

ISSUE

The issue is whether appellant met her burden of proof to establish a consequential right knee condition causally related to her September 8, 2003 employment injury.

FACTUAL HISTORY

This case has previously been before the Board.⁴ The facts as presented in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

OWCP accepted that on September 8, 2003 appellant, then a 52-year-old nursing assistant, sustained a left knee strain and left knee medial meniscus tear when she twisted her left knee while assisting with the transfer of a patient from a bed to a stretcher.⁵ Appellant stopped work on September 9, 2003 and returned on September 10, 2003.

On February 27, 2004 Dr. James T. Bilbo, an attending Board-certified orthopedic surgeon, performed OWCP-approved surgery on appellant's left knee, including arthroscopy, partial medial meniscectomy, abrasion arthroplasty of her medial femoral condylar and lateral tibial plateau articular surfaces, partial lateral meniscectomy with chondroplasty of her lateral compartment and articular surfaces, and chondroplasty of her patella and femoral trochlear groove articular surfaces.⁶

In a January 30, 2006 report, Dr. Bilbo noted that appellant's need for a joint replacement was the result of dormant, preexisting degenerative changes in her left knee that were further aggravated by her work-related injury. Because appellant had failed limited operative and nonoperative treatment, the only other alternative was to undergo total joint replacement. Dr. Bilbo indicated, "Were it not for the work[-]related injury and subsequent surgery, she may not have required the joint replacement, especially at this time."

On April 5, 2007 OWCP updated the accepted conditions due to the September 8, 2003 work injury to include aggravation of left knee osteoarthritis.

⁴ Docket No. 13-1149 (issued January 16, 2014).

⁵ OWCP assigned File No. xxxxxx441. Appellant has a prior claim, under OWCP File No. xxxxxx298, wherein OWCP accepted that on July 23, 1998 appellant sustained a left knee medial meniscus tear and left shoulder rotator cuff syndrome. On November 9, 1998 she underwent OWCP-approved left knee surgery in connection with this claim, including partial medial meniscectomy, and chondroplasty/abrasion arthroplasty of her patellar articular, medial femoral condylar, and lateral tibial plateau articular surfaces. On October 6, 2000 appellant underwent right knee surgery, including partial medial meniscectomy, and chondroplasty of her patella, medial femoral condylar, and lateral tibial plateau articular surfaces. The procedure was not approved by OWCP. OWCP administratively combined File Nos. xxxxxx298 and xxxxxx441, with OWCP File No. xxxxxx441 serving as the master file.

⁶ In an August 26, 2003 report, Dr. Bilbo noted that appellant reported that both of her knees were becoming increasingly symptomatic. He observed that she had a somewhat antalgic gait pattern and that there was guarding at terminal motion. Dr. Bilbo stated that x-ray testing showed progression of degenerative changes in both knees with marginal spur formation and narrowing, but not complete collapse of the medial compartments.

On August 21, 2007 Dr. Forest Heis, an attending Board-certified orthopedic surgeon, performed OWCP-approved left total knee arthroplasty using all-cemented spacers.

In a November 13, 2008 report, Dr. Heis noted that appellant sustained a right knee injury as a consequence of her September 8, 2003 employment-related left knee injury. He indicated that, while she had a preexisting right knee condition, the effects of her left knee condition caused a worsening of her right knee condition. Dr. Heis advised that appellant experienced persistent right knee pain and noted, "It is within a reasonable degree of medical probability that the significant problems she is having with her left knee did cause an otherwise dormant condition in her right knee to develop into a disabling reality for which she has been getting treatment continuously since 2003."

In letters dated February 5, 10 and 13, 2009, counsel argued that appellant had sustained a right knee injury as a consequence of her accepted left knee injury.

In a March 5, 2009 report, Dr. Paul Cangemi, a Board-certified orthopedic surgeon serving as an OWCP referral physician, described appellant's medical history and reported the findings of his examination. He concluded, "The additional stress of weight bearing following the injury on her left knee was inconsequential as compared to the history of the disease process in her right knee. I do not feel that this resulted in a relevant or significant aggravation of a preexisting condition or arthritis in the right knee."

By decision dated April 30, 2009, OWCP granted appellant a schedule award for 50 percent permanent impairment of her left leg. The award ran for 144 weeks from April 15, 2009 to January 17, 2012.

OWCP determined that there was a conflict in the medical opinion evidence between Dr. Heis and Dr. Cangemi regarding whether appellant sustained a right knee injury as a consequence of her accepted left knee injuries. In order to resolve the conflict, it referred appellant to Dr. Arthur F. Lee, a Board-certified orthopedic surgeon, for an impartial medical examination and opinion on whether she sustained such a consequential injury.

In August 7 and October 17, 2009 reports, Dr. Lee detailed appellant's factual and medical history and provided his examination findings.⁷ He noted that she was involved in a September 8, 2003 event where she sustained a left knee strain, but indicated that the left knee strain "did not appear to cause any significant alteration or change in this woman's natural history when one considers the medical records." Dr. Lee noted that this statement took into account Dr. Bilbo's own medical records describing absolutely no change in appellant's examination between August 26 and September 23, 2003. He indicated that appellant had progressive degeneration changes with gait abnormalities and early varus deformities before the September 8, 2003 accident occurred, as documented by an August 26, 2003 report. Dr. Lee noted that the natural history of her arthritic knees, particularly considering her weight, necessitated left total knee arthroscopy because of her preexisting nonwork-related arthritis. He posited that none of the surgeries performed were necessitated by the September 8, 2003 employment injury and noted that there

⁷ The August 7, 2009 report contained examination findings from that date and the October 17, 2009 report contained a review of the medical records.

was no indication that the natural history of appellant's right knee was in anyway altered or changed due to the September 8, 2003 event. Dr. Lee indicated that there would be no limitations or restrictions due to the September 8, 2003 employment injury and noted that appellant completely recovered from this event and was left with no permanent sequelae.

By decision dated November 17, 2009, OWCP denied appellant's claim, noting that Dr. Lee, the impartial medical specialist, provided a well-rationalized opinion finding that she had not sustained a right knee injury as a consequence of her accepted left knee injuries. Appellant requested an oral hearing before an OWCP hearing representative.

By decision dated February 22, 2010, OWCP's hearing representative set aside OWCP's November 17, 2009 decision and remanded the case to OWCP for further development. He found that OWCP had not produced a proper statement of accepted facts (SOAF) that included all of the accepted work conditions and surgeries. The hearing representative indicated that, on remand, OWCP should produce an updated, complete SOAF and should refer the case to Dr. Lee for a supplemental opinion regarding whether appellant sustained a right knee injury as a consequence of her accepted left knee injuries.

On remand, OWCP produced a new SOAF and referred the case to Dr. Lee for a supplemental report and requested that Dr. Lee respond to various questions. It asked Dr. Lee whether appellant's right knee condition had been caused or aggravated by the work-related injuries and authorized surgeries of November 9, 1998, February 27, 2007, or August 21, 2007 as described in the SOAF. On April 7, 2010 Dr. Lee responded that appellant's right knee condition had not, in anyway, been caused or aggravated by the work-related injuries and authorized surgeries.

In an April 28, 2010 decision, OWCP denied appellant's claim that she sustained a right knee injury as a consequence of her accepted left knee injuries, noting that the well-rationalized opinion of Dr. Lee, the impartial medical specialist, showed that she did not sustain such an injury.

Appellant submitted a May 10, 2011 report in which Dr. Heis again indicated that she sustained a right knee injury as a consequence of her accepted left knee injuries. Dr. Heis explained that, after appellant had OWCP-approved left knee surgery on November 9, 1998, she was protective of her left knee, causing added stress to her right knee, and significant problems to her right knee. He indicated that reference was made to this fact by attending physicians, including Dr. Bilbo in his report dated August 26, 2003.

By decision dated July 27, 2012, OWCP affirmed its April 28, 2010 decision denying appellant's consequential injury claim, finding that the weight of the medical opinion evidence on this matter continued to rest with the opinion of the impartial medical specialist, Dr. Lee.

Counsel continued to argue that appellant sustained a consequential right leg condition and submitted additional medical reports regarding the condition of her legs.

By decision dated October 15, 2012, OWCP affirmed its July 27, 2012 decision denying appellant's consequential injury claim, again noting that the special weight of the medical opinion evidence on this matter continued to rest with the opinion of Dr. Lee.

Appellant appealed to the Board and, by decision dated January 16, 2014,⁸ the Board found an unresolved conflict in the medical opinion evidence, and remanded the case to OWCP for further development. The Board noted that OWCP properly determined that there was a conflict in the medical opinion evidence regarding whether appellant sustained a right knee injury as a consequence of her accepted left knee injuries, and referred appellant to Dr. Lee for an impartial medical examination and an opinion on the matter. However, despite being provided an opportunity to produce a supplemental report, Dr. Lee failed to produce a well-rationalized opinion on the question of whether appellant sustained a consequential right knee injury. The Board found that, therefore, Dr. Lee's opinion did not represent the weight of the medical evidence with respect to the consequential injury claim and that appellant should be referred to a new impartial medical specialist for examination and an opinion on the matter.

On remand, OWCP referred appellant to Dr. Alan Kohlhaas, a Board-certified orthopedic surgeon, for an impartial medical examination and opinion regarding whether she sustained a right knee injury as a consequence of her accepted left knee injuries.

In a May 2, 2014 report, Dr. Kohlhaas discussed appellant's factual and medical history and reported the findings of the physical examination he conducted on that date. He indicated that, prior to her September 8, 2003 left knee injury, appellant had fairly severe preexisting osteoarthritis of her right knee which was confirmed by the arthroscopic procedure performed in 2000. Dr. Kohlhaas indicated that the records of Dr. Bilbo showed that appellant had knee pain in both knees that had progressed. Moreover, it appeared from the records that the knee pain was chronic on both sides and that the osteoarthritis progressed due to the natural aging process. Dr. Kohlhaas indicated that there was no documentation of an intervening injury. He posited that the mere fact of having a left total knee replacement and several prior arthroscopic procedures on the left knee did not document that the left knee injuries caused injury to the right knee because in a normal gait process both lower extremities are full weight bearing alternatively. Dr. Kohlhaas noted that, therefore, it was impossible to overload either lower extremity by not using one or the other. He indicated that this was particularly important in an individual such as appellant with a body mass index of 41, placing her in the very obese category.

OWCP requested that Dr. Kohlhaas produce a supplemental report which would take into account both work injuries (July 23, 1998 and September 8, 2003) and all subsequent left knee surgeries with respect to the question of whether appellant sustained a consequential right knee injury.

In his supplemental report dated June 4, 2014, Dr. Kohlhaas opined that during appellant's October 2000 surgery it was confirmed by Dr. Bilbo that appellant already had severe osteoarthritis of the right knee. He indicated that the level of appellant's osteoarthritis would not have had time to develop to the level of severity requiring surgery between the date of the July 23, 1998 injury to her left knee and the October 2000 surgery involving her right knee. Dr. Kohlhaas indicated that the medical evidence of record showed that the knee pain was chronic on both sides and that the osteoarthritis progressed due to the natural aging process. He noted that there was no documentation of an intervening injury to the right knee.

⁸ See *supra* note 4.

By decision dated June 24, 2014, OWCP denied appellant's claim for a right knee injury sustained as a consequence of her accepted left knee injuries. It found that the weight of the medical opinion evidence rested with the well-rationalized opinion of Dr. Kohlhaas, the impartial medical specialist. OWCP noted that Dr. Kohlhaas opined that appellant's right knee condition was not caused or aggravated by the accepted left knee injuries.

Appellant, through counsel, requested a telephone hearing with a representative of OWCP's Branch of Hearings and Review, held on February 18, 2015. By decision dated May 12, 2015, OWCP's hearing representative set aside the June 24, 2014 decision and remanded the case to OWCP for further development. He found that the opinion of Dr. Kohlhaas was not sufficiently well rationalized to represent the special weight of the medical evidence with respect to appellant's claim for a consequential right knee injury. The hearing representative noted that Dr. Kohlhaas failed to directly address whether appellant had an alternating gait pattern before and after her prior left knee surgeries, as noted in the medical reports from attending physicians, including the May 10, 2011 report of Dr. Heis. He indicated that Dr. Kohlhaas did not discuss whether appellant had an altered gait that was in any way due to the accepted work injury, whether an alternating gait pattern could physiologically cause a consequential injury to the knees, and whether appellant did in fact develop such a consequential injury to her right knee. The hearing representative directed OWCP, upon remand, to refer the case back to Dr. Kohlhaas and request that he produce a supplemental report addressing these matters. After appropriate development, OWCP was to issue a *de novo* decision regarding appellant's claim for a consequential right knee injury.

On remand, OWCP requested that Dr. Kohlhaas produce a supplemental report addressing the matters raised by OWCP's hearing representative in his May 12, 2015 decision.

In a supplemental report dated June 17, 2015, Dr. Kohlhaas indicated that he had reviewed the medical reports of record, including the May 10, 2011 report of Dr. Heis. He indicated that the evidence of record revealed that appellant had an antalgic gait during different periods of her treatment, but posited that there was no documentation that there was an injury to her right knee as a result of injuries sustained to her left knee and/or the surgeries performed on her left knee. Dr. Kohlhaas noted that appellant had prior surgery on her right knee and most likely the ongoing symptoms in her right knee were due to the progression of arthritis in her right knee because of the natural aging process. He indicated that Dr. Heis in his May 10, 2011 report found a consequential right knee condition because he felt that appellant's two work injuries led to added stress being placed on the right knee while she favored the left knee. Dr. Kohlhaas noted, however, that he disagreed with this opinion because, after the left knee was injured, appellant's activity level markedly decreased and therefore the stress on both lower extremities was markedly reduced. He noted that in the normal gait pattern there was full weight bearing alternating on each knee, and therefore, it was impossible to overload either lower extremity by shifting weight from one lower extremity to the other. Dr. Kohlhaas indicated that the medical literature did not support a so-called flow through injury to the opposite side.

By decision dated September 23, 2015, OWCP denied appellant's claim for a right knee injury sustained as a consequence of her accepted left knee injuries. It found that the special weight of the medical opinion evidence rested with the well-rationalized opinion of Dr. Kohlhaas, the impartial medical specialist. OWCP noted that, in his June 17, 2015 supplemental report,

Dr. Kohlhaas provided additional explanation of his opinion that appellant did not sustain a right knee injury as a consequence of her accepted left knee injuries.

In a form received on September 20, 2016, appellant requested reconsideration of OWCP's September 23, 2015 decision.

In an August 27, 2016 report, Dr. John W. Ellis, a Board-certified family practitioner, discussed his review of the medical evidence of record. He noted that appellant's surgeries caused the cartilage pads between the bones of the left knee and the cartilage on the joint surface of the bones to be partially amputated. This amputation of tissue caused more space in the left knee, which made the knee unstable and caused abnormal biomechanical stresses on the knee. Dr. Ellis posited that the left knee injuries and surgeries caused additional stresses on the soft tissues and bones of all the joints in the lower extremities, which in turn caused degeneration of the cartilage and osteoarthritis of the bones. He noted that he observed when examining appellant in 2006 that she had an antalgic gait or limp due to her left knee and indicated that this fact was observed by other providers, as indicated in the reports of record. Dr. Ellis noted, "It is my medical opinion, based on my examination of the employee, reasonable medical certainty, the medical literature, and my understanding of anatomy, that the injury to the left knee and the loss of tissue in the left knee caused abnormal stress on the right knee which has aggravated and accelerated osteoarthritis in the right knee." He noted that the medical literature did, in fact, support the theory of a flow through injury from an injured lower extremity to the opposite side and he attached an excerpt from a medical journal article regarding the effects of antalgic gait on lower extremity conditions.

In a September 9, 2015 report, Dr. Neil Allen, a Board-certified internist and neurologist, provided a discussion of his review of the medical evidence of record. He detailed the contents of several medical journal articles regarding the effects of antalgic gait on lower extremity conditions. Dr. Allen noted that the lack of knee extension on appellant's symptomatic left side reduced the time spent in the stance phase of her gait on the left, hastening heel strike load and force on the right to reduce load on the painful left knee. This would not only increase the axial load on the right knee, but would also increase time spent in the stance phase of gait on the right. Dr. Allen posited that, over time, appellant's abnormal gait pattern, related to pain resulting from injury and osteoarthritis in her left knee, resulted in the increased degradation of the articular cartilage at a rate at which repair could not keep pace with hastening the progression of the osteoarthritic process in the right knee. He indicated that the opinion of Dr. Kohlhaas lacked citation and support from current medical literature.

By decision dated November 3, 2016, OWCP denied modification of its September 23, 2015 decision. It found that the special weight of the medical opinion evidence rested with the well-rationalized opinion of Dr. Kohlhaas, the impartial medical specialist. OWCP determined that the reports of Dr. Ellis and Dr. Allen were of limited probative value.

LEGAL PRECEDENT

Where an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.⁹

When an injury arises in the course of employment, every natural consequence that flows from that injury likewise arises out of the employment, unless it is the result of an independent intervening cause attributable to claimant's own intentional misconduct.¹⁰ Thus, a subsequent injury, be it an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.¹¹

FECA provides that, if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.¹² For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."¹³ Where OWCP has referred the case to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well-reasoned and based upon a proper factual background, must be given special weight.¹⁴

ANALYSIS

OWCP accepted that on September 8, 2003 appellant, then a 52-year-old nursing assistant, sustained a left knee strain and left knee medial meniscus tear when she twisted her left knee while assisting with the transfer of a patient from a bed to a stretcher.¹⁵ Appellant later claimed that she sustained a right knee injury as a consequence of her accepted left knee injuries.

⁹ *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004). Causal relationship is a medical question, which generally requires rationalized medical opinion evidence to resolve the issue. *See 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 factors 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 factors. *Id.*

¹⁰ *Mary Poller*, 55 ECAB 483, 487 (2004); 1 Arthur Larson & Lex K. Larson, *The Law of Workers' Compensation* 10-1 (2006).

¹¹ *Susanne W. Underwood (Randall L. Underwood)*, 53 ECAB 139, 141 n.7 (2001).

¹² 5 U.S.C. § 8123(a); *see* 20 C.F.R. § 10.321; *Shirley L. Steib*, 46 ECAB 309, 317 (1994).

¹³ *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

¹⁴ *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

¹⁵ Under OWCP File No. xxxxxx298, now combined with the file for the September 8, 2003 employment injury, OWCP accepted that on July 23, 1998 appellant sustained a left knee medial meniscus tear and left shoulder rotator cuff syndrome. On November 9, 1998 appellant underwent OWCP-approved left knee surgery in connection with this claim, including partial medial meniscectomy, and chondroplasty/abrasion arthroplasty of her patellar articular, medial femoral condylar, and lateral tibial plateau articular surfaces.

In a January 16, 2014 decision, the Board found an unresolved conflict in the medical opinion evidence, and remanded the case to OWCP for further development. The Board noted that OWCP properly determined that there was a conflict in the medical opinion evidence regarding whether appellant sustained a right knee injury as a consequence of her accepted left knee injuries, and referred appellant to Dr. Lee for an impartial medical examination and an opinion on the matter.¹⁶ However, despite being provided an opportunity to produce a supplemental report, Dr. Lee failed to produce a well-rationalized opinion on the question of whether appellant sustained a consequential right knee injury. The Board found that, therefore, Dr. Lee's opinion did not represent the weight of the medical evidence with respect to the consequential injury claim and that appellant should be referred to a new impartial medical specialist for examination and an opinion on the matter.

On remand, OWCP referred appellant to Dr. Kohlhaas for an impartial medical examination and opinion regarding whether she sustained a right knee injury as a consequence of her accepted left knee injury.

In a May 2, 2014 report, Dr. Kohlhaas posited that the mere fact of having a left total knee replacement and several prior arthroscopic procedures on the left knee did not document that the left knee injuries caused injury to the right knee since in a normal gait process both lower extremities are full weight bearing alternatively. He noted that therefore it was impossible to overload either lower extremity by not using one or the other. OWCP requested that Dr. Kohlhaas clarify his opinion and, in a supplemental report dated June 4, 2014, he noted that the level of appellant's osteoarthritis would not have had time to develop to the level of severity requiring surgery between the date of the July 23, 1998 injury to her left knee and the October 2000 surgery involving her right knee. Dr. Kohlhaas indicated that the medical evidence of record showed that the knee pain was chronic on both sides and that the osteoarthritis progressed due to the natural aging process. OWCP again requested that Dr. Kohlhaas clarify his opinion and, in a supplemental report dated June 17, 2015, he noted that in the normal gait pattern there was full weight bearing alternating on each knee and therefore it was impossible for appellant to overload either lower extremity by shifting weight from one lower extremity to the other. Dr. Kohlhaas indicated that the medical literature did not support a so-called flow through injury to the opposite side.

The Board finds that Dr. Kohlhaas' reports do not collectively constitute a well-rationalized opinion on the question of whether appellant sustained a right knee injury as a consequence of her accepted left knee injuries. Therefore, the special weight of the medical opinion evidence regarding this matter does not presently rest with his opinion and there is an unresolved conflict in the medical opinion evidence.¹⁷ The Board has carefully reviewed the several reports of Dr. Kohlhaas and notes that he has essentially provided an opinion that it is not possible for an individual with an antalgic gait due to injury in one lower extremity to develop an injury in the opposite, previously uninjured lower extremity. Dr. Kohlhaas generally indicated that the medical literature did not support a flow through injury from an injured lower extremity

¹⁶ The Board noted that OWCP properly determined that there was a conflict in the medical opinion evidence between Dr. Heis, an attending physician, and Dr. Cangemi, an OWCP referral physician, regarding whether appellant sustained a right knee injury as a consequence of her accepted left knee injuries.

¹⁷ See *supra* note 14.

to the opposite side. However, he did not describe the medical literature to which he referred or explain how it applied to the specific facts of appellant's case. The Board notes that the medical evidence of record supports that appellant at times exhibited an antalgic gait, but Dr. Kohlhaas did not adequately discuss these periods of antalgic gait or explain why they would not have been competent to bring about a consequential injury to appellant's right knee. Dr. Kohlhaas opined that appellant's right knee condition was solely due to a nonwork-related degenerative process, but he did not adequately explain this opinion.

In a situation where OWCP secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from such specialist requires clarification or elaboration, it has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original opinion.¹⁸ If the impartial medical specialist is unable to clarify or elaborate on his or her original report or if his or her supplemental report is also vague, speculative, or lacking in rationale, OWCP must submit the case record and a detailed SOAF to a second impartial specialist for the purpose of obtaining his or her rationalized medical opinion on the issue.¹⁹

Consequently, given the above-described deficiencies of Dr. Kohlhaas' medical opinion found in his several reports, the case must be referred to a new impartial medical specialist to resolve the conflict in the medical opinion evidence regarding whether appellant sustained a right knee injury as a consequence of her accepted left knee injuries. On remand, OWCP should refer appellant, along with the case file and the SOAF, to an appropriate specialist for an impartial medical evaluation and report including a rationalized opinion on this matter. After carrying out this development, OWCP should issue a *de novo* decision regarding appellant's claim.

CONCLUSION

The Board finds that the case is not in posture for decision.

¹⁸ *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232, 238 (1988).

¹⁹ *Harold Travis*, 30 ECAB 1071, 1078 (1979).

ORDER

IT IS HEREBY ORDERED THAT the November 3, 2016 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: April 5, 2018
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