



## **FACTUAL HISTORY**

This case has previously been before the Board.<sup>1</sup> On November 21, 2002 the Board set aside a May 26, 2000 decision and remanded the case to the Office to conduct a merit review, which included an evaluation of the June 8, 1997 report submitted by Dr. Frank B. Watkins, an attending Board-certified orthopedic surgeon. The facts and the circumstances of the case as set out in the Board's prior decision are incorporated herein by reference.<sup>2</sup> Facts relevant to the present appeal will be set forth as necessary.

On November 12, 1987 appellant, then a 36-year-old electrician, injured his right leg when he slipped on a sheet of ice while walking down a flight of stairs. The Office accepted appellant's claim for a fractured right ankle and peroneal tendinitis. Appellant returned to light duty on January 18, 1988. The Office accepted that he sustained a recurrence of disability on August 21, 1991 and paid appropriate compensation benefits. Appellant returned to full-time work on September 16, 1991.

In an August 31, 1988 report, Dr. B. Morgenstern, a Board-certified neurologist and an Office medical adviser, indicated that "it is a known fact that during, and after fracture treatment, there is indirect burden on knee to compensate the ankle joint." In an August 2, 1995 report, Dr. Charles F. Colao, Board-certified in internal medicine, noted the history of injury. He noted, after the injury, that appellant indicated he had trouble getting the proper alignment and his leg was set three times, and subsequently had problems bearing weight on the right knee. Dr. Colao opined that "[i]t is my opinion that the knee problems are directly related to the injury of November 12, 1987."

In a report dated January 18, 1996, Dr. David Johnson, a Board-certified orthopedic surgeon and second opinion physician, noted that appellant's chief complaints were for a right knee and right ankle injury and explained that appellant began to experience right knee discomfort with prolonged standing and walking on August 12, 1988. On examination, appellant walked without a limp, and had minimal click of the right knee with flexion and extension which were derived from the patellofemoral joint. Dr. Johnson noted clicking on the left knee as well. Right ankle examination revealed no loss of subtalar motion and no instability. Flexion and extension were 27 degrees on the right and 25 degrees on the left, with plantar flexion at 65 degrees for both ankles, and an equal girth of 37.2 centimeters for both the right and left calf. Dr. Johnson noted minimal click with flexion and extension of the ankle, but no swelling. He opined that appellant was post fracture of the lateral malleolus, with chondromalacia of the tibial

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<sup>1</sup> Docket No. 01-1551 (issued November 21, 2002).

<sup>2</sup> The record includes a December 16, 1994 schedule award decision awarding appellant an 18 percent impairment to the right lower extremity. By decision dated January 29, 1996, the Office denied appellant's claim for an additional schedule award and denied appellant's claim that his knee condition was causally related to his November 12, 1987 work injury. In a decision dated November 25, 1996, the Office found that appellant had not submitted medical evidence establishing that his right knee condition was due to his work injury or that he had more than an 18 percent impairment of the right lower extremity for which he received a schedule award. By decisions dated February 9, 1998 and June 14, 1999, the Office denied appellant's requests for reconsideration after reviewing the case on the merits. In a May 26, 2000 decision, the Office denied appellant's request for reconsideration without reviewing the case on the merits.

plafond related to the injury of November 1987; and that appellant had chondromalacia of the patella of the right knee with no direct relationship to the injury of November 12, 1987. Dr. Johnson referred to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*) (4<sup>th</sup> ed. 1993) and advised that appellant had no impairment due to loss of motion. However, he noted that appellant had chondromalacia of the ankle and that pursuant to Table 62, page 83 of the A.M.A. *Guides*, appellant would be entitled to a five percent impairment rating to the lower extremity for chondromalacia, patella, and opined that the chondromalacia of the ankle was analogous. Dr. Johnson opined that appellant was entitled to a five percent impairment rating to the right lower extremity because of chondromalacia of the tibial plafond with resulting pain with prolonged walking and opined that the chondromalacia of the patella, not related to the work injury, would result in five percent impairment. He indicated no further treatment was needed.

In a January 26, 1996 report, an Office medical adviser recommended that x-rays be taken to allow measurement of the cartilage density in the whole knee area and noted that Dr. Johnson's measurements were a proper application of standards for rating impairment.

In an August 20, 1996 report, Dr. A. Roy Rosenthal, an attending Board-certified orthopedic surgeon, indicated that on November 12, 1987 appellant "was at work and fell down the steps and injured his right knee." Examination revealed significant subpatella crepitation, tenderness over the medial femoral condyle, swelling consistent with a medial plica, and minimal quadriceps atrophy. He advised that x-rays presented by appellant indicated "no evidence of fracture or dislocation" of the knee. Dr. Rosenthal also advised that he reviewed an magnetic resonance imaging (MRI) scan of August 18, 1988, which showed a "thin medial patella plica and no evidence of ligamentous or meniscal injury." He also noted "a small to moderate effusion and the patella appears to be somewhat higher than usual. Some degenerative changes present in the meniscus probably related to aging." However, the physician opined that "I feel that the patient's present symptomatology is directly related to the injuries sustained at work on November 12, 1987 when he fell at work injuring his knee and sustained a fracture of his ankle." Dr. Rosenthal referred to the A.M.A. *Guides*, and opined that appellant had sustained a permanent disability to his right lower extremity of seven percent secondary to chondromalacia and an additional four percent secondary to the plica. He concluded that appellant had sustained a permanent partial disability of 11 percent to his right lower extremity secondary to the injuries sustained to his right knee on November 12, 1987.

In a June 8, 1997 report, Dr. Watkins noted that he examined appellant on November 13, 1987 for work-related injuries sustained to his right lower extremity on November 12, 1987, and advised that he last saw appellant on January 29, 1990. He advised that his original findings were antalgic gait, and right lateral ankle swelling, with x-rays positive for lateral malleolar fracture of the right ankle. Dr. Watkins noted that appellant did not have any prior right knee or right ankle injuries. He explained that his initial treatment focused on appellant's right lower extremity because it warranted more attention initially. After treating the right ankle fracture, the physician shifted his treatment to right knee symptoms and alleged that appellant's right knee symptoms and condition were directly related to his work-related injury of November 12, 1987. Dr. Watkins opined that "the fall on the icy sidewalk curb constitutes a probable mechanism of injury to both [appellant's] right ankle and right knee conditions."

In a November 21, 1997 report, Dr. Karenga R. Lemmons, a Board-certified internist, noted that she reviewed the reports provided by appellant and opined that “[b]ecause of this injury, there is a great probability that the Rt [sic] knee was injured at the same time of the incident, based upon extensive medical reports involving the Rt [sic] knee over the past ten years.” She concurred with Dr. Rosenthal’s assessment of an 11 percent permanent impairment to the right lower extremity. On May 5, 1998 Dr. Lemmons amended her previous report and advised that “Mr. Jackson sustained a spiral fracture to his right fibula as x-rays and medical reports clearly state this in addition to a right ankle fracture. The location of the fibula fracture, approximately halfway between the knee and the ankle would definitely suggest the right knee and ankle joints were involved as they are connected to the same bone.” Dr. Lemmons explained that Dr. Johnson was incorrect with respect to the first time that appellant began experiencing knee discomfort, noting that his opinion was not supported by the records, and alleged that Dr. Johnson only conducted an ankle examination, and did not request diagnostic studies of the ankle or knee. She further advised that MRI scan results of appellant’s right knee dated August 18, 1988 showed a right medial patella pica which did not show up on a subsequent MRI scan, which suggested a healing injury. Dr. Lemmons opined that appellant “probably did in fact, fracture his right patella when he fell down the stairs on Nov[ember] 12, 1987.” She further indicated that she concurred with the “eight other physician’s reports, two of them workers’ compensation physician’s, along with the numerous reports on file that [appellant] did in fact injure his right knee on November 12, 1987.” Regarding impairment, Dr. Lemmons opined that appellant sustained an 11 percent permanent impairment of the right knee, in addition to the 18 percent of the foot, to total 29 percent for the right lower extremity.

In a report dated September 28, 1998, Jerry S. Farber, a Board-certified orthopedic surgeon diagnosed sciatic entrapment and stated that it was related to the November 12, 1987 injury. Dr. Farber advised that sciatic entrapment would frequently occur as a part of an initial problem if traction effect had occurred to the nerve at the time of the injury to the lower part of the leg, and would be consistent with appellant’s symptoms from the outset, although they were initially masked by the more severe pain from the fracture. In his October 16, 1998 report, Dr. Farber indicated that appellant continued to show signs of paresthesias in the right foot on straight-leg raising, and noted tenderness over the sciatic bifurcation. In a December 30, 1998 report, Dr. Farber opined that appellant had sciatic entrapment and persistent symptoms which were directly related to the injuries of November 12, 1987.<sup>3</sup>

The Office medical adviser on February 4, 1999 advised that the sciatic entrapment was not causally related as appellant sustained an ankle fracture.

By decision dated March 12, 2003, the Office denied modification of the June 14, 1999 decision. The Office found that the medical evidence did not establish that appellant’s right knee condition was causally related to the work injury of November 12, 1987, nor did it support that appellant was entitled to an additional impairment to the right lower extremity due to the accepted November 12, 1987 employment injury.

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<sup>3</sup> He recommended a surgical decompression of the sciatic nerve.

### **LEGAL PRECEDENT -- ISSUE 1**

An employee seeking benefits under the Federal Employees' Compensation Act<sup>4</sup> has the burden of establishing 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 the Act, that the claim was timely filed within the applicable time limitation period of the Act, that an injury was sustained in the performance of duty as alleged and that any disability and specific condition for which compensation is claimed is causally related to the employment injury.<sup>5</sup> The medical evidence required to establish a causal relationship between a claimed period of disability and an employment injury is rationalized medical opinion 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 compensable 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.<sup>6</sup>

An award of compensation may not be based on surmise, conjecture, speculation or upon appellant's own belief that there is causal relationship between his claimed condition and his employment.<sup>7</sup> To establish causal relationship, appellant must submit a physician's report in which the physician reviews what factors of employment identified by appellant as causing her condition and, taking these factors into consideration as well as findings upon examination of appellant and appellant's medical history, state whether these employment factors caused or aggravated appellant's diagnosed condition and present medical rationale in support of his opinion.<sup>8</sup>

### **ANALYSIS -- ISSUE 1**

The Office accepted appellant's claim for a right ankle fracture and peroneal tendinitis as a result of an employment-related fall on November 12, 1987. The Office relied upon Dr. Johnson who in a January 18, 1996 report conducted an examination of the right knee and right ankle. With respect to the right knee, he noted that appellant began experiencing pain in the right knee for the first time on August 12, 1988 with prolonged standing and walking. The physician indicated that an MRI scan of the right knee dated August 18, 1988 showed probable mild chondromalacia with no evidence of ligamentous or meniscal muscle injury and that appellant's gait was normal by August 25, 1988. Dr. Johnson observed the right knee and conducted flexion and extension tests which showed some clicking; however, he noted that there was no swelling at the knee, no instability and tests for internal derangement were negative. He

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<sup>4</sup> 5 U.S.C. §§ 8101-8193.

<sup>5</sup> *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

<sup>6</sup> *See Donna Faye Cardwell*, 41 ECAB 730, 741-42 (1990).

<sup>7</sup> *Robert Broome*, 55 ECAB \_\_\_\_ (Docket No. 04-93, issued February 23, 2004).

<sup>8</sup> *Gary J. Watling*, 52 ECAB 278 (2001).

opined that appellant had chondromalacia of the right knee with no direct relationship to the injury of November 12, 1987.

In support of his claim that he also sustained a right knee condition as a result of the employment-related fall, appellant submitted numerous reports from several physicians, and also asserted that the reports of the Office medical advisers were supportive of causal relationship.

In an August 31, 1988 report, Dr. Morgenstern indicated that, it was “a known fact” that during and after fracture treatment, an indirect burden is placed on the knee. However, he did not further explain how this applied to appellant’s situation and, at best, this appears to be speculative support for causal relationship.<sup>9</sup>

In an August 2, 1995 report, Dr. Colao opined that appellant’s knee problems were directly related to the injury of November 12, 1987; however, he did not provide any rationale to support his conclusion. The Board has held that a medical opinion not fortified by medical rationale is of little probative value.<sup>10</sup>

In an August 20, 1996 report, Dr. Rosenthal opined that appellant fell on November 12, 1987 and “injured his right knee.” However, he found “no evidence of fracture or dislocation” of the knee. Although he reviewed an August 18, 1988 MRI scan and noted a “thin medial patella pica and no evidence of fracture or dislocation of the knee” he opined that there was “no evidence of ligamentous or meniscal injury.” Dr. Rosenthal also referred to a small to moderate effusion and advised that the patella appeared to be somewhat higher than usual. He also noted degenerative changes present in the meniscus which he indicated were probably related to aging. Dr. Rosenthal concluded that appellant’s present symptomatology was “directly related to the injuries sustained at work on November 12, 1987 when he fell at work injuring his knee and sustained a fracture of his ankle.” However, the Board notes that this report is based on incorrect facts as there is no evidence in the record to suggest that appellant injured his knee when he fell. The Board notes that there were no complaints about the knee until August 12, 1988. Therefore, this report is of diminished value because it is based on incorrect facts. Part of a claimant’s burden of proof is the submission of rationalized medical evidence based on a complete and accurate factual and medical background showing causal relationship.<sup>11</sup>

In a June 8, 1997 report, Dr. Watkins explained that appellant was treated for injuries to his right lower extremity on November 12, 1987 and his original findings included antalgic gait, and right lateral ankle swelling, and a lateral malleolar fracture of the right ankle. He advised that after the right ankle fracture was treated, he shifted his treatment to the right knee symptoms and opined that appellant’s right knee symptoms were directly related to November 12, 1987 injury. Dr. Watkins opined that “the fall on the icy sidewalk curb constitute a probable mechanism of injury to both Mr. Jackson’s right ankle and right knee conditions.” He opined

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<sup>9</sup> See *Leonard J. O’Keefe*, 14 ECAB 42, 48 (1962) (where the Board held that medical opinions which are speculative or equivocal in character have little probative value).

<sup>10</sup> *Annie L. Billingsley*, 50 ECAB 210 (1998).

<sup>11</sup> *Kenneth R. Love*, 50 ECAB 193 (1998).

that “[i]t is my opinion that Mr. Jackson’s right knee symptoms and condition is directly related to his work-related injury of November 12, 1987. The fall on the icy sidewalk curb constitutes a probable mechanism of injury to both Mr. Jackson’s right ankle and right knee conditions.” However, his report was not rationalized as it did not explain the connection between the knee symptoms and the accepted ankle condition.<sup>12</sup>

In a November 12, 1997 report, Dr. Lemmons opined that there was a great probability that the right knee was injured at the same time based upon her review of the extensive medical reports involving the right knee over the past 10 years. However, this report is speculative. While the medical opinion of a physician supporting causal relationship does not have to reduce the cause or etiology of a disease or condition to an absolute certainty, neither can such opinion be speculative or equivocal. The opinion of a physician supporting causal relationship must be one of reasonable medical certainty that the condition for which compensation is claimed is causally related to federal employment and such relationship must be supported with affirmative evidence, explained by medical rationale and be based upon a complete and accurate medical and factual background of the claimant.<sup>13</sup> In a May 5, 1998 report, Dr. Lemmons advised that appellant sustained a spiral fracture to his right fibula in addition to a right ankle fracture. She opined that the location of the fibula fracture, which was about halfway between the knee and the ankle “would definitely suggest the right knee and ankle joints were involved” as they were connected to the same bone.” In addition, Dr. Lemmons explained that the August 18, 1988 MRI scan of the right knee suggested a healing injury, and that appellant probably fractured his right patella when he fell down the stairs on Nov[ember] 12, 1987. She concluded her report by advising that she concurred with the numerous physicians who advised that appellant injured his right knee on November 12, 1987. The Board finds that this report is also speculative and without sufficient medical rationale to support the doctor’s conclusion.<sup>14</sup>

Other medical reports are insufficient because they did not specifically address how and why the accepted ankle injury caused or aggravated a knee injury. Appellant has failed to discharge his burden of proof.

### **LEGAL PRECEDENT -- ISSUE 2**

Section 8107 of the Act<sup>15</sup> sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.<sup>16</sup> The Act, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under

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<sup>12</sup> 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. *Bonnie Goodman*, 50 ECAB 139 (1998); *James H. Botts*, 50 ECAB 265 (1999).

<sup>13</sup> *Samuel Senkow*, 50 ECAB 370 (1999); *Thomas A. Faber*, 50 ECAB 566 (1999).

<sup>14</sup> *Id.*

<sup>15</sup> 5 U.S.C. §§ 8101-8193.

<sup>16</sup> 5 U.S.C. § 8107.

the law, good administrative practice requires the use of uniform standards applicable to all claimants.<sup>17</sup> The Act's implementing regulation has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule award losses.<sup>18</sup>

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the tables in the A.M.A., *Guides*.<sup>19</sup> However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment.

### ANALYSIS -- ISSUE 2

Appellant received a schedule award for an 18 percent permanent impairment of his right lower extremity. Appellant appealed the schedule award in conjunction with his claim that he had a right knee condition causally related to the employment injury.

The Office based its denial of an additional schedule award on the opinions of Dr. Johnson, and the Office medical adviser. In a report dated January 18, 1996, Dr. David C. Johnson, a Board-certified orthopedic surgeon, conducted a physical examination, and advised that appellant had no loss of motion. He opined that, pursuant to the A.M.A. *Guides*, appellant would not be entitled to any impairment because there was no loss of motion. However, he noted that appellant had chondromalacia of the ankle and that pursuant to Table 62, A.M.A., *Guides*, appellant would be entitled to a five percent impairment rating to the lower extremity for chondromalacia, patella, and opined that the chondromalacia of the ankle was analogous.<sup>20</sup> Dr. Johnson opined that appellant was entitled to a five percent impairment rating to the right lower extremity because of chondromalacia of the tibial plafond with resulting pain with prolonged walking and opined that the chondromalacia of the patella, which was not related to the employment injury, would result in a five percent impairment rating. He indicated no further treatment was warranted. In a January 26, 1996 report, Dr. Hoover, the Office medical adviser, reviewed Dr. Johnson's report and noted that there was no significant reduction in the range of motion in the knee.<sup>21</sup> However, the Office did not accept that appellant sustained a right knee injury and this report is of limited probative value.

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<sup>17</sup> *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

<sup>18</sup> 20 C.F.R. § 10.404.

<sup>19</sup> See *William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

<sup>20</sup> A.M.A., *Guides* 83, Table 62 (4<sup>th</sup> ed. 1993).

<sup>21</sup> Although he advised that x-rays, would be a superior method to calculate the cartilage density in the knee area, this additional method of calculation is irrelevant as appellant did not establish that his right knee condition was causally related to his accepted employment injury.



Reports from Drs. Morganstern, Colao, Watkins, Lemons and Farber do not specifically address whether appellant was entitled to an additional impairment rating.

Appellant also submitted two reports from Dr. Lemmons. In her November 21, 1997 report, Dr. Lemmons merely agreed with Dr. Rosenthal that appellant had an 11 percent impairment. She did not provide any explanation as to how she arrived at her conclusion.<sup>22</sup> For example she failed to explain how her determination was reached in accordance with the relevant standards of the A.M.A., *Guides*.<sup>23</sup> Dr. Lemmons failed to refer to specific tables or charts in the A.M.A., *Guides* or to provide her calculations in support of this determination. In a report dated May 5, 1998, Dr. Lemmons explained that appellant sustained an 11 percent impairment to the right knee which should be added to the 18 percent impairment of the foot. However, as appellant did not meet his burden to show that the knee was causally related to the accepted employment injury, this opinion is insufficient to meet appellant's burden. Furthermore, she did not refer to the A.M.A. *Guides* to support her conclusion.<sup>24</sup>

In an August 20, 1996 report, Dr. Rosenthal, whose report as noted above was based on an incorrect factual history, opined that appellant was entitled to an 11 percent impairment to the right lower extremity and 7 percent to the chondromalacia. However, in addition to being based on an incorrect history, appellant did not meet his burden to show that his knee condition was causally related to the accepted injury. Therefore, any percentages of impairment based on the knee would be inapplicable.

Appellant has not provided any medical reports, based on objective findings, which establish that he is entitled to more than an 18 percent permanent impairment of the right lower extremity for which he already received a schedule award. Therefore, appellant has failed to establish his entitlement to an increased schedule award.

### **CONCLUSION**

The Board finds that appellant has not met his burden of proof to establish that he sustained a right arm condition causally related to factors of his federal employment. The Board further finds that appellant is not entitled to an additional schedule award.

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<sup>22</sup> *Michael E. Smith*, 50 ECAB 313 (1999).

<sup>23</sup> *See Tonya R. Bell*, 43 ECAB 845, 849 (1992).

<sup>24</sup> *Id.*

**ORDER**

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated March 12, 2003 is hereby affirmed.

Issued: February 7, 2005  
Washington, DC

Colleen Duffy Kiko  
Member

Willie T.C. Thomas  
Alternate Member

Michael E. Groom  
Alternate Member