United States Department of Labor
Employees' Compensation Appeals Board

D.H., Appellant	)	
and	)	**Docket No. 25-0743**
	)	**Issued: November 19, 2025**
U.S. POSTAL SERVICE, CHICAGO INTERNATIONAL SERVICE CENTER, Chicago, IL, Employer	)	

Appearances:
Appellant, pro se
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 July 29, 2025 appellant filed a timely appeal from a March 18, 2025 merit decision 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.

ISSUE

The issue is whether appellant has met his burden of proof to establish a foot condition causally related to the accepted July 5, 2024 employment incident.

FACTUAL HISTORY

On December 26, 2024 appellant, then a 44-year-old tractor trailer operator, filed a traumatic injury claim (Form CA-1) alleging that on July 5, 2024 he injured his foot when he

[1] 5 U.S.C. § 8101 *et seq*.

slipped exiting his truck while in the performance of duty. He stopped work on July 5, 2024 and returned to full-time regular duty on July 6, 2024.

In a development letter dated January 3, 2025, OWCP informed appellant of the deficiencies of his claim. It advised him of the type of factual and medical evidence needed and afforded him 60 days to submit the necessary evidence. No additional evidence was received.

In a follow-up development dated February 4, 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 January 3, 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.

In a March 10, 2025 statement, appellant indicated that he injured the big toe on his left foot when he slipped on July 5, 2025. He stated that he saw a doctor after his toe became swollen.

The record reflects appellant was hospitalized on August 14, 2024 and discharged on August 20, 2024. In the August 15, 2024 hospital report, Dr. Karim Abou El Joud, a Board-certified internist, noted appellant's past medical history and that he presented with a diabetic left foot infection. He provided assessments of diabetic left foot infection; chronic multifocal osteomyelitis of right foot; Charcot's joint arthropathy in type 2 diabetes mellitus; diabetic peripheral neuropathy associated with type 2 diabetes mellitus; type 2 diabetes mellitus with hyperglycemia and long-term current use of insulin; acute kidney injury superimposed on chronic disease; stage 3(a) chronic kidney disease; chronic anemia; and cellulitis of the left foot. Copies of diagnostic testing were contained within the hospital record. These documents included an August 14, 2024 left foot x-ray, which revealed no acute displaced fracture or dislocation; a small posterior calcaneal spur, mild degenerative changes in the first metatarsophalangeal joint with mild hallux valgus, mild degenerative joint disease in the midfoot joints, soft tissue swelling and intact bones with no focal cortical bony erosions; an August 14, 2024 venus duplex lower extremity study of the left lower extremity, which was normal; and an August 14, 2025 magnetic resonance imaging (MRI) scan of the left foot which revealed osteomyelitis involving the distal phalanx of the first toe, edema in the first, second, and third digits and extended along the dorsum of the foot; and fluid in the intrinsic musculature of the foot suggesting myositis or denervation.

In an August 15, 2024 consult note, Dr. Maureen McShane, a podiatrist, provided an assessment of cellulitis of the left foot, diabetic ulcer of foot associated with diabetes mellitus due to underlying condition, limited to breakdown of skin, fever, acute renal insufficiency, and dehydration. In an August 16, 2025 note, she noted that appellant was admitted through the emergency department with a diabetic left foot infection with significant edema, erythema of the left great toe and ulceration of the distal tip of the digit with gradual onset of symptoms three weeks ago with a rapidly worsening course. Dr. McShane indicated that appellant's MRI scan was consistent with osteomyelitis of the distal phalanx of the left great toe. She recommended amputation of the left great toe, which appellant underwent on August 16, 2024.

In consultation notes dated August 19, 2024, Dr. Kathleen Ruggero, an osteopathic physician Board-certified in infectious disease and internal medicine, assessed appellant's condition. She related appellant's findings as left foot diabetic infection, chronic multifocal

osteomyelitis of the right foot, Charcot's joint arthropathy in type 2 diabetes mellitus, type 2 diabetes mellitus with hyperglycemia, stage 3 chronic kidney disease, essential hypertension, chronic anemia, cellulitis of the left foot, acute kidney injury, and partial amputation of the left great toe on August 16, 2024.

Discharge diagnoses by Dr. El Joud were cellulitis of left foot, diabetic ulcer of foot associated with diabetes mellitus due to underlying condition, limited to breakdown of skin, fever, acute renal insufficiency, dehydration, type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin; acute osteomyelitis of left foot, abscess of left foot, and status post left hallux amputation.

In a March 3, 2025 attending physician's report (Form CA-20), Dr. McShane noted that appellant presented with traumatic osteomyelitis of the left great toe which appellant stated occurred when he bumped the toe on his work vehicle. She diagnosed lymphedema left great toe with underlying diabetes and ulcer of the left great toe. Dr. McShane related that appellant was disabled from August 15 to December 11, 2024.

By decision dated March 18, 2025, OWCP denied appellant's claim, finding that the medical evidence was insufficient to establish that the diagnosed conditions were causally related to the accepted July 5, 2024 employment incident.

LEGAL PRECEDENT

An employee seeking benefits under FECA[2] 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,[3] 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.[4] 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.[5]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether fact of injury has been established. First, the employee must submit sufficient evidence to establish that he or she actually experienced the

[2] *Id*.

[3] *S.J.,* Docket No. 25-0359 (issued April 15, 2025); *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).

[4] *S.J., id.*; *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).

[5] *S.J., supra* note 3; *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).

employment incident at the time and place, and in the manner alleged. Second, the employee must submit sufficient evidence to establish that the employment incident caused an injury.[6]

The medical evidence required to establish causal relationship is rationalized medical opinion evidence.[7] The opinion of the physician must be based on a complete factual and medical background of the employee, 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 specific employment incident identified by the employee.[8]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish a foot condition causally related to the accepted July 5, 2024 employment incident.

OWCP received an August 15, 2024 hospital report from Dr. El Joud which indicated that appellant had presented with a diabetic left foot infection. Dr. El Joud provided assessments of several conditions, initial conditions, including cellulitis of left foot; diabetic ulcer of foot associated with diabetes mellitus due to underlying condition, limited to breakdown of skin; fever; acute renal insufficiency; type 2 diabetes mellitus with hyperglycemia, acute osteomyelitis of toe of left foot; abscess of left foot; and status post left hallux amputation. Likewise, in consultation notes dated August 19, 2024, Dr. Ruggero assessed appellant's condition. She related appellant's findings as left foot diabetic infection, chronic multifocal osteomyelitis of the right foot, Charcot's joint arthropathy in type 2 diabetes mellitus, type 2 diabetes mellitus with hyperglycemia, stage 3 chronic kidney disease, essential hypertension, chronic anemia, cellulitis of the left foot, acute kidney injury, and partial amputation of the left great toe on August 16, 2024. These physicians, however, did not provide an opinion that any of the diagnosed conditions were causally related to the accepted July 5, 2024 employment incident. The Board has held that medical evidence that does not offer an opinion regarding the cause of an employee's condition or disability is of no probative value on the issue of causal relationship.[9] Therefore, this evidence is insufficient to establish appellant's claim.

OWCP also received several reports from Dr. McShane. In an August 15, 2024 report, Dr. McShane provided an assessment of cellulitis of left foot, diabetic ulcer of foot associated with diabetes mellitus due to underlying condition, limited to breakdown of skin, fever, acute renal insufficiency, and dehydration. In her August 16, 2025 note, she noted that appellant was admitted through the emergency department with a diabetic left foot infection and significant edema,

[6] *J.P.,* Docket No. 25-0507 (issued June 10, 2025); *T.J.,* Docket No. 19-0461 (issued August 11, 2020); *K.L.,* Docket No. 18-1029 (issued January 9, 2019); *John J. Carlone*, 41 ECAB 354 (1989).

[7] *See C.M.,* Docket No. 25-0408 (issued April 16, 2025); *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).

[8] *See R.D.,* Docket No. 25-0625 (issued July 30, 2025); *C.M., id.*; *T.L.,* Docket No. 18-0778 (issued January 22, 2020); *Y.S.,* Docket No. 18-0366 (issued January 22, 2020); *Victor J. Woodhams,* 41 ECAB 345, 352 (1989).

[9] *See R.D.,* Docket No. 25-0625 (issued July 30, 2025); *J.B.,* Docket No. 24-0946 (issued November 4, 2024); *F.S.,* Docket No. 23-0112 (issued April 26, 2023); *L.B.,* Docket No. 18-0533 (issued August 27, 2018); *D.K.,* Docket No. 17-1549 (issued July 6, 2018).

erythema of the left great toe and ulceration of the distal tip of the digit with a gradual onset of symptoms three weeks ago with a rapidly worsening course. Dr. McShane indicated that the MRI scan was consistent with osteomyelitis of the distal phalanx of the left great toe and recommended amputation. In her March 3, 2025 Form CA-20, she noted that appellant presented with traumatic osteomyelitis of the left great toe which he stated occurred when he bumped the toe on his work vehicle. She diagnosed lymphedema left great toe with underlying diabetes and ulcer of the left great toe. While Dr. McShane did note appellant's history of injury in the March 3, 2025 Form CA-20, she did not provide an opinion in either report that appellant's diagnosed left foot conditions were causally related to the accepted July 5, 2024 employment incident. As noted, medical evidence that does not offer an opinion regarding the cause of an employee's condition or disability is of no probative value on the issue of causal relationship.[10] Therefore, this evidence is insufficient to establish appellant's claim.

Appellant also submitted reports of diagnostic testing. The Board has held that diagnostic studies, standing alone, lack probative value as they do not address whether the accepted employment injury caused or aggravated any of the additional diagnosed conditions.[11] For this reason, this evidence is also insufficient to establish appellant's claim.

As the medical evidence of record is insufficient to establish a foot condition causally related to the accepted July 5, 2024 employment incident, the Board finds that appellant has not met his 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 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 foot condition causally related to the accepted July 5, 2024 employment incident.

[10] *See id.*

[11] *C.J.,* Docket No. 25-0147 (issued April 9, 2025); *S.S.*, Docket No. 23-0391 (issued October 24, 2023); *J.P.*, Docket No. 19-0216 (issued December 13, 2019); *A.B.*, Docket No. 17-0301 (issued May 19, 2017).

ORDER

IT IS HEREBY ORDERED THAT the March 18, 2025 decision of Office of Workers' Compensation Programs is affirmed.

Issued: November 19, 2025
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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