

ISSUE

The issue is whether appellant has established that her claim should be expanded to include aggravation of preexisting internal derangement of her right knee and aggravation of preexisting moderate degenerative joint disease of her right knee causally related to her January 29, 2016 employment injury.

On appeal counsel asserts that the medical evidence submitted is sufficient to warrant expansion of the claim to include additional right knee conditions or, in the alternative, to find a conflict in medical evidence between Dr. Teofilo A. Dauhajre, an attending Board-certified orthopedic surgeon, and Dr. Arnold T. Berman, an OWCP medical adviser who is also Board-certified in orthopedic surgery.³

FACTUAL HISTORY

On January 29, 2016 appellant, then a 62-year-old secretary/office assistant, filed a traumatic injury claim (Form CA-1) alleging that she injured her right foot and knee on that date when she slipped on wet ground at Building 7 of the employing establishment. She stopped work on the date of injury.

In a report dated January 29, 2016, Dr. B.W. Yang, an employing establishment physician, noted a history that appellant slipped and fell on a wet ramp, landing on her right side and striking her right knee, leg, and foot. Clinical findings included right lower leg and right knee abrasions and ecchymosis with tenderness to touch and difficulty with weight-bearing. Dr. Yang advised that appellant could not work. A right tibia and fibula x-ray performed that day showed no acute abnormality. Right foot x-rays demonstrated fracture deformities of the third and fourth metatarsals. A right knee x-ray demonstrated mild-to-moderate degenerative changes in the medial tibiofemoral and patellofemoral joints.

In a February 16, 2016 report, Dr. Dauhajre noted seeing appellant the previous day. He reported a history that appellant injured her right knee, leg, foot, and ankle while going down a wet ramp at work on January 29, 2016. Dr. Dauhajre indicated that appellant had previously injured her right knee when she fell on July 31, 2004.⁴ Appellant also had a right knee magnetic resonance imaging (MRI) scan and a left knee arthroscopy in 2013. Dr. Dauhajre described the x-ray findings and appellant's complaint of right knee and right foot pain. Right knee examination revealed full range of motion, scant effusion, stable collateral ligaments, and negative drawer, Lachman, and pivot-shift signs with diffuse medial joint line tenderness, no lateral joint line tenderness, good patellar tracking, no patellofemoral grind, no evidence of plica, and a negative apprehension sign. Right leg examination demonstrated ecchymoses, and right foot examination revealed tenderness over the third and fourth toes. Dr. Dauhajre diagnosed contusion to the right knee and proximal right leg, ecchymoses of right leg, aggravation of

³ Counsel specifically indicated that appellant was not seeking expansion to include right foot conditions.

⁴ The record indicates that appellant has an accepted July 31, 2004 employment injury, adjudicated by OWCP under File No. xxxxxx755. That claim is not presently before the Board. The instant claim was adjudicated by OWCP under File No. xxxxxx028.

preexisting internal derangement of right knee, preexisting moderate degenerative joint disease of right knee, and contusion/sprain of right distal forefoot and third and fourth toes. He found that appellant was totally disabled from work. A February 22, 2016 right foot x-ray showed no fracture.

In other reports dated February 26 to March 11, 2016, Dr. Dauhajre reiterated his findings and conclusions. He additionally diagnosed healing, nondisplaced fracture of the second, third, and fourth metatarsal necks of the right foot and advised that appellant continued to be totally disabled from work.

By letter dated March 28, 2016, OWCP informed appellant of the type of evidence needed to support her claim. It specifically noted that she had a separate claim for a right foot injury that occurred on January 22, 2016, adjudicated under File No. xxxxxx226 and inquired whether these were two separate injuries. OWCP advised appellant to submit a detailed and well-rationalized medical report explaining how the claimed conditions resulted from the alleged January 29, 2016 employment incident.

In an April 11, 2016 statement, appellant indicated that the January 29, 2016 injury alleged in the present claim (File No. xxxxxx028) was a new injury when she broke three toes.

On April 11, 2016 Dr. Dauhajre noted that appellant continued to complain of residual, intermittent medial joint line pain and stiffness of the right knee with recurrent giving out, and resolving right foot pain. He reviewed an October 3, 2013 right knee MRI scan, indicating that it showed degenerative changes at the medial compartment, with an occult plateau fracture of unknown age, a medial meniscal tear, joint effusion, edema, chondromalacia patella, and an occult hairline fracture of the proximal fibula. Physical examination of the right foot revealed mild residual swelling of the distal forefoot and toes. Right knee examination demonstrated similar findings to those seen on previous examinations. Dr. Dauhajre reiterated his diagnoses and conclusion that appellant continued to be totally disabled from work.

On May 6, 2016 OWCP accepted the present claim, assigned File No. xxxxxx028, for right knee, right lower leg, and right foot contusions, right foot sprain, and nondisplaced fractures of the second, third, and fourth metatarsal bones of the right foot. By separate May 6, 2016 decision, it denied that the January 29, 2016 injury caused dislocation of tarsometatarsal joints of the right and left foot or aggravation of preexisting internal derangement of right knee and preexisting moderate degenerative joint disease of right knee.

On May 23, 2016 appellant, through counsel, requested a hearing with OWCP's Branch of Hearings and Review. She thereafter filed claims for compensation (CA-7 forms) for periods of disability beginning March 15, 2016.⁵ OWCP paid appellant wage-loss compensation for the claimed periods.

Appellant provided the October 3, 2013 right knee MRI scan report which noted degenerative changes, medial meniscus tear, joint effusions, edema, chondromalacia patella, and

⁵ The employing establishment indicated that appellant received continuation of pay for the period January 30 to March 14, 2016.

an occult hairline fracture at the proximal fibula. A June 13, 2016 right knee MRI scan showed advanced degenerative disease in the medial femorotibial compartment with tears of the posterior horn, essentially complete absence of the body, an inferior surface tear at the anterior horn body junction, a lax anterior cruciate ligament, advanced degenerative disease in the patellofemoral compartment, and edema anterior to the patella and patellar tendon.

Appellant returned to modified duty on July 18, 2016.

In reports dated through June 6, 2016, Dr. Dauhajre described appellant's condition. On July 5, 2016 he noted the June 13, 2016 MRI scan findings and additionally diagnosed internal derangement of the right knee. Dr. Dauhajre advised that appellant's clinical examination and the MRI scan supported a probable tear of the right medial meniscus. On August 1 and September 12, 2016 he noted appellant's continued complaints of residual right knee pain associated with recurrent giving out, and effusions. Examination findings remained the same. Dr. Dauhajre reiterated his diagnoses and requested authorization for diagnostic arthroscopic surgery.

During the hearing, held on September 27, 2016, appellant testified regarding the circumstances of the January 22 and 29, 2016 employment injuries. She explained that, since her fall on January 29, 2016, her right knee pain had increased with locking and that she now walked with a cane.

In correspondence dated October 4, 2016, OWCP denied authorization for right knee arthroscopic surgery.

Dr. Dauhajre submitted an October 15, 2016 report in which he described appellant's care from her first visit on February 15, 2016 to September 12, 2016.⁶ He opined, with a reasonable degree of medical certainty, that appellant sustained residual permanency to the right foot and additional permanency to the right knee that was causally related to the January 29, 2016 work injury. Dr. Dauhajre noted continued complaints of residual intermittent right distal forefoot pain with residual mild swelling and slight tenderness of the fourth metatarsal shaft. Regarding the right knee, he advised that the contusion appellant sustained on January 29, 2016 resulted in aggravation of her preexistent internal derangement and aggravation of her preexistent moderate degenerative joint disease. Dr. Dauhajre described residual subjective complaints of frequent deep-seated right knee pain, associated with recurrent giving out and recurrent right knee effusions. He described right knee findings of residual moderate medial joint line tenderness midbody and posteriorly, which supported a clinical diagnosis of a probable tear of the medial menisci, noting that the June 13, 2016 MRI scan showed a complex tear of the posterior mid horn of the medial meniscus, with dislocation into the joint and slight laxity of the anterior cruciate ligament, residual medial marginal osteophytes, and moderate-to-advanced degenerative changes of the patellofemoral joint. Dr. Dauhajre opined that appellant's current right knee condition was 30 percent causally related to the January 29, 2016 employment injury and 70 percent causally related to her preexistent right knee condition, and this made her more susceptible to experience her current symptoms. He advised that appellant's prognosis for the January 29, 2016 right foot and right knee injuries were guarded. Dr. Dauhajre recommended a

⁶ Dr. Dauhajre incorporated his treatment notes into the October 15, 2016 report.

diagnostic operative arthroscopy of the right knee to trim away the complex tear of the posterior horn of the medial meniscus, and concluded that appellant would require total joint arthroplasty of the right knee in the future. In a treatment note dated October 24, 2016, he reiterated his findings and conclusions.

By decision dated December 6, 2016, an OWCP hearing representative affirmed the May 6, 2016 decision, finding that the medical evidence of record did not contain a sufficient explanation to establish that the claim should be expanded.

On December 29, 2016 appellant, through counsel, requested reconsideration and provided a December 19, 2016 report from Dr. Dauhajre. Dr. Dauhajre advised that, as an addendum to his October 15, 2016 report, he had telephoned appellant to discuss the exact mechanism of injury. Appellant related that the January 29, 2016 employment injury occurred when she slipped and fell, landing her right knee directly onto the concrete pavement. Dr. Dauhajre opined that a direct contusion to the right knee could result in a direct impact to the right knee in a flexed position and subsequent twisting motion at the time of injury could result in a tear of the menisci of the knee. He concluded that, with a reasonable degree of medical probability, the complex tear of the posterior mid horn of the medial meniscus, noted by the June 13, 2016 right knee MRI scan, was a result of the direct impact to the right knee when appellant fell on concrete pavement on January 29, 2016, causing a twisting motion of the right knee in a flexed position.

Dr. Dauhajre also submitted treatment notes dated December 12, 2016 and January 20, 2017 in which he noted knee examination findings of mild effusion and joint line tenderness. He reiterated his diagnoses and indicated that he was awaiting approval for arthroscopic surgery.

On February 1, 2017 OWCP referred the medical record and statement of accepted facts (SOAF) to Dr. Berman, its medical adviser, for review. Dr. Berman was specifically asked to comment on whether the complex tear of the posterior mid horn of the medial meniscus was a consequence of the January 29, 2016 employment injury and whether the requested surgery was medically necessary for and causally related to the complex tear. He was also asked to discuss any disagreement with Dr. Dauhajre's opinion.

In a February 14, 2017 report, Dr. Berman noted his review of the SOAF and medical record, including the October 3, 2013 and June 13, 2016 MRI scans. He opined that the January 29, 2016 employment injury was not competent to produce a medial meniscus tear or degenerative arthritis. Dr. Berman explained that a "complex tear" meant that it was degenerative in nature and, in this instance, there was irrefutable evidence of it being degenerative because the nature of appellant's right knee arthritic disease as found in the medial and lateral compartments and patellofemoral articulation. He referenced the October 3, 2013 MRI scan, noting that it showed degenerative medial compartment changes. The MRI indicated that the meniscus tear was preexisting and degenerative in nature as it was performed almost three years before the January 29, 2016 work injury. Dr. Berman commented that, while appellant fell directly on her right knee and had a contusion, a direct impact was not a mechanism of injury to cause a meniscal tear, but was the mechanism to cause a contusion superimposed on degenerative changes, adding that her direct fall impact was contrary to having a torsional injury.

Dr. Berman noted that the June 13, 2016 MRI scan, five months after the work injury, showed continued degeneration that would be expected from the natural progression of the advanced degenerative changes seen three years previously, and that the marked abnormalities of the medial meniscus were all of a degenerative nature. He opined that appellant would not benefit from an arthroscopic medial meniscectomy as the meniscal changes were severely degenerative and, clinically, her condition would not be improved by arthroscopy. Dr. Berman indicated that, while appellant would ultimately need total knee replacement, this was not work related and was rather due to her degenerative disease, which was very well documented three years before the January 29, 2016 work injury. He commented that natural progression over the three years was expected with the normal natural history of degenerative changes.

Dr. Berman advised that, for these reasons, diagnostic and operative arthroscopy should not be approved because it would not represent a therapeutic measure for appellant who would not benefit from the procedure, because even if the procedure was done, her pain would persist, and there would be no improvement as a result of the procedure. He concluded that, based upon current orthopedic knowledge and within a reasonable degree of medical certainty, appellant did not develop a complex tear of the posterior and midportion of the medial meniscus as a result of the January 29, 2016 work injury and that the requested surgery should not be approved.

In a March 24, 2017 decision, OWCP denied modification of its prior decisions. It found Dr. Dauhajre's opinion insufficient to establish that appellant's knee conditions were caused by the January 29, 2016 employment injury, noting that Dr. Dauhajre did not reference a twisting motion until his December 19, 2016 report when he advised that this could result in a tear.

LEGAL PRECEDENT

An employee has the burden of proof to establish that any specific condition for which compensation is claimed is causally related to the employment injury.⁷ Causal relationship is a medical issue, and the medical evidence required to establish causal relationship is rationalized medical evidence.⁸ 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 employee.⁹ Neither the mere fact that a disease or condition manifests itself during a period of employment, nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.¹⁰

⁷ *Kenneth R. Love*, 50 ECAB 276 (1999).

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

⁹ *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

¹⁰ *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish that additional right knee conditions were caused or aggravated by the accepted January 29, 2016 employment injury. OWCP accepted right knee, right lower leg, and right foot contusions, right foot sprain, and nondisplaced fractures of the second, third, and fourth metatarsal bones of the right foot. It did not accept aggravation of preexisting internal derangement of right knee and preexisting moderate degenerative joint disease of right knee.

The opinion of a physician supporting causal relationship must be based on a complete factual and medical background, supported by affirmative evidence, must address the specific factual and medical evidence of record, and must provide medical rationale explaining the nature of the relationship between the diagnosed condition and the established incident or factor of employment.¹¹ No physician did so in this case.

The relevant medical record includes numerous reports from Dr. Dauhajre, an attending orthopedic surgeon, who began treating appellant on February 15, 2016. In a February 16, 2016 report, Dr. Dauhajre noted that appellant injured her right knee, leg, foot, and ankle while going down a wet ramp at work on January 29, 2016. He also reported that she had previously injured her right knee when she fell on July 31, 2004. Dr. Dauhajre noted findings and diagnosed contusion to the right knee and proximal right leg, ecchymoses of right leg, aggravation of preexisting internal derangement of right knee and preexisting moderate degenerative joint disease of right knee, and contusion/sprain of right distal forefoot and third and fourth toes. In subsequent treatment notes through June 6, 2016, he reported similar complaints and described similar examination findings. On July 5, 2016 Dr. Dauhajre noted the June 13, 2016 MRI scan findings and additionally diagnosed internal derangement of the right knee, advising that appellant's clinical examination and the MRI scan supported a probable tear of the right medial meniscus. In subsequent reports, he noted appellant's complaints of right knee pain with locking and give-way and provided similar examination findings. Dr. Dauhajre, however, did not explain how the January 29, 2016 fall caused an aggravation of appellant's previous degenerative right knee condition or a newly diagnosed internal derangement in any of the preceding reports.

In his October 15, 2016 report, after noting the June 13, 2016 MRI scan results and describing appellant's complaints and findings, Dr. Dauhajre merely concluded that appellant's right knee condition was partially caused by the January 29, 2016 employment injury with a specific explanation of the mechanics of the injury. It was not until December 19, 2016, almost 11 months after the employment injury, that he provided a mechanism of injury by explaining that a direct contusion to the right knee could result in a direct impact to the right knee in a flexed position and subsequent twisting motion at the time of injury and could result in a tear of the menisci of the knee. Dr. Dauhajre concluded that, with a reasonable degree of medical probability, the complex tear of the posterior mid horn of the medial meniscus, noted by the June 13, 2016 right knee MRI scan, was a result of the direct impact to the right knee when appellant fell on concrete pavement on January 29, 2016, causing a twisting motion of the right knee in a flexed position.

¹¹ *Robert Broome*, 55 ECAB 339 (2004).

The Board finds Dr. Dauhajre's opinion contains insufficient rationale to meet appellant's burden of proof. The December 19, 2016 report was couched in equivocal terms. Moreover, Dr. Dauhajre did not previously mention a twisting injury in any of his reports that began in February 2016 and did not discuss how appellant's preexisting right knee degenerative conditions had progressed beyond what might be expected from the natural progression of degeneration.¹²

While the medical opinion of a physician supporting causal relationship does not have to reduce the cause or etiology of a disease or condition to an absolute certainty, neither can such opinion be speculative or equivocal. The opinion of a physician supporting causal relationship must be one of reasonable medical certainty that the condition for which compensation is claimed is causally related to federal employment and such relationship must be supported with affirmative evidence, explained by medical rationale and be based upon a complete and accurate medical and factual background of the claimant.¹³ A well-rationalized opinion is particularly warranted in this case due to appellant's history of preexisting conditions.¹⁴

Other medical evidence provided by appellant, including x-rays and MRI scans, did not address whether the January 29, 2016 work injury caused or aggravated the claimed conditions. The Board has held that 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.¹⁵ Thus, this evidence is of limited probative value and insufficient to establish that additional conditions are causally related to the January 29, 2016 employment injury.

The medical record was also reviewed by Dr. Berman, an OWCP medical adviser. In his February 14, 2017 report, Dr. Berman discussed the medical evidence of record, including the MRI scan findings, noting that appellant exhibited degenerative right knee changes in October 2013, almost three years prior to the January 29, 2016 employment injury. He opined that the changes seen on the June 13, 2016 MRI scan were also degenerative in nature, showing a natural progression of appellant's right knee degenerative joint disease. Dr. Berman further noted that the contemporaneous medical evidence did not indicate that appellant sustained a torsional injury, and advised that arthroscopic surgery would not benefit appellant, indicating that at some point she would need knee replacement surgery but that this was due to degenerative pathology and was not employment related.

To establish causal relationship, a claimant must submit a physician's report in which the physician reviews the employment factors identified as causing the claimed condition and, taking these factors into consideration as well as findings upon examination, states whether the employment injury caused or aggravated the diagnosed conditions and presents medical rationale in support of his or her opinion.¹⁶ Rationalized medical evidence is evidence which relates a

¹² *R.E.*, Docket No. 14-868 (issued September 24, 2014).

¹³ *Patricia J. Glenn*, 58 ECAB 159 (2001).

¹⁴ *K.P.*, Docket No. 14-1330 (issued October 17, 2014).

¹⁵ *Willie M. Miller*, 53 ECAB 697 (2002).

¹⁶ *D.E.*, 58 ECAB 448 (2007).

work incident or factors of employment to a claimant's condition, with stated reasons of a physician. The opinion must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship of the diagnosed condition and the specific employment factors or employment injury.¹⁷ The Board finds that appellant has not submitted sufficient rationalized medical evidence supporting causal relationship between the January 29, 2016 employment injury and any of the claimed additional right knee conditions.

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 her burden of proof to establish additional right knee conditions causally related to the January 29, 2016 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated March 24, 2017 and December 6, 2016 are affirmed.

Issued: January 10, 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

¹⁷ *C.O.*, Docket No. 10-189 (issued July 15, 2010).