United States Department of Labor
Employees' Compensation Appeals Board

J.P., Appellant	)	
and	)	**Docket No. 09-494**
	)	**Issued: December 23, 2009**
DEPARTMENT OF COMMERCE, BUREAU OF THE CENSUS Suitland, MD, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On December 10, 2008 appellant filed a timely appeal from a November 21, 2008 merit decision of the Office of Workers' Compensation Programs.[1] Pursuant to 20 C.F.R. §§ 501.2 and 501.3, the Board has jurisdiction over the merits of this appeal of the left knee.

ISSUES

The issues are: (1) whether appellant sustained a recurrence of total disability commencing October 10, 2007 causally related to her July 13, 2005 employment injury; and (2) whether the Office properly rescinded acceptance of a torn lateral meniscus of the left knee.

FACTUAL HISTORY

On July 13, 2005 appellant, then a 42-year-old secretary, was injured when she slipped and fell on a wet restroom floor. The Office accepted her claim for cervical sprain, left knee

[1] By decision dated April 16, 2008, the Office denied authorization for a total knee replacement procedure. Appellant did not file an appeal from this decision. Therefore, it is not an issue in the present appeal.

sprain, left hip strain and a torn lateral meniscus. Appellant stopped work on July 13, 2005 and returned on July 25, 2005 before undergoing a left knee arthroscopy.[2] She returned to light-duty work as a program assistant following surgery.

Appellant came under treatment by Dr. Dennis A. Carlini, a Board-certified orthopedic surgeon, who performed surgery on August 17, 2006 noting that the preoperative diagnosis was a medial meniscal tear with patellofemoral overhang. Dr. Carlini found an osteochondral fracture of the intercondylar notch and shaved a prolapse tear of the medial meniscus. He described degenerative fraying of the medial side of the lateral meniscus which was trimmed. Appellant was seen in follow up following surgery and prescribed physical therapy. On November 20, 2006 Dr. Carlini released her to return to light-duty work.[3] Appellant was seen again on March 15, 2007, at which time Dr. Carlini recommended an MRI scan. Dr. Carlini reported on April 23, 2007 that the MRI scan did not reveal any major recurrent meniscal damage but did show advancing arthritis to the left knee.[4] He recommended a follow-up bone scan. On August13, 2007 Dr. Carlini advised that appellant's bone scan showed significant osteoarthritic changes and he recommended total knee replacement.

Appellant stopped work on October 10, 2007 when found totally disabled by another attending physician, Dr. Rida N. Azer, a Board-certified orthopedic surgeon. In a September 21, 2007 report, Dr. Azer noted that she had pain in the left knee, hip, left side of the back and her neck following the July 13, 2005 injury. He opined that her conditions of left knee traumatic arthritis, arthroscopic surgery and cervical disc syndrome and lumbosacral strain were due to the employment injury. On October 10, 2007 Dr. Azer reiterated that appellant was totally disabled as of October 10, 2007 due to traumatic arthritis of the left knee. Additional treatment records from him continued her disability. On December 5, 2007 Dr. Azer stated that an MRI scan showed a fusion of the disc between C5-6 and C6-7 with no fragments or spinal stenosis. On December 19, 2007 he advised that a December 11, 2007 MRI scan of the left knee revealed low-grade synovitis and early medial meniscal degenerative changes without frank surgical tear or displacement. Dr. Azer noted that appellant's neurologist had advised against her return to work.

On November 26 and December 31, 2007 appellant filed claims for compensation (Form CA-7) for the period commencing October 10, 2007. On January 7, 2008 the Office advised her to submit a comprehensive medical report from her treating physician to support her disability claim. On January 31, 2008 it noted that its records reflected that appellant returned to duty on May 7, 2007. Appellant was advised to file a Form CA-2a, notice of recurrence. On

[2] A March 22, 2006 magnetic resonance imaging (MRI) scan of the left knee revealed the lateral meniscus to be normal and intact. There was a low-grade medial meniscus prolapse and subluxation partially out of the weight bearing joint space and arthropathic spurring about the prolapsed body. Low-grade degenerative changes and intermediate chondromalacia of the patellofemoral joint was found.

[3] On December 7, 2006 Dr. Carlini noted that appellant was to maintain her office work status. On January 4, 2007 he noted that appellant was able to do most of her work just with prolonged sitting.

[4] An April 12, 2007 MRI scan revealed partial subluxation prolapse of the lateral meniscus body out of the weight bearing joint space with an otherwise intact lateral meniscus. Degenerative changes and chondromalacia of the medial joint space were also noted.

February 26, 2008 she submitted a recurrence of disability claim. Appellant stated that she experienced an aggravation and worsening of her accepted conditions on September 21, 2007 and was working a light-duty position when she stopped work on October 10, 2007. In an October 3, 2007 report, Dr. Manisha Jariwala, a Board-certified internist, found that appellant was totally disabled from October 2 to 8, 2007. She advised that appellant could return to work on October 9, 2007. In a February 21, 2008 report, Dr. Jariwala listed examination findings pertaining to appellant's neck and left knee.

In an October 17, 2007 report, Dr. Guy W. Gargour, a Board-certified neurologist, noted an impression of cervical myofascial pain with brachial plexus irritation of the left side and possible cervical and ligamentous instability. The clinical picture was of an injury two years prior followed by an acute exacerbation with a myofascial component suggestive of a cervical ligamentous instability flare up. On November 28, 2007 Dr. Gargour reviewed a November 14, 2007 cervical spine x-ray that showed calcification at C5-6 and C6-7 anteriorly in the anterior longitudinal ligament, which he believed was a sign of bleeding and healing that occurred at the time of appellant's injury. Dr. Gargour stated that appellant's neck pain, cervicogenic headaches and difficulty with sitting for any length of time were related to the 2005 work injury. He recommended a two-level fusion of the cervical spine.

In a December 10, 2007 report, Dr. Faheem A. Sandu, a neurosurgeon, reviewed a November 14, 2007 MRI scan and x-rays of the cervical spine. He found that appellant had mild cervical spondylosis and that surgery was not warranted. On January 14, 2008 Dr. Sandu stated that a December 19, 2007 electromyogram (EMG) study of the upper extremities showed no evidence of abnormality. He diagnosed mild cervical spondylosis and cervical strain as contributing to her radicular symptoms and recommended epidural injections. In a January 21, 2008 report, Dr. Carey-Walter Clossom, a Board-certified anesthesiologist, noted that appellant had neck and left upper extremity pain following a work-related accident. He diagnosed cervical degenerative disc disease at C5-6 and C6-7, cervical myofascial pain and possible cervical facet arthropathy with radiculitis. Dr. Clossom also recommended epidural steroid injections.

In a January 21, 2008 report, Dr. Azer stated that appellant's left knee was very symptomatic but she did not want to undergo a total knee replacement. Appellant's cervical and lumbar spine limitations remained the same and that she could not engage in any activities involving bending, stooping, kneeling, squatting, prolonged standing or walking, pushing or lifting heavy objects, or unprotected use or strenuous use of the hands. She advised Dr. Azer that she could not perform her job with such limitations. Dr. Azer stated that, "if that is so," appellant was unable to work. Additional treatment records found appellant totally disabled from January 21 to March 10, 2008 due to a tear of the lateral meniscus and sprain of left knee.

The Office referred appellant for a second opinion examination by Dr. Robert Smith, a Board-certified orthopedic surgeon. In a March 28, 2008 report, Dr. Smith reviewed the history of injury and medical treatment, the statement of accepted facts and presented findings on physical examination. He advised that appellant had no objective clinical findings to support any ongoing cervical sprain, left hip sprain or left knee sprain. Dr. Smith diagnosed degenerative arthritis of her spine and left knee, which the Office had not accepted as being either caused or aggravated by the work incident. Based on the most recent MRI scan of appellant's left knee and the benign physical examination, he found that she did not have any residuals of a left knee

condition related to her federal employment generally or the July 13, 2005 injury. Dr. Smith noted that the MRI scan revealed some degenerative changes involving the meniscal tissues as well as the articular surface, but concluded these findings were not related to the accepted work injury. He reported that appellant had received appropriate medical treatment for her work-related injuries, including arthroscopic surgery and there appeared to be objective resolution of the accepted soft tissue strains of the neck, hip and knee. Dr. Smith opined that she could return to work as a secretary and no further medical treatment was necessary. If appellant required a total knee replacement in the future, it was related to her underlying degenerative arthritis.

In an April 10, 2008 report, an Office medical adviser noted that the left knee x-ray and MRI scan obtained several months after injury showed preexisting degenerative changes. The medical adviser stated that, although the claim had been accepted for lateral meniscus tear, the March 22, 2006 MRI scan of the left knee showed an intact lateral meniscus. An April 12, 2007 MRI scan showed partial subluxation prolapse of the lateral meniscus body out of the weight bearing joint space with small surrounding arthropathic spurring, but otherwise a normal intact lateral meniscus. The Office medical adviser attributed appellant's residual knee pain to degenerative arthritis instead of any lateral meniscus tear. As to appellant's cervical spine, her neck symptoms were a residual of the accepted condition but did not prevent her from working full time as a secretary. The Office medical adviser found that she was able to work in a sedentary position with restrictions on squatting, stair climbing and kneeling, climbing ladders or work continuously overhead. Appellant's restrictions on activities involving the left knee were permanent while overhead work activity restrictions involving neck extension were temporary. The Office medical adviser advised that a total knee replacement was not an appropriate procedure for the accepted conditions, but was due to advanced arthritis that did not respond to conservative management.

In a May 5, 2008 decision, the Office denied wage-loss compensation commencing October 10, 2007. It rescinded its acceptance of a torn lateral meniscus as related to the accepted injury and accepted a lateral meniscus sprain.

At appellant's request, a telephonic hearing was held on September 23, 2008. She submitted a copy of her light-duty position together with medical evidence. Dr. Azer provided treatment records dated April 21 to October 29, 2008 that described residuals which he attributed to the accepted injury. He found that appellant remained totally disabled.

Dr. Daniel Ignacio, a Board-certified physiatrist, provided medical reports dated July 21 to August 25, 2008. He reviewed the history of injury and medical treatment and listed an impression of chronic trauma to the left knee with post-traumatic arthropathy, traumatic chondromalacia, chronic cervical disc syndrome with radiculopathy, chronic left shoulder strain and chronic lumbar disc syndrome. Dr. Ignacio stated that appellant continued to be symptomatic along the left knee and the cervical spine since the July 13, 2005 injury to the point that she was taken off work in 2007. He attributed her medical conditions to the work injury and found that she was totally disabled and required continuing medical treatment.

By decision dated November 21, 2008, an Office hearing representative affirmed the May 5, 2008 decision.

LEGAL PRECEDENT -- ISSUE 1

For each period of disability claimed, the employee has the burden of establishing that she was disabled for work as a result of the accepted employment injury.[5] Whether a particular injury causes an employee to become disabled for work and the duration of that disability, are medical issues that must be proved by a preponderance of probative and reliable medical opinion evidence.[6]

When an employee, who is disabled from the job he or she held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence of record establishes that he or she can perform the light-duty position, the employee has the burden to establish by the weight of the reliable, probative and substantial evidence a recurrence of total disability and show that he or she cannot perform such light duty. As part of this burden, the employee must show either a change in the nature and extent of the injury-related condition or a change in the nature and extent of the light-duty job requirements.[7] To establish a change in the nature and extent of the injury-related condition, there must be probative medical evidence of record. The evidence must include a medical opinion, based on a complete and accurate factual and medical history and supported by sound medical reasoning, that the disabling condition is causally related to employment factors.[8]

ANALYSIS -- ISSUE 1

The Office accepted that appellant sustained sprains to the cervical spine, left knee and left hip on July 13, 2005 when she slipped and fell at work. It also accepted a lateral meniscus sprain and rescinded acceptance of a torn lateral meniscus. The record reflects that following surgery to her left knee on August 17, 2006 appellant returned to light-duty work with restrictions as a program assistant. She stopped work on October 10, 2007 and has claimed wage loss for total disability since that date due to residuals of her accepted conditions. Appellant did not attribute her disability for work to a change in the nature and extent of her light-duty requirements or to any requirement that she perform duties which exceeded her medical restrictions. Rather, she attributed her inability to work to her accepted medical conditions which she claimed worsened on September 21, 2007 such that she became disabled for work on October 10, 2007.

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[5] *See Amelia S. Jefferson, supra* note 4; *see also David H. Goss*, 32 ECAB 24 (1980).

[6] *See G.T.*, 59 ECAB ___ (Docket No. 07-1345, issued April 11, 2008); *Edward H. Horton*, 41 ECAB 301 (1989).

[7] *Albert C. Brown*, 52 ECAB 152, 154-55 (2000); *Terry R. Hedman*, 38 ECAB 222, 227 (1986); 20 C.F.R. § 10.5(x) provides, recurrence of disability means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition which had resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness. This term also means an inability to work that takes place when a light-duty assignment made specifically to accommodate an employee's physical limitations due to his or her work-related injury or illness is withdrawn (except when such withdrawal occurs for reasons of misconduct, nonperformance of job duties or a reduction-in-force) or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations.

[8] *Mary A. Ceglia*, 55 ECAB 626, 629 (2004); *Maurissa Mack*, 50 ECAB 498, 503 (1999).

Dr. Azer treated appellant on September 21, 2007 for pain in the areas of her left hip, knee, back and neck.[9] On October 10, 2007 he advised that she was given an injection in the left knee that date and was totally disabled for work due to traumatic arthritis of the left knee. The brief treatment records from Dr. Azer did not list any findings on examination of the left knee or provide a rationalized explanation from a medical perspective as to why appellant became disabled from performing light duty that date due to residuals of her accepted conditions.[10] The Board notes that the Office accepted soft tissue injuries to appellant's left hip, knee, back and to her cervical spine from the fall at work. The diagnosis of traumatic arthritis provided by Dr. Azer is not a medical condition accepted by the Office as employment related. Moreover, he did not address how the accepted left knee strain in 2005 would cause or contribute to the arthritic changes to appellant's left knee noted in 2007 and for which he found her totally disabled.[11] The subsequent treatment notes of Dr. Azer do not provide any narrative opinion addressing the issue of disability or causal relation. On December 19, 2007 he noted only that appellant's neurologist had also advised against work. In addressing a December 17, 2007 MRI scan of the left knee, Dr. Azer noted early medial meniscal degenerative changes without any frank surgical tear or displacement. On January 21 and February 11, 2008 he again advised that appellant's left knee was symptomatic and he restricted her from certain activities. Although Dr. Azer reiterated that she was totally disabled, he did not explain how any residuals of the July 13, 2005 injury prevented her from performing light-duty work activities or caused a worsening of her left knee condition and total disability as of October 10, 2007. The Board finds that his reports are insufficient to establish a causal relation between the osteoarthritis for which appellant was treated and found disabled on October 10, 2007 to the accepted left knee or lateral meniscus strains. Rather, Dr. Azer noted on January 21, 2008 that appellant advised him that she could not perform her job within the limitations he prescribed. He stated, "if that is so" she could not work.[12] Dr. Azer did not provide sufficient opinion to establish a worsening of appellant's accepted left knee condition beginning October 10, 2007 as the cause of her total disability.

On October 17, 2007 Dr. Gargour listed an impression of cervical myofascial pain with brachial plexus irritation with possible cervical and ligamentous instability. He reviewed the history of appellant's fall at work in 2005, stating that her cervical condition was not very actively treated due to her left knee complaints. Dr. Gargour noted that she stated that her condition had worsened and became disabling about a month prior to examination. He noted that Dr. Azer took appellant off work as of October 10, 2007 and started her on physical therapy. The Board notes that Dr. Gargour did not provide a firm diagnosis of her cervical condition. The Office accepted a strain related to appellant's fall at work. Dr. Gargour reviewed diagnostic

[9] In an August 13, 2007 report, Dr. Carlini, an orthopedic surgeon, noted that a recent bone scan revealed significant osteoarthritic changes to the left knee. He recommended total knee replacement surgery.

[10] *See Joan R. Donovan*, 54 ECAB 615 (2003). Medical opinions not fortified by medical rationale are of diminished probative value. *See Charles W. Downey*, 54 ECAB 421 (2003).

[11] For conditions not accepted by the Office, appellant has the burden to submit rationalized medical opinion addressing the issue of causal relation. *See Robert Broome*, 55 ECAB 339 (2004).

[12] The record reflects that the employing establishment advised that it could provide work within appellant's physical restrictions.

studies which showed some straightening of the cervical spine but not definite disc rupture. He stated that cervical and ligamentous instability were yet to be ruled out and recommended epidural injections. In a brief November 28, 2007 treatment record, Dr. Gargour stated that November 14, 2007 cervical spine x-rays showed a normal alignment with no stenosis. However, there was calcification at C5-6 and C6-7. Dr. Gargour stated that the calcification "is a sign of bleeding and heeling that occurred at the time of her initial accident." Based on this finding, he opined that appellant's neck pain, cervicogenic headaches and difficulty with sitting for any length of time were related to the 2005 work injury. Dr. Gargour failed to provide a fully rationalized medical opinion in support of his opinion on causal relationship. He did not address the nature of the cervical strain accepted by the Office or explain why the finding in the November 14, 2007 x-rays could be ascribed to the fall at work in July 2005.[13] The reports fail to provide a full medical history of appellant's cervical and upper extremity conditions or address whether any preexisting conditions were aggravated by the fall she sustained at work. A mere medical conclusion without rationale for the opinion reached is of diminished probative value.[14] Dr. Gargour did not contrast the findings in the November 2007 cervical x-ray with any other diagnostic study of record. Of importance to this claim, he did not address how appellant was prevented from continuing in her light-duty work as of October 10, 2007 due to any change or worsening of her accepted cervical strain. Rather, Dr. Gargour noted only that she had been found disabled by Dr. Azer as of that date.

The treatment records of Dr. Jariwala, Dr. Sandu and Dr. Clossom noted appellant's complaints of neck and left upper extremity pain and diagnosed various conditions. Dr. Jariwala found appellant disabled from October 2 to 8, 2007, but advised that she could return to work on October 9, 2007. Dr. Sandu reviewed the November 14, 2007 diagnostic studies. He diagnosed a mild cervical spondylolysis and recommended against surgery. Dr. Sandu recommended epidural injections but did not address the issue of her disability commencing October 10, 2007. Dr. Clossom diagnosed degenerative disc disease at C5-6 and C6-7 and also recommended epidural injections as treatment. The records from these physicians do not provide any opinion explaining how appellant's disability beginning October 10, 2007 was due to the accepted medical conditions. For this reason, they are not probative on the issue of appellant's claim of total disability.

Dr. Smith, the second opinion physician, and the Office medical adviser did not support that appellant had any disability from work due to residuals of her accepted conditions. He provided a narrative medical opinion reviewing the history of injury, medical treatment and statement of accepted facts. Dr. Smith reviewed the diagnostic studies of record to find that appellant was disabled due to degenerative changes involving her left knee and cervical spine and not the strains accepted in this case. He did not relate the degenerative disease to appellant's July 13, 2005 injury; rather, he stated that there was resolution of the soft tissue injuries and that her arthritis was not employment related. The Office medical adviser also noted that she

[13] The delay in diagnostic testing raises a question as to whether the conditions found are attributable to the accepted employment injury. *See Mary A. Ceglia*, *supra* note 8. Dr. Gargour did not state whether he had reviewed any prior diagnostic studies of appellant's cervical spine obtained prior to November 17, 2007 or address how the findings obtained were consistent with or varied from any prior tests.

[14] *See Beverly A. Spencer*, 55 ECAB 501 (2004).

sustained degenerative changes to her left knee. On review of the 2006 MRI scan he noted that the lateral meniscus was found to be intact and not torn, as was accepted by the Office. The medical adviser advised that appellant's degenerative changes would not prevent her from performing work in a sedentary position under the medical restrictions that had been recommended. He did not ascribe her advanced arthritis to the accepted employment injury. This medical evidence does not support appellant's claim of employment-related disability commencing October 10, 2007.

Following the denial of her claim appellant submitted treatment records from Dr. Ignacio. On August 18, 2008 Dr. Ignacio stated that she continued to be symptomatic along the left knee and the cervical spine since the work injury of July 13, 2005, which caused her to be taken off work in 2007. However, the brief records also fail to provide a fully-rationalized medical opinion addressing how the July 13, 2005 work injury caused disability for work beginning October 10, 2007. Dr. Ignacio did not indicate any familiarity with the light-duty work appellant had been performing or explain why the accepted conditions spontaneously worsened such that she could no longer work as of October 10, 2007. His report does not provide sufficient medical rationale in support of a causal relationship between her July 13, 2005 injury and alleged disability.

The Board finds that appellant has failed to establish a recurrence of disability commencing October 10, 2007. Appellant has not shown a change in the nature and extent of the injury-related condition or a change in the nature and extent of the light-duty job requirements.

LEGAL PRECEDENT -- ISSUE 2

Section 8128 of the Federal Employees' Compensation Act provides that the Secretary of Labor may review an award for or against payment of compensation at any time on her own motion or on application.[15] The Board has upheld the Office's authority to reopen a claim at any time on its own motion under section 8128 of the Act and, where supported by the evidence, set aside or modify a prior decision and issue a new decision.[16] The Board has noted, however, that the power to annul an award is not an arbitrary one and that an award for compensation can only be set aside in the manner provided by the compensation statute.[17]

Workers' compensation authorities generally recognize that compensation awards may be corrected, in the discretion of the compensation agency and in conformity with statutory provision, where there is good cause for so doing, such as mistake or fraud. It is well established that, once the Office accepts a claim, it has the burden of justifying the termination or modification of compensation benefits. This holds true where, as here, it later decides that it

[15] 5 U.S.C. §§ 8101-8193, 8128.

[16] *John W. Graves*, 52 ECAB 160, 61 (2000).

[17] *See* 20 C.F.R. § 10.610.

erroneously accepted a claim. In establishing that its prior acceptance was erroneous, the Office is required to provide a clear explanation of the rationale for rescission.[18]

ANALYSIS -- ISSUE 2

As noted, the Office accepted that appellant sustained a torn lateral meniscus on July 13, 2005. However, following the acceptance of his claim, further development of the medical evidence produced diagnostic studies of the left knee, which did not establish a torn lateral meniscus. The studies obtained for Dr. Carlini, the orthopedic surgeon, who performed surgery on August 17, 2006, include a March 22, 2006 MRI scan of the left knee in which the lateral meniscus was described as normal and intact. There was a low-grade medial meniscus prolapse and subluxation partially out of the weight-bearing joint space and arthropathic spurring about the prolapsed body. The surgical record from Dr. Carlini noted findings on arthroscopic examination, stating that there was medial degenerative fraying at the lateral meniscus which was trimmed back to a good peripheral rim. This evidence does not support a torn lateral meniscus of the left knee. Subsequently, on April 12, 2007 a further diagnostic MRI scan was obtained, which now revealed a partial subluxation prolapse of the lateral meniscus body out of the weight-bearing joint space with an otherwise intact lateral meniscus.

Dr. Smith advised that appellant had degenerative arthritis of her spine and left knee, conditions which were not accepted by the Office as being caused or aggravated by the fall at work. He further noted that the MRI scan of the left knee showed some degenerative changes involving the meniscal tissues as well as the articular surface, but concluded these findings were not causally related to the July 13, 2005 injury. The Office medical adviser reviewed the medical evidence of record and found that appellant had preexisting arthritis in her left knee as found on the x-ray and MRI scan obtained a few months following the accepted injury. He reviewed the March 22, 2006 MRI scan of the left knee, which showed an intact lateral meniscus. The medical adviser compared this with the April 12, 2007 MRI scan, which also reported an intact lateral meniscus with partial subluxation prolapse of the lateral meniscus body with small surrounding arthropathic spurring. Based on this evidence, the Board finds that the Office met its burden of proof to rescind acceptance of a lateral meniscus tear. There are no diagnostic studies contemporaneous to the date of injury which establishes a tear of the lateral meniscus. Dr. Smith and the Office medical adviser explained how appellant's left knee condition was due to underlying degenerative disease.

Although Dr. Azer reviewed a December 11, 2007 MRI scan of the left knee and stated that it revealed no frank surgical tear or displacement of the meniscus; he subsequently opined that appellant had a tear of the lateral meniscus. However, he did not state the basis for this change in opinion in view of diagnostic tests obtained prior to and subsequent to the left knee surgery performed on August 17, 2006. The Office met its burden of proof to rescind acceptance for this medical condition.

[18] *John W. Graves, supra* note 16.

CONCLUSION

The Board finds that appellant has not established that her disability as of October 10, 2007 was due to her July 13, 2005 injury. The Board also finds that the Office met its burden of proof to rescind its acceptance of a torn lateral meniscus to her left knee.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated November 21, 2008 is affirmed.

Issued: December 23, 2009
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board