United States Department of Labor
Employees' Compensation Appeals Board

S.B., Appellant	)	
and	)	**Docket No. 19-1778**
	)	**Issued: October 23, 2020**
U.S. POSTAL SERVICE, SHELBY TOWNSHIP POST OFFICE, Shelby Township, MI, 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
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 23, 2019 appellant, through counsel, filed a timely appeal from a June 4, 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.

ISSUE

The issue is whether appellant has met his burden of proof to establish a left knee condition causally related to the accepted factors of his 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 September 21, 2017 appellant, then a 52-year-old letter carrier, filed a notice of recurrence claim (Form CA-2a) alleging that on September 11, 2017 he sustained a recurrence of his August 28, 2006 employment injury,[3] after his return to light-duty work, caused by work-related activities such as repetitive stair climbing, kneeling, squatting, and driving. He noted that he experienced significant pain and discomfort in his left knee in addition to substantial swelling. Appellant stopped work on September 20, 2017.

In a September 21, 2017 report, Dr. Steven Plomaritis, an osteopathic physician specializing in orthopedic surgery, related appellant's complaints of left knee pain and swelling. He reviewed anteroposterior, lateral, and sunrise view x-rays of appellant's left knee and diagnosed him with left knee pain and effusion, displaced meniscal tear, and medial compartment bone on bone arthritis.

On October 5, 2017 OWCP reviewed appellant's claim and determined that he had identified new work factors as the cause of his alleged conditions. Accordingly, it administratively changed his Form CA-2a to an occupational disease claim (Form CA-2) with an alleged date of injury of "around" September 11, 2017.

In a development letter dated October 11, 2017, OWCP informed appellant that the evidence of record was insufficient to establish his claim. It advised him of the type of factual and medical evidence needed and provided a questionnaire for his completion. OWCP afforded appellant 30 days to submit the necessary evidence.

In an October 25, 2017 narrative statement, appellant responded to OWCP's development questionnaire. He indicated that he believed that loading and unloading trays and packages along with an increased number of deliveries over the past few years contributed to his left knee condition. Appellant noted that he worked eight or more hours each day and spent a majority of his time delivering a heavy volume of packages. He reported that he underwent left knee surgery in 1986 following an injury in private employment, sustained a work-related right knee injury in 2003 while working at the employing establishment, and a work-related left knee injury in 2006 while working at the employing establishment. Appellant related that he first noticed the pain in his knee while delivering packages on September 11, 2017.

In an October 25, 2017 report, Dr. Plomaritis reviewed appellant's prior history of bilateral knee injuries and reported that appellant was currently experiencing bilateral knee pain. He related that appellant had a recurrence of left knee pain onset on or about September 11, 2017 while at work performing repetitively cumulative demands, delivering packages, and getting in and out of his truck. Dr. Plomaritis reviewed x-rays and a diagnostic ultrasound of appellant's left knee and diagnosed left knee medial compartment arthritis, possible medial meniscal tear, and possible stress fracture of the medial tibial plateau.

[3] OWCP assigned OWCP File No. xxxxxx779. Upon return of the case file OWCP should consider administratively combining both claim files.

By decision dated November 28, 2017, OWCP denied appellant's claim finding that the medical evidence of record was insufficient to establish a causal relationship between appellant's diagnosed left knee conditions and the accepted factors of his federal employment.

On April 18, 2018 appellant, through counsel, requested reconsideration.

In a September 19, 2017 report, Dr. Christina Blake, an osteopathic physician specializing in family medicine, related appellant's complaints of bilateral knee pain. She related his physical examination findings and diagnosed chronic pain of the left knee.

A December 12, 2017 magnetic resonance imaging (MRI) scan of appellant's left knee revealed thinning of the articular surfaces with narrowing of the joint spaces and osteophytes throughout the knee. It also showed a tear in the posterior horn of the medial meniscal cartilage, small osteochondral injuries along the articular surface of the medial condyle, and a small amount of patellar chondromalacia.

In an unsigned December 21, 2017 report of unknown origin, appellant was diagnosed with a left knee medial meniscal tear, stress fractures of the medial tibia and the medial femoral condyle, and medial compartment arthritis. The report indicated that his work activities, particularly his climbing in and out of trucks and delivering packages, had aggravated and propagated his cartilage tear and joint degeneration.

In a December 21, 2017 return to work letter, Dr. Plomaritis recommended that appellant refrain from all work from December 21, 2017 until after his surgery. In a January 23, 2018 operative report, he provided information related to appellant's January 19, 2018 surgical procedures. Dr. Plomaritis noted postoperative diagnoses of medial meniscal tear of the left knee, stress fractures of the medial femoral condyle and the medial tibial plateau, and full thickness tenosynovitis.

In support of his request for reconsideration, appellant also submitted a narrative statement dated April 3, 2018. The statement detailed his employment and medical history. It listed appellant's job duties which included loading parcels weighing up to 70 pounds, loading mail trays weighing between 25 to 40 pounds, exiting and entering a delivery vehicle, delivering packages weighing up to 70 pounds, and walking to deliver mail or packages. The statement further indicated that he was participating in physical therapy treatment following January 19, 2018 surgical procedures.

In a July 16, 2018 letter, OWCP requested that Dr. Plomaritis provide a detailed narrative report which addressed whether appellant's specific employment duties caused, precipitated, accelerated, or aggravated his diagnosed conditions. It provided Dr. Plomaritis with FECA definitions of disability, causal relationship, acceleration, precipitation, aggravation, temporary aggravation, and permanent aggravation.

In a July 26, 2018 letter, Dr. Plomaritis responded and reported that appellant's pain in appellant's left knee had gradually increased though 2017 and that it was difficult to exclude his lack of full function in the right knee as a contributing factor to his left knee symptomatology. He related that there was "a plausible causal relationship" between appellant's traumatic injury in 2006 "as well as the ongoing contribution from [appellant's] repetitive bending, squatting, climbing, and walking demands as a postal letter and mail carrier," and his left knee conditions.

By decision dated September 14, 2018, OWCP denied modification of the November 28, 2017 decision.

On March 6, 2019 appellant, through counsel, requested reconsideration.

In a February 20, 2019 report, Dr. Neil Allen, a Board-certified internist, reviewed February 8, 2019 statements from appellant detailing his work duties and medical history and an October 25, 2017 report from Dr. Plomaritis which discussed the results of x-rays and a diagnostic ultrasound. He opined that Dr. Plomaritis had provided adequate history and findings to support a diagnosis of permanent aggravation of unilateral primary osteoarthritis of the left knee. Dr. Allen related a definition of osteoarthritis as a "degenerative loss of articular cartilage, subchondral bony sclerosis, and cartilage and bone proliferation at the joint margins with subsequent osteophyte formation," that occurred "when cartilage repair [did] not keep pace with degeneration." He noted that, as one ages, the ability to repair cartilage slows and greater periods of rest for regeneration are required. Dr. Allen opined that the full-time schedule of an aging letter carrier combined with the repetitive loading required by the position (climbing out of a vehicle, climbing stairs and curbs, walking, standing, and pushing and pulling) would result in a greater amount of degeneration than what could be restored by the body. He indicated that the result of this incomplete regeneration was destruction/disruption of cartilage, reduction of joint space (primary and patellofemoral), and bony destruction/deformity. As such, Dr. Allen found that the repetitive wear associated with appellant's work duties, more than what would be normally expected as a result of aging, resulted in the permanent aggravation of appellant's underlying arthritic condition. He reported that the aggravation was permanent because current treatments for osteoarthritis provide only temporary relief and not full resolution of the underlying condition.

By decision dated June 4, 2019, OWCP denied modification of the September 14, 2018 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[4] 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,[5] 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.[6] 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.[7]

[4] *Id.*

[5] *E.W.*, Docket No. 19-1393 (issued January 29, 2020); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

[6] *L.C.*, Docket No. 19-1301 (issued January 29, 2020); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[7] 20 C.F.R. § 10.115; *E.S.*, Docket No. 18-1580 (issued January 23, 2020); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (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 identified employment factors.[8]

Causal relationship is a medical question that requires rationalized medical opinion evidence to resolve the issue.[9] 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.[10] Neither the mere fact that, a disease or condition manifests itself during a period of employment, nor the belief that the disease or condition was caused or aggravated by employment factors or incidents, is sufficient to establish causal relationship.[11]

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.[12]

ANALYSIS

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

In support of his March 6, 2019 request for reconsideration, appellant submitted a February 20, 2019 report from Dr. Allen. Dr. Allen explained that he reviewed February 8, 2019 statements from appellant detailing his work duties and medical history and an October 25, 2017 report from Dr. Plomaritis which discussed the results of x-rays and a diagnostic ultrasound to determine whether a causal relationship existed between appellant's left knee condition and the accepted factors of his federal employment. He indicated that Dr. Plomaritis had provided adequate history and findings to support a diagnosis of permanent aggravation of unilateral primary osteoarthritis of the left knee. Dr. Allen opined that appellant's full-time schedule as an aging letter carrier combined with the repetitive loading required by his position (climbing out of a vehicle, climbing stairs and curbs, walking, standing, and pushing and pulling) would result in a greater amount of degeneration than what could be restored by the body. He noted that the result of this incomplete regeneration was destruction/disruption of cartilage, reduction of joint space (primary and patellofemoral), and bony destruction/deformity. Accordingly, Dr. Allen concluded

[8] *See T.L.*, Docket No. 18-0778 (issued January 22, 2020); *Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[9] *J.F.*, Docket No. 18-0492 (issued January 16, 2020); *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[10] *A.M.*, Docket No. 18-0562 (issued January 23, 2020); *Leslie C. Moore*, 52 ECAB 132 (2000).

[11] *E.W.*, *supra* note 5; *Gary L. Fowler*, 45 ECAB 365 (1994).

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013); *see R.A.*, Docket No. 19-0650 (issued January 15, 2020); *D.H.*, Docket No. 19-0633 (issued January 8, 2020).

that the repetitive wear associated with appellant's work duties, more than what would be normally expected as a result of aging, resulted in the permanent aggravation of his underlying arthritic condition. He found that the aggravation was permanent because current treatments for osteoarthritis provide only temporary relief and not full resolution of the underlying condition.

OWCP determined that Dr. Allen's February 20, 2019 report was insufficient to establish causal relationship because it did not include a well-rationalized opinion explaining how a diagnosed condition was related to the claimed exposures at work. Factors considered by OWCP in weighing medical reports include whether the opinion is based on a complete, accurate, and consistent history covering both the medical and factual aspects of the case; whether the opinion was well reasoned and well rationalized; whether the physician has the expertise and credentials to provide a medical opinion in this case; and whether the medical opinion was speculative or equivocal.[13] There is no requirement that a physician providing an opinion on the limited issue of causal relationship must base his or her opinion on his or her own examination as opposed to the detailed findings of an attending physician's physical examination.[14]

The Board finds that Dr. Allen provided an affirmative and rationalized opinion on causal relationship. Dr. Allen identified employment factors which appellant claimed caused his condition and explained how the identified employment factors, specifically the repetitive climbing out of a vehicle, climbing stairs and curbs, walking, standing, and pushing and pulling, aggravated appellant's underlying arthritic condition. He provided a pathophysiological explanation as to how the accepted employment factors were sufficient to cause the diagnosed condition, and his opinion was supported by the physical findings of attending physician. The Board finds that Dr. Allen's opinion while insufficiently rationalized to meet appellant's burden of proof, is sufficient, given the absence of any opposing medical evidence, to require further development of the record.[15]

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While it is appellant's burden of proof to establish the claim, OWCP shares responsibility in the development of the evidence.[16] It has the obligation to see that justice is done.[17] The Board will therefore remand the case to OWCP for further development of the medical evidence. On remand OWCP shall refer appellant, a statement of accepted facts, and the medical evidence of record to a physician in the appropriate field of medicine for a rationalized opinion as to whether appellant's diagnosed left knee conditions are causally related to the accepted factors of his federal employment. Following this and any other further development as deemed necessary, OWCP shall issue a *de novo* decision on his claim.

[13] *Id*. at Chapter 2.810.6(a) (September 2010); *see S.M.*, Docket No. 18-1195 (issued January 6, 2020).

[14] *Id.*

[15] *See R.A.*, *supra* note 12; *B.M.*, Docket No. 18-0448 (issued January 2, 2020); *E.G.*, Docket No. 19-1296 (issued December 18, 2019).

[16] *Id.*

[17] *Id.*

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the June 4, 2019 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: October 23, 2020
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

Alec J. Koromilas, Chief Judge, dissenting:

The majority opinion finds that, although the February 8 2019 medical report of Dr. Neil Allen, a Board-certified internist, was insufficient to meet appellant's burden of proof to establish their claim, it was sufficient to require the Office of Workers' Compensation Programs to further develop the medical evidence. I disagree.

As a standard proposition, the Board has long held that the weight of medical opinion is determined by the opportunity for thoroughness of examination, the accuracy, and completeness of the physician's knowledge of the facts of the case, the medical history provided, the care of analysis manifested, and the medical rationale expressed in support of stated conclusions.[1]

The Federal Employees' Compensation Act Procedural Manual also sets out parameters for the weighing of medical evidence.[2] It describes a comprehensive report as one which reflects that all testing and analysis necessary to support the physician's final conclusions were performed. OWCP's procedures provide that, in general, greater probative value is given to a medical opinion

[1] *R.C.*, Docket No 14-1964 (issued January 22, 2015); *Anna C. Leanza*, 48 ECAB 115 (1996).

[2] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.810.6(a)(4) (September 2010).

based on an actual examination. An opinion based on a cursory or incomplete examination will have less value compared to an opinion based on a more complete evaluation.[3]

The case at bar raises a novel constellation of facts where appellant's physician is providing a causal opinion without seeing or examining appellant. While arguably considered a treating physician, Dr. Allen never saw nor physically examined appellant. In this case, he premised his opinion both on what he characterized as medical records that he had reviewed and indicated that the claimant was contacted for a statement. The contents of appellant's statement which appeared in Dr. Allen's report described the job tasks he performed, and the duration of same. Dr. Allen did not affirmatively indicate whether he in fact spoke with appellant nor did he reference any questions he may have asked appellant relative to his injury. Arguably, a telephone call at a minimum gives the treating doctor an opportunity to discuss the incident with appellant without just relying on medical records. However, I conclude that this is insufficient as I believe a conversation coupled with a visualization is minimally required.

It is an important distinction that the medical report of Dr. Allen in this case is being used to remand the case for further development.[4] The majority finds that, although his opinion contains insufficient medical rationale to establish the claim, it is sufficient to remand for OWCP to further develop the claim. This is effectuated by the 30-year-old Board-created standard, which provides that "when there is sufficient evidence to establish that the incident occurred, as alleged, but the medical evidence was insufficiently developed to establish the component of fact of injury, evidence submitted by appellant, which contains a history of injury, an absence of any other noted trauma, and an opinion that the condition found was consistent with the original injury is sufficient, given the absence of any opposing medical evidence, to require further development of the record."[5] It could be characterized as a reduced subjective standard, which effectively shifts the burden of proof to OWCP. This case was previously denied by OWCP based on in-person physical examination(s), which were found to be insufficient under the same reduced standard.

Especially, in this posture, I believe certain basic medical examination parameters must be met. Dr. Allen espoused an opinion on causal relationship without the benefit of direct physical examination or observations and based his findings on the second-hand opinion(s) of other physicians. This is the type of injury that lends itself to an examination for the purposes of diagnosis and causation, where the physician is able at a minimum to see the patient, question and receive a first-hand account of the injury and compare same. This remains critical even when the only issue is causation. I do not agree that words of causation in the ordinary course alone can be separated from some type of examination of appellant by appellant's physician.

Of course, there are occasions where a physical examination cannot be conducted, such as when appellant is deceased. In that situation, record reviews are required and the weight of medical

[3] *Id*.

[4] *R.H.*, Docket No. 17-1966 (issued March 6, 2018); *John J. Carlone*, 41 ECAB 354 (1989).

[5] *Id*.

reports in the first instance are weighed using the above-mentioned criteria. But those circumstances are rare and that is inapplicable in the present case.

One could argue that this type of situation is similar to the use by OWCP of a district medical adviser (DMA). The Board has found that the unique status of the DMA, which allows for an advisory medical opinion without a physical examination, can be of sufficient probative value in certain circumstances.[6] I believe that there is an important distinction between a DMA as described in *Jackson* and a treating physician such as Dr. Allen in this case. A treating physician and DMA do not share the same status. DMAs have a much more defined and narrow purpose. They are generally charged with the computations of schedule awards, the medical necessity of requested surgeries, and other such issues that do not require an in-person examination. As well, they operate under parameters that ensure appropriate review of the evidence, as they have the benefit of the complete OWCP record, as well as a statement of accepted facts created by OWCP, which they must follow for the purposes of history, knowledge, and analysis. In Dr. Allen's situation, there are no such safeguards.

If Dr. Allen was able to view, speak with, and examine appellant, I would be inclined to perhaps be satisfied with his knowledge and understanding of the matter and agree with the majority that his opinion would be sufficient to remand for OWCP to further develop the medical evidence. However, the majority finding in my view, without the benefit of a conversation coupled with a visualized examination effectively shifts the burden of proof to OWCP to disprove the claim based on a medical report that is of questionable probative value.

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

[6] *Melvina Jackson*, 38 ECAB 443 (1987) (regarding the importance, when assessing medical evidence, of such factors as a physician's knowledge of the facts and medical history, and the care of analysis manifested and the medical rationale expressed in support of the physician's opinion).