United States Department of Labor
Employees' Compensation Appeals Board

P.B., Appellant	)	
and	)	**Docket No. 21-0157**
	)	**Issued: September 2, 2021**
U.S. POSTAL SERVICE, LAS VEGAS PROCESSING & DISTRIBUTION CENTER, Las Vegas, NV, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

ORDER REMANDING CASE

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

On November 9, 2020 appellant filed a timely appeal from an October 5, 2020 merit decision of the Office of Workers' Compensation Programs (OWCP). The Clerk of the Appellate Boards assigned Docket No. 21-0157.

On July 18, 2020 appellant, then a 58-year-old maintenance mechanic, filed an occupational disease claim (Form CA-2) alleging that he developed pain in his lower back, knees, feet, shoulders, and neck due to factors of his federal employment, including repetitive motion stooping, overhead reaching, climbing, kneeling, squatting as well as prolonged standing and walking throughout his 24-year career with the employing establishment. He indicated that he first became aware of his condition on January 17, 2017 and realized its relation to his federal employment on July 9, 2020.

In a development letter dated July 24, 2020, OWCP advised appellant of the factual and medical deficiencies of his claim. It requested a narrative medical report from his treating physician, which contained a detailed description of findings and diagnoses, explaining how his work activities caused, contributed to, or aggravated his medical conditions. OWCP afforded appellant 30 days to respond.

Appellant submitted multiple diagnostic reports dated from November 10, 2016 to September 18, 2017 in which he underwent x-ray scans of his lumbar spine, neck, left foot, right humerus and right shoulder, as well as an electromyography and nerve conduction velocity (EMG/NCV) study of his right arm.

In an October 25, 2017 medical report, Craig Mosier, a physician assistant, evaluated appellant for his bilateral shoulder pain, observing that he began experiencing pain in his right shoulder two months prior for no apparent reason. Appellant asserted that his pain was a result of hard work and labor over many years.

In a January 19, 2018 medical report, Dr. Ryhor Habacheyski, a Board-certified orthopedic surgeon, evaluated appellant for right shoulder pain. He noted that appellant presented with impingement-like symptoms in October 2017 and that after completing physical therapy, his right shoulder pain still remained. A magnetic resonance imaging (MRI) scan of appellant's right shoulder revealed diffuse tendinosis. He was treated with corticosteroid injection to his right shoulder.

In medical reports dated April 11 and July 6, 2018, Mr. Mosier evaluated appellant for right knee pain. He noted that an x-ray scan of appellant's right knee revealed minimal to no chronic or acute degenerative findings, while MRI scans of his right knee and lumbar spine were largely unremarkable. Mr. Mosier diagnosed a normal right knee with scant chondromalacia. He informed appellant of his treatment options and opined that the history of his symptoms did not support joint etiology, nor did the MRI scans of his knees or spine support a structural etiology to explain the episode of muscle dysfunction.

In a September 6, 2018 medical report, Dr. Michael Horan, a Board-certified neurologist, evaluated appellant for diffuse dysesthesia, low back pain, pain in his neck and shoulders as well as bilateral leg weakness. He observed that a September 1, 2017 NCV study of appellant's right upper extremity returned as normal and a May 18, 2018 MRI scan of his lumbar spine demonstrated mild degenerative joint disease with no central stenosis and minimal foraminal narrowing. On evaluation of appellant's cervical spine, Dr. Horan opined that there was very little evidence to suggest myelopathy and that the issue was most likely cervical radiculopathy. He observed that appellant's EMG/NCV study revealed neuropathy and recommended an MRI scan of his cervical spine for further evaluation.

OWCP received additional diagnostic reports dated from March 1 to October 18, 2018 in which appellant underwent MRI scans of his right knee, lumbar spine, and cervical spine.

In an October 18, 2018 letter, Remeliza Tukay, a registered nurse, explained that appellant's knee pain was being treated with a brace and that the MRI scan of his right knee revealed moderate chondromalacia patella. Appellant's low back pain was being treated with steroid injections and acupuncture and an MRI scan of lower back demonstrated degenerative disc changes. An MRI scan of his right shoulder demonstrated moderate rotator cuff tendinosis and mild bursitis.

In medical reports dated from December 12, 2018 to October 28, 2019, Dr. Horan evaluated appellant for his diffuse dysesthesia. In subsequent April 29 and October 28, 2019

medical reports, he discussed appellant's symptoms related to fibromyalgia and recommendations for continued treatment.

OWCP received x-ray scans of appellant's right foot, left hip, and lumbar spine dated March 4 and 11, 2020.

In a May 28, 2020 medical information and restriction assessment form, Nurse Tukay diagnosed fibromyalgia, asthma, migraine as well as chronic back, bilateral foot, and knee pain.

In a July 2, 2020 medical report, Dr. Mandy Olcott, a Board-certified podiatrist, noted that appellant had been experiencing pain in the bottom of his feet for years, especially with prolonged standing and walking. She diagnosed osteopenia of the right foot and opined that he was probably progressing towards foot surgery to treat his condition. In a medical form of even date, Dr. Olcott released appellant to work effective January 7, 2021, with restrictions.

Appellant also submitted an August 9, 2020 list of conditions he was being treated for, including fibromyalgia, knee pain, internal impingement of the right shoulder, migraine, osteopenia, chronic body aches, low back pain, foot pain and plantar fasciitis.

By decision dated October 5, 2020, OWCP denied appellant's occupational disease claim, finding that the medical evidence of record was insufficient to establish his diagnosed medical conditions were causally related to the accepted factors of his federal employment. It noted that "[no] further evidence was received" following the issuance of the July 24, 2020 development letter.

The Board has duly considered the matter and Board finds that the case is not in posture for decision.[1]

In the case of *William A. Couch*,[2] the Board held that when adjudicating a claim, OWCP is obligated to consider all evidence properly submitted by a claimant and received by OWCP before the final decision is issued. While OWCP is not required to list every piece of evidence submitted to the record, the record is clear that medical reports were not reviewed by OWCP in its October 5, 2020 decision.[3] OWCP only acknowledged receipt of medical notes from Dr. Horan, diagnostic reports and other medical restriction assessments. It provided no discussion of the numerous other medical reports submitted to the record following its July 24, 2020 development letter. As OWCP did not note receipt or consideration of this medical evidence, it failed to follow its own procedures by properly discussing the relevant medical reports of record.[4]

[1] *See K.F.*, Docket No. 19-0888 (issued January 2, 2020); *J.J.*, Docket No. 13-1666 (issued August 18, 2014).

[2] 41 ECAB 548, 553 (1990).

[3] *See T.G.*, Docket No. 19-1930 (issued January 8, 2021).

[4] All evidence submitted should be reviewed and discussed in the decision. Evidence received following development that lacks probative value should also be acknowledged. Whenever possible, the evidence should be referenced by author and date. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Initial Denials*, Chapter 2.1401.5(b)(2) (November 2012).

As the Board's decisions are final as to the subject matter appealed, it is crucial that all evidence relevant to the subject matter of the claim which was properly submitted to OWCP prior to the time of issuance of its final decision be reviewed and addressed by OWCP.[5] Because OWCP failed to consider all of the medical evidence submitted by appellant, the Board cannot review such evidence for the first time on appeal.[6]

For this reason, the case will be remanded to OWCP to properly consider all of the evidence of record.[7] Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.[8] Accordingly,

IT IS HEREBY ORDERED THAT the October 5, 2020 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for proceedings consistent with this order of the Board.

Issued: September 2, 2021
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

[5] *See S.K.*, Docket No. 18-0478 (issued January 2, 2019); *Yvette N. Davis*, 55 ECAB 475 (2004); *see also Linda Johnson*, 45 ECAB 439 (1994) (applying *Couch* where OWCP did not consider a medical report received on the date of its decision).

[6] 20 C.F.R. § 501.2(c). *See also G.M.*, Docket No. 16-1766 (issued February 16, 2017).

[7] *M.J.*, Docket No. 18-0605 (issued April 12, 2019).

[8] *B.N.*, Docket No. 17-0787 (issued July 6, 2018).