United States Department of Labor
Employees' Compensation Appeals Board

S.T., Appellant	)	
and	)	**Docket No. 17-1292**
	)	**Issued: February 8, 2018**
DEPARTMENT OF HOMELAND SECURITY, FEDERAL AIR MARSHAL SERVICE, East Elmhurst, NY, Employer	)	

Appearances:
Benjamin R. Zimmermann, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On May 24, 2017 appellant, through counsel, filed a timely appeal from a May 4, 2017 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 this case.[3]

[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.*

[3] Together with his appeal request, appellant submitted a timely request for oral argument pursuant to 20 C.F.R. § 501.5(b). By order dated November 2, 2017, the Board exercised its discretion and denied the request as appellant's arguments on appeal could be adequately addressed in a decision based on a review of the case as submitted on the record. *Order Denying Request for Oral Argument,* Docket No. 17-1292 (issued November 2, 2017).

ISSUE

The issue is whether appellant met his burden of proof to establish a left knee condition causally related to the accepted October 1, 2014 employment incident.

FACTUAL HISTORY

On October 1, 2014 appellant, then a 42-year-old federal air marshal, filed a traumatic injury claim (Form CA-1) alleging that he sustained an unspecified left knee condition, which allegedly occurred at 9:45 a.m. that day while using an elliptical machine in the employing establishment's gym. His left knee buckled and appellant immediately felt pain and discomfort. However, appellant did not stop working that day.

In an October 7, 2014 attending physician's report (Form CA-20) Dr. Bruce R. Ross, a Board-certified orthopedic surgeon, diagnosed left knee internal derangement. He indicated that the condition was employment related, having noted that appellant was on an elliptical machine at work when the injury occurred. Dr. Ross also reported that appellant had a similar left knee injury that was treated from October 2011 to May 2012.[4] He advised that appellant was totally disabled as of October 8, 2014.

On October 8, 2014 appellant stopped work and received continuation of pay. He submitted physical therapy reports dated October 29 and 31, 2014.

In a November 11, 2014 follow-up report (Form CA-20), Dr. Ross continued to diagnose employment-related left knee internal derangement. He also advised that appellant was unable to work until further notice.

In a second report dated November 11, 2014, Dr. Ross noted that appellant had chronic pain in the left knee and indicated that the knee had buckled and locked in place, as well. Appellant reportedly finished 12 sessions of physical therapy. Upon examination of the knee, Dr. Ross found an effusion, chronicity, and severe pain to palpation of the fibular head. He continued to diagnose internal derangement of the left knee and ruled out occult fibular head fracture. Dr. Ross requested additional physical therapy and continued to advise that appellant remained disabled and unemployable.

In a December 18, 2014 development letter, OWCP advised appellant of the deficiencies of his claim and afforded him 30 days to submit additional evidence and respond to its inquiries.

[4] In a September 29, 2011 report, Dr. Ross noted that appellant tripped on August 31, 2011 injuring his left knee. He found that x-rays of the left knee showed mild tri-compartmental degenerative changes and the impression was that of an internal derangement of the left knee versus sprain of the knee. A November 21, 2011 magnetic resonance imaging (MRI) scan of the left knee revealed nondisplaced fibular head fracture, areas of meniscal degeneration within the posterior horn of the medial meniscus, and anterior and posterior horns of the lateral meniscus, thickened lateral plica, and small effusion. In a January 26, 2012 report, Dr. Ross noted that appellant presented with left knee pain as a result of a work-related injury which occurred on August 31, 2011. He also noted that appellant was on an airplane when he tripped and injured his left knee. Dr. Ross diagnosed post-traumatic work-related injury to the left knee and pain refractory to conservative treatment.

In response, appellant submitted a December 26, 2014 narrative statement indicating that on October 1, 2014 he was assigned a 0900-1700 nonmission office day. He explained that, during office days, he was permitted to use the gym to work out and that is what he was doing when he was injured during regular workhours.

Appellant further submitted a December 2, 2014 report from Dr. Ross who indicated that appellant experienced left knee pain if he sat for more than 2 minutes and also reported that he could not stand for more than 10 minutes without the knee becoming painful laterally and posteriorly. Dr. Ross found marked pain over the lateral joint line and a positive McMurray's sign. He diagnosed a tear of the lateral meniscus as well as mild osteoarthritis and advised that appellant remained unemployable.

By decision dated January 21, 2015, OWCP accepted that the October 1, 2014 incident occurred as alleged, but denied appellant's claim because he failed to submit evidence containing a medical diagnosis in connection with the injury or events. Thus, it concluded that he had not established the medical component of fact of injury.

On January 20, 2016 counsel requested reconsideration. In support of the request, he submitted a September 1, 2015 report from Dr. Ross, who asserted that appellant had been under his care since September 29, 2011 for evaluation and treatment of a left knee injury. Dr. Ross noted that on September 29, 2011 appellant tripped on a plane and sustained injuries to his left knee. He further indicated that on October 8, 2014 appellant had returned to work and stated that he reinjured the left knee after the knee buckled. Dr. Ross explained that his initial impression was internal derangement of the knee with osteoarthritis. However, on May 20, 2015, appellant had an MRI scan of the left knee, which indicated a new partial tear of the mid substance of the anterior cruciate ligament. Dr. Ross reported that on June 30, 2015 appellant continued to have pain and instability of the left knee. The knee was very unstable and buckled several times a day. Dr. Ross informed appellant that surgery would be a good choice. However, with the preexisting degenerative changes of the knee, appellant could be left with pain postoperatively. Dr. Ross reported that appellant conducted research on the surgery and decided that it was not an option for him. He opined that appellant's two work-related injuries were a direct cause of his left knee conditions. Dr. Ross advised that appellant was unable to participate in physical activities without significant possibility of the left knee buckling. Dr. Ross concluded that this was a permanent injury and noted that appellant's osteoarthritis would increase over time.

In a note dated October 8, 2014, Dr. Ross indicated that appellant had reported that his left knee was buckling while working. His chief complaints were pain, swelling, and instability. Appellant stated that in 2011, he had an injury to the left knee and at that time an MRI scan had shown a nondisplaced fibular head fracture with meniscal degeneration. No surgery was conducted at that time. Dr. Ross diagnosed "[t]ear lateral meniscus posterior horn with mild osteoarthritis knee."

A May 20, 2015 MRI scan of the left knee demonstrated areas of meniscal degeneration again identified within the posterior horn of the medial meniscus as well as the anterior and posterior horns of the lateral meniscus, new partial tear of the mid substance of the anterior cruciate ligament, and joint effusion. There was no evidence of meniscal tear. Slightly, thickened medial plica now identified.

In an affidavit dated January 20, 2016, appellant stated that on October 1, 2014 his left knee buckled while he was using the elliptical machine in the second floor office gym and he felt immediate pain and discomfort in his left knee. At the time of the incident, he stated that he was a federal employee who was required to meet qualifying medical and physical fitness standards each quarter and he had been regularly engaged in a physical fitness training program since starting his employment in January 2002. Appellant reiterated that he was injured on an elliptical machine that was purchased by the employing establishment and located inside the office gym which he used during office training days.

By decision dated August 16, 2016, OWCP accepted that the October 1, 2014 employment incident occurred as alleged, but denied the claim because the medical evidence of record failed to establish causal relationship between appellant's diagnosed conditions and the October 1, 2014 work incident.

On September 12, 2016 counsel requested reconsideration and submitted a February 3, 2016 report from Dr. Ross who noted that appellant had related to him that his knee buckled, reinjuring his left knee on October 1, 2014 while exercising on an elliptical machine while he was trying to strengthen the knee and diminish the instability that was occurring. Dr. Ross opined that appellant's previous injury on August 31, 2011 resulted in a nondisplaced fibular head fracture and anterior cruciate ligament (ACL) sprain that was responsible for the weakened knee joint allowing further injury to enter as a result of the instability. He noted the fact that the initial injury had taken place three years earlier led him to believe that there was a partial tear at the time, which left the ligament in a weakened state allowing subsequent buckling incidents to occur years later. Dr. Ross further opined that the fact that the 2014 incident was described as buckling was significant due to the fact that such a description was often made with injuries by appellant to the ACL which was already in a debilitated condition. He concluded that appellant's conditions were work related.

By decision dated November 23, 2016, OWCP denied modification of its prior decision.

On February 6, 2017 counsel requested reconsideration and submitted an undated report from Dr. Ross who explained that a left knee MRI scan showed a new partial tear of appellant's ACL, an injury which was not previously present. He indicated that appellant's history of his knee buckling on October 1, 2014 resulting in pain and swelling, his unsuccessful attempt at physical therapy, and his MRI scan showing this new injury was a classic presentation and history of an acute ACL tear. Dr. Ross further indicated that the mechanism of injury was also classic in that the physical activity appellant was engaged in at work on October 1, 2014 created a downward force and impact load that caused the new ACL tear, as well as the resulting pain, swelling, and failed course of physical therapy. He noted that in his prior reports he had indicated that the ACL may have had a small tear from a prior injury, but the MRI scan findings made clear that the injury suffered on October 1, 2014 was an entirely new injury resulting in a tear that was not present on appellant's prior MRI scans. Dr. Ross diagnosed acute ACL tear and noted that his only point in addressing the prior injury was that it made appellant's knee susceptible to the tear that occurred on October 1, 2014, which was directly related to the work activities appellant was performing that day.

In a May 4, 2017 statement, the employing establishment confirmed that appellant was required to participate in a health, fitness, and wellness program as part of his federal duties and

that he was exercising in the gym located in the approved New York Field Office fitness center during regular workhours when the injury occurred.

By decision dated May 4, 2017, OWCP denied modification of its prior decision.

LEGAL PRECEDENT

A claimant seeking benefits under FECA[5] 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.[6]

To determine whether 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.[7] The second component is whether the employment incident caused a personal injury.[8] 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.[9]

Causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue.[10] A physician's opinion on whether there is causal relationship between the diagnosed condition and the implicated employment factor(s) must be based on a complete factual and medical background.[11] 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).[12]

In any case where a preexisting condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation, acceleration, or precipitation, the physician must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.[13]

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[5] *See supra* note 2.

[6] 20 C.F.R. § 10.115(e), (f); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996).

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

[8] *John J. Carlone*, 41 ECAB 354 (1989).

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

[10] *Robert G. Morris*, 48 ECAB 238 (1996).

[11] *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[12] *Id.*

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013).

While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence and to see that justice is done.[14]

ANALYSIS

OWCP accepted that the October 1, 2014 employment incident occurred as alleged, and also accepted that there was a medical diagnosis in connection with the employment incident. However, it denied appellant's traumatic injury claim finding that the medical evidence of record was insufficient to establish causal relationship between the diagnosed condition(s) and the accepted employment incident. The issue, therefore, is whether appellant's left knee condition resulted from the October 1, 2014 employment incident. Counsel argues that the claim should be accepted for left knee acute ACL tear.

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

In his reports of record, Dr. Ross initially diagnosed lateral meniscus tear and mild osteoarthritis of the left knee. His later reports noted that appellant had related to him that his knee buckled, reinjuring his left knee on October 1, 2014 while he was exercising on an elliptical machine, trying to strengthen the knee and diminish instability. Dr. Ross opined that a previous work injury on August 31, 2011, where appellant had tripped on a plane, resulted in a nondisplaced fibular head fracture and ACL sprain that was responsible for the weakened knee joint allowing further injury to occur as a result of the instability. He indicated the fact that the initial injury had taken place three years earlier led him to believe that there was a partial tear at the time, which left the ligament in a weakened state allowing subsequent buckling incidents to occur years later. Dr. Ross further explained that the fact that the 2014 incident was described as "buckling" was significant due to the fact that such a description was often made by patients who had ACL injuries. He indicated that appellant's history of his knee buckling on October 1, 2014 resulting in pain and swelling, his unsuccessful attempt at physical therapy, and his MRI scan showing this new injury was a classic presentation and history of an acute ACL tear.

Dr. Ross further indicated that the mechanism of injury was classic in that the physical activity appellant was engaged in at work on October 1, 2014 created a downward force and impact load that caused the new ACL tear, pain, swelling, and failed course of physical therapy. He found that MRI scan findings made clear that the injury suffered on October 1, 2014 was an entirely new injury resulting in a tear that was not presented on appellant's prior MRI scans. Dr. Ross opined that appellant's left knee conditions were causally related to the October 1, 2014 elliptical incident at work.

The Board finds that the medical reports by Dr. Ross, which were submitted into the record, provide sufficient medical rationale explaining how the accepted employment incident caused or contributed to the manifestation of the new ACL tear, which resulted in pain and swelling. The reports of Dr. Ross strongly suggest and support a relationship between the accepted October 1, 2014 employment incident on the elliptical exercise machine and the new

[14] *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *Jimmy A. Hammons*, 51 ECAB 219 (1999); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

left knee ACL tear.[15] He provided significant rationale to explain how the described "buckling" injury had evidenced an ACL injury at the time of the incident and that the physical activity appellant was engaged in at work on October 1, 2014 created a downward force and impact load that caused the new ACL tear. While the reports by Dr. Ross are not completely rationalized, they are consistent in indicating that appellant sustained a new ACL tear due to the accepted incident and they are not contradicted by any substantial or factual evidence of record.[16]

It is well established that proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter.[17] While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence and to see that justice is done.[18] Thus, the Board will remand the case to OWCP for further development to obtain a rationalized medical opinion as to whether appellant's condition is causally related to the accepted employment incident and issue a *de novo* decision on whether he sustained an injury causally related to the accepted October 1, 2014 employment incident, as alleged.[19]

CONCLUSION

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

[15] *See L.F.*, Docket No. 14-1906 (issued August 13, 2015) (the Board determined that while reports by a claimant's treating physician were not completely rationalized to establish a work-related injury they strongly supported a relationship between the employment incident and diagnosed condition and remanded the case for OWCP to further develop the medical evidence).

[16] *See C.T.*, Docket No. 17-0593 (issued December 15, 2017); *E.J.*, Docket No. 09-1481 (issued February 19, 2010). *Richard E. Simpson*, 55 ECAB 490, 500 (2004); *John J. Carlone*, 41 ECAB 354, 360 (1989).

[17] *See Vanessa Young*, 56 ECAB 575 (2004).

[18] *Supra* note 14.

[19] *Supra* note 13 at Chapter 2.805.5 (January 2013).

ORDER

IT IS HEREBY ORDERED THAT the May 4, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for further action consistent with this decision of the Board.

Issued: February 8, 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