United States Department of Labor
Employees' Compensation Appeals Board

D.C., Appellant	)	
	)	
and	)	**Docket No. 10-2052**
	)	**Issued: August 16, 2011**
DEPARTMENT OF THE NAVY,	)	
PUGENT SOUND NAVAL SHIPYARD,	)	
Bremerton, WA, Employer	)	
	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case submitted on the record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On August 10, 2010 appellant filed a timely appeal from the July 6, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP), which affirmed OWCP's December 18, 2009 rescission decision. Pursuant to the Federal Employees' Compensation Act[1] 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The issue is whether OWCP properly rescinded the accepted conditions of left leg osteoarthritis and left medial meniscal tear.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been on appeal before the Board.[2] In an August 21, 2008 decision, the Board affirmed a March 27, 2007 OWCP decision and found that OWCP met its burden of proof in reducing appellant's compensation based upon its determination that the constructed position of a mechanical drafter represented his wage-earning capacity effective October 1, 2006. The facts and history contained in the prior appeal are incorporated by reference.[3]

The relevant facts germane to the present appeal include that OWCP accepted appellant's claim for sprain of the left knee on April 1, 1999.[4] On September 17, 1999 OWCP accepted left knee sprain.

In an April 20, 1999 report, Dr. David Stackhouse, a Board-certified family practitioner, diagnosed sprain of the left knee and traumatic arthropathy. He advised that left knee pain was increasing and checked a box "yes" that appellant's condition was work related. In a separate report also dated April 20, 1999, Dr. Stackhouse diagnosed arthritis of the left knee secondary to severe arthritis of the right knee and morbid obesity and inability to exercise. An April 20, 1999 left knee x-ray revealed degenerative arthritis. In a May 6, 1999 treatment note, Dr. Michael McManus, Board-certified in occupational medicine, opined that appellant's left knee degenerative arthritis was due to chronic antalgic gait and excessively pushing off on the left knee when walking on stairs. He noted that the left knee degenerative condition was accelerated by "chronic refractory obesity resulting from severe activity limitation due to chronic right knee condition." Dr. McManus diagnosed "moderately severe degenerative arthritis (tricompartment) left knee (work related)." In a September 20, 1999 report, he diagnosed moderate tricompartment degenerative arthritis, left knee, and "possible degenerative tear in medial meniscus (work related)." In a December 6, 1999 report, Dr. McManus noted a "probable degenerative tear, medial meniscus, left knee (work related)." On December 8, 1999 Dr. Kent Van Buecken, a Board-certified orthopedic surgeon, diagnosed left knee degenerative arthritis. On January 12, 2000 he noted that a magnetic resonance imaging (MRI) scan revealed a left knee medial meniscus tear. Dr. Buecken noted that appellant had a prior "ACL reconstruction done in the distant past" and opined that it was "work related."[5]

On January 26, 2000 OWCP requested that its medical adviser determine whether a left knee/left medial meniscectomy should be authorized, and whether appellant's right knee condition contributed to the left knee deterioration and medial meniscus tear. On March 27,

[2] Docket No. 07-1518 (issued August 21, 2008).

[3] Appellant elected to receive a retirement annuity on September 1, 2006.

[4] Appellant also has an accepted March 4, 1985 right knee injury for which he received a schedule award for 51 percent right leg impairment. The claim for the 1985 knee injury has been doubled with the claim before the Board. Conditions for which the right knee claim was accepted include a tibial plateau fracture and end-stage osteoarthritis. Appellant underwent authorized right knee arthrotomy, medial meniscectomy, partial lateral meniscectomy, reconstruction of the anterior cruciate ligament and total right knee replacement.

[5] A January 4, 2000 MRI scan report found a complete tear of the posterior horn and body of the medial meniscus.

2000 OWCP's medical adviser opined that left knee surgery was appropriate but was not work related. He noted that, on March 4, 1985, appellant weighed 285 pounds, and that he weighed nine pounds less in April 1999. OWCP's medical adviser explained that appellant's obesity had nothing to do with appellant's knee problems and advised that it was a preexisting condition. He also noted that appellant's claim that he was morbidly obese due to his inability to exercise because of his impaired leg was not truthful. OWCP's medical adviser explained that the left knee arthritis was a natural progression of an arthritic condition, which was "probably accelerated by an unrelated morbid obesity condition." He opined that the most probable source of the "left knee problem is the morbid obesity, rather than the on-going problem with the opposite right knee problem." OWCP's medical adviser opined that the left knee condition was not work related.

On April 19, 2000 OWCP referred appellant to Dr. Allan R. Wilson, a Board-certified orthopedic surgeon, for a second opinion. In a May 5, 2000 report, Dr. Wilson described appellant's history of injury and treatment and examined appellant. He diagnosed a "medial meniscus tear, left knee, on a more probable than not basis, unrelated to the industrial injury." Dr. Wilson advised that it was a developmental condition which was not related to the March 4, 1985 work injury or the right knee condition or its complications. He explained that appellant was active and able to carry out work and home activities but was "deconditioned" which "has taken its toll with degenerative changes in the left knee, mainly manifesting on an MRI scan with a medial meniscal tear." Dr. Wilson noted that "obesity is caused by oral ingestion of food." He opined that the "left knee condition, was not related directly to the injury of the right knee sustained on March 4, 1985, or a consequence thereof."

In a June 28, 2000 report, Dr. McManus disagreed with Dr. Wilson. He explained that appellant's weight was stable until his 1985 right knee injury but, since the injury, appellant was unable to control his weight. Dr. McManus noted that the right knee injury contributed to degenerative changes of the right knee, which caused chronic pain and limited tolerance for weight-bearing and push-off. Appellant chronically relied upon his left knee to compensate. He opined that, because of the "chronic increased load of his left knee and weight gain, he has developed degenerative changes in the left knee with a tear of the medial meniscus."

On December 13, 2000 OWCP referred appellant to Dr. Dean S. Ricketts, a Board-certified orthopedic surgeon, for an impartial medical evaluation to resolve the conflict in opinion between Dr. McManus and Dr. Wilson regarding whether the medial meniscus tear of the left knee was work related or a consequence of the work-related injuries.

In a January 8, 2001 report, Dr. Ricketts noted appellant's history and examined appellant. He noted that diagnostic x-rays revealed degenerative changes in all three compartments of the knee and a tear of the posterior horn of the medial meniscus. Dr. Ricketts explained that it was "possible that this represents a degenerative tear rather than a traumatic tear." He also explained that appellant's "large size compromised the study slightly." Dr. Ricketts opined that the "left knee condition is in no way related to overcompensating for the accepted right knee." He noted that appellant ambulated with a fairly symmetrical gait and his position did not require excessive use of the knees since 1988 due to his work restrictions. Dr. Ricketts stated that appellant did not have limitations on the right knee which would cause injury to the left knee. Regarding appellant's inability to lose weight due to being unable to

exercise, he explained that appellant confirmed that he had never exercised on a regular basis and attributed his obesity to overeating. Dr. Ricketts noted that appellant would have been capable of exercising with a swimming pool to control his weight. He opined that it is "far more likely that his morbid obesity is the primary cause of his left knee condition." Dr. Ricketts noted that, while Dr. McManus opined that appellant's weight was steady until his 1985 right knee injury, this was incorrect as the medical evidence showed he had increased weight in 1985.

Dr. McManus continued to treat appellant. On February 12, 2001 he indicated that appellant had an aggravation of tricompartment degenerative arthritis and tear of medial meniscus of the left knee that was work related. On March 13, 2001 Dr. McManus advised that the aggravation was permanent. He continued treating appellant. In an April 29, 2001 report, Dr. Van Buecken repeated the diagnosis of medial meniscus tear of the left knee and noted that appellant wished to proceed with the left knee arthroscopy.

In a November 1, 2006 report, Dr. Wajahat Khan, a Board-certified family practitioner, noted that appellant presented with chronic left knee pain and knee osteoarthritis. He diagnosed left knee sprain and strain and degenerative disease. On November 28, 2006 Dr. Elizabeth Carter, a Board-certified diagnostic radiologist, diagnosed degenerative joint disease of the left knee and right knee total knee replacement.

Appellant subsequently requested a schedule award.

In an April 30, 2007 report, Dr. Derek E. Costa, a Board-certified family practitioner, diagnosed left knee arthritis and opioid-type dependence. On October 17, 2007 he noted that appellant came in for his chronic knee pain and diagnosed osteoarthritis of both knees, a history of some pain in the soft tissue of his lower legs, chronic pain and unspecified deficiency anemia. In a January 10, 2008 report, Dr. Costa diagnosed osteoarthritis of the left knee. He continued to treat appellant.

On May 9, 2008 OWCP referred appellant for a second opinion examination and impairment rating, with Dr. Thomas Castle, a Board-certified orthopedic surgeon. In a May 20, 2008 report, Dr. Castle noted appellant's history and examined appellant. He determined that appellant's left knee was fixed and stable with arthritis based on permanent partial disability of the left knee equal to 15 percent permanent impairment of the left leg.

In a July 27, 2008 report, OWCP's medical adviser noted that Dr. Castle did not provide any evidence of residuals to support his rating. He opined that appellant was not entitled to any left knee impairment. OWCP's medical adviser also noted that arthritis was not an accepted condition.

In a December 29, 2008 report, Dr. Richard Tanaka, a Board-certified family practitioner, noted appellant's history and diagnosed osteoarthritis in the knees and a history of a right total knee replacement.

On April 17, 2009 OWCP expanded the claim to include localized primary osteoarthritis, lower left leg and tear of medial meniscus of the left knee.

On April 22, 2009 OWCP's medical adviser requested additional documentation regarding the claim for a schedule award. He explained that the medical evidence did not contain any diagnostic tests to support a medial meniscal tear and requested documentation to support the conditions. OWCP's medical adviser requested a second opinion examination be scheduled if Dr. Castle was unable to provide the requested information.

In a letter dated April 29, 2009, OWCP requested that Dr. Castle provide additional information to support the claim for a schedule award. In a June 19, 2009 telephone call memorandum, it advised appellant that no response had been received. In a July 1, 2009 telephone call memorandum, OWCP authorized an impairment rating with Dr. McManus.

In a July 2, 2009 report, Dr. McManus diagnosed severe osteoarthritis, greatest medial compartment of the left knee with degenerative tear medial meniscus, which was work related. He opined that appellant had 28 percent impairment of the left lower extremity.

In a September 28, 2009 report, OWCP's medical adviser reviewed Dr. McManus' report and explained that, if the osteoarthritis was now accepted, then his rating would be a 26 percent impairment of his left lower extremity.

On November 3, 2009 OWCP proposed to rescind the accepted conditions of left lower leg osteoarthritis and left medial meniscal tear. It noted that appellant was referred to Dr. Ricketts for an impartial opinion on the cause of his left knee condition. Based on the reports of Drs. Wilson and Ricketts and its medical adviser, OWCP found that appellant's left knee conditions were not due to his right knee injury.

In a November 4, 2009 telephone call memorandum, OWCP advised appellant that his schedule award was on hold as two of the three currently accepted conditions were determined by OWCP's medical adviser, second opinion physician and impartial medical examiner to not be related to the injury.

In a November 23, 2009 statement, appellant questioned why OWCP took over 10 years to rescind the acceptance of his condition. He reiterated that Dr. McManus, his treating physician, indicated that the conditions were work related. In an October 26, 2009 treatment note, Dr. Derek Costa, a Board-certified family practitioner, advised that appellant was post "right total knee replacement and has more pain in the right knee than in the left. This is work related." Dr. Costa diagnosed chronic pain and osteoarthritis involving left knee with continued pain in his knees.

On December 18, 2009 OWCP rescinded acceptance of the left medial meniscal tear and left lower extremity osteoarthritis on the grounds that the medical evidence established that these conditions were not work related.

Appellant requested a hearing, which was held on April 14, 2010.

By decision dated July 6, 2010, OWCP's hearing representative affirmed the December 18, 2009 decision. He found that appellant had failed to submit any new medical evidence to support that OWCP's decision rescinding acceptance of left knee arthritis and degenerative medial meniscal tear was incorrect.

LEGAL PRECEDENT

OWCP may review an award for or against the payment of compensation at any time on its own motion or upon application.[6] The Board has upheld OWCP's authority to reopen a claim at any time on its own motion and, where supported by the evidence, to set aside or modify a prior decision and issue a new decision.[7] The Board has noted, however, that the power to annul an award is not an arbitrary one and that an award for compensation can be set aside only in the manner provided by the compensation statute.[8] It is well established that once OWCP accepts a claim, it has the burden of justifying termination or modification of compensation. This holds true where OWCP later decides that it has erroneously accepted a claim for compensation.[9] In establishing that its prior acceptance was erroneous, OWCP is required to provide a clear explanation of its rationale for rescission.[10]

ANALYSIS

The Board finds that OWCP improperly rescinded acceptance of appellant's claim for left leg osteoarthritis and left medial meniscal tear. OWCP accepted appellant's claim for sprain of the left knee on April 1, 1999. On April 17, 2009 it accepted localized primary osteoarthritis, lower left leg and a left knee medial meniscus tear.

Appellant requested a schedule award and upon development of the claim, OWCP referred the file to Dr. Castle, who provided an impairment rating, which included arthritis. In a July 27, 2008 report, OWCP's medical adviser indicated that arthritis was not an accepted condition. After OWCP accepted the claim for localized primary osteoarthritis, OWCP's medical adviser, on April 22, 2009, noted that the medical evidence contained no diagnostic tests to support a medial meniscal tear. OWCP's medical adviser requested documentation to support the conditions and noted that, if Dr. Castle did not provide such documentation, OWCP should schedule a new examination. As noted, Dr. Castle did not respond but OWCP, instead of scheduling a second opinion examination as recommended by its medical adviser, rescinded acceptance of left lower leg osteoarthritis and left medial meniscus tear based on the reports of its medical adviser, Dr. Wilson's May 5, 2000 report and Dr Ricketts' January 8, 2001 report.

The Board notes that the opinion of OWCP's medical adviser is insufficient to meet OWCP's burden of proof as he provided no rationalized opinion in support of OWCP's decision to rescind.[11] While the medical adviser asserted that no diagnostic tests support a left meniscal tear, the record contains a January 4, 2000 MRI scan report that found a tear of the medial

[6] 5 U.S.C. § 8128(a).

[7] *Eli Jacobs*, 32 ECAB 1147 (1981).

[8] *Doris J. Wright*, 49 ECAB 230 (1997); *Shelby J. Rycroft*, 44 ECAB 795 (1993).

[9] *See* 20 C.F.R. § 10.610.

[10] *Alice M. Roberts*, 42 ECAB 747 (1991).

[11] *See George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of little probative value).

meniscus. Furthermore, with respect to the additional medical development recommended by the medical adviser, the Board has held that, once OWCP undertakes development of the medical evidence, it has the responsibility to do so in a proper manner.[12]

The reports of Drs. Wilson, and Ricketts were over eight years old at the time of the rescission and were requested by OWCP with respect to whether the claim should be accepted and not whether an acceptance should be rescinded. Dr. Wilson opined that appellant's left knee condition was not "directly" related to the right knee injury. This opinion is of diminished probative value as a claimant need not show that a condition was directly due to work factors. Any degree of contribution from work factors renders the condition and resulting disability compensable.[13] Dr. Ricketts opined that appellant had a "degenerative tear rather than a traumatic tear." However, he did not provide reasoning to explain how he arrived at this conclusion. Dr. Ricketts also explained that it was "far more likely that his morbid obesity is the primary cause of his left knee condition" and concluded that the "left knee condition was in no way related to overcompensating for the accepted right knee." The Board notes that his conclusory opinion is speculative and unrationalized. The Board has held that speculative and equivocal medical opinions regarding causal relationship are of diminished probative value.[14] Thus, the reports of Drs. Wilson and Ricketts are insufficient to meet OWCP's burden of proof to rescind acceptance.

The Board finds that OWCP did not offer a clear explanation of its rationale for rescission. OWCP has failed to meet its burden of proof to rescind the acceptance of the claim.

CONCLUSION

The Board finds that OWCP improperly rescinded the accepted conditions of left leg osteoarthritis and left medial meniscal tear.

[12] *Melvin James*, 55 ECAB 406 (2004).

[13] *See Arnold Gustafson*, 41 ECAB 131 (1989); *Beth P. Chaput*, 37 ECAB 158 (1985).

[14] *Ricky S. Storms*, 52 ECAB 349 (2001) (while the opinion of a physician supporting causal relationship need not be one of absolute medical certainty, the opinion must not be speculative or equivocal. The opinion should be expressed in terms of a reasonable degree of medical certainty).

ORDER

IT IS HEREBY ORDERED THAT the July 6, 2010 decision of the Office of Workers' Compensation Programs is reversed.

Issued: August 16, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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