

ISSUE

The issue is whether appellant has met his burden of proof to establish right knee and bilateral elbow conditions causally related to the accepted factors of his federal employment.

FACTUAL HISTORY

On January 18, 2016 appellant, then a 64-year-old customs and border protection officer, filed a traumatic injury claim (Form-CA-1) alleging that he injured his right knee in the performance of duty on December 23, 2015. He alleged that he had to repetitively move between sitting and standing, and due to the lack of a foot rest in the primary booths at the concourse, this resulted in repetitive twisting of his right knee from side to side. Appellant noted that he had three right knee ligament tears, which resulted in swelling in the right knee, and pain when turning and when seated in chairs without a foot rest or rail. He explained that he was forced to use a brace with hinges in order to prevent further damage to his knee. Appellant did not stop work. S.T., a supervisor, responded “yes” in response to whether appellant was injured in the performance of duty and also as to whether his knowledge of the facts about the injury agreed with statements of appellant and witnesses.

A December 30, 2015 right knee magnetic resonance imaging (MRI) scan read by Dr. Michael Zistkin, a diagnostic radiologist, revealed a lateral meniscus tear, internal degenerative signal change involving the medial meniscus, suggestion of a focal tear involving the posterior horn centrally, tricompartmental chondral thinning and degenerative change, and a right knee joint effusion. There was also nonspecific edema and inflammation within the soft tissues surrounding the right knee.

In a January 18, 2016 report, Dr. Fernando Moya, a Board-certified orthopedic surgeon, noted that appellant was seen for pain in his right knee joint. He indicated that appellant injured his knee before Christmas and had problems with flexion, extension, and using his knee joint. Dr. Moya advised that he had reviewed the MRI scan and the findings which included that the right knee had a lateral meniscal tear, internal degeneration of the medial meniscus, and early signs of three compartment arthritis. Dr. Moya also noted that a January 18, 2016 x-ray of the right knee revealed the joint space to be open, a bone spur on the proximal superior aspect of the patella, no fracture or dislocation, and no focal bone lesion. He examined the right knee and noted that appellant had discomfort with patella tilting, gliding, and grinding. Dr. Moya found focal joint-line tenderness, positive effusion, and mild restriction of flexion and extension with lateral joint line tenderness. He diagnosed internal derangement of the right knee, a tear of the lateral meniscus of the right knee, a tear of the medial meniscus of the right knee, and arthritis of the right knee he classified as mild and early.

In a May 26, 2016 report, Dr. Felipe Cubas, a Board-certified orthopedic surgeon, noted that appellant injured his right knee and both elbows at work due to repetitive motion. He diagnosed right meniscus tear and epicondylitis of the bilateral elbows. Dr. Cubas responded “no” with regard to whether there were preexisting conditions, with regard to an exacerbation of a preexisting condition, and with regard to whether there were other relevant comorbidities. He recommended light duty with work restrictions including to limit repetitive motion of the elbow and limit activities with the right knee.

In a separate report also dated May 26, 2016, Dr. Cubas noted that appellant was seen for follow up of joint pain in the right knee and explained that he was originally seen on March 7, 2016. He advised that the original onset was December 23, 2015. Dr. Cubas examined appellant and diagnosed medial epicondylitis of the right elbow, worsening, sprain of other specified parts of the right knee, subsequent encounter, stable and improved, and medial epicondylitis of the left elbow, worsening. His assessment was that appellant could return to duty with restrictions including no kneeling, squatting, jumping, running, or climbing ladders, limited repetitive motion with the right hand, no exercise of the right arm, no exercise of the right leg, and to wear a right knee splint.

In a letter dated June 15, 2016, OWCP informed appellant of the type of evidence needed to establish his claim and requested that he submit such evidence within 30 days. It also requested that appellant complete a questionnaire describing his injury, the immediate effects, history of any other injury, and physicians who were consulted with regarding his claim. OWCP also explained the difference between a traumatic injury and an occupational disease.

Appellant provided a copy of an old traumatic injury claim from December 18, 1987. It described an injury to his right knee he suffered while working as a letter carrier.

Appellant provided a July 14, 2016 response. He explained that, on the date, he was injured when working at Miami International Airport, in Concourse D, using hand stamps to document each passenger's entry into the country. Appellant noted that the booth he worked in had an elevated chair the height of the counter so that he could use the computer, passport scanner, biometric scanner, and camera. He explained that there were no foot rails in Concourse D as opposed to Concourse J, which was designed with foot rails to support officers as they were performing their duties. Appellant noted that his feet could not touch the floor while seated. His left foot dangled without support and his right foot was partially supported on a small drawer. The twisting to the right to reach the drawer was very uncomfortable. Appellant alleged that dismounting from the elevated chair, combined with the lack of a foot rail resulted in a ligament injury to the right knee. He noted that, on December 23, 2015, his right knee pain and swelling became so severe, that he went to see his physician, Dr. Cubas. Appellant also noted that it was the Christmas and holiday season and he was unaware of the nature of his injury until January 18, 2016, when his orthopedic specialist notified him that workers' compensation should have been applied rather than his health insurance.

Appellant described the immediate effects of his injury, which included pain and an inability to walk normally, as he walked with a limp. He also indicated that, when he arrived home the night of the injury, he observed gross swelling in the knee. Appellant advised that he first saw Dr. Cubas on December 23, 2015. He noted that he had a prior history of right knee symptoms with the employing establishment in 1987. Appellant explained that he believed he had a traumatic injury.

Appellant also provided witness statements from R.L. and A.P. R.L. noted that in the prior year, in November 2015, he asked appellant why he was limping, and appellant indicated that he had injured his right knee on the job. A.P. indicated that he had witnessed appellant limping at work and saw appellant's swollen knee. Appellant informed him that he had twisted or snapped his knee at the end of their tour of duty in November 2015.

In a July 14, 2016, report, Dr. Cubas summarized his treatment of appellant. He explained that, on December 28, 2015, he saw appellant for right knee pain. Dr. Cubas related that appellant indicated that he suffered from an injury at work due to a lack of foot rest in the primary booths at Concourse D and that he was frequently standing and sitting. He noted that a right knee MRI scan had been ordered. Dr. Cubas instructed appellant to immobilize the knee and to take anti-inflammatories. He reviewed the MRI scan which revealed: a lateral meniscal tear; degenerative joint disease (DJD); DJD involvement in medial meniscus; a focal tear involving the medial meniscus posterior horn; reactive edema; three compartmental chondral thinning; right knee joint effusion; edema; and inflammation within the soft tissues surrounding the right knee.

Dr. Cubas indicated that, on January 12, 2016, appellant was again seen for right knee pain and new complaints of right elbow pain that he attributed to repetitive motion of the right arm when he was at work stamping documents. He examined appellant's right elbow and determined that it was very tender and swollen on the medial aspect and on the medial epicondyle. Dr. Cubas also examined the right knee and found it was tender on the lateral joint line and the entire knee was swollen. He recommended a referral to an orthopedic surgeon. Dr. Cubas continued to see and treat appellant on January 18, February 11 and 15, 2016. On these occasions appellant had continued right knee and right elbow pain.

Dr. Cubas advised that, on March 7, 2016, appellant returned for a follow up. Although appellant's elbow pain had improved, he still had knee pain. In another follow up on April 12, 2016, Dr. Cubas noted that appellant was still experiencing right knee and elbow pain that he attributed to repetitive tasks at his job. He instructed him to use his opposite arm to stamp. In a May 26, 2016 follow-up visit, Dr. Cubas noted that appellant had right knee pain and bilateral elbow pain with the right worse than the left.

On June 20, 2016 Dr. Cubas advised that appellant returned for a recheck of his right knee and bilateral elbow pain. He noted that appellant was seeing Dr. Moya and had mild improvement of the right knee, but elbow pain was progressively worse. Dr. Cubas explained that appellant was instructed to return to work with light-duty similar restrictions as in the past, in addition to limit repetitive motions of the right arm and hand. He diagnosed: right knee meniscus tear; right elbow epicondylitis, medial; and left elbow epicondylitis, medial.

By decision dated July 25, 2016, OWCP denied appellant's claim, finding that the evidence of record was insufficient to establish that the claimed injury and/or event(s) occurred as alleged. It explained that there were discrepancies with regard to whether appellant actually injured his right knee on December 23, 2015 or developed right knee problems over time.

On August 5, 2016 counsel requested a telephonic hearing, which was held before an OWCP hearing representative on March 17, 2017. During the hearing, he argued that the claim should be treated as an occupational disease claim. Appellant explained his duties and noted that he was usually in Concourses D, R, and J. He discussed the passenger entry processing procedures and noted that he sat in an elevated booth chair/stool greeting and processing passengers. Appellant explained that there were no foot rests on the Concourse D level, and that he had to use the chair's foot rest to turn or swivel. He also noted that repeated stamping of passports and documents and turning between using the computer and addressing passengers caused his elbow problems and radiating pain in his fingers. Appellant indicated that he processed between 600 and 900 passengers or more on a daily basis. Furthermore, his knee bothered him more than the elbow, but the elbow and knee pain began at the same time. Counsel argued that Dr. Cubas' July 2016

report sufficiently addressed the development of appellant's diagnosed right knee meniscus tear and left elbow epicondylitis. He explained that appellant attempted to self-treat himself and subsequently sought treatment when his condition did not improve.

In a March 17, 2017 report, Dr. Moya advised that appellant had reached maximum medical improvement (MMI) as of March 31, 2017.

In a March 31, 2017 report, Dr. Moya noted that appellant presented with knee pain and evaluation of his right knee joint. Appellant related to him that he had a trauma at work on December 23, 2015, when he twisted his right knee joint. Dr. Moya noted that appellant related that he had pain and discomfort to his right knee joint with swelling. He related that appellant received treatment with medication by mouth, bracing, and an exercise and strengthening program. Dr. Moya advised that the right knee MRI scan from December 30, 2015 revealed findings that were consistent with a lateral meniscal tear and degeneration of the medial meniscus. He also related that appellant continued to have pain and discomfort and that he could not recall any prior traumas to his right knee joint before December 23, 2015. Dr. Moya noted that appellant indicated that he was active and was able to do activities without any limitations. He further noted that appellant felt that his knee still flared up at times and he still had pain. Dr. Moya determined that appellant did not have full strength or motion. He examined the right knee and found discomfort with patella tilting, gliding and grinding, and focal joint-line tenderness. Dr. Moya also found: positive effusion; mild restriction of flexion and extension; equivocal McMurray test; positive bounce and hyperflexion test; instability; negative anterior drawer sign, negative Lachman's test; no pivot shift or glide; no varus laxity in extension or in 30 degrees of flexion; no valgus laxity at full extension and knee flexed to 30 degrees; no posterior laxity; no "PCL" insufficiency; and negative active quad test. He provided findings for range of motion.

Dr. Moya diagnosed a tear of the medial meniscus of the right knee, initial encounter and a tear of the lateral meniscus of the right knee, initial encounter. He opined that appellant had reached MMI and had five percent permanent impairment. Dr. Moya opined that the impairment was a direct result of the injuries that he sustained on December 23, 2015. He explained that prior to this injury, appellant was active, could not recall any prior traumas, and was able to do activities. Dr. Moya opined that "[f]rom this injury [of December 23, 2015], appellant tore his meniscus. [Appellant] is still having pain and discomfort. He is wearing a brace. [Appellant] does not want to have surgery. The injuries that he has to his knee joint are a direct result of the accident of [December 23, 2015]." Dr. Moya noted that with regards to his work status, appellant was retired from work. However, he indicated that appellant "should be able to do desk work and activities of daily living. I am encouraging the patient to continue exercising and strengthen as tolerated."

By decision dated June 9, 2017, OWCP's hearing representative affirmed the July 25, 2016 decision, as modified. She found that appellant had established fact of injury as his account of his job duties supported that his claim should be considered occupational in nature. The hearing representative explained that appellant confirmed that his duties occurred over a period of time. She found that the claim remained denied as the medical evidence submitted did not offer a sufficient discussion explaining how appellant's duties resulted in either a meniscal tear, degenerative condition, or bilateral epicondylitis. The hearing representative explained that appellant had not provided medical evidence from an examining physician explaining an injury, condition, or diagnosis due to employment.

LEGAL PRECEDENT

A claimant seeking benefits under FECA⁴ 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 establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the diagnosed condition is causally related to the identified employment factors.⁶

Causal relationship is a medical question, which generally requires rationalized medical opinion evidence to resolve the issue.⁷ A physician's opinion on whether there is causal relationship between the diagnosed condition and the implicated employment factors must be based on a complete factual and medical background.⁸ 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.⁹

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish that his right knee and bilateral elbow conditions are causally related to the accepted factors of his federal employment.

The relevant evidence submitted by appellant includes reports from Dr. Moya. In his January 18, 2016 report, Dr. Moya noted that appellant was seen for pain in his right knee joint and indicated that it had occurred before Christmas. Dr. Moya reviewed MRI scan findings which revealed a lateral meniscal tear, internal degeneration of the medial meniscus, and early signs of three compartment arthritis. He also reviewed a January 18, 2016 x-ray of the right knee, which revealed a bone spur on the proximal superior aspect of the patella, with no fracture or dislocation, and no focal bone lesion. Dr. Moya diagnosed: arthritis of the knee, mild and early; tear of the lateral meniscus on the right; tear of the medial meniscus on the right; and internal knee derangement on the right. In a March 17, 2017 report, he advised that appellant had reached MMI. However, Dr. Moya did not offer an opinion regarding the cause of appellant's condition. The Board has long held that medical evidence that does not offer an opinion regarding the cause of an

⁴ *Supra* note 2.

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

⁶ *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

⁷ *See Robert G. Morris*, 48 ECAB 238 (1996).

⁸ *Supra* note 6.

⁹ *Id.*

employee's condition is of no probative value on the issue of causal relationship.¹⁰ Thus, these reports by Dr. Moya lack probative value on the issue of causal relationship.

In his March 31, 2017 report, Dr. Moya diagnosed a tear of the medial meniscus of the right knee, right, initial encounter and a tear of the lateral meniscus of the right knee initial encounter. He opined that appellant reached MMI and had five percent permanent impairment. Dr. Moya opined that the impairment was a direct result of the injuries that he sustained on December 23, 2015. He explained that, prior to this injury, appellant was active, he could not recall any prior traumas, and was able to do activities. The Board notes that Dr. Moya appears to suggest that appellant had an injury on a specific day, as opposed to over a period of time as testified by appellant during his hearing. Furthermore, Dr. Moya did not describe exactly how appellant tore his meniscus on that date. The Board finds that he appeared to suggest that appellant did not have prior symptoms to support his conclusion. The Board has held that an opinion finding causal relationship because an employee is asymptomatic before an employment injury is insufficient, without supporting medical rationale, to establish causal relationship.¹¹ Additionally, Dr. Moya advised that appellant reported that his work activities aggravated his knee. However, he did not provide his own opinion on causal relationship.¹² As Dr. Moya did not provide sufficient rationale explaining how and why appellant's activities at work on December 23, 2015 caused or aggravated a particular diagnosed condition these additional reports lack probative value.¹³

In a May 26, 2016 report, Dr. Cubas noted that appellant injured his right knee and both elbows at work. He diagnosed right meniscus tear and epicondylitis of the bilateral elbows. Dr. Cubas responded "no" with regard to whether there were preexisting conditions, with regard to an exacerbation of a preexisting condition and with regard to whether there were other relevant comorbidities. In a separate report also dated May 26, 2016, Dr. Cubas noted that he examined appellant and diagnosed: medial epicondylitis of the right elbow; sprain of other specified parts of the right knee; subsequent encounter, stable and improved; and medial epicondylitis of the left elbow, worsening. He repeated his light-duty restrictions. However, Dr. Cubas did not offer an opinion on causal relationship. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is 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.¹⁴ The Board thus finds that these reports of Dr. Cubas lack probative value on the issue of causal relationship.

¹⁰ See *L.B.*, Docket No. 18-0533 (issued August 27, 2018); *D.K.*, Docket No. 17-1549 (issued July 6, 2018).

¹¹ See *Thomas Petrylak*, 39 ECAB 276, 281 (1987).

¹² See *A.M.*, Docket No. 10-205 (issued October 5, 2010) (a physician's opinion must be independent from a claimant's belief regarding causal relationship).

¹³ See *George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of diminished probative value).

¹⁴ *D.E.*, 58 ECAB 448 (2007); *G.G.*, 58 ECAB 389 (2007); *L.D.*, 58 ECAB 344 (2007); *A.D.*, 58 ECAB 149 (2006).

In subsequent reports, Dr. Cubas diagnosed: right knee meniscus tear; right elbow epicondylitis, medial; and left elbow epicondylitis, medial. However, while he noted that appellant attributed his condition to his activities at work, he again did not offer an opinion that the diagnosed conditions were causally related to his employment activities.¹⁵

The Board has held that the mere fact that a condition manifests itself during a period of employment does not raise an inference that there is causal relationship between the two.¹⁶ Neither the fact that the condition became apparent during a period of employment nor the belief that the condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.¹⁷

As the evidence of record does not contain rationalized medical evidence explaining how and why appellant's employment duties caused or aggravated a medical condition involving his right knee and or elbows, appellant has not met his burden of proof to establish an injury causally related to the accepted factors of his federal employment.

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 not met his burden of proof to establish that his right knee and bilateral elbow conditions are causally related to the accepted factors of his federal employment.

¹⁵ See *supra* note 10.

¹⁶ See *Joe T. Williams*, 44 ECAB 518, 521 (1993).

¹⁷ *Id.*

ORDER

IT IS HEREBY ORDERED THAT the June 9, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 6, 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