United States Department of Labor
Employees' Compensation Appeals Board

T.E., Appellant	)	
and	)	**Docket No. 16-1903**
	)	**Issued: May 22, 2017**
U.S. POSTAL SERVICE, POST OFFICE, St. Louis, MO, Employer	)	

Appearances:
Sean Barry, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 27, 2016 appellant, through counsel, filed a timely appeal from June 24 and September 6, 2016 merit decisions 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 met her burden of proof to establish an injury causally related to an accepted February 10, 2016 employment incident.

[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 February 12, 2016 appellant, then a 50-year-old rural carrier, filed a traumatic injury claim (Form CA-1) alleging that on February 10, 2016 she sustained an injury to her left knee when she slipped on snow while in the performance of duty. She stopped work.

Appellant was initially treated in the emergency room by Christine Kamp, a certified physician assistant. In the February 10, 2016 emergency room report, Ms. Kamp related that appellant was walking at work when her right knee twisted, popped, and gave out, which caused her to fall down onto her left side. Appellant complained of right knee and left shoulder pain. Ms. Kamp provided physical examination findings and diagnosed acute right knee pain. In a work status note, she indicated that appellant could return to work on February 14, 2016.

Dr. Kristin Philbrick, a Board-certified family practitioner, provided medical treatment for appellant. In a February 12, 2016 progress note, she indicated that appellant sustained a left elbow injury and complained of knee pain after falling on her left side two days ago. Appellant described that her right foot slipped laterally and she fell onto her left side. Dr. Philbrick noted that emergency room films immediately after injury showed no fracture. Upon examination of appellant's left elbow, she observed soft tissue tenderness and swelling at the olecranon, reduced range of motion, olecranon tenderness, and normal radial pulse of appellant's left elbow. Dr. Philbrick reported that examination of appellant's right knee showed antalgic gait, soft tissue tenderness, and reduced range of motion. McMurray sign on the right was positive. Dr. Philbrick diagnosed left elbow injury, initial encounter, and right knee injury, subsequent encounter.[3]

Appellant also underwent several diagnostic examinations. In a February 12, 2016 left elbow x-ray examination report, Dr. Karen F. Goodhope, a diagnostic radiologist, related that appellant initially just had some mild pain in the posterior elbow, but it seemed to worsen. She reported that the examination revealed nothing acute.

In a February 24, 2016 left elbow magnetic resonance imaging (MRI) scan report, Dr. Tim Propeck, a Board-certified diagnostic radiologist, noted a history of left elbow pain. He observed a small-to-moderate-sized partial-thickness articular surface tear of the common extensor tendon off the lateral condyle with no acute fracture. In a right knee MRI scan report, Dr. Propeck observed a tear of the posterior root of the medial meniscus and a mildly extruded medial meniscus. He also noted a six millimeter ganglion cyst off the anterior central aspect of the knee joint.

Dr. Daniel T. Cohen, a Board-certified diagnostic radiologist, indicated in a March 8, 2016 left shoulder x-ray examination report, that appellant had minimal acromioclavicular (AC) joint hypertrophic change. He indicated that there was no imaging evidence of acute osseous fracture or traumatic malalignment, or soft tissue swelling. Dr. Cohen diagnosed minor degenerative changes.

[3] The Board notes that Dr. Philbrick did not provide any examination findings or diagnosis relating to appellant's left knee claim.

A March 22, 2016 right ankle x-ray examination report by Dr. Mohammed F. Majeed, a Board-certified diagnostic radiologist, revealed no acute fracture or dislocation.

Appellant continued to seek medical treatment from Dr. Philbrick. In progress notes dated March 8 to 22, 2016, she related appellant's complaints of ongoing elbow and knee pain and worsening left shoulder and neck pain. Dr. Philbrick noted that appellant had a traumatic fall. She provided findings on examination and diagnosed primary left shoulder pain, left knee pain, and left elbow pain.[4]

Dr. Jonathan D. Root, a Board-certified internist and diagnostic radiologist, conducted several diagnostic examinations on April 7, 2016. In a right ankle MRI scan report, he observed mild degenerative changes and large calcaneal spur. Dr. Root noted no evidence of acute injury. In a left shoulder MRI scan report, he noted moderate tendinosis of the distal supraspinatus tendon without evidence of a full-thickness rotator cuff tear and mild hypertrophic changes to the AC joint with probably a small associated subacromial bursitis.

Appellant began to seek medical treatment from Dr. Richard C. Lehman, a Board-certified orthopedic surgeon specializing in sports medicine. In an April 7, 2016 report, Dr. Lehman described that on February 10, 2016 appellant slipped and fell down at work and sustained a valgus stress to her knee. He related appellant's complaints of pain in both knees, primarily the right knee, left elbow, left hip, and left shoulder and conducted an examination of appellant's knee, elbow, shoulder, and hip. Upon examination of appellant's knee, Dr. Lehman reported pain over the medial joint line and tenderness to palpation medially over appellant's knee. Extension and flexion were full with no instability. Dr. Lehman indicated that elbow examination revealed tenderness over the anterolateral aspect and along the extensor mechanism. Extension and flexion of appellant's left elbow demonstrated pain. Upon examination of appellant's shoulder, Dr. Lehman noted minor tenderness in the anterior aspect of her shoulder and full unrestricted range of motion. Examination of appellant's hip revealed mild tenderness in the posterior aspect and full range of motion. Dr. Lehman related that the February 24, 2016 right knee MRI scan and left elbow MRI scan reports showed a tear in appellant's medial meniscus and degenerative changes in her joint with degenerative arthritis. He reported that appellant also had underlying breakdown of the lateral epicondyle with lateral epicondylitis and an inability to fully extend and flex her elbow. Dr. Lehman opined that this was a compensable injury and noted that he believed appellant would be able to return to her previous job activities.

Dr. Philbrick again examined appellant and indicated in an April 13, 2016 progress note that appellant continued to complain of pain in the shoulder and ankle after a fall. She diagnosed a tear of the medial meniscus of the right knee, subsequent encounter.

In an April 14, 2016 examination report, Dr. Lehman noted appellant's complaints of right knee, foot, and ankle pain and reviewed appellant's history. He diagnosed left shoulder, left elbow, right hip, and right knee pain.

[4] The Board notes that Dr. Philbrick did not provide any examination findings or diagnosis relating to appellant's left knee claim.

Appellant began to undergo physical therapy treatment on April 27, 2016 and submitted physical therapy reports.

By letter dated May 18, 2016, OWCP informed appellant that her claim was initially approved as a minor injury, but it was being reopened because her medical bills had exceeded $1,500.00. It advised her that the evidence submitted was insufficient to establish her claim. OWCP requested that appellant provide medical evidence to establish a diagnosed condition causally related to the alleged February 10, 2016 incident.

OWCP denied appellant's claim in a decision dated June 24, 2016. It accepted that the February 10, 2016 incident occurred as alleged and that she was diagnosed with a left knee and elbow conditions, but denied her claim finding that the medical evidence failed to establish that her medical conditions were causally related to the accepted February 10, 2016 employment incident. OWCP found that none of the medical evidence adequately explained the mechanism of injury of how appellant's diagnosed conditions resulted from the accepted employment incident.

On July 25, 2016 appellant, through counsel, requested reconsideration. Counsel indicated that he was enclosing a medical report by Dr. Philbrick, which supported that appellant's medical condition was causally related to the accepted work incident.

Counsel submitted a July 20, 2016 report by Dr. Philbrick in which he indicated that appellant sustained an injury on February 10, 2016 after a fall at work and was seen in the emergency room for a head injury, right knee pain, and left elbow pain. Dr. Philbrick reported that a left elbow MRI scan showed a small-to-moderate-sized partial-thickness articular surface tear of the common extensor tendon. She also observed a tear of the posterior root of the medial meniscus of the right knee. Dr. Philbrick noted that appellant had no symptoms of either injury prior to the fall.

On August 16, 2016 Dr. Paul A. Baekey, a Board-certified anatomic and clinical pathologist, performed an excision of a ganglion cyst on appellant's right wrist. He noted that microscopic examination corroborated the diagnosis of ganglion cyst.

On August 23, 2016 appellant filed a claim for wage-loss compensation (Form CA-7) for disability from work for the period May 8 to August 19, 2016.

By decision dated September 6, 2016, OWCP denied modification of the June 24, 2016 denial decision. It found that the medical evidence of record was insufficient to establish causal relationship between the February 10, 2016 employment incident and appellant's diagnosed conditions. OWCP determined that Dr. Philbrick provided no medical rationale explaining how the accepted employment incident caused or contributed to appellant's diagnosed conditions.

LEGAL PRECEDENT

An employee seeking benefits under FECA[5] has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative, and substantial

[5] *See supra* note 2.

evidence[6] including that he or she sustained an injury in the performance of duty and that any specific condition or disability for work for which he or she claims compensation is causally related to that employment injury.[7]

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.[8] There are two components involved in establishing the fact of injury. First, the employee must submit sufficient evidence to establish that she actually experienced the employment incident at the time, place and in the manner alleged.[9] Second, the employee must submit evidence, generally only in the form of probative medical evidence, to establish that the employment incident caused a personal injury.[10] An employee may establish that the employment incident occurred as alleged, but fail to show that his or her disability or condition relates to the employment incident.[11]

Whether an employee sustained an injury in the performance of duty requires the submission of rationalized medical opinion evidence.[12] 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 the specific employment factors identified by the employee.[13] The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[14]

ANALYSIS

Appellant alleged that on February 10, 2016 she sustained a left knee injury when she slipped on snow at work. Subsequently she submitted medical reports which noted right knee medial meniscus tear, a left elbow tendon tear, left shoulder pain, right ankle and wrist pain, and a head injury. OWCP accepted that the February 10, 2016 employment incident occurred as alleged. However, it denied her claim, finding that the medical evidence of record failed to establish that appellant's diagnosed conditions were causally related to the accepted employment

[6] *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

[7] *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[8] *S.P.*, 59 ECAB 184 (2007); *Alvin V. Gadd*, 57 ECAB 172 (2005).

[9] *Bonnie A. Contreras*, 57 ECAB 364 (2006); *Edward C. Lawrence*, 19 ECAB 442 (1968).

[10] *David Apgar*, 57 ECAB 137 (2005); *John J. Carlone*, 41 ECAB 354 (1989).

[11] *T.H.*, 59 ECAB 388 (2008); *see also Roma A. Mortenson-Kindschi*, 57 ECAB 418 (2006).

[12] *See J.Z.*, 58 ECAB 529 (2007); *Paul E. Thams*, 56 ECAB 503 (2005).

[13] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 465 (2005).

[14] *James Mack*, 43 ECAB 321 (1991).

incident. The Board finds that appellant has not established that she sustained an employment injury on February 10, 2016.

Appellant received medical treatment from Dr. Philbrick. In progress notes dated February 12 to July 20, 2016, Dr. Philbrick described that on February 10, 2016 appellant sustained a left elbow injury and experienced left knee pain when she fell down on to her left side at work. She provided findings on examination and reviewed various diagnostic examinations. In a March 22, 2016 progress note, Dr. Philbrick diagnosed primary left shoulder pain, left knee, and left elbow pain. Symptoms of pain, however, are not considered compensable diagnoses.[15] As Dr. Philbrick did not provide a firm medical diagnosis of any condition, her reports are of limited probative value.[16]

In a February 12, 2016 progress note, Dr. Philbrick diagnosed left elbow injury, initial encounter, and right knee injury, subsequent encounter. In an April 13, 2016 progress note, she also diagnosed right knee medial meniscus tear. Dr. Philbrick related in a July 20, 2016 report that appellant complained of a head injury, right knee pain, and left elbow pain after a February 10, 2016 fall at work. Although she mentioned the February 10, 2016 fall at work, Dr. Philbrick did not provide an opinion or explanation of whether the February 10, 2016 work incident caused or contributed to appellant's various conditions. The Board has held that medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[17]

Similarly, the diagnostic examination reports noted several diagnosed conditions relating to appellant's left elbow, left shoulder, right wrist, right ankle, and right knee, but contained no opinion on the cause of these conditions. In a February 12, 2016 left elbow x-ray scan report, Dr. Goodhope found nothing acute and noted some mild pain in appellant's posterior elbow. In a February 24, 2016 left elbow MRI scan report, Dr. Propeck diagnosed a small-to-moderate-sized partial-thickness surface tear. He also related that a right knee MRI scan also showed a tear of the posterior root of the medial meniscus, a mildly extruded medial meniscus, and a six millimeter ganglion cyst. In a March 8, 2016, left shoulder x-ray scan report, Dr. Cohen diagnosed minimal AC joint hypertrophic change and minor degenerative change. In an April 7, 2016 right ankle MRI scan, Dr. Root noted no acute injury. He also reported that a left shoulder MRI scan showed moderate tendinosis of the distal supraspinatus tendon and mild hypertrophic changes to the AC joint. In Dr. Baekey's August 16, 2016 report, he diagnosed a ganglion cyst of appellant's right wrist. As none of these physicians offered an opinion on whether appellant's condition was causally related to her employment, they are insufficient to establish appellant's claim.[18]

[15] *B.P.*, Docket No. 12-1345 (issued November 13, 2012); *C.F.*, Docket No. 08-1102 (issued October 2008).

[16] *Roy L. Humphrey*, 57 ECAB 238, 242 (2005); *Michael E. Smith*, 50 ECAB 313 (1999).

[17] *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *J.F.*, Docket No. 09-1061 (issued November 17, 2009); *A.D.*, 58 ECAB 149 (2006).

[18] *R.E.*, Docket No. 10-679 (issued November 16, 2010); *K.W.*, 59 ECAB 271 (2007).

Dr. Lehman also treated appellant. In reports dated April 7 and 14, 2016, he accurately described the February 10, 2016 slip and fall incident at appellant's work. Dr. Lehman related that she still complained of pain in both knees, her left hip, and left shoulder. He reviewed appellant's history and provided examination findings. Dr. Lehman diagnosed right knee tear of the medial meniscus, degenerative changes in the joint with degenerative arthritis, underlying breakdown of the lateral epicondyle with lateral epicondylitis, and an inability to fully extend and flex her left elbow. He opined that this was a compensable injury. The Board notes that although Dr. Lehman believed that appellant's diagnosed conditions should be compensated, he did not offer any rationalized medical explanation to support his affirmative opinion supporting causal relationship. Medical evidence which states a conclusion, but does not offer any rationalized medical explanation regarding the cause of an employee's condition, is of limited probative value on the issue of causal relationship.[19] Furthermore, Dr. Lehman did not provide any examination findings or diagnosis regarding appellant's alleged left knee injury. Accordingly, his reports fail to establish appellant's claim.

The record also contains a February 10, 2016 emergency room record by a physician assistant. This report is also insufficient to establish appellant's claim because physician assistants are not considered physicians under FECA and her opinion, therefore, is of no probative value.[20]

On appeal, counsel alleges that appellant submitted sufficient medical evidence to support causation between the February 10, 2016 work incident and diagnosed conditions. He asserts that OWCP's denial to date was unreasonable, arbitrary, and capricious, and not supported by the clear medical evidence. As previously explained, the medical evidence fails to establish that appellant sustained an injury as a result of the accepted February 10, 2016 employment incident. In order to obtain benefits under FECA an employee has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative, and substantial evidence.[21] Because appellant has failed to provide such evidence demonstrating that any of her diagnosed conditions were causally related to the accepted February 10, 2016 employment incident, she has failed to meet her burden of proof to establish her claim and has not established that OWCP's denial was arbitrary or capricious.

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.

[19] *J.F.*, Docket No. 09-1061 (issued November 17, 2009); *A.D., supra* note 17.

[20] 5 U.S.C. § 8101(2); Section 8101(2) of FECA provides that the term "physician" includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. *R.M.*, Docket No. 16-1845 (issued March 6, 2017); *see also David P. Sawchuk*, 57 ECAB 316, 320, n.11 (2006).

[21] *Supra* note 8.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish an injury causally related to the accepted February 10, 2016 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the September 6 and June 24, 2016 merit decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: May 22, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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