that the evidence of record was insufficient to establish a causal relationship between appellant's diagnosed conditions and her accepted October 9, 2015 employment incident.

LEGAL PRECEDENT

An employee seeking benefits under FECA[5] 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 of FECA,[6] 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 to the employment injury.[7] 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.[8]

To determine if an employee sustained a traumatic injury in the performance of duty, OWCP begins with an analysis of whether fact of injury has been established.[9] Fact of injury consists of two components that must be considered in conjunction with one another. The first component is whether the employee actually experienced the employment incident that allegedly occurred.[10] The second component is whether the employment incident caused a personal injury.[11]

Rationalized medical opinion evidence is required to establish causal relationship. The opinion of the physician must be based on a complete factual and medical background, 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 incident.[12]

In any case where a preexisting condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation, acceleration, or precipitation,

[5] *Id*.

[6] *J.P.*, Docket No. 19-0129 (issued April 26, 2019); *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *Joe D. Cameron*, 41 ECAB 153 (1989).

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

[8] *R.R.*, Docket No. 19-0048 (issued April 25, 2019); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

[9] *E.M.*, Docket No. 18-1599 (issued March 7, 2019); *T.H.*, 59 ECAB 388, 393-94 (2008).

[10] *L.T.*, Docket No. 18-1603 (issued February 21, 2019); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[11] *B.M.*, Docket No. 17-0796 (issued July 5, 2018); *John J. Carlone*, 41 ECAB 354 (1989).

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

the physician must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.[13]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish a medical condition causally related to the accepted October 9, 2015 employment incident.

Dr. Patel's October 9, 2015 medical report indicated that appellant fell in the workplace and presented with left shoulder pain and bilateral anterior knee pain which radiated up and down her right leg. He conducted a physical examination, reviewed x-rays of her knees, left shoulder, and left elbow, and diagnosed appellant with acute shoulder pain, left elbow pain, bilateral anterior knee pain, and a closed fracture of the distal clavicle, and additionally indicated that a fall caused her "injury." The Board has held that pain is a symptom and not a compensable medical diagnosis.[14] Additionally, the report fails to mention appellant's preexisting left shoulder injury. As stated above, the opinion of the physician must be based on a complete factual and medical background.[15]

Dr. Vu's October 11, 2015 medical report indicated that appellant presented with pain in the left anterior and left lateral areas of her left shoulder radiating into her arm, the olecranon area of her left elbow, the anterior area of both of her knees, and right foot/toe pain. She conducted a physical examination and diagnosed pain in appellant's right foot, left elbow, both knees, and acute left shoulder pain, and noted that a fall from tripping caused her "injury." As stated above, the Board has held that pain is a symptom and not a compensable medical diagnosis.[16]

Dr. Steingart's medical reports and summaries indicated that appellant presented with pain in her left shoulder, left elbow, left hip, right foot, right ankle, and both knees. Appellant recounted her workplace fall and mentioned preexisting injuries in both of her feet, her right ankle, and her right shoulder. Dr. Steingart viewed diagnostic imaging, conducted a physical examination, and diagnosed her with a nontraumatic right tibialis posterior tendon tear, posterior tibialis tendon insufficiency, right ankle chondromalacia, left bicep tendinitis, left shoulder rotator cuff disorder, and medial meniscus tear of the left knee. In his September 6, 2016 letter, he stated that appellant's injuries "were caused as a factor" of her job and "not to nonexistent preexisting conditions." As stated above, in any case where a preexisting condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation, acceleration, or precipitation, the physician must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.[17] Additionally,

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013); *see A.S.*, Docket No. 19-1955 (issued April 9, 2020).

[14] *T.G.*, Docket No. 19-0904 (issued November 25, 2019).

[15] *Supra* note 11.

[16] *T.O.*, Docket No. 19-1291 (issued December 11, 2019).

[17] *Supra* note 12.

Dr. Steingart indicated that appellant's injuries were caused by a factor of her employment rather than by her October 9, 2015 fall. As noted above, the opinion of the physician must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment incident.[18]

Dr. Berghoff's reports indicated that appellant presented with left knee and shoulder pain and recounted her October 9, 2015 workplace fall. He conducted physical examinations and reviewed diagnostic imaging of appellant, which he stated revealed acromioclavicular arthritis, tendinosis of the subscapularis with some partial thickness tearing, a partial tear of the biceps tendon, tendinosis of the supraspinatus tendon and mild degenerative changes in the glenohumeral joint in her shoulder, and a medial meniscus tear and chondral loss in the central area of the medial compartment in her left knee.[19] These reports fail to mention appellant's preexisting shoulder and feet injuries. As stated above, the opinion of the physician must be based on a complete factual and medical background.[20] Additionally, Dr. Berghoff fails to explain how appellant's workplace fall caused her left knee tear. To be of probative medical value, a medical opinion must explain how physiologically the movements involved in the employment incident caused or contributed to the diagnosed conditions.[21]

Appellant also submitted a December 23, 2015 left shoulder MRI scan and a February 22, 2016 right foot MRI scan. The Board has explained that diagnostic studies lack probative value as they do not address whether the employment incident caused any of the diagnosed conditions.[22]

In support of her claim, appellant submitted an October 9, 2015 attending physician's report (Form CA-20) containing an illegible signature and an October 9, 2015 duty status report (Form CA-17) also containing an illegible signature. The Board has held that reports that are unsigned or bear an illegible signature lack proper identification and cannot be considered probative medical evidence as the author cannot be identified as a physician.[23] Therefore, these reports have no probative value and are insufficient to establish the claim.

The Board finds that there is no rationalized medical evidence of record establishing a medical condition causally related to the accepted October 9, 2015 employment incident. Thus, appellant has not met her burden of proof.

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.

[18] *Supra* note 11.

[19] *Supra* note 14.

[20] *Supra* note 12.

[21] *A.W.*, Docket No. 19-0327 (issued July 19, 2019).

[22] *N.B.*, Docket No. 19-0221 (issued July 15, 2019).

[23] *Supra* note 16.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish a medical condition causally related to the accepted October 9, 2015 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the May 13, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 30, 2020
Washington, DC

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

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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