United States Department of Labor
Employees' Compensation Appeals Board

C.M., Appellant	)	
and	)	**Docket No. 25-0772**
	)	**Issued: December 15, 2025**
U.S. POSTAL SERVICE, OMAHA POST OFFICE, Omaha, NE, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 5, 2025 appellant filed a timely appeal from June 17 and July 7, 2025 merit decisions 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.[2]

ISSUE

The issue is whether appellant has met his burden of proof to establish a medical condition causally related to the accepted factors of his federal employment.

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the July 7, 2025 decision, appellant submitted additional evidence to OWCP. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

FACTUAL HISTORY

On March 14, 2025 appellant, then a 43-year-old postal distribution clerk, filed an occupational disease claim (Form CA-2) alleging that he developed a left shoulder condition due to factors of his federal employment including various repetitive motions related to loading, swiping, and pulling trays of mail. He noted that he first became aware of his condition and realized its relation to his federal employment on February 26, 2025. Appellant stopped work on March 11, 2025.

In support of his claim, appellant submitted largely illegible after-visit summaries dated March 9 and 11, 2025 regarding emergency department treatment for left shoulder pain. A March 14, 2025 magnetic resonance imaging (MRI) scan of the left shoulder was also submitted, which revealed an impression of supraspinatus tendinosis with low-grade partial thickness interstitial tear; mild long head biceps tenosynovitis; no evidence of labral tear; mild subacromial/subdeltoid bursitis; and mild degenerative change of the acromioclavicular (AC) joint.

In a March 24, 2025 development letter, OWCP informed appellant of the deficiencies of his claim. It advised him of the type of factual and medical evidence needed and provided a questionnaire for his completion. OWCP afforded appellant 60 days to submit the necessary evidence.

Appellant subsequently submitted a March 9, 2025 report from Dr. Dean Karas, Board-certified in family medicine, noting that appellant presented to the emergency department with complaints of left shoulder pain which radiated down into his arm for the past two weeks which had been fairly steady. He described worsening pain with use of his arm or excessive movement. Appellant denied any particular injury and explained that he worked for the employing establishment which entailed frequent heavy lifting. Dr. Karas noted that physical examination revealed significant tenderness with both passive and active range of motion in the left shoulder, movements of the left elbow elicited discomfort in the shoulder, no active synovitis, and distal neurovascular examination was intact with good sensation. He diagnosed left shoulder pain and ordered an x-ray of the left shoulder.

A March 9, 2025 x-ray of the left shoulder revealed an impression of no acute or articular abnormality as evidenced by no acute fracture or dislocation, AC and glenohumeral joints were intact, subacromial space appeared maintained, no significant degenerative changes, and visualized portion of the left lung was clear.

In a March 11, 2025 report, Dr. Benjamin Gibson, a Board-certified urologist, reported that appellant presented to the emergency department with continued complaints of left shoulder pain on that date which was unchanged from his visit two days prior as the medication provided was not effective. He provided examination findings, noting that appellant was able to extend his left arm anterior to approximately 90 degrees, adduct to approximately 90 degrees, and circulatory motor sensory (CMS) and neurovascular status were adequate to the left lower arm and hand. Dr. Gibson noted that the pain was localized to the left shoulder and somewhat in the left armpit which revealed some tenderness with palpation to the left trapezoid. He diagnosed left shoulder

pain, reporting that appellant's left shoulder x-ray from two days prior was without acute injury. As such, Dr. Gibson referred appellant for an MRI scan of the left shoulder.

In progress notes dated March 13 through 20, 2025, Wyatt Schmidt, a physician assistant, evaluated appellant for left shoulder pain, reviewed diagnostic testing, and diagnosed pain in left shoulder, stiffness in left shoulder, and unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic. In a March 20, 2025 return to work status note, Mr. Schmidt restricted appellant from returning to work until he was evaluated by orthopedics.

In an April 7, 2025 report, Dr. Matthew Dilisio, a Board-certified orthopedic surgeon, evaluated appellant for complaints of left shoulder pain and provided physical examination findings. He discussed the history of injury, noting that appellant had ongoing left shoulder pain for the last five weeks which began at work on February 26, 2025 and had slowly progressed. Appellant denied any previous shoulder issues and reported pain behind the shoulder, particularly with excessive movement. Dr. Dilisio noted that an MRI scan of his left shoulder showed a partial supraspinatus tear and reported that appellant was currently not working per his doctor's recommendation as he attempted light-duty work, but continued to experience pain as any movement involving his left shoulder at work triggered pain that radiated throughout his entire left arm. He noted review of the March 9, 2025 left shoulder x-ray which revealed some AC joint arthrosis and no gross arthritis, as well as the March 14, 2025 left shoulder MRI scan which demonstrated maintained glenohumeral alignment, high-grade partial versus full-thickness leading edge rotator cuff tear with impingement and degenerative labral tear. Dr. Dilisio diagnosed partial-thickness left rotator cuff tear, administered a left shoulder steroid injection, and restricted appellant from returning to work for three weeks following a home therapy program, after which surgical repair would be considered if he remained symptomatic.

In an April 7, 2025 note, Dr. Dilisio restricted appellant from returning to work. In an April 16, 2025 addendum report, he reviewed diagnostic testing and noted that two views of the cervical spine demonstrated degenerative changes within the lower cervical vertebrae with marginal osteophyte formation and disc space narrowing. Dr. Dilisio found a mild facet hypertrophy impression for mild cervical spondylosis.

In a follow-up letter dated April 28, 2025, OWCP advised appellant that it had conducted an interim review, and the evidence remained insufficient to establish his claim. It noted that he had 60 days from the March 24, 2025 letter to submit the necessary evidence. OWCP further advised that if the evidence was not received during this time, it would issue a decision based on the evidence contained in the record.

Appellant submitted additional evidence, including Dr. Gibson's previously submitted March 11, 2025 report documenting treatment at the emergency department for left shoulder pain.

In a May 8, 2025 report, Dr. M.O. Dada, Board-certified in family medicine, reported that appellant presented with complaints of left shoulder pain and discussed his history of injury noting that he was seen in the emergency room twice in March 2025, underwent an MRI scan of the left shoulder on March 14, 2025, received a steroid injection from Dr. Dilisio, and underwent an MRI scan of his neck on May 7, 2025. He reported that the March 14, 2025 MRI scan of the left shoulder revealed an impression of supraspinatus tendinosis with low-grade partial-thickness

interstitial tear; mild long head biceps tenosynovitis; no evidence of labral tear; mild subacromial/subdeltoid bursitis; and mild degenerative change acromioclavicular joint. Dr. Dada noted that appellant attempted light-duty work with no success and Dr. Dilisio recommended undergoing a steroid injection for cervical radiculopathy. He diagnosed left shoulder pain and work-related injury, explaining that appellant worked in a warehouse, performed repetitive movements at work, and that his injury came from working and pulling carts of mail.

In a May 19, 2025 report, Dr. Samuel Dubrow, a Board-certified orthopedic surgeon, reported that appellant presented for evaluation of his left shoulder. He discussed the history of injury, noting that appellant was working on February 26, 2025 sweeping and loading parcels when he experienced some pain in his left shoulder, reporting that two days later the pain became significantly worse. Appellant tried to continue performing his work activities but ultimately, had to present to the emergency room on March 9, 2025 due to left shoulder pain, weakness, and difficulty raising the left arm overhead since that time. He denied prior left shoulder pain until the repetitive pushing and pulling incident on February 26, 2025. Dr. Dubrow provided physical examination findings, reviewed the diagnostic testing, and diagnosed biceps tendinitis of left upper extremity, left shoulder pain, unspecified chronicity, traumatic incomplete tear of left rotator cuff, bursitis of left shoulder, and impingement syndrome of left shoulder. He administered a left shoulder glenohumeral joint injection, recommended a course of physical therapy, and restricted appellant from returning to work.

In a May 19, 2025 note, Dr. Dubrow reported that appellant was evaluated for his left shoulder injury sustained at work, and a cortisone injection was administered. He opined that appellant was unable to return to work, would seek physical therapy treatment, and follow up in four to five weeks for further evaluation.

In a May 22, 2025 statement, appellant responded to OWCP's development letter and described his repetitive employment duties and circumstances surrounding his injury. He reported that he had no history of a left shoulder injury prior to February 26, 2025 and never had surgery before. Appellant noted that even before the injury occurred, he was complaining about working alone on the machine which required two people to operate. He reported that he was performing these tasks almost one month prior to the injury resulting in a new condition as he never felt pain in his shoulder prior to these events.

By decision dated June 17, 2025, OWCP denied appellant's occupational disease claim, finding that the medical evidence of record was insufficient to establish a medical condition causally related to the accepted factors of his federal employment.

On June 23, 2025 appellant requested reconsideration and submitted additional evidence in support of his claim.

In a June 23, 2025 report, Dr. Dubrow evaluated appellant for follow up of his left shoulder since his prior visit on May 19, 2025, noting that appellant reported some improvement with overhead activity, while other activities continued to provoke the left shoulder when reaching overhead or out to the side. He discussed his history of injury which was significant for repetitive pushing and pulling at work on February 26, 2025 resulting in increased pain and weakness in the left shoulder a few days later. Dr. Dubrow provided physical examination findings and reviewed

diagnostic testing. He reported that appellant appeared to be doing much better than his previous visit but continued to struggle with pain and decreased function which was secondary to a work-related injury that occurred, causing pain to his left shoulder. Dr. Dubrow diagnosed biceps tendinitis of left upper extremity; traumatic incomplete tear of left rotator cuff, initial encounter; bursitis of left shoulder; and impingement syndrome of left shoulder, and opined that the pain and injury to appellant's left shoulder was caused by the work-related injury. He reported that appellant could return to work on June 26, 2025 with restrictions of no lifting, pulling, or pushing greater than 10 pounds.

In a June 24, 2025 report, Dr. Dada reported that appellant presented for follow-up evaluation of his left shoulder. He noted a prior history of significant repetitive pushing and pulling of carts of heavy items on February 26, 2025 while working for the employing establishment, reporting increased pain and weakness in his left shoulder a couple days later which resulted in treatment at the emergency department on March 9 and 11, 2025. Dr. Dada reported that appellant was not currently working and had been off work for about three months, noting that he first evaluated appellant on May 8, 2025 following treatment with Dr. Dilisio of orthopedic surgery. He diagnosed work-related injury (primary), acute left shoulder pain, and instructed appellant to follow-up with orthopedic surgery.

By decision dated July 7, 2025, OWCP denied modification of the June 17, 2025 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] has the burden of proof to establish the essential elements of his or her claim, including 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,[4] 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.[5] 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.[6]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, an employee 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

[3] *Supra* note 1.

[4] *E.K.*, Docket No. 22-1130 (issued December 30, 2022); *F.H.*, Docket No. 18-0869 (issued January 29, 2020); *J.P.*, Docket No. 19-0129 (issued April 26, 2019); *Joe D. Cameron*, 41 ECAB 153 (1989).

[5] *S.H.*, Docket No. 22-0391 (issued June 29, 2022); *L.C.,* Docket No. 19-1301 (issued January 29, 2020); *J.H.,* Docket No. 18-1637 (issued January 29, 2020); *James E. Chadden, Sr.,* 40 ECAB 312 (1988).

[6] *E.H.,* Docket No. 22-0401 (issued June 29, 2022); *P.A.,* Docket No. 18-0559 (issued January 29, 2020); *K.M.,* Docket No. 15-1660 (issued September 16, 2016); *Delores C. Ellyett,* 41 ECAB 992 (1990).

condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[7]

Causal relationship is a medical question that requires rationalized medical opinion evidence to resolve the issue.[8] A physician's opinion on whether there is causal relationship between the diagnosed condition and the implicated employment factor(s) must be based on a complete factual and medical background.[9] Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factor(s).[10]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish a medical condition causally related to the accepted factors of his federal employment.

In support of his claim, appellant submitted reports dated May 8 through June 24, 2025, wherein Dr. Dada discussed appellant's history of injury at work on February 26, 2025. He diagnosed work-related injury (primary) and acute left shoulder pain and opined that appellant's injury resulted from pulling carts of mail at work. The Board has held that a report is of limited probative value regarding causal relationship if it does not contain medical rationale explaining how a given medical condition/disability was related to employment factors.[11] Therefore, this evidence is insufficient to establish the claim.

In reports and work status notes dated May 19 through June 23, 2025, Dr. Dubrow provided examination findings, reviewed diagnostic testing, and diagnosed biceps tendinitis of left upper extremity, traumatic incomplete tear of left rotator cuff, bursitis of left shoulder, and impingement syndrome of left shoulder, which he opined was caused by appellant's employment duties. While Dr. Dubrow provided an affirmative opinion in support of causal relationship, he did not offer sufficient rationale to support his opinion.[12] The Board has held that medical opinion

[7] *R.G.*, Docket No. 19-0233 (issued July 16, 2019); *see also Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *Ruby I. Fish*, 46 ECAB 276, 279 (1994); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[8] *S.M.*, Docket No. 22-0075 (issued May 6, 2022); *S.S.*, Docket No. 19-0688 (issued January 24, 2020); *A.M.,* Docket No. 18-1748 (issued April 24, 2019); *Robert G. Morris,* 48 ECAB 238 (1996).

[9] *M.V.*, Docket No. 18-0884 (issued December 28, 2018).

[10] *J.D.*, Docket No. 22-0935 (issued December 16, 2022); *T.L.,* Docket No. 18-0778 (issued January 22, 2020); *Y.S.,* Docket No. 18-0366 (issued January 22, 2020); *Victor J. Woodhams, supra* note 7.

[11] *See Y.D.*, Docket No. 16-1896 (issued February 10, 2017) (finding that a report is of limited probative value regarding causal relationship if it does not contain medical rationale describing the relation between work factors and a diagnosed condition/disability).

[12] *See J.S.,* Docket No. 25-0231 (issued March 7, 2025); *A.C.*, Docket No. 24-0661 (issued September 11, 2024); *R.B.*, Docket No. 23-1027 (issued April 3, 2024); *S.B.*, Docket No. 24-0064 (issued February 28, 2024); *S.C.*, Docket No. 21-0929 (issued April 28, 2023); *J.D.*, Docket No. 19-1953 (issued January 11, 2021); *M.W.*, Docket No. 14-1664 (issued December 5, 2014).

evidence must offer a medically-sound explanation of how the specific employment incident physiologically caused injury.[13] This evidence is therefore insufficient to establish the claim.

In a March 9, 2025 report from Dr. Karas and March 11, 2025 report from Dr. Gibson, documenting treatment at the emergency department and diagnosing left shoulder pain. The reports of Drs. Karas and Gibson, however, are insufficient to establish appellant's claim as the physicians failed to provide an opinion on causal relationship. The Board has held that medical evidence that does not offer an opinion regarding the cause of an employee's condition is of no probative value on the issue of causal relationship.[14] Therefore, this evidence is insufficient to establish appellant's claim.

In reports and work status notes dated April 7 through 16, 2025, Dr. Dilisio evaluated appellant for complaints of left shoulder pain, provided physical examination findings, and discussed the history of injury noting that appellant's ongoing left shoulder pain slowly progressed which began at work on February 26, 2025. He diagnosed partial-thickness left rotator cuff tear and mild cervical spondylosis, administered a left shoulder steroid injection, and restricted appellant from returning to work. Dr. Dilisio did not, however, provide an opinion on the cause of the diagnosed medical condition. As explained above, the Board has held that medical evidence that does not offer an opinion regarding the cause of an employee's condition is of no probative value on the issue of causal relationship.[15] As such, this evidence is insufficient to establish appellant's claim.

OWCP also received largely illegible after-visit summaries dated March 9 and 11, 2025. However, the Board has long held that reports that are unsigned or bear an illegible signature lack proper identification and cannot be considered probative medical evidence because the author cannot be identified as a physician.[16] Therefore these reports are insufficient to establish the claim.

Appellant also submitted progress and work notes dated March 13 through 20, 2025 signed by Mr. Schmidt, a physician assistant. The Board has held, however, that medical reports signed solely by a physician assistant, registered nurse, or medical assistant are of no probative value as such healthcare providers are not considered physicians as defined under FECA and are, therefore,

[13] *C.L*, Docket No. 25-0593 (issued July 15, 2025); *K.J*., Docket No. 21-0020 (issued October 22, 2021); *L.R*., Docket No. 16-0736 (issued September 2, 2016); *J.R*., Docket No. 12-1099 (issued November 7, 2012); *Douglas M. McQuaid*, 52 ECAB 382 (2001).

[14] *See L.B.*, Docket No. 18-0533 (issued August 27, 2018); *D.K.,* Docket No. 17-1549 (issued July 6, 2018).

[15] *G.M.,* Docket No. 24-0388 (issued May 28, 2024); *C.R.,* Docket No. 23-0330 (issued July 28, 2023); *K.K.,* Docket No. 22-0270 (issued February 14, 2023); *S.J.,* Docket No. 19-0696 (issued August 23, 2019); *M.C.,* Docket No. 18-0951 (issued January 7, 2019); *L.B.,* Docket No. 18-0533 (issued August 27, 2018); *D.K.,* Docket No. 17-1549 (issued July 6, 2018).

[16] *L.B.*, Docket No. 21-0353 (issued May 23, 2022); *T.D.*, Docket No. 20-0835 (issued February 2, 2021); *Merton J. Sills,* 39 ECAB 572, 575 (1988).

not competent to provide medical opinions.[17] Consequently, their medical findings and/or opinions will not suffice for the purpose of establishing entitlement to FECA benefits.[18] Accordingly, these reports are insufficient to establish the claim.

The remaining medical evidence consists of diagnostic test results, including the March 9, 2025 x-ray and March 14, 2025 MRI scan of the left shoulder. The Board has held that diagnostic studies, standing alone, lack probative value as they do not address whether the employment factors caused any of the diagnosed conditions.[19] Such reports are therefore insufficient to establish appellant's claim.

As the medical evidence of record is insufficient to establish causal relationship between a medical condition and the accepted factors of federal employment, the Board finds that appellant has not met his burden of proof.[20]

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 a medical condition causally related to the accepted factors of his federal employment.

[17] Section 8101(2) provides that physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law, 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t). *See also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3a(1) (May 2023); *David P. Sawchuk,* 57 ECAB 316, 320 n.11 (2006) (lay individuals such as physician assistants, nurses, and physical therapists are not competent to render a medical opinion under FECA); *H.S.,* Docket No. 20-0939 (issued February 12, 2021) (physician assistants are not considered physicians as defined under FECA).

[18] *Id.*

[19] *See M.P.*, Docket No. 23-1131 (issued June 18, 2024); *V.A.*, Docket No. 21-1023 (issued March 6, 2023); *M.K.*, Docket No. 21-0520 (issued August 23, 2021); *F.D.*, Docket No. 19-0932 (issued October 3, 2019).

[20] *I.D.*, Docket No. 22-0848 (issued September 2, 2022); *T.G.*, Docket No. 14-751 (issued October 20, 2014).

ORDER

IT IS HEREBY ORDERED THAT the June 17 and July 7, 2025 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: December 15, 2025
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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