

May 4, 2005. On May 10, 2005 Dr. Gary S. Ulrich, an osteopath and appellant's attending physician, performed a chondroplasty of the patellofemoral, medial femoral condyle and lateral femoral condyle and a lateral release.

In a report dated August 2, 2005, Dr. Robert J. Burkle, a Board-certified orthopedic surgeon and Office referral physician, noted that appellant was unable to straighten her left knee. He opined that the employment injury aggravated her left knee degenerative arthritis. Dr. Burkle found that appellant could not resume her usual employment but could work in a sedentary capacity. He related, "I would not recommend a total knee until standing x-rays shows bone on bone, in other words, no joint space."

On September 1, 2005 Dr. Ulrich asserted that appellant's work injury "exacerbated a condition of osteoarthritis in her affected left knee. This required meniscal surgery and chondroplasty and she has had progressive deterioration of her knee since that time. The direct trauma of the injury is involved in her symptom complex and therefore her treatment recommendations." Dr. Ulrich found that appellant required a "knee arthroplasty to alleviate her pain and improve function and activity level." On September 23, 2005 he opined that appellant was "severely limited in her activity" and that her "best treatment is to have the knee arthroplasty...."

On September 20, 2005 the Office determined that a conflict existed between Dr. Ulrich and Dr. Burkle regarding the extent of appellant's work injury and disability, whether she sustained a medial meniscus tear due to her March 11, 2005 work injury and whether she required surgical intervention. The Office referred her to Dr. Arthur Lorber, a Board-certified orthopedic surgeon, for resolution of the conflict.

On November 21, 2005 Dr. E. Michael Keating, a Board-certified orthopedic surgeon, diagnosed patellofemoral knee pain probably due to osteoarthritis and chondroplasties. He noted that her chondroplasty was "probably causing as much trouble as anything since not all chondroplasties are successful." Dr. Keating recommended a total knee replacement.

Dr. Lorber provided a report on February 6, 2006. He related that he had previously examined appellant in May 1988 for an insurance company in connection with an injury to her left knee she sustained while working at the Pillsbury Company. The Office found that he was unable to act as an impartial medical examiner as he had previously examined appellant. On March 31, 2006 the Office referred her to Dr. Otto W. Wickstrom, Jr., a Board-certified orthopedic surgeon, for an impartial medical examination. In a report dated April 24, 2006, Dr. Wickstrom diagnosed knee joint arthritis preexisting her employment injury and opined that appellant did not have a meniscal tear based on the arthroscopic findings. He noted that a March 11, 2005 magnetic resonance imaging (MRI) scan study found inferior surface cartilage tears but that Dr. Ulrich did not remove any cartilage during the arthroscopy. Dr. Wickstrom asserted that the tears were degenerative in nature and of no clinical significance. On physical examination, he found lateral displacement of the right and left patella and Grade 3 and 4 chondromalacia of the right knee with no effusion or loss of movement or stability. On the left side Dr. Wickstrom found mild effusion, minimal chondromalacia and limited range of motion. He indicated that it seemed practical that appellant's bumping of the left knee could cause

“tricompartamental osteoarthritic changes that Dr. Ulrich addressed in his operative note.”¹ Dr. Wickstrom found that appellant was “heading for a total joint replacement.” He asserted that she had no residuals of her March 11, 2005 work injury.

On May 1, 2006 the Office noted that Dr. Wickstrom did not appear to include an aggravation of arthritis as an accepted condition and requested that he address whether the aggravation was temporary or permanent and whether appellant had any residuals of the aggravation. The Office further noted that Dr. Wickstrom had evaluated appellant to determine the need for a total knee replacement but had not addressed the need for surgery and its relationship to the March 11, 2005 employment injury. In a supplemental report dated May 10, 2006, Dr. Wickstrom opined that appellant no longer had an aggravation of her left knee osteoarthritis due to her employment injury. He agreed with Dr. Lorber and Dr. Burkle that “the need for a total knee joint replacement was not caused by her work[-]related accident.” Dr. Wickstrom stated, “I feel that ‘aggravation’ no longer exists. It is progressive osteoarthritis that is causing her problems. I feel she will need the total knee joint replacement if she continues to fail to improve from physical therapy.”

By decision dated May 24, 2006, the Office denied appellant’s request for surgical authorization for a total knee replacement.² The Office noted that it had accepted that she sustained a left medial meniscal tear but that the May 10, 2005 arthroscopy did not reveal a tear.

On May 25, 2006, the Office notified appellant that Dr. Wickstrom’s opinion created a conflict regarding whether she had any residuals of her accepted employment injury. The Office referred her to Dr. Mark O. Hansen, a Board-certified orthopedic surgeon, for resolution of the conflict.

On June 21, 2006 appellant requested an oral hearing on the denial of surgical authorization. On July 27, 2006 the Office accepted that she sustained cervicalgia as a consequential injury.

In a July 12, 2006 report, Dr. Hansen noted that as there was no meniscal tear found by arthroscopy it should not be an accepted condition. He stated:

“I believe that the residuals of the March 11, 2005 work injury continue with respect to the fact that her preexisting degenerative changes were likely aggravated to a degree. It is difficult for me to assess how much aggravation is from the initial injury versus aggravation from her arthroscopic procedure. It is not uncommon for arthroscopic chondroplasties to end up causing additional pain rather than resolving the pain as intended. It is therefore difficult for me to assess how much aggravation she is currently having as a result of her injury versus her surgery.”

¹ It appears from the context of the report that Dr. Wickstrom meant that it seemed impractical rather than practical that the arthritis could result from the work injury.

² Appellant returned to work with restrictions on April 1, 2006.

Dr. Hansen opined that appellant would “ultimately need a knee replacement...” He listed permanent work restrictions.³

On October 12, 2006 the Office expanded acceptance of appellant’s claim to include left shoulder tendinitis and a right shoulder rotator cuff sprain.

Following a March 7, 2007 hearing, in a decision dated May 21, 2007, a hearing representative set aside the May 10, 2005 decision. The hearing representative noted that, based on Dr. Hansen’s report, the Office had accepted an ongoing aggravation of osteoarthritis. The hearing representative instructed the Office to revise the statement of accepted facts to state that the May 10, 2005 surgery was authorized, that any impairment from the surgery was compensable and that the Office has accepted an ongoing aggravation. He further noted that the Office had not determined whether appellant sustained a knee injury while working for the Pillsbury Company.⁴ The hearing representative instructed the Office to obtain a supplemental report from Dr. Wickstrom regarding whether the left knee replacement should be authorized.⁵

On August 9, 2007 the Office requested that Dr. Wickstrom provide a rationalized report regarding whether appellant required a total knee replacement due to her accepted ongoing aggravation of left knee osteoarthritis or residuals from the May 10, 2005 surgery. The Office provided Dr. Wickstrom with an updated statement of accepted facts.

In an August 14, 2007 supplemental report, Dr. Wickstrom discussed a March 21, 2005 report from Dr. George Myo, an orthopedic surgeon,⁶ who diagnosed a tender, swollen left knee with soft tissue damage and a possible medial meniscal tear or loose body. Dr. Myo ordered an MRI scan study of the left knee. Dr. Wickstrom stated, “At this point I can see no indication that structural damage occurred to the joint which could lead to degeneration significant enough to warrant a total knee joint replacement.” He reviewed March 14, 2005 x-ray findings and stated, “It is readily apparent she has moderate degenerative changes involving her left knee. This leads to indication for total knee joint replacement as time passes and further degeneration occurs. The injury of March 11, 2005 did not cause these findings. They obviously have been present for some consideration period of time before the incident occurred at work.” Dr. Wickstrom diagnosed tricompartmental degenerative joint disease based on the May 10, 2005 operative report. He asserted:

“I read Dr. Ulrich’s operative report of May 10, 2005. He noted ‘[G]rade [3] osteochondral lesion’ of the patella. Similarly, to no surprise, the medial femoral condyle has the same defect. Because, the rough patella wears on the rough

³ In supplemental reports dated November 6 and December 5, 2006, Dr. Hansen clarified appellant’s work restrictions.

⁴ By letter dated June 18, 2007, appellant related that she did not remember if she injured her knee working for Pillsbury in 1988.

⁵ The hearing representative referred to Dr. Keating as a second opinion physician; however, it does not appear that he evaluated appellant at the request of the Office.

⁶ The report from Dr. Myo is dated March 18, 2005.

femur and each becomes rougher. This is the aging process that leads to the need for total joint replacement. He also reports [G]rade [3] osteochondral lesions of the lateral femoral condyle.

“At this point I detect tricompartmental degenerative joint disorder exists. No surgeon expects much improvement from this condition. It is my experience that operating on this by scope methods will not solve the problem. The smoothing out of the fibrillated cartilage may give some relief. This does not hasten deterioration of the joint. However, while osteoarthritis exists only worsening of the joint will occur as time passes.”

Dr. Wickstrom maintained that his opinion was unaltered after further review of the case file, including the reports of Drs. Burkle and Lorber. He noted that Dr. Lorber found that appellant had a left knee injury prior to March 11, 2005 and knee problems dating back to 1988. Dr. Wickstrom concluded, “Life gives us many insults to our musculoskeletal system. Micro-trauma occurs daily. Fortunately, we generally heal but as age progresses osteoarthritis takes over and we are destined to have joint problems. Such is the case with degenerative joint disorder.”

By decision dated September 19, 2007, the Office denied appellant’s request for authorization for a total knee replacement. The Office found that Dr. Wickstrom determined that she required a total knee replacement due to preexisting degenerative joint arthritis.

LEGAL PRECEDENT

Section 8103 of the Federal Employees’ Compensation Act⁷ provides that the United States shall furnish to an employee who is injured while in the performance of duty, the services, appliances and supplies prescribed or recommended by a qualified physician, which the Office considers likely to cure, give relief, reduce the degree of the period of disability or aid in lessening the amount of monthly compensation.⁸ In interpreting this section of the Act, the Board has recognized that the Office has broad discretion in approving services provided under section 8103, with the only limitation on the Office’s authority being that of reasonableness.⁹ Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment or actions taken which are contrary to both logic and probable deductions from established facts. It is not enough to merely show that the evidence could be construed so as to produce a contrary factual conclusion.¹⁰ In order to be entitled to reimbursement for medical expenses, a claimant must establish that the expenditures were incurred for treatment of the effects of an employment-related injury.¹¹

⁷ 5 U.S.C. §§ 8101-8193.

⁸ 5 U.S.C. § 8103; *see Thomas W. Stevens*, 50 ECAB 288 (1999).

⁹ *Joseph P. Hofmann*, 57 ECAB 456 (2006); *James R. Bell*, 52 ECAB 414 (2001).

¹⁰ *Claudia L. Yantis*, 48 ECAB 495 (1997).

¹¹ *Cathy B. Mullin*, 51 ECAB 331 (2000).

Proof of causal relationship in a case such as this must include supporting rationalized medical evidence. Thus, in order for a surgery to be authorized, appellant must submit evidence to show that the requested procedure is for a condition causally related to the employment injury and that it is medically warranted. Both of these criteria must be met in order for the Office to authorize payment.¹²

Section 8123(a) provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.¹³ The implementing regulations states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an Office medical adviser, the Office shall appoint a third physician to make an examination. This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.¹⁴

When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.¹⁵

ANALYSIS

The Office accepted that appellant sustained a left knee effusion, a torn left medial meniscus and an aggravation of left knee degenerative arthritis due to a March 24, 2005 employment injury. Appellant underwent arthroscopic surgery on May 10, 2005. The Office determined that a conflict in opinion existed between Dr. Ulrich, appellant's attending physician, and Dr. Burkle, an Office referral physician, regarding whether she required a total knee replacement due to her March 24, 2005 employment injury.

The Office initially referred appellant to Dr. Lorber for resolution of the conflict in opinion; however, it found that he could not provide an opinion as the impartial medical examiner as he had previously examined her on behalf of an insurance company. It then referred her to Dr. Wickstrom for an impartial medical examination.

In situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.¹⁶ In a report dated April 24, 2006,

¹² *Id.*

¹³ 5 U.S.C. § 8123(a).

¹⁴ 20 C.F.R. § 10.321.

¹⁵ *David W. Pickett*, 54 ECAB 272 (2002); *Barry Neutuch*, 54 ECAB 313 (2003).

¹⁶ *Id.*

Dr. Wickstrom diagnosed knee joint arthritis which he found preexisted her employment injury. On examination, he found “long[-]standing patella problems” and lateral displacement of the right and left patella. Dr. Wickstrom found Grade 3 and 4 chondromalacia of the right knee and minimal chondromalacia of the left knee. He further measured limited motion of the left knee. Dr. Wickstrom opined that appellant had no residuals of her March 11, 2005 employment injury. He clarified in a supplemental opinion dated May 10, 2006 that she had no further employment-related aggravation of her left knee osteoarthritis. Subsequent to his report, the Office found that appellant continued to experience an aggravation of osteoarthritis. The Office requested that Dr. Wickstrom address whether appellant required surgery due to her continuing aggravation of osteoarthritis or residuals of the May 10, 2005 authorized surgery. He again reviewed the medical evidence, including the x-ray reports and operative report. Dr. Wickstrom noted that an x-ray dated March 14, 2005 showed degenerative changes. He asserted that the worsening over time of the moderate degenerative changes of the left knee would result in the need for a total knee replacement “as time passes and further degeneration occurs. The injury of March 11, 2005 did not cause these findings.” Dr. Wickstrom found that the May 10, 2005 operative report showed Grade 3 osteochondral lesions of the patella, medial femoral condyle and lateral femoral condyle. He opined that the osteochondral lesions of the patella and medial femoral condyle would worsen over time because the “rough patella wears on the rough femur and each becomes rougher.” Dr. Wickstrom diagnosed tricompartmental degenerative joint disorder based on the operative report. He maintained that the operation usually did not cure the condition but also “did not hasten deterioration of the joint.” Dr. Wickstrom attributed the continued degeneration of the osteoarthritis which would ultimately result in the need for a total knee replacement to the passage of time. He reviewed the relevant medical evidence, provided detailed findings on examination and reached conclusions about appellant’s condition which comported with his findings.¹⁷ As Dr. Wickstrom’s report is detailed, well rationalized and based on a proper factual background, his opinion is entitled to the special weight accorded an impartial medical examiner.¹⁸ The Office therefore did not abuse its discretion under section 8103 in finding that appellant did not require a total left knee replacement due to her accepted employment injury.

On appeal, appellant’s attorney contends that Dr. Wickstrom improperly relied upon the opinion of Dr. Lorber in reaching his conclusions. He asserts that Dr. Lorber’s opinion should be excluded from the record. The Office’s procedure manual provides the instances in which medical evidence will be excluded. These include when the physician selected for referee examination is regularly involved in performing fitness-for-duty examinations for the claimant’s employing agency; when a second referee specialist’s report is requested before the Office has attempted to clarify the original referee specialist’s report; when a medical report is obtained through telephone contact; and when leading questions have been posed to the physician in either a second opinion or referee context. The procedure manual notes that the excluded report need not be physically removed from the file.¹⁹ The Board’s case law draws a distinction between

¹⁷ *Manuel Gill*, 52 ECAB 282 (2001).

¹⁸ *See M.B.*, 58 ECAB ____ (Docket No. 07-413, issued July 5, 2007).

¹⁹ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.6 (September 1995).

those situations in which the Office may have influenced the opinion of the impartial medical specialist from circumstances in which the evidence establishes that the medical report obtained is defective for other procedural reasons.²⁰

Dr. Lorber's report does not fall within the categories of impartial reports which should be excluded from the record. There is no evidence that he performed fitness-for-duty examinations for the employing establishment, that the Office had previously requested an impartial report and failed to seek clarification before seeking his opinion, that his report was obtained through telephone contact or that the Office improperly utilized leading questions. The Office was thus not required to exclude Dr. Lorber's report from the record.

Appellant's attorney further asserts that Dr. Wickstrom erred in finding that the early medical reports showed a minor injury in view of the fact that an MRI scan study showed a large effusion of the knee. He, however, reviewed the entire record and reached conclusions based on his interpretation of the evidence. The Office has broad discretion in approving services under section 8103 with the only limitation being that of reasonableness.²¹ It is not enough to merely show that the evidence could be construed so as to produce a contrary factual conclusion.²²

Appellant's attorney also contends that the Office should accord weight to the opinion of Dr. Hansen on the issue of surgical authorization. Dr. Hansen, however, was selected to resolve a conflict on the issue of whether she had continuing residuals of her work injury rather than the need for surgery. Appellant also questions why Dr. Keating was not considered a referee physician. It does not appear from the record, however, that the Office referred appellant to Dr. Keating for an examination.²³

CONCLUSION

The Board finds that the Office properly denied appellant's request for authorization of a total knee replacement.

²⁰ *Beverly Grimes*, 54 ECAB 543 (2003); *Terrance R. Stath*, 45 ECAB 412, 421 (1994) (in procedural instances, the medical report is not excluded from the record, but is not accorded special weight).

²¹ See *Joseph P. Hoffman*, *supra* note 9.

²² See *Claudia L. Yantis*, *supra* note 10.

²³ The hearing representative referred to Dr. Keating as an Office referral physician.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 19, 2007 is affirmed.

Issued: July 1, 2008
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board