# United States Department of Labor
# Employees' Compensation Appeals Board

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| **D.J., Appellant** | ) | |
| **and** | ) | **Docket No. 14-1604** |
| | ) | **Issued: December 18, 2014** |
| **DEPARTMENT OF THE NAVY, MARINE CORPS LOGISTICS BASE, Barstow, CA, Employer** | ) | |

*Appearances:*
*Brett E. Blumstein, Esq.*, for the appellant
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge

### *JURISDICTION*

On July 15, 2014 appellant, through counsel, filed a timely appeal from a May 8, 2014 merit decision 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 established left knee and lumbar conditions causally related to an accepted right knee injury.

### *FACTUAL HISTORY*

OWCP accepted that on November 16, 2009 appellant, then a 59-year-old computer assistant, sustained a torn right medial meniscus when he tripped on a rotted restroom floor.

[1] 5 U.S.C. § 8101 *et seq.*

Appellant did not stop work at the time of injury. He submitted treatment records regarding a 1985 right knee injury and June 1, 2001 injuries to the left hand and left leg. Appellant underwent a right knee arthroscopy on June 16, 1989 to repair a lateral meniscal tear.[2] OWCP accepted a February 1, 2005 lumbar strain under File No. xxxxxx498. Imaging studies from February 21, 2003 to March 24, 2009 showed degenerative disc disease with osteophytes and mild disc bulging throughout the thoracic and lumbar spine.

Dr. Rana T. Pathi, an attending Board-certified orthopedic surgeon, provided reports from January 19 to May 7, 2010, noting ongoing right knee symptoms and a normal left knee. On April 15, 2010 he diagnosed "lumbar syndrome." Dr. Pathi requested that OWCP authorize an evaluation of appellant's left knee and lumbar spine.

On March 2, 2010 appellant filed a claim for recurrence of disability (Form CA-2a) asserting that, when he stood up at work on February 5, 2010, he experienced a sharp pain in his right knee radiating upward into the lumbar spine, then downward into his left knee. In a May 4, 2010 letter, OWCP advised appellant of the type of evidence needed to establish his claim for left knee and low back injuries, including a statement from his attending physician explaining how and why the accepted right knee injury would cause the claimed conditions. Appellant was afforded 30 days to submit such evidence.

Dr. Pathi performed right knee arthroscopy on May 11, 2010, with partial medial and lateral meniscectomies, abrasion of chondromalacia, lysis of adhesions, and thermal shrinkage of a partial tear of the anterior cruciate ligament. In a May 26, 2010 report, he diagnosed multilevel lumbar and thoracic degenerative disease. Dr. Pathi submitted periodic reports through February 2, 2011 diagnosing continued right knee symptoms, left knee pain, and low back pain.[3] In reports from March 14 to November 14, 2011, he stated that appellant experienced left knee and lumbar pain following the May 11, 2010 right knee surgery as he was overcompensating for a weakened right knee.[4]

In a February 7, 2012 letter, counsel requested that OWCP expand appellant's claim to include a left knee condition. He provided a July 14, 2012 magnetic resonance imaging (MRI)

[2] A May 5, 2009 electromyography (EMG) study showed bilateral peripheral polyneuropathy of the lower extremities.

[3] April 29 and June 14 and 18, 2010 imaging studies showed degenerative osteophytes and disc bulges throughout the thoracic and lumbar spine.

[4] Appellant claimed compensation for total disability from May 11 to December 2, 2010. In an August 17, 2011 letter, OWCP advised him of the additional medical evidence needed to establish his claim for compensation, including a report from his attending physician explaining how and why the accepted right knee injury continued to disable him for work. Appellant remained off work through May 2013 and continuing. On October 19, 2011 he claimed a schedule award. Appellant submitted a September 22, 2011 report from Dr. Jacob E. Tauber, an attending Board-certified orthopedic surgeon, who found a 48 percent impairment of the right lower extremity due to primary and patellofemoral arthritis, according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. In a November 14, 2011 report, Dr. Pathi offered a 20 percent impairment of the right lower extremity. An OWCP medical adviser reviewed the record and calculated a 12 percent impairment of the right lower extremity, explaining that appellant's physicians misapplied the A.M.A., *Guides*. By decision dated January 30, 2012, OWCP granted appellant a schedule award for a 12 percent impairment of the right leg.

scan of the left knee showing severe chondromalacia and degenerative changes. The July 16, 2012 lumbar imaging studies showed osteophytes at L3-4 and mild disc space narrowing at L5-S1.

On January 30, 2013 OWCP obtained a second opinion from Dr. Ronny G. Ghazal, a Board-certified orthopedic surgeon, who reviewed the medical record and a statement of accepted facts. On examination, he found full motion of both knees with no instability, arthroscopic portal scars on both knees, a normal neurologic examination of both lower extremities, a full range of motion in the lumbar spine, and no lumbar spasm or tenderness. Dr. Ghazal diagnosed bilateral patellofemoral compression syndrome, a partial tear of the right anterior cruciate ligament, status postarthroscopy of the left knee, status postmultiple arthroscopies of the right knee, chronic mechanical low back pain superimposed on underlying spinal stenosis, and diffuse degenerative changes of the lumbar and thoracic spine. He explained that, while it was possible that overcompensation following right knee surgery caused a temporary increase in left knee and lumbar symptoms, this did not result in organic changes to the left knee or lumbar spine. Dr. Ghazal found that appellant did not require additional treatment. He noted that appellant continued to have residuals of the accepted right knee injury. In an April 11, 2013 addendum report, Dr. Ghazal emphasized that appellant's left knee and lumbar symptoms did not indicate any organic change in his degenerative disc disease or left knee arthritis. He explained that appellant had been symptomatic for many years prior to the accepted right knee injury. The left knee and lumbar conditions remained unrelated to the accepted right knee injury.

In a March 13, 2014 letter, counsel again requested that OWCP expand the claim to include a left knee and lumbar conditions. He submitted June 3 and 14, 2013 reports from Dr. Pathi opining that overcompensating due to the right knee injury aggravated appellant's preexisting left knee and low back symptoms. Dr. Tauber stated on August 29, 2013 that appellant's left knee condition was possibly caused by appellant's "extensive duties over the years," then aggravated after the right knee surgery.

In an April 8, 2014 letter, OWCP advised counsel and appellant of the type of additional evidence needed to establish his claim for a left knee and lumbar conditions, including a report from appellant's attending physician explaining how and why the accepted right knee injury would cause the claimed conditions. It afforded appellant 30 days to submit such evidence.

Appellant provided an April 16, 2014 report from Dr. Tauber, opining that appellant's work duties, including prolonged standing and working in awkward positions, caused a cumulative left knee condition.

By decision dated May 8, 2014, OWCP denied appellant's claim for left knee and lumbar conditions on the grounds that causal relationship was not established. It accorded the weight of the medical evidence to Dr. Ghazal, who explained clearly that appellant's left knee and low back symptoms were unrelated to work factors. OWCP noted that Dr. Ghazal's report outweighed Dr. Tauber's inference that appellant's left knee symptoms were due to cumulative trauma.

## ***LEGAL PRECEDENT***

It is an accepted principle of workers' compensation law that when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent, intervening cause attributable to the employee's own intentional conduct.[5]

When an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he bears the burden of proof to establish that the condition is causally related to the employment injury.[6] To establish a causal relationship between the condition claimed, as well as any attendant disability and the employment event or incident, an employee must submit rationalized medical evidence based on a complete medical and factual background supporting such a causal relationship.[7] Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[8] Rationalized medical evidence is evidence which includes a physician's rationalized medical opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated 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.[9]

Neither the fact that a disease or condition manifests itself during a period of employment, nor the belief that the disease or condition was caused or aggravated by employment factors or incidents, is sufficient to establish causal relationship.[10]

## ***ANALYSIS***

OWCP accepted that appellant sustained a torn right medial meniscus. On March 2, 2010 appellant filed a claim for his left knee and lumbar symptoms on and after a February 5, 2010 work incident. Counsel submitted February 7, 2012 and March 13, 2014 letters requesting that OWCP expand the claim to include a left knee, and lumbar conditions.

In support of his claim, appellant submitted reports from Dr. Pathi, an attending Board-certified orthopedic surgeon, who performed right knee arthroscopy on May 11, 2010. However, he found no abnormalities of the left knee in reports from January 19 to May 7, 2010. Dr. Pathi diagnosed lumbar syndrome on April 15, 2010, but did not specify a cause. He first proposed a

[5] *John R. Knox*, 42 ECAB 193 (1990); *Lee A. Holle*, 7 ECAB 448 (1955).

[6] *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[7] *Jennifer Atkerson*, 55 ECAB 317 (2004).

[8] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[9] *Leslie C. Moore*, 52 ECAB 132 (2000).

[10] *Ernest St. Pierre*, 51 ECAB 623 (2000).

cause for these symptoms on March 14, 2011, when he opined that overcompensation following the May 11, 2010 surgery aggravated preexisting left knee and lumbar symptoms. Dr. Pathi reiterated this opinion on June 3 and 14, 2013. However, he did not explain the medical reasons that the accepted right knee injury would cause or aggravate a left knee or lumbar condition. This lack of rationale is particularly problematic considering appellant's complex medical history, including a June 16, 1989 right knee arthroscopy, a February 1, 2005 lumbar strain, and degenerative disc disease from 2003 onward. Dr. Pathi's opinion is therefore insufficient to meet appellant's burden of proof.[11]

Appellant also provided reports from Dr. Tauber, an attending Board-certified orthopedic surgeon, dated from September 22, 2011 to April 16, 2014. Dr. Tauber diagnosed degenerative arthritis of the left knee. He attributed the condition variously to the accepted right knee injury and to cumulative trauma due to his "extensive duties over the years." The equivocal nature of this opinion diminishes its probative value.[12] Although imaging studies document both lumbar degenerative disc disease and degenerative arthritis of the left knee, Dr. Tauber did not explain a medical connection between the study and the accepted injuries.

The Board finds that OWCP properly accorded the weight of the medical evidence to Dr. Ghazal, a Board-certified orthopedic surgeon and second opinion physician. Dr. Ghazal based his opinion on a thorough clinical examination, a review of the medical record, and on the statement of accepted facts. He explained that appellant's left knee and lumbar symptoms did not signal an organic change in preexisting degenerative disc disease or degenerative arthritis. Also, appellant's left knee and lumbar spine were symptomatic for many years prior to the accepted right knee injury. Dr. Ghazal noted that appellant did not require treatment of the left knee or lumbar spine as there were no physical changes caused by the right knee injury, he did not require additional treatment.

OWCP advised appellant on May 4, 2010 and April 8, 2014 of the necessity of submitting a statement from his attending physician explaining the medical reasoning for supporting a causal relationship between the accepted right knee injury and conditions of the left knee and lumbar spine. However, appellant did not submit such evidence. Therefore, OWCP's May 8, 2014 decision was proper under the law and circumstances of this case.

On appeal, counsel asserts that OWCP should have expanded the claim to accept left knee and lumbar conditions, based on the opinions of Dr. Pathi and Dr. Tauber. As set forth above, neither Dr. Pathi nor Dr. Tauber explained how and why the accepted right knee injury would cause or aggravate a left knee or lumbar condition. Alternatively, counsel argues that there is a conflict of medical opinion between Dr. Ghazal and appellant's physicians regarding the etiology of the lumbar and left knee conditions. The Board notes that Dr. Ghazal presented extensive medical rationale, based on the complete medical record and a statement of accepted facts, explaining why appellant's preexisting left knee and lumbar conditions were not altered or accelerated by the accepted right knee injury. Dr. Ghazal's opinion is of superior probative quality to those of Dr. Pathi and Dr. Tauber, who did not explain why they believed the right

[11] *Deborah L. Beatty*, 54 ECAB 340 (2003).

[12] *Ricky S. Storms*, 52 ECAB 349 (2001).

knee injury caused or aggravated appellant's left knee or lumbar conditions. Therefore, there is no conflict of medical opinion.

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 did not establish that he sustained left knee or lumbar spine conditions causally related to an accepted right knee injury.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated May 8, 2014 is affirmed.

Issued: December 18, 2014
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board