United States Department of Labor
Employees' Compensation Appeals Board

M.S., Appellant	)	
and	)	**Docket No. 16-1497**
	)	**Issued: December 20, 2016**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Orlando, FL, Employer	)	

Appearances: *Case Submitted on the Record*
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 14, 2016 appellant, through counsel, filed a timely appeal from a May 9, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of appellant's claim.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant established that his claimed left knee condition is causally related to the accepted August 13, 2015 employment incident.

FACTUAL HISTORY

On August 20, 2015 appellant, then a 61-year-old carpenter, filed a traumatic injury claim (Form CA-1) alleging that on August 13, 2015 he injured his left knee while laying carpet in the performance of duty. He explained that he had been on his knee for two hours and injured his knee when he stood up.

In an August 14, 2015 employing establishment report of injury, appellant stated that on August 13, 2015 he was laying carpet with knee pads on and after approximately two hours of crawling on the floor he stood up and his left knee popped. He reportedly had been experiencing pain ever since the incident, and despite icing his knee, it was still very tender.

Appellant visited the employee health unit on August 14, 2015 and was treated by Linda Baco, a physician assistant. Ms. Baco noted that on August 13, 2015 appellant was laying carpet with his knees on pads and with two hands crawling on the floor. She further reported that when appellant stood up "his left knee popped," and he had been in pain ever since. Ms. Baco diagnosed possible left knee meniscal tear. She recommended a magnetic resonance imaging (MRI) scan to rule out meniscal tear. Ms. Baco also advised that appellant could return to work with restrictions of no squatting, no repetitive bending, and no kneeling.

An August 14, 2015 left knee x-ray revealed degenerative changes and no acute abnormality.[3]

On August 17, 2015 the employing establishment provided appellant a transitional assignment that allowed him to return to work with restrictions of no stooping, squatting, or kneeling. Appellant was to perform office-related work with various administrative tasks.

The record revealed that appellant previously filed a traumatic injury claim (Form CA-1) for an August 5, 2010 left knee injury, which OWCP denied under OWCP File No. xxxxxx797. A September 8, 2010 left knee MRI scan revealed a bone bruise of the medial femoral condyle and a tear of the posterior horn of the medial meniscus.[4] On September 21, 2010 Dr. Richard M. Konsens, a Board-certified orthopedic surgeon, examined appellant and reported left knee pain of about six weeks' duration. He noted an August 5, 2010 date of injury and reported that appellant had been doing a lot of kneeling and when he got up, he noted a pop and the onset of pain and swelling. Dr. Konsens also noted the results of appellant's recent left knee MRI scan, as well as bilateral knee x-rays, which showed mild medial compartment narrowing. He diagnosed left knee medial meniscus tear and mild medial compartment arthritis, bilaterally. Dr. Konsens recommended knee arthroscopy, and advised that in the interim appellant could

[3] Dr. Rashmi Mediratta, a Board-certified diagnostic radiologist, interpreted the August 14, 2015 left knee x-ray.

[4] Dr. Mark J. Timken, a Board-certified diagnostic radiologist, interpreted the September 8, 2010 MRI scan.

perform light-duty work with no kneeling, squatting, twisting, or climbing. In follow-up reports dated September 28 and October 14, 2010, he continued to diagnose left knee medial meniscus tear, and noted that appellant was awaiting authorization for surgery.

On August 26, 2015 appellant returned to see Dr. Konsens. Dr. Konsens noted that he last saw appellant approximately five years ago for medial meniscus tear per MRI scan at that time. He explained that he never received approval for surgery and appellant ultimately decided to live with the problem. Dr. Konsens related that appellant was doing fairly well until August 13, 2015, when he noted the traumatic onset of knee pain. He examined appellant and provided findings. Dr. Konsens noted that x-rays revealed no acute osseous abnormality, fracture or malalignment, and only minimal degenerative changes. He diagnosed prior history of left knee degenerative medial meniscus tear. Dr. Konsens related that appellant wished to have the knee arthroscoped. He recommended a new left knee MRI scan to confirm the size and location of the tear.

A September 2, 2015 MRI scan of the left knee, read by Dr. Kevin W. McLean, a Board-certified diagnostic radiologist, revealed tearing of the medial meniscus, mild compartment chondromalacia, no acute ligamentous pathology, no lateral meniscus tear, and patellofemoral compartment chondromalacia.

In a September 8, 2015 report, Dr. Konsens noted that the MRI scan revealed an oblique tearing of the medial meniscus primarily in the posterior third and a grade 3 and grade 4 chrondrosis in the patellofemoral joint. He examined appellant and diagnosed medial meniscus tear of the left knee and grade 3 and 4 chrondrosis in the patellofemoral joint. Dr. Konsens indicated that appellant wished to proceed with arthroscopy and requested authorization for surgery.

In a letter dated September 25, 2015, OWCP informed appellant of the type of evidence needed to support his claim and requested that he submit such evidence within 30 days. Specifically, it requested a narrative report from appellant's attending physician, including an explanation of how appellant's August 13, 2015 employment injury affected his preexisting left knee condition.

In an October 1, 2015 report, Dr. Konsens noted that x-rays obtained on August 26, 2015 demonstrated no acute osseous abnormality, fracture, or malalignment. He opined that appellant's current symptoms were related to his injury from 2010. Dr. Konsens explained that, at that time, he had an MRI scan which revealed a tear of the posterior horn of the medial meniscus. He explained that, because of the continued symptoms, he would like to have the knee arthroscoped, as the meniscal tear was "not inclined to improve over time." Dr. Konsens advised that appellant had intermittent symptoms over the years, which were consistent with a meniscus tear.

In an October 13, 2015 disability certificate, Dr. Konsens recommended light-duty work with restrictions of no bending, stooping, kneeling, climbing, or prolonged walking.

By decision dated November 6, 2015, OWCP denied appellant's claim as he failed to establish causal relationship between the diagnosed condition and the accepted employment

incident of August 13, 2015. It found the medical evidence of record insufficient as there was no rationale to support causal relationship.

On December 8, 2015 appellant requested a review of the written record before an OWCP hearing representative.

In a December 4, 2015 report, Dr. Konsens noted that appellant had an injury on the job five years ago. He explained that appellant was kneeling, and when he got up he felt a pop in the knee. Dr. Konsens explained that a left knee MRI scan revealed a medial meniscus tear. He explained that appellant never fixed it and the knee continued to bother him intermittently over the years. Dr. Konsens indicated that appellant never got approval for the surgery but on August 13, 2015, he noted traumatic worsening of pain. He explained that a new MRI scan confirmed a broad-sided tear of the medial meniscus and a parameniscal cyst with medial compartment chondromalacia.

By decision dated May 9, 2016, the hearing representative affirmed OWCP's November 6, 2015 decision. She too found that appellant failed to establish a causal relationship between his left knee condition and the accepted August 13, 2015 employment incident.

LEGAL PRECEDENT

A claimant seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative, and substantial evidence, including that an injury was sustained in the performance of duty as alleged and that any specific condition or disability claimed is causally related to the employment injury.[5]

To determine if an employee sustained a traumatic injury in the performance of duty, OWCP begins with an analysis of whether "fact of injury" has been established. Generally, fact of injury consists of two components that must be considered in conjunction with one another. The first component is whether the employee actually experienced the employment incident that allegedly occurred.[6] The second component is whether the employment incident caused a personal injury.[7] An employee may establish that an injury occurred in the performance of duty as alleged, but fail to establish that the disability or specific condition for which compensation is being claimed is causally related to the injury.[8]

[5] 20 C.F.R. § 10.115(e), (f); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996).

[6] *Elaine Pendleton*, 40 ECAB 1143 (1989).

[7] *John J. Carlone*, 41 ECAB 354 (1989). Causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue. *Robert G. Morris*, 48 ECAB 238 (1996). A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factor(s) must be based on a complete factual and medical background. *Victor J. Woodhams*, 41 ECAB 345, 352 (1989). Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factor(s). *Id.*

[8] *Shirley A. Temple*, 48 ECAB 404, 407 (1997).

Certain healthcare providers such as physician assistants, nurse practitioners, physical therapists, and social workers are not considered "physician[s]" as defined under FECA.[9] Consequently, their medical findings and/or opinions will not suffice for purposes of establishing entitlement to FECA benefits.[10]

ANALYSIS

OWCP accepted that the August 13, 2015 employment incident occurred as alleged. Appellant reported that he had been crawling on his knees for about two hours laying carpet, and when he stood his left knee popped. The record establishes a diagnosis of left knee medial meniscus tear. However, OWCP denied appellant's traumatic injury claim based on his failure to establish causal relationship between the diagnosed left knee condition and the August 13, 2015 employment incident. An OWCP hearing representative subsequently conducted a review of the written record and similarly found that appellant failed to establish causal relationship between his current left knee condition and the accepted August 13, 2015 employment incident.

The Board finds that the medical evidence of record contains no reasoned explanation of how the specific employment incident on August 13, 2015 caused or aggravated appellant's claimed left knee condition.[11]

The record contains an August 14, 2015 treatment note from a physician assistant. Under FECA the term "physician" includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by the applicable state law.[12] Consequently, the physician assistant's August 14, 2015 treatment notes are irrelevant as the records provided cannot be considered medical evidence and, as noted above, the underlying point at issue is medical in nature.

OWCP also received August 14, 2015 x-rays of the left knee read by Dr. Mediratta and a September 2, 2105 MRI scan of the left knee read by Dr. McLean. However, these reports merely reported findings and did not contain an opinion regarding the cause of the reported condition. Thus, they are of limited probative value.[13]

Appellant submitted several reports from Dr. Konsens, who previously treated him for a medial meniscus tear in 2010. In an August 26, 2015 report, Dr. Konsens explained that despite

[9] 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t).

[10] *K.W.*, 59 ECAB 271, 279 (2007); *David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006). A report from a physician assistant or certified nurse practitioner will be considered medical evidence if countersigned by a qualified physician. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3a(1) (January 2013).

[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).

[12] *See* 5 U.S.C. § 8101(2). *See also B.L.*, Docket No. 16-1205 (issued November 23, 2016); *Roy L. Humphrey*, 57 ECAB 238 (2005).

[13] *See L.L.*, Docket No. 16-0896 (issued September 13, 2016); *A.D.*, 58 ECAB 149 (2006).

recommending surgery, appellant never received approval for surgery. He related that appellant was doing fairly well until August 13, 2015, when appellant experienced a traumatic onset of knee pain. Dr. Konsens examined appellant, provided findings, and diagnosed a prior history of left knee degenerative medial meniscus tear. The Board finds that this report supports the prior injury, but does not offer any support that the August 13, 2015 incident caused or aggravated an injury.

In a September 8, 2015 report, Dr. Konsens diagnosed left knee medial meniscus tear and grade 3 and 4 patellofemoral joint chrondrosis. He noted that appellant wished to proceed with arthroscopy and requested authorization for surgery. Dr. Konsens merely provided diagnoses and did not offer any opinion on causal relationship. 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.[14] In his October 1, 2015 report, Dr. Konsens specifically opined that appellant's current symptoms were related to his injury from 2010.

In a December 4, 2015 report, Dr. Konsens noted that appellant had an injury on the job five years prior, which occurred when appellant got up from kneeling and felt a pop in his knee. He explained that a left knee MRI scan revealed a medial meniscus tear. However, appellant never fixed it and the knee continued to bother him intermittently over the years. Dr. Konsens explained that on August 13, 2105 appellant noted a traumatic worsening of pain. He confirmed that a new MRI scan revealed a broad-sided tear of the medial meniscus and a parameniscal cyst with medial compartment chondromalacia. In this case, Dr. Konsens referenced the prior injury and noted the date of the employment incident. However, other than that he did not describe the employment incident or offer an opinion regarding the cause of the diagnosis. To establish a causal relationship between the condition, as well as any attendant disability claimed and the employment event or incident, the employee must submit rationalized medical opinion evidence based on a complete factual and medical background, supporting such a causal relationship.[15] 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. The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.[16] The Board finds that Dr. Konsens' December 4, 2015 report is of limited probative value.

Because the medical reports submitted by appellant do not address how the August 13, 2015 activities at work caused or aggravated his left knee condition, these reports are of limited probative value and are insufficient to establish that the August 13, 2015 employment incident caused or aggravated a specific injury.[17]

[14] *K.W., supra* note 10.

[15] *See* 20 C.F.R. § 10.110(a); *John M. Tornello*, 35 ECAB 234 (1983).

[16] *James Mack*, 43 ECAB 321 (1991).

[17] *See Linda I Sprague*, 48 ECAB 386, 389-90 (1997).

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 failed to establish that his claimed left knee condition is causally related to the August 13, 2015 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the May 9, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 20, 2016
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board