United States Department of Labor
Employees' Compensation Appeals Board

L.M., Appellant	)	
	)	
and	)	**Docket No. 10-1299**
	)	**Issued: February 8, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, 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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 6, 2010 appellant, through her representative, filed a timely appeal from the December 10, 2009 merit decision of the Office of Workers' Compensation Programs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether appellant sustained a right knee injury in the performance of duty on June 16, 2007.

FACTUAL HISTORY

On December 5, 2007 appellant, then a 47-year-old mail carrier, filed a claim for compensation alleging that she injured her right knee in the performance of duty on June 16, 2007: "I was walking back to vehicle and my knee popped and couldn't walk. When I finally could move I couldn't put pressure as it was so painful." A witness confirmed that [appellant] came to a sudden stop while walking to her postal vehicle after delivery: "Employee indicated to me that she felt knee popped."

Appellant identified the nature of her injury as a radial tear of the right medial meniscus, a subchondral stress fracture of the right medial femoral condyle that appeared to progress to osteonecrosis with slight collapse of the articular surface and large right knee joint effusion with synovial proliferation. She did not stop work. Appellant advised the Office: "I was just walking when it popped (right knee)."

The Office asked appellant to submit a physician's opinion on how her employment caused her diagnosed condition. Dr. Barry S. Ziring, the attending internist and an assistant professor of medicine, saw appellant for bilateral knee degenerative joint disease years before the June 16, 2007 incident at work. On December 10, 2007 he reported that appellant was walking along to return to her truck when she heard a popping in her right knee, became acutely disabled and developed effusion. Dr. Ziring stated that a September 19, 2007 imaging study was consistent with an acute injury on June 16, 2007.

On January 24, 2008 the Office denied appellant's claim for compensation. It found that the medical evidence did not demonstrate that the claimed medical conditions were related to the "established work-related event." The Office noted that Dr. Ziring did not explain how the mere act of walking to one's vehicle could have caused or aggravated the diagnosed condition. Given appellant's history of preexisting knee problems, it considered it crucial that Dr. Ziring explain how the June 16, 2007 incident at work caused or aggravated the diagnosed medical conditions.

Dr. Ziring objected that the requested explanation was impossible without imaging studies the day before the injury and repeated the day of. Relying on observation evidence, he found it clear that appellant injured herself on the stated day. Dr. Ziring added: "The mechanism of injury appears to be normal shear forces as a result of walking superimposed on underlying chronic pathology."

Dr. Ziring found that the acute traumatic injury to appellant's knee resulted in a torn cartilage and a subchondral insufficiency fracture of the right femoral condyle. He identified findings that supported his opinion: appellant's imaging study changed from a previous study; she had a witnessed injury with acute swelling and pain, which became acutely worse after the injury; the mechanism of injury with a popping noise was consistent with an acute meniscal tear; this was a witnessed event with acute resulting disability and her symptomatology prior to the traumatic injury was entirely different than it became on the day of the injury. Dr. Ziring made clear that appellant's preexisting arthritis was not the cause of her current disability; it was her injury, which occurred during work and which resulted in a traumatic injury to the knee.

In an April 12, 2006 treatment note, Dr. Ziring indicated that appellant was told her knee was "bone on bone." He diagnosed severe bilateral knee degenerative joint disease and stated she might need knee replacement.

In a May 9, 2007 treatment note, Dr. Ziring indicated that appellant had pain behind her right knee. He again noted she was "bone on bone." Dr. Ziring diagnosed post right knee pain and questionable "partial gastrocnemius."

In a June 18, 2007 treatment note, Dr. Ziring indicated that appellant was walking and suddenly felt pain behind her right calf. Findings included a tender right gastrocnemius and right

lateral knee. There was no swelling and no edema. Dr. Ziring diagnosed a partial tear of the right gastrocnemius muscle, recommended bed, ice and nonsteroidal anti-inflammatories and released appellant to return as needed.

A July 12, 2007 treatment note indicated that appellant complained of pain in her right lower thigh after injury with symptoms increasing gradually over several days. It was hard to step down without calf symptoms and usually chronic knee pain. Findings included positive swelling and tenderness medially above the right knee. The diagnosis was quadriceps sprain.

An x-ray report on July 26, 2007 noted "small knee joint effusion." On July 31, 2007 Dr. Ziring found moderate right knee joint effusion, which he aspirated.

On December 23, 2008 Dr. Ziring reported there was no question in his mind based on the events described by appellant that there was an acute injury to her right knee on June 16, 2007. Appellant's description of sudden pain followed by acute disability and swelling was consistent with an acute injury. While it was clear she had underlying osteoarthritic changes, Dr. Ziring noted there was diagnostic evidence during that time of a radial tear of the medial meniscus.

Dr. Ziring again indicated that the Office's denial appeared to be based on the lack of imaging studies from immediately before and after the injury. There was no need to image the knee before the injury, he explained, because appellant was asymptomatic at that point. Dr. Ziring added that the events bore no similarity to the finding of May 9, 2007, at which time there was no popping sound and she was able to bear weight on the same leg. He also stated, "Radial tears are usually traumatic and not an overuse injury. This fits with patient's twisting motion which resulted in this injury on June 16, 2007." Further, the osteonecrosis and stress fracture shown on the imaging study supported post-traumatic injury. In summary, all of the clinical facts of this case strongly support an acute traumatic injury to [appellant's] knee which occurred on June 16, 2007 while at work. Dr. Ziring strongly supported an additional view of this case, as appellant remained in chronic partially disabling pain since the day of the injury.

On December 10, 2009 the Office reviewed the merits of appellant's claim and denied modification of its prior decision. It found that the medical evidence remained insufficient to support that the diagnoses of radial tear of the medial meniscus, subchondral stress fracture of the medial femoral condyle with osteonecrosis, and right knee effusion with synovial proliferation were related to the claimant's walking to her vehicle on June 16, 2007. The Office noted that appellant never provided a history of twisting her knee. It observed that Dr. Ziring never explained why he considered the meniscal tear to be a traumatic injury and not a degenerative tear. Dr. Ziring did not address how other findings, such as the subchondral stress fracture, could have occurred as a result of the underlying osteoarthritis. The Office stated that "it would appear reasonable that the underlying osteoarthritis and weakened bone conditions could have caused the popping and pain that the claimant experienced on June 16, 2007." It noted that Dr. Ziring was incorrect in assuming the denial was based on a lack of imaging studies immediately before and after the claimed injury. The Office explained that he did not discuss whether the finding on the latter imaging study represented the natural course of appellant's osteoarthritis condition.

On appeal, counsel argues that the medical evidence establishes an aggravation of a preexisting arthritic condition and further injury in the nature of a fracture of the right medial femoral condyle and tear of the medial meniscus. He argues that Dr. Ziring provided medical reasons for his conclusion that appellant suffered a twisting motion on June 16, 2007 and felt an audible pop in the right knee, causing a traumatic injury. Counsel ask the Board to reverse the Office's December 10, 2009 decision or remand the case for further development.

LEGAL PRECEDENT

The Federal Employees' Compensation Act provides compensation for the disability of an employee resulting from personal injury sustained while in the performance of duty.[1] An employee seeking benefits under the Act has the burden of proof to establish the essential elements of her claim. When an employee claims that she sustained an injury in the performance of duty, she must submit sufficient evidence to establish that she experienced a specific event, incident or exposure occurring at the time, place and in the manner alleged. She must also establish that such event, incident or exposure caused an injury.[2]

To establish that an injury occurred as alleged, the injury need not be confirmed by eyewitnesses, but the employee's statements must be consistent with the surrounding facts and circumstances and her subsequent course of action. In determining whether a *prima facie* case has been established, such circumstances as late notification of injury, lack of confirmation of injury, and failure to obtain medical treatment may, if otherwise unexplained, cast sufficient doubt on a claimant's statements. The employee has not met this burden when there are such inconsistencies in the evidence as to cast serious doubt on the validity of the claim.[3]

Causal relationship is a medical issue,[4] and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence that includes a physician's rationalized opinion on whether there is a causal relationship between the claimant's diagnosed condition and the established incident or factor of employment. The opinion of the physician must be based on a complete factual and medical background of the claimant,[5] must be one of reasonable medical certainty,[6] and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the established incident or factor of employment.[7]

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[1] 5 U.S.C. § 8102(a).

[2] *John J. Carlone*, 41 ECAB 354 (1989).

[3] *Carmen Dickerson*, 36 ECAB 409 (1985); *Joseph A. Fournier*, 35 ECAB 1175 (1984). *See also George W. Glavis*, 5 ECAB 363 (1953).

[4] *Mary J. Briggs*, 37 ECAB 578 (1986).

[5] *William Nimitz, Jr.*, 30 ECAB 567, 570 (1979).

[6] *Morris Scanlon*, 11 ECAB 384, 385 (1960).

[7] *William E. Enright*, 31 ECAB 426, 430 (1980).

The mere fact that a condition manifests itself or is worsened during a period of employment does not raise an inference of causal relationship between the two. Such a relationship must be shown by rationalized medical evidence of causal relation based upon a specific and accurate history of employment conditions which are alleged to have caused or exacerbated a disabling condition.[8]

Medical conclusions unsupported by rationale are of little probative value.[9] Medical conclusions based on inaccurate or incomplete histories are also of little probative value.[10]

ANALYSIS

The Office accepted that appellant was walking in the course of her federal employment on June 16, 2007, as she stated on her claim form, when her right knee popped. Appellant did not file this form until December 5, 2007, the first question that arises whether her relatively late account of events is accurate and supported by more contemporaneous evidence.

The most contemporaneous description of the injury comes from the June 18, 2007 treatment note of Dr. Ziring, the attending internist, who related the history provided by appellant: "walking suddenly felt pain behind right calf." He did not mention that her right knee popped. Apart from some tenderness on the lateral aspect of the knee -- Dr. Ziring would later diagnose medial injuries -- he did not find a right knee injury. There was no swelling and no edema. Instead, Dr. Ziring diagnosed a partial tear of the right calf muscle and released appellant to return as needed.

Indeed, Dr. Ziring would make no mention of a popping in appellant's right knee until after she filed her claim for compensation benefits on December 5, 2007. The December 5, 2007 claim form stands as the earliest reference to any popping in the right knee. One would reasonably expect that, if appellant felt her right knee pop on June 16, 2007, she would mention such a thing to her treating doctor two days later and he would record that history. It appears from the record that she did not tell Dr. Ziring about her right knee popping until December 10, 2007.

Because appellant's late account of the injury materially differs from the history of injury reflected in the contemporaneous medical evidence, the Board is not persuaded that she has met her burden to establish that she experienced a specific event, incident or exposure occurring at the time, place and in the manner alleged. Her claim finds some support from the December 5, 2007 witness statement, but that statement does not resolve the questions that arise from the history appellant related to her treating physician.

[8] *Lawrence A. Meece*, 28 ECAB 87 (1976).

[9] *Ceferino L. Gonzales*, 32 ECAB 1591 (1981); *George Randolph Taylor*, 6 ECAB 968 (1954).

[10] *James A. Wyrick*, 31 ECAB 1805 (1980) (physician's report was entitled to little probative value because the history was both inaccurate and incomplete). *See generally Melvina Jackson*, 38 ECAB 443, 450 (1987) (addressing factors that bear on the probative value of medical opinions).

Further, the Board finds that the medical opinion evidence is not sufficiently rationalized to support the claimed injury. Dr. Ziring made a number of attempts to convince the Office that appellant's right knee condition arose in the course of her employment on June 16, 2007. None of his efforts successfully reconciled his initial treatment notes. Dr. Ziring opined that appellant tore her right medial meniscus and fractured her right medial femoral condyle on June 16, 2007. To support that view, he observed that, when her right knee popped, she became acutely disabled and developed effusion.

Appellant did not stop work. When she saw Dr. Ziring two days later, she related that she was walking and suddenly felt pain behind her right calf. Dr. Ziring made no mention of a popping in the right knee. On physical examination he found no effusion. Dr. Ziring diagnosed a partially torn calf muscle, not a right knee injury. On July 12, 2007 he would diagnose a quadriceps sprain.

It was not until July 26, 2007 that an x-ray report indicated a small knee effusion. Five days later, Dr. Ziring described the effusion as moderate. This was a full month after the claimed knee injury. Dr. Ziring did not explain how the history and findings in his post-incident treatment notes squared with his opinion that appellant tore her right medial cartilage and fractured her right femoral condyle while walking in the course of her employment on June 16, 2007. He explained that the radial tear in her right medial meniscus fit with her "twisting motion which resulted in this injury on June 16, 2007." Like the late account of right knee popping, there is no history of a twisting motion resulting in a right knee injury.

The Board finds that appellant has not met her burden of proof to establish fact of injury. Inconsistencies in the evidence cast some doubt on the validity of appellant's claim that she sustained a right knee injury in the performance of duty on June 16, 2007. The medical opinion evidence is not sufficiently rationalized to establish the critical element of causal relationship. The Board will therefore affirm the Office's denial of compensation benefits for the claimed right knee injury.

Counsel argues that Dr. Ziring provided medical reasons for his conclusion that appellant suffered a twisting motion on June 16, 2007 and felt an audible pop in the right knee, causing a traumatic injury. As the Board indicated above, Dr. Ziring's opinion is not well or fully reasoned and is not based on a proper history. His opinion carries little probative value on the issue of causal relationship.

Although the evidence does not establish a right knee injury on July 16, 2007, it does support that appellant felt something when she walked back to her postal vehicle that day, something that caused her to stop walking and start limping. As her medical examination two days later supported a partially torn right gastrocnemius, the Board will remand the case to the Office for further development and an appropriate final decision on whether appellant sustained a right calf injury in the performance of duty on June 16, 2007.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that she sustained a right knee injury in the performance of duty on June 16, 2007. The case is remanded for development regarding an alleged employment-related right calf injury.

ORDER

IT IS HEREBY ORDERED THAT the December 10, 2009 decision of the Office of Workers' Compensation Programs is affirmed. The case is remanded for further action consistent with this opinion regarding the right calf injury.

Issued: February 8, 2011
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board