United States Department of Labor
Employees' Compensation Appeals Board

C.B., Appellant	)	
and	)	**Docket No. 17-1499**
	)	**Issued: July 25, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Citrus Heights, CA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 28, 2017 appellant, through counsel, filed a timely appeal from an April 10, 2017 merit decision 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.[3]

[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.*

[3] The record provided the Board includes evidence received after OWCP issued its April 10, 2017 decision. The Board's jurisdiction is limited to the evidence that was before OWCP at the time of its final decision. Therefore, the Board is precluded from reviewing this additional evidence for the first time on appeal. 20 C.F.R. § 501.2(c)(1).

ISSUE

The issue is whether appellant has met his burden of proof to establish additional left knee conditions causally related to an accepted February 22, 2011 employment injury.

FACTUAL HISTORY

On March 16, 2011 appellant, then a 46-year-old mail carrier, filed a traumatic injury claim (Form CA-1) alleging that he experienced left knee pain when he stepped out of his postal vehicle to deliver mail on February 22, 2011. OWCP accepted the conditions of left knee sprain, lateral collateral ligament and left ankle sprain.[4]

Appellant received conservative care for his injury from Dr. Meredith G. Tallman, an occupational medicine specialist.[5] With regard to appellant's left knee, in a report dated March 22, 2011, Dr. Tallman noted appellant's history of injury. She diagnosed knee joint pain. In an April 15, 2011 report, Dr. Tallman reported that appellant's knee pain was of unclear etiology. She indicated that it was possible patellofemoral syndrome versus arthritis versus internal derangement of cartilage. In an April 20, 2011 report, Dr. Tallman indicated that appellant's left knee x-ray of March 22, 2011 showed trivial degenerative changes developing and equivocal, subtle chondrocalcinosis. She continued to diagnose left knee joint pain. Additional progress reports from Dr. Tallman diagnosed left knee joint pain.

In a June 3, 2011 report, Dr. Kevin A. Kirby, D.P.M., a Board-certified podiatrist, noted the history of the February 22, 2011 work injury and provided an assessment of left knee plica syndrome. In a June 17, 2011 report, he indicated that appellant had possible plica syndrome.

In a July 13, 2011 report, Dr. Tallman reported findings from the magnetic resonance imaging (MRI) scan of the left knee. The findings were noted as a four millimeter osteochoncdral lesion of the central medial femoral condyle without displaced cartilage fragment. No meniscus or ligamentous tear or patellar plica was seen. Dr. Tallman diagnosed unchanged knee pain of unclear etiology.

In July 22, August 5 and 26, 2011 reports, Dr. Robert S. Burger, an orthopedic surgeon, provided cortisone injections for appellant's symptomatic left knee medial plica band. He indicated that appellant had complete relief of symptoms.

[4] Appellant lost time from work to attend medical appointments and when no work was available within his medical restrictions.

[5] Appellant has other cases involving the left knee or ankle. Under OWCP File No. xxxxxx475, an occupational disease claim (Form CA-2) filed in August 2006 was accepted for left foot/ankle sprain. This claim is closed. Under OWCP File No. xxxxxx387, an occupational disease claim (Form CA-2) filed in December 2007 was accepted for bilateral plantar fibromatosis. This claim remains open. Under OWCP File No. xxxxxx143, an occupational disease claim (Form CA-2) filed September 16, 2015 was accepted for left ankle sprain and temporary aggravation of left sinus tarsi syndrome. This claim remains open.

Appellant returned to full-time, full duty on December 1, 2011 without permanent restrictions.

In reports dated November 12 and December 14, 2012, February 14, March 20, and May 17, 2013 reports, Dr. Kirby assessed bilateral plantar fasciitis. He noted that appellant underwent bilateral plantar fasciotomies three and a half years prior.

In a December 7, 2015 report, Dr. Randall K. Schaefer, a Board-certified orthopedic surgeon, noted that appellant injured his left knee on February 26, 2011[6] and developed gradual onset of left parapatellar knee pain and weakness. He took left knee x-rays and diagnosed left patellofemoral pain syndrome.

Appellant stopped working on December 8, 2015. He filed a claim for compensation (Form CA-7) for total disability commencing December 8, 2015.

In a January 18, 2016 report, Dr. Schaefer noted that appellant developed gradual weakness in early 2011 and that he had reported his injury on February 26, 2011. Appellant was referred for orthopedic evaluation on December 7, 2015 and was diagnosed with patellofemoral pain syndrome. He was treated with physical therapy, Motrin, and ice and had minimal improvement. Dr. Schaefer indicated that he had recommended that appellant continue his knee rehabilitation program with therapy, home exercises, Tylenol, ice, and weight loss. Because of appellant's anterior knee pain, he recommended that appellant avoid all climbing, squatting, and kneeling, and limit his walking and standing to occasional. Dr. Schaefer opined that appellant's symptoms were caused by daily activities at work, which resulted in gradual onset of patellar pain. He stated that there was no specific injury for appellant's patellofemoral tenderness and crepitus. In his January 18, 2016 progress report, Dr. Schaefer diagnosed left patellofemoral pain syndrome and obesity.

By decision dated February 8, 2016, OWCP denied appellant's claim for disability compensation for the period December 8, 2015 and continuing as there was no medical evidence which established appellant's accepted conditions had worsened such that he was no longer able to perform the full duties of his position. It noted that Dr. Kirby's January 12, 2016 report indicated that appellant had suffered a new left ankle injury and that it was expected that he would have further disability as a result of his plantar fasciitis. However, Dr. Kirby did not attribute appellant's working in a modified capacity to the original injury of February 22, 2011. It also noted that while Dr. Schafer's January 18, 2016 report attributed appellant's need to work in a modified capacity to patellofemoral pain syndrome and obesity, neither of which were accepted conditions.[7]

In a February 29, 2016 progress report, Dr. Schaefer continued to diagnose left patellofemoral pain syndrome and obesity and restricted appellant's activities. He opined that

[6] The date of injury appears to be a typographical error and should refer to the February 22, 2011 work injury. This error is consistent in all of Dr. Schaefer's reports.

[7] OWCP indicated that appellant could file a Form CA-2a (notice of recurrence) under OWCP File No. xxxxxx387, which was accepted for bilateral plantar fibrosis with date of injury on December 27, 2007, for his current plantar fibrosis condition.

appellant's current condition was simply continued pain from his industrial injury of February 2011. Dr. Schaefer noted that appellant's symptoms were the same and failed to improve with nonoperative measures. He opined that appellant's initial diagnoses of knee sprain and lateral collateral ligament injury were incorrect and that it should have been patellofemoral pain syndrome. Dr. Schaefer indicated, however, that this did not represent a new diagnosis. He referred appellant to physical therapy.

Dr. Kirby continued to submit reports which pertained to appellant's continued left ankle pain in the sinus tarsi region.

In a March 24, 2016 report, Dr. Schaefer indicated that the March 16, 2016 MRI scan revealed chondromalacia of the medial condyle and patellofemoral joint and possible loose bodies or a free meniscus fragment. He diagnosed left patellofemoral pain syndrome, articular cartilage injury to medial femoral condyle, and possible meniscus tear or loose bodies and provided restrictions on walking and standing. Copies of the March 16, 2016 left knee MRI scan was provided. Dr. Schaefer also requested authorization from OWCP for left knee arthroscopy.

In an April 5, 2016 letter, OWCP advised Dr. Schaefer that, if he believed that a newly diagnosed condition and the need for a left knee arthroscopy were causally related to the accepted work injury of February 22, 2011, then he should provide a detailed narrative medical report. It indicated that the report should include medical rationale as to why the condition(s) diagnosed were believed to have been caused or aggravated by the February 22, 2011 work injury.

In an April 8, 2016 report, Dr. Schaefer stated that, when appellant was last seen on March 24, 2016, he was diagnosed with patellofemoral pain syndrome, articular cartilage injury of the medial femoral condyle, loose bodies, or possible meniscus tear. He indicated that appellant's primary diagnosis was patellofemoral pain syndrome. Dr. Schaefer explained that this was the same diagnosis that he provided when appellant was first evaluated for his left knee injury on December 7, 2015 and that his diagnosis had been consistent.

By decision dated May 12, 2016, OWCP denied appellant's claim for additional left knee conditions finding that the medical evidence of record did not establish that the claimed medical conditions were causally related to the February 22, 2011 employment injury. It found that Dr. Schaefer had not provided a well-rationalized medical explanation as to how appellant's stepping out of a vehicle on February 22, 2011 had caused or contributed to his additional left knee conditions of patellofemoral pain syndrome, articular cartilage injury of the medial femoral condyle, loose bodies, or possible meniscus tear.

On June 7, 2016 OWCP received appellant's June 1, 2016 request for an oral hearing before an OWCP hearing representative. A telephonic hearing was held on January 25, 2017. It was noted that an addendum report from Dr. Schaefer was needed to address the additional left knee conditions causally related to the accepted February 22, 2011 employment injury.

In a January 15, 2017 report, Dr. Schaefer advised that appellant was diagnosed with patellofemoral pain syndrome and obesity and treated conservatively. However, due to persistent pain, appellant had elected to proceed with surgical treatment, which was pending. Dr. Schaefer

indicated that appellant was last seen on March 24, 2016 and that there was patellofemoral tenderness and crepitus and a positive patellar compression test on physical examination.

By decision dated April 10, 2017, an OWCP hearing representative affirmed OWCP's May 12, 2016 decision. She found that the medical evidence of record was insufficient to establish causal relationship for the additional left knee conditions. Appellant was advised to file a Form CA-2 occupational disease claim if he believed that his condition was a result of his mail carrier activities over a period of time.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim, including the fact 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 period of FECA, that an injury was sustained in the performance of duty as alleged, and that any disability and/or specific condition for which compensation are claimed is causally related to the employment injury. 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.[8]

The medical evidence required to establish causal relationship between a diagnosed condition and an accepted employment incident is usually rationalized medical evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, 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 claimant.[9]

ANALYSIS

The Board finds that appellant has failed to establish that his left knee conditions of patellofemoral pain syndrome, articular cartilage injury of the medial femoral condyle, loose bodies, or possible meniscus tear are causally related to the February 22, 2011 employment injury.

OWCP accepted that appellant's accepted February 22, 2011 employment injury caused left knee sprain, lateral collateral ligament, and left ankle sprain. It subsequently denied his claim for additional left knee conditions of patellofemoral pain syndrome, articular cartilage injury of the medial femoral condyle, loose bodies, or possible meniscus tear.

[8] *Jussara L. Arcanjo*, 55 ECAB 281, 283 (2004).

[9] *Judith A. Peot*, 46 ECAB 1036 (1995); *Ruby I. Fish*, 46 ECAB 276 (1994).

Dr. Tallman submitted several reports, which diagnosed left knee pain of unclear etiology. However, knee pain does not constitute a definitive diagnosis, rather it is a symptom.[10] Furthermore, Dr. Tallman indicated that there was an unclear etiology concerning the left knee condition, thus, her reports are insufficient to establish appellant's claim.

Dr. Kirby related in reports dated June 3 and 17, 2011 that appellant had possible left knee plica syndrome. However, this diagnosis is speculative and of limited probative value.[11] Furthermore, Dr. Kirby offered no opinion as to the cause of this diagnosis. As previously noted, to be of probative value, the opinion of the physician must be based on a complete factual and medical background of the claimant, 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 incident.[12]

Several reports from Dr. Schaefer were also submitted. Although Dr. Schaefer noted appellant's left knee conditions and was aware of his February 22, 2011 employment injury, he did not provide a rationalized medical opinion addressing causal relationship for any of the diagnosed conditions. In his initial report of December 7, 2015, Dr. Schaefer noted that appellant injured his left knee on February 26, 2011[13] and developed gradual onset of left patellar knee pain and weakness. He diagnosed left patellofemoral pain syndrome. Dr. Schaefer never discussed the cause of this diagnosed condition. Medical evidence that does not offer an opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[14]

In a January 18, 2016 progress report, Dr. Schaefer again diagnosed left patellofemoral pain syndrome. However, he opined that appellant's symptoms were caused by daily activities at work. Dr. Schaefer noted that there was no specific injury for appellant's patellofemoral tenderness and crepitus. This opinion does not causally relate the diagnosed condition to the accepted February 22, 2011 employment incident, but rather suggests that the condition was caused by new occupational exposures due to additional events over a period of time.[15]

Subsequently, in his February 29 and April 8, 2016 progress reports, Dr. Schaefer indicated that appellant's left patellofemoral pain syndrome was in fact continued pain from his employment injury of February 2011 and that the initial diagnosis of knee sprain and lateral collateral ligament injury were incorrect. Besides noting that appellant's symptoms were the same, he did not provide any medical rationale explaining how appellant's left patellofemoral pain

[10] *J.H.*, Docket No. 11-0933 (issued November 7, 2011).

[11] *See Irene St. John*, 50 ECAB 521 (1999); *Michael E. Smith*, 50 ECAB 313 (1999).

[12] *Supra* note 9.

[13] The date of injury appears to be a typographical error and should refer to the February 22, 2011 work injury. This error is consistent throughout all of Dr. Schaefer's reports.

[14] *See C.L.*, Docket No. 17-0249 (issued June 22, 2017).

[15] *See R.B.*, Docket No. 10-1492 (issued February 9, 2011).

syndrome was causally related to the accepted work injury. The Board has held that a medical opinion not fortified by rationale is of diminished probative value.[16]

In his March 24, 2016 report, Dr. Schaefer related that appellant's March 16, 2016 MRI scan revealed chondromalacia of the medial condyle, patellofemoral joint possible loose bodies, or free meniscus fragment. He diagnosed left patellofemoral pain syndrome, articular cartilage injury to medial femoral condyle, and possible meniscus tear, or loose bodies and requested authorization for left knee arthroscopy. However, Dr. Schaefer again offered no opinion regarding the cause of these conditions. As previously noted, the Board has held that medical evidence that does not offer any opinion regarding the cause of an employee' condition is of limited probative value on the issue of causal relationship.[17]

As appellant has failed to submit any medical report containing a rationalized medical opinion showing a causal relationship between his accepted employment injury and the additional diagnosed left knee conditions of patellofemoral pain syndrome, articular cartilage injury of the left medial femoral condyle, loose bodies of the left knee, and possible left knee meniscal tear, he has failed to meet his burden of proof to establish his claim for these conditions. An award of compensation may not be based on surmise, conjecture, speculation, or on the employee's own belief of causal relation.[18]

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 additional left knee conditions causally related to the accepted employment injury of February 22, 2011.

[16] *M.F.*, Docket No. 15-0081 (issued January 15, 2016); *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value).

[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] *D.D.*, 57 ECAB 734 (2006).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 10, 2017 is affirmed.

Issued: July 25, 2018
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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