United States Department of Labor
Employees' Compensation Appeals Board

V.B., Appellant	)	
and	)	**Docket No. 23-0133**
	)	**Issued: January 20, 2026**
DEPARTMENT OF VETERANS AFFAIRS, G.V. (SONNY) MONTGOMERY MEDICAL CENTER, Jackson, MS, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On November 5, 2022 appellant filed a timely appeal from a September 28, 2022 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.[2]

ISSUE

The issue is whether appellant has met her burden of proof to establish the remaining claimed disability from work, commencing August 29, 2011, causally related to the accepted

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the issuance of OWCP's September 28, 2022 decision, OWCP received additional evidence. 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.*

August 28, 2011 employment injury and/or expansion of the acceptance of the claim to include lymphedema, causally related to her accepted August 28, 2011 employment injury.

FACTUAL HISTORY

On September 19, 2011 appellant, then a 47-year-old staff pharmacist, filed a traumatic injury claim (Form CA-1) alleging that on August 28, 2011 she injured her right knee as a result of extensive standing and repetitive sitting/standing while in the performance of duty. She stopped work on August 28, 2011.[3]

OWCP received an undated employing establishment health unit record, which indicated that appellant was excused from work from August 31 through September 6, 2011. The signature on the form was illegible.

On September 22, 2011 Dr. Daniel P. Dare, a Board-certified orthopedic surgeon, completed a return to work note wherein he indicated that appellant could not return to work for one week until she was reevaluated. In an accompanying report, he noted appellant's diagnoses of internal derangement of the right knee, with probable torn meniscus, medial collateral ligament (MCL) tear of the right knee, right knee degenerative arthritis, and prior anterior cruciate ligament (ACL) reconstruction of the right knee. In another September 22, 2011 return to work form, Dr. Dare indicated that appellant would be totally disabled from work as of August 29, 2011 until she underwent a magnetic resonance imaging (MRI) scan. In an October 31, 2011 form report, he indicated that appellant could not return to work for one week. In a note dated October 31, 2011, Dr. Dare related that appellant was still unable to work as she was still unable to squat and climb stairs.

By decision dated October 31, 2011, OWCP denied the claim, finding that the evidence of record was insufficient to establish that the alleged employment factors occurred as described.

OWCP continued to receive reports from Dr. Dare. In an April 29, 2012 report, Dr. Dare recounted appellant's history of injury. In a January 14, 2013 report, he recounted appellant's medical history.

In a work capacity evaluation for musculoskeletal conditions (Form OWCP-5c) dated July 24, and another Form OWCP-5c dated September 24, 2013, Dr. Michael Stonnington, a Board-certified orthopedic surgeon, related that appellant could return to sedentary work.

In unsigned progress notes dated April 28, 2014, appellant's diagnoses were noted by checkmark as bilateral knee meniscal tear, bilateral knee osteoarthritis, right knee instability, right knee cartilage restoration surgery, and right knee patellofemoral pain syndrome. Appellant was assessed as totally disabled from work.

[3] OWCP assigned the present claim OWCP File No. xxxxxx351. It previously accepted that appellant sustained a medial collateral ligament strain of the left knee, a torn left medial meniscus, chondromalacia patella of the left knee, and a left hip strain due to a May 9, 2007 employment injury, assigned OWCP File No. xxxxxx015. OWCP has administratively combined File Nos. xxxxxx351 and xxxxxx015, with the latter serving as the master file number.

In an April 28, 2014 report, Dr. Stonnington diagnosed severe degenerative disease of the right knee. He opined that the condition was preexisting, but was directly exacerbated by her August 28, 2011 employment injury. In a report dated May 5, 2014, Dr. Stonnington recommended that she undergo a right total knee arthroplasty. He concluded that her condition was directly exacerbated and worsened by her August 28, 2011 injury.

In a report dated March 23, 2016, Dr. Apurva R. Dalal, an orthopedic surgeon, related that appellant had severe osteoarthritis of the right knee, which was aggravated by her employment injury. He concluded that she required a total knee replacement.

On April 7, May 9, and June 20, 2017 Dr. Stonnington again reported that appellant had severe degenerative changes in the right knee. He recommended that appellant undergo total right knee arthroplasty. Dr. Stonnington performed a total right knee arthroplasty on June 29, 2017. Appellant continued treatment with Dr. Stonnington. On August 14, 2017 Dr. Stonnington reported that appellant was progressively improving. In a follow-up report dated November 13, 2017, he related that appellant had moderate right knee pain. Dr. Stonnington assessed bilateral primary osteoarthritis with stable right total knee arthroplasty. He concluded that appellant's pain and episodes of instability were due to muscle weakness and fatigue.

In a report dated January 17, 2018, Dr. Stonnington summarized appellant's medical history. He related that appellant had recovered well from her right total knee arthroplasty, but she still had residual pain and episodes of instability related to muscle weakness and fatigue. Dr. Stonnington concluded that appellant remained totally disabled due to her right knee condition and that her limitations and restrictions were permanent.

On April 17, 2018 OWCP accepted the claim for permanent aggravation of unilateral primary osteoarthritis of the right knee.

On April 23, 2018 appellant filed a claim for wage-loss compensation (Form CA-7) for disability from work commencing August 29, 2011.

By development letters dated May 15 and August 14, 2018, OWCP informed appellant of the deficiencies of her claim for wage-loss compensation. It advised her of the type of the medical evidence needed and afforded her 30 days to submit the necessary medical evidence.

By decision dated October 11, 2018, OWCP denied appellant's claim for wage-loss compensation for disability from work commencing August 29, 2011. It found that the medical evidence of record was insufficient to establish causal relationship between the claimed disability and the accepted August 28, 2011 employment injury.

OWCP subsequently received a report dated September 30, 2019, indicating that appellant was treated by Christy L. Egbert, a family nurse practitioner, for bilateral knee pain.

On October 11, 2019 appellant requested reconsideration of the October 11, 2018 decision. In support thereof, appellant submitted a report dated October 7, 2019, wherein Dr. Michael E. Steuer, Board-certified in anesthesiology and pain medicine, related that appellant received a right knee genicular nerve block for a diagnosis of unilateral primary

osteoarthritis. In a report dated October 9, 2019, he related that appellant had an abrupt return of her right knee symptoms following her October 7, 2019 nerve block.

In an operative report dated November 4, 2019, Dr. Steuer noted that he had completed another right knee genicular nerve block for appellant's diagnosis of unilateral primary osteoarthritis of the right knee.

By decision dated November 19, 2019, OWCP denied modification.

OWCP subsequently received additional medical evidence. In a November 25, 2019 addendum to his January 1, 2018 report, Dr. Stonnington related that traumatic injuries can contribute to lymphedema, and it was likely that appellant's traumatic work events contributed to her lymphedema.

On December 6, 2019 appellant requested reconsideration. She also requested expansion of the acceptance of her claim to include permanent aggravation of preexisting secondary (acquired) lymphedema.

In a December 2, 2019 report, Dr. Steuer related that appellant had undergone a third right knee genicular nerve block. Appellant also resubmitted the September 24, 2013 OWCP-5c form signed by Dr. Stonnington.

In a report dated December 5, 2019, Ms. Egbert related that appellant did not feel she obtained long-term relief from the nerve block procedures. In a report dated January 16, 2020, she related that appellant had unchanged findings of bilateral primary knee arthritis and bilateral lymphedema.

By decision dated February 13, 2020, OWCP found that the medical evidence of record was sufficient to vacate the November 19, 2019 decision, in part. It explained that she was entitled to wage-loss compensation for disability work during the period June 29 through July 1, 2017, and on October 7, November 4, and December 2, 2019, as it had authorized appellant's June 29, 2017 right knee arthroplasty and October 7, November 4 and December 2, 2019 nerve block procedures. The medical evidence of record, however, was insufficient to establish the remaining claimed disability as causally related to the accepted August 28, 2011 employment injury.

In a report dated February 24, 2020, Dr. Steuer related appellant's diagnoses of chronic pain syndrome, right leg cellulitis, bilateral unilateral osteoarthritis of the knees, and bilateral leg lymphedema. Ms. Egbert reiterated these diagnoses in a report dated April 14 and May 13, 2020.

In reports dated April 16 and June 25, 2020, Dr. Eugene B. Ferris, III, a physician, related that appellant was seen for a history of fairly severe bilateral lower extremity edema, right worse than left. In the June 25, 2020 report, he related that a chronic venous duplex scan showed patency of deep superficial veins. Support stockings were ordered, and when removed that day revealed that appellant's edema as well as stasis changes were almost completely resolved.

On February 11, 2021 appellant, through her then-counsel, requested reconsideration and submitted additional medical evidence.

In a report dated February 3, 2021, Dr. David J. Gandy related appellant's histories of prior right knee injuries as well as the August 28, 2011 incident during which appellant leaned against a counter, turned, and twisted her knee. He reviewed appellant's history of medical treatment. Regarding appellant's diagnosis of lymphedema, Dr. Gandy related that there were multiple known causes. Obesity was a factor and she was morbidly obese, surgery was a factor, as was disuse, and staying in the sitting position for prolonged periods of time without muscular activity. Dr. Gandy concluded that he could not state that appellant's prior surgery or arthritis were the primary cause of the injury. He explained that even after appellant's total knee arthroplasty she had problems that required restrictions as she did not do as well as expected. Appellant fell again in 2018 and used a cane following that injury. Dr. Gandy also related that appellant's persistent swelling to her legs (lymphedema) would cause problems with prolonged standing and walking. Dr. Gandy then related that the positions appellant was offered to her in 2013, even with some limitations, would require that she stand and walk some; however, she was only capable of sitting with occasional standing.

OWCP also received unsigned emergency department records, dated May 12, 2018, which related that appellant was seen for right knee pain.

By decision dated May 12, 2021, OWCP denied modification of the denial of wage-loss compensation for disability from work commencing August 29, 2011. OWCP also denied appellant's request for expansion of the acceptance of the claim, finding that the medical evidence of record was insufficient to establish that her lymphedema condition was causally related to the accepted employment injury.

On November 3, 2021 appellant requested reconsideration.

OWCP received a partial unsigned document entitled ambulatory summary. This document listed appellant's prescriptions, diagnoses, diagnostic test results, and some past medical encounters. Physical therapy reports were also received.

By decision dated January 27, 2022, OWCP denied appellant's request for reconsideration, pursuant to 5 U.S.C. § 8128(a).

On June 30, 2022, appellant again requested reconsideration and submitted additional evidence. In a note dated April 27, 2022, Shalonda Reed, a licensed vocational nurse, noted chronic pain secondary to lymphedema.

On June 30, 2022 OWCP received undated employing establishment health unit records. Appellant's complaints of chronic knee pain were noted.

Additional physical therapy records were also received.

By decision dated September 28, 2022, OWCP denied modification of the May 12, 2021 merit 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 that any disability or specific condition for which compensation is claimed is causally related to the employment injury.[5] For each period of disability claimed, the employee has the burden of proof to establish that he or she was disabled from work as a result of the accepted employment injury.[6] Whether a particular injury causes an employee to become disabled from work, and the duration of that disability, are medical issues that must be proven by a preponderance of probative and reliable medical opinion evidence.[7]

Under FECA, the term disability means an incapacity because of an employment injury, to earn the wages the employee was receiving at the time of the injury.[8] When, however, the medical evidence establishes that the residuals or sequelae of an employment injury are such that, from a medical standpoint, prevent the employee from continuing in his or her employment, he or she is entitled to compensation for any loss of wages.[9]

To establish causal relationship between the disability claimed and the employment injury, an employee must submit rationalized medical evidence, based on a complete factual and medical background, supporting such causal relationship.[10] The opinion of the physician must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the claimed disability and the accepted employment injury.[11]

When an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.[12]

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[4] *Supra* note 1.

[5] *See C.B.*, Docket No. 20-0629 (issued May 26, 2021); *D.S.*, Docket No. 20-0638 (issued November 17, 2020); *F.H.*, Docket No. 18-0160 (issued August 23, 2019); *C.R.*, Docket No. 18-1805 (issued May 10, 2019); *Kathryn Haggerty*, 45 ECAB 383 (1994); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[6] *See L.F.*, Docket No. 19-0324 (issued January 2, 2020); *T.L.*, Docket No. 18-0934 (issued May 8, 2019); *Fereidoon Kharabi*, 52 ECAB 291, 293 (2001).

[7] *See* 20 C.F.R. § 10.5(f); *N.M.*, Docket No. 18-0939 (issued December 6, 2018).

[8] *Id.* at § 10.5(f); *see e.g., G.T.*, Docket No. 18-1369 (issued March 13, 2019); *Cheryl L. Decavitch*, 50 ECAB 397 (1999).

[9] *G.T.*, *id.*; *Merle J. Marceau*, 53 ECAB 197 (2001).

[10] *See S.J.*, Docket No. 17-0828 (issued December 20, 2017); *Kathryn E. DeMarsh*, 56 ECAB 677 (2005).

[11] *Id.*

[12] *See S.L.*, Docket No. 19-0603 (issued January 28, 2020); *T.E.*, Docket No. 18-1595 (issued March 13, 2019); *T.F.*, Docket No. 17-0645 (issued August 15, 2018); *Jaja K. Asaramo*, 55 ECAB 200 (2004).

Causal relationship is a medical question that requires rationalized medical opinion evidence to resolve the issue.[13] A physician's opinion on whether there is causal relationship between the diagnosed condition and the accepted employment injury must be based on a complete factual and medical background.[14] 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 employment injury.[15]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish the remaining claimed disability from work, commencing August 29, 2011, causally related to the accepted August 28, 2011 employment injury or expansion of the acceptance of the claim to include lymphedema, causally related to her accepted August 28, 2011 employment injury.

OWCP initially received an undated employing establishment health unit record which indicated that appellant was excused from work from August 31 to September 6, 2011. Reports dated September 22 and October 31, 2011 were also received from Dr. Dare who related that appellant could not return to work. Dr. Dare noted appellant's diagnoses of internal derangement of the right knee, with probable torn meniscus, MCL tear of the right knee, right knee degenerative arthritis, and prior ACL reconstruction of the right knee. None of these reports, however, contain 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.[16] This evidence is, therefore, insufficient to establish appellant's disability and expansion claims.

In reports dated April 29, 2012 and January 14, 2013, Dr. Dare recounted appellant's history of injury and medical history. In OWCP-5c forms dated July 24 and September 24, 2013 Dr. Stonnington related that appellant could return to sedentary work. However, neither physician provided an opinion on causal relationship. This evidence is, therefore, of no probative value and insufficient to establish appellant's disability and expansion claims.[17]

In unsigned progress notes dated April 28, 2014, appellant's diagnoses were noted by checkmark as bilateral knee meniscal tear, bilateral knee osteoarthritis, right knee instability, right knee cartilage restoration surgery, and right knee patellofemoral pain syndrome. Appellant was assessed to be totally disabled. However, the Board has held that reports that are unsigned

[13] *E.M.*, Docket No. 18-1599 (issued March 7, 2019); *Robert G. Morris*, 48 ECAB 238 (1996).

[14] *M.V.*, Docket No. 18-0884 (issued December 28, 2018); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[15] *Id.*

[16] *See N.W.,* Docket No. 25-0270 (issued April 7, 2025); *M.T.,* Docket No. 24-0465 (issued September 27, 2024); *A.O.,* Docket No. 24-0382 (issued May 16, 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).

[17] *Id.*

or bear an illegible signature lack proper identification and cannot be considered probative medical evidence because the author cannot be identified as a physician.[18] This evidence is, therefore, insufficient to establish appellant's disability and expansion claims.

OWCP continued to receive reports from Dr. Stonnington dated from April 28, 2014 through November 13, 2017, and a March 23, 2016 report from Dr. Dalal. These reports related appellant's diagnosis of aggravation of severe degenerative disease of the right knee, for which total right knee arthroplasty was recommended. Dr. Stonnington performed appellant's total right knee total arthroplasty on June 29, 2017. However, these reports did not offer an opinion on causal relationship. As previously noted, evidence which do not provide an opinion on causal relationship is of no probative value.[19]

In a report dated January 17, 2018, Dr. Stonnington related that appellant had a good recovery from her total right total arthroplasty, but she still had residual pain and episodes of instability related to muscle weakness and fatigue. He concluded that appellant remained totally disabled due to her right knee condition and that her limitations and restrictions were permanent. Dr. Stonnington did not provide sufficient rationale for his opinion. The Board has held that a report is of limited probative value regarding causal relationship if it does not contain sufficient medical rationale explaining causal relationship.[20] Therefore, this report is insufficient to establish appellant's disability and expansion claims.

The case record also contains reports dated October 7 through December 2, 2019. Dr. Steuer related that appellant received right knee genicular nerve blocks for a diagnosis of unilateral primary osteoarthritis. However, he did not address disability or expansion of the acceptance of the claim. This evidence is, therefore, of no probative value and insufficient to establish appellant's claim.[21]

In a November 25, 2019 addendum to his January 1, 2018 report, Dr. Stonnington related that traumatic injuries can contribute to lymphedema, and it was likely that appellant's traumatic work events contributed to her lymphedema. In his February 3, 2021 report, Dr. Gandy concluded that he could not state that appellant's prior surgery or arthritis were the primary cause

[18] *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).

[19] *P.L.,* Docket No. 22-0337 (issued September 9, 2022); *K.F.,* Docket No. 19-1846 (issued November 3, 2020); *L.B.,* Docket No. 18-0533 (issued August 27, 2018); *D.K.,* Docket No. 17-1549 (issued July 6, 2018).

[20] *See J.R.,* Docket No. 23-0215 (issued July 28, 2023); *H.A.,* Docket No. 20-1555 (issued December 22, 2022); *S.K.,* Docket No. 19-0272 (issued July 21, 2020); *T.T.,* Docket No. 18-1054 (issued April 8, 2020); *Y.D.,* Docket No. 16-1896 (issued February 10, 2017).

[21] *Supra* note 17.

of the injury. The Board has long held that an opinion, which is equivocal or speculative in nature is of limited probative value.[22]

In a report dated February 24, 2020, Dr. Steuer related appellant's diagnoses of chronic pain syndrome, right leg cellulitis, bilateral unilateral osteoarthritis of the knees, and bilateral leg lymphedema. In reports dated April 16 and June 25, 2020, Dr. Ferris related that a chronic venous duplex scan showed patency of deep superficial veins. Support stockings were ordered, and when removed that day revealed that appellant's edema as well as statis changes were almost completely resolved. However, as neither physician provided an opinion on causal relationship, this evidence is of no probative value and insufficient to establish appellant's disability and expansion claims.

The record also contains reports from nurses and physical therapists. However, these providers are not considered physicians as defined under FECA.[23] Consequently, their medical findings and/or opinions will not suffice for purposes of establishing entitlement to FECA benefits.[24]

As the medical evidence of record is insufficient to establish the remaining claimed disability from work, commencing August 29, 2011, causally related to the accepted August 28, 2011 employment injury or expansion of the acceptance of the claim to include lymphedema, causally related to her accepted August 28, 2011 employment injury, the Board finds that 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.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish the remaining claimed disability from work, commencing August 29, 2011, causally related to the accepted August 28, 2011 employment injury or expansion of the acceptance of the claim to include lymphedema, causally related to her accepted August 28, 2011 employment injury.

[22] *S.L.*, Docket No. 23-0152 (issued May 16, 2023); *see L.L.,* Docket No. 21-0981 (issued July 1, 2022); *C.A.,* Docket No. 21-0601 (issued November 15, 2021); *J.P.,* Docket No. 19-0216 (issued December 13, 2019); *T.M.,* Docket No. 08-0975 (issued February 6, 2009).

[23] 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* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3a(1) (May 2023); *R.B.,* Docket No. 25-0361 (issued April 23, 2025) (nurse practitioners are not considered physicians under FECA and, therefore, are not competent to provide a medical opinion); *H.S.,* Docket No. 20-0939 (issued February 12, 2021) (physician assistants are not considered physicians as defined under FECA). *R.L.,* Docket No. 19-0440 (issued July 8, 2019) (physical therapists are not considered physicians under FECA).

[24] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the September 28, 2022 merit decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 20, 2026
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board