United States Department of Labor
Employees' Compensation Appeals Board

R.M., Appellant	)	
	)	**Docket No. 13-1186**
and	)	**Issued: October 22, 2013**
	)	
DEPARTMENT OF VETERANS AFFAIRS, MOUNTAIN HOME VETERANS ADMINISTRATION MEDICAL CENTER, Mountain Home, TN, Employer	)	

Appearances:
Rob Starnes, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On April 18, 2013 appellant, through her attorney, filed a timely appeal from the December 18, 2012 and March 28, 2013 merit decisions of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) 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 appellant has established a recurrence of disability on September 10, 2011 causally related to her August 11, 2011 employment injuries.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On August 22, 2011 appellant, then a 66-year-old nurse, filed a traumatic injury claim alleging that on August 11, 2011 she fractured her nose and bruised and fractured her right elbow when she fellwhile walking on an uneven sidewalk. She stopped work on the date of injury. On August 23, 2011 appellant returned to limited-duty work.

On February 1, 2012 appellant filed a claim (Form CA-2a) alleging that she sustained a recurrence of disability on September 10, 2011, when she began to experience knee pain. She did not stop work until January 4, 2012and returned on January 19, 2012. Appellant alleges that her knee condition was a result of the August 11, 2011 incident; but that she did not become symptomatic until September 10, 2011.

By letter dated July 31, 2012, OWCP accepted appellant's claim for right lateral epicondylitis, right radial styloid tenosynovitis and other tenosynovitis of the right hand and wrist. It also requested that she submit medical evidence to establish her recurrence claim.

In a December 16, 2011 report, Dr. Todd A. Fowler, a Board-certified family practitioner, provided a history that in October 2011appellant had received an injection in her left knee, but she had increasing pain in the popliteal area for which she took medication. He reported essentially normal findings on physical examination with the exception of continued tenderness in the knee joint and popliteal area. Dr. Fowler diagnosed osteoarthritis, a Baker's cyst and a possible meniscus tear more than arthritis, which caused the fluid and Baker's cyst.

A December 19, 2011 magnetic resonance imaging (MRI) scan report was read by Dr. Donald L. Resnick, a Board-certified radiologist, which revealed a radial tear at the junction of the posterior horn and posterior root of the medial meniscus with peripheral extrusion of the body, a small inner margin tear of the body of the lateral meniscus, a moderate-sized popliteal cyst with synovial hypertrophy and fluid leaking posteriorly and fluid in the semimembranosis bursa.

In a December 21, 2011 report, on physical examination of the left knee, Dr. Fowler reported a small amount of fluid in the popliteal area and tenderness in the medial joint more than the lateral joint.He reviewed the left knee MRI scan and diagnosed a medial meniscus tear with peripheral extrusion of the body of the meniscus, a small lateral meniscus tearand osteoarthritis with full thickness cartilage loss of the medial femoral condyle central weight bearing area that was mild in the lateral joint and fairly severe in the patellofemoral joint of the left knee. Dr. Fowler discussed left knee surgery with Dr. Marc A. Aiken, a Board-certified orthopedic surgeon and appellant.

On January 5, 2012 appellant underwent left knee surgery for a torn meniscus caused by a Baker's cyst. In a January 16, 2012 report, Dr. Aiken noted her continued discomfort following left knee arthroscopy and partial meniscectomy and chondroplasty of the patellofemoral joint. He reported normal physical examination findings and advised that appellant was status post the stated surgical procedure. Dr. Aiken released her to return to work on January 19, 2012 as tolerated.

In a February 20, 2012 report, Dr. Aiken listed normal findings on physical examination of appellant's left knee and diagnosed much improved left knee pain. Henoted that when she was originally seen by Dr. Fowler at the time of the August 2011 injury she had also twisted her knee. Dr. Aiken stated that much more attention was initially paid to appellant's arm and shoulder injuries. When appellant returned in October 2011 her knee had not improved and she was diagnosed as having a meniscus tear. Noting that she had no other history of any injury or trauma, Dr. Aiken concluded that this condition was probably medically related.

In a September 5, 2012 decision, OWCP denied appellant's recurrence claim, finding that the medical evidence was insufficient to establish that she sustained an additional left knee condition causally related to her accepted August 11, 2011 employment injuries.

On October 15, 2012 appellant requested reconsideration.

Appellant submitted additional medical reports related to the original injury that are not discussed herein. Reports were also submitted to support her alleged recurrence of disability due to a knee injury.

In reports dated September 30, 2011 through January 11, 2012, Dr. Fowler provided a history of the August 2011 employment injuries and appellant's medical treatment, family and social background. He noted her right wrist and left knee symptoms. In an October 28, 2011 report, the knee injury was first reported. Dr. Fowler related a history that appellant stated that she had left knee pain for several months and she could not recall an injury. Appellant complained of global knee pain, worse with motion or weight-bearing and had edema with weight-bearing. She noted that her symptoms were becoming worse. Appellant stated that she had no previous similar symptoms and had no treatment prior to arrival. Dr. Fowlerreviewed x-rays of the left knee. On physical examination of the left knee,he reported fullness in the popliteal area and grade 2 effusion. There was tenderness with full flexion of the knee because of tightness. Ligamentous stability was good and there was no popping or clicking in the medial lateral joint area. Dr. Fowler advised that appellant hadgrade 2 effusion, pain and a Baker's cyst of the left knee. Appellant also had a medial meniscus tear with peripheral extrusion of the body of the meniscus, a small lateral meniscus tear and osteoarthritis with full thickness cartilage loss of the medial femoral condyle in the central weight-bearing area that was mild in the lateral joint and fairly severe in the patellofemoral joint of the left knee.She was administered cortisone injections as a conservative treatment.

In affidavits dated October 1 and 3, 2012, Drs. Aiken and Fowler, respectively, provided a history that on August 11, 2011 appellant fell at work. Appellant sustained a radial head fracture. On October 28, 2011 she presented with a chief complaint of left knee pain with an onset of several months. There was edema. Appellant was diagnosed as having grade 2 effusion, pain and a Baker's cyst of the left knee. The physicians noted her left knee surgery. After their review of the records, Drs. Aiken and Fowler opined that appellant's pain and surgery were related to her August 8, 2011 fall. They based their opinion on the absence in the record of any other mechanism of injury and on the nature of the injury.

Notes from appellant's physical therapist addressed the treatment of appellant's left knee condition from January 12 to 25, 2012.

In a December 18, 2012 decision, OWCP denied modification of the September 5, 2012 decision, finding that the medical evidence did not establish that appellant's current left knee condition was causally related to her accepted employment injuries.

By letter dated December 27, 2012, appellant requested reconsideration.

In a February 5, 2013 affidavit, Dr. Fowler reiterated the findings set forth in his October 3, 2012 affidavit. He advised that appellant's pain and surgery were related to her August 11, 2011 employment injuries.

In a March 5, 2013 report, Dr. William E. Kennedy, a Board-certified orthopedic surgeon, obtained a history of the August 11, 2011 employment injuries and appellant's left knee symptoms. During the next few weeks after appellant fell,she became aware of gradually increasing pain deep in her left knee for which she sought testing and treatment. She did not recall having any pain or injury to her left knee that required any treatment prior to her August 11, 2011 trip and fall. Dr. Kennedy reviewed appellant's medical records. He reported normal findings on physical examination of the right and left knees. Dr. Kennedy diagnosed a tear of the medial and lateral menisci and a chondral injury including a flap tear in the patellofemoral compartment of the left knee that were treated by the January 5, 2012 surgery.He advised that the August 11, 2011 employment injury caused appellant's nose, right upper extremity and left knee conditions. Dr. Kennedy attributed her ongoing permanent left knee symptoms and losses of physical function to the accepted injury based on the objective findings of record and his examination findings. He concluded that appellant had 10 percent impairment of the left lower extremity under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

In a March 28, 2013 decision, OWCP denied modification of the December 18, 2012 decision. Appellant did not submit any rationalized medical evidence establishing that she sustained a left knee injury causally related to her accepted August 11, 2011 employment injuries.

LEGAL PRECEDENT

A 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.[2] 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.[3]

[2] 20 C.F.R. § 10.5(x).

[3] *Id.*

When an employee who is disabled from the job he or she held when injured on account of employment-related residuals returns to a limited-duty position or the medical evidence of record establishes that he or she can perform the limited-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 to show that he or she cannot perform such limited-duty work. As part of this burden, the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the limited-duty job requirements.[4]

To show a change in the degree of the work-related injury or condition, the claimant must submit rationalized medical evidence documenting such change and explaining how and why the accepted injury or condition disabled the claimant for work on and after the date of the alleged recurrence of disability.[5]

ANALYSIS

OWCP accepted appellant's claim for right lateral epicondylitis, right radial styloid tenosynovitis and other tenosynovitis of the right hand and wrist. On August 23, 2011 appellant returned to limited-duty work at the employing establishment. She claimed a recurrence of disability onSeptember 10, 2011 due to her accepted injuries. Appellant does not allege that this disability was a result of a change in the nature and extent of her limited-duty job requirements. Herburden therefore is to show a change in the nature and extent of her injury-related conditions.

The Board finds that appellant has not submitted sufficient medical opinion evidence to support the disability claimed. Dr. Kennedy's March 5, 2013 report found that her current left knee symptoms and losses of physical function were caused by the August 11, 2011 employment injuries. He provided normal findings on physical examination and advised that the tear of the medial and lateral menisci and a chondral injury including a flap tear in the patellofemoral compartment in her left knee were treated by the January 5, 2012 surgery. Dr. Kennedy determined that appellant had 10 percent impairment of the left lower extremity under the sixth edition of the A.M.A., *Guides*. Hedid not explain how her left knee condition, impairment and any resultant disability were caused by the accepted August 11, 2011 employment injuries.[6] The Board finds that Dr. Kennedy's report is insufficient to establish her claim.

Dr. Aiken's February 20, 2012 report found that appellant's meniscus tear of the left knee was "probably" medically related to the August 2011 employment injuries as she had no other history of any injury or trauma. He listed normal findings on physical examination and stated that when she was initially evaluated in August 2011 by Dr. Fowler, little attention was paid to her twisted left knee, which was subsequently diagnosed as a meniscus tear.The Board has held that medical opinions which are speculative or equivocal in character have little probative value.[7]

[4] *Albert C. Brown*, 52 ECAB 152, 154-155 (2000); *Barry C. Petterson*, 52 ECAB 120 (2000); *Terry R. Hedman*, 38 ECAB 222, 227 (1986).

[5] *James H. Botts*, 50 ECAB 265 (1999).

[6] *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value); *Jimmie H. Duckett*, 52 ECAB 332 (2001).

[7] *L.R.(E.R.)*, 58 ECAB 369 (2007); *Kathy A. Kelley*, 55 ECAB 206 (2004).

Moreover, the Board has found that an opinion that a condition is causally related to an employment injury because the employee was asymptomatic before the injury but symptomatic afterwards is insufficient, without supporting rationale, to establish causal relationship.[8] Dr. Aiken's opinion is speculative regarding causal relation and was not supported by medical rationale explaining how or why appellant's left knee condition was caused by the August 11, 2011 employment injuries.[9] In affidavits dated October 1 and 3, 2012, Drs. Aiken and Fowler, respectively, opined that her left knee pain and resultant surgery were related to her August 2011 fall.[10]Thephysicians noted that appellantpresented on October 28, 2011 with a chief complaint of left knee pain with an onset of several months and was diagnosed as having grade 2 effusion, pain and a Bakers' cyst of the left knee. The Board has found, however, that pain is not a compensable medical diagnosis.[11] Dr. Aiken and Dr. Fowler have also failed to explain how appellant's condition and any resultant disability were caused by the accepted August 11, 2011 employment injuries.[12] The other reports from Drs. Aiken and Fowler failed to provide any opinion on the cause of appellant's left knee conditionand resultant disability or explain how her left knee conditionand disability were causally related to the accepted injury. In his October 28, 2011 report, Dr. Fowler noted that, with regard to her left knee pain, she could not recall an injury. The Board has found that medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[13] For the stated reasons, the Board finds that the reports of Drs. Aiken and Fowler are insufficient to meet appellant's burden of proof.

Similarly, Dr. Resnick's December 19, 2011 diagnostic test results addressed appellant's left knee conditions, but failed to provide a rationalized opinion regarding the causal relationship between the work injuries and her continuing conditions and claimed disability.[14]The Board finds that his report is insufficient to establish her claim.

Appellant failed to submit sufficiently rationalized medical evidence establishing that her knee condition and resultant disability beginningSeptember 10, 2011 resulted from the residuals of her accepted injury.[15] She has not met her burden of proof.[16]

---

[8]*John F. Glynn*, 53 ECAB 562 (2002).

[9] *See* cases cited, *supra* note 7.

[10]While the physicians stated that, August 8, 2011 rather than August 11, 2011 was the date of injury, this is harmless error as they provided a history that appellant fell at work on August 11, 2011. In addition, Dr. Fowler provided a correct date of injury in his February 5, 2013 affidavit when he opined that her left knee pain and surgery were related to the August 11, 2011 employment injuries.

[11]*Robert Broome*, 55 ECAB 339, 342 (2004).

[12]*See* cases cited, *supra* note 7.

[13]*A.D.*, 58 ECAB 149 (2006); *Jaja K. Asaramo*, 55 ECAB 200 (2004); *Willie M. Miller*, 53 ECAB 697 (2002); *Michael E. Smith*, 50 ECAB 313 (1999).

[14]*Id.*

[15]*Cecelia M. Corley*, 56 ECAB 662 (2005).

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has failed to establish that she sustained a recurrence of disability on September 10, 2011 causally related to her August 11, 2011 employment injuries.

ORDER

IT IS HEREBY ORDERED THATthe March 28, 2013 and December 18, 2012 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: October 22, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

[16] *Tammy L. Medley*, 55 ECAB 182 (2003).