United States Department of Labor
Employees' Compensation Appeals Board

TIFFANY F. COLLINS, Appellant	)	
and	)	**Docket No. 04-1787**
	)	**Issued: November 22, 2004**
DEPARTMENT OF THE INTERIOR, BUREAU OF LAND MANAGEMENT, Vale, OR, Employer	)	

Appearances:
Tiffany F. Collins, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member

JURISDICTION

On July 6, 2004 appellant timely filed an appeal from an April 30, 2004 merit decision by the Office of Workers' Compensation Programs, which denied her request for modification of its February 13, 2004 decision. In the February 13, 2003 decision, the Office denied appellant's request for an autologous cartilage implantation on her left knee on the grounds that the medical evidence of record did not establish that the surgery was medically necessary for her accepted employment injury. The Board has jurisdiction over the merits of this case pursuant to 20 C.F.R. §§ 501.2(c) and 501.3.

ISSUE

The issue is whether the Office properly denied appellant's request for surgery on her left knee.

FACTUAL HISTORY

On April 27, 2000 appellant, then a 29-year-old firefighter, was climbing over a gate when she landed and twisted her left knee and felt the knee pop. She filed a claim for a traumatic injury. The Office accepted the claim for left anterior cruciate ligament (ACL) strain.

In a May 3, 2000 report, Dr. John Gambino, a Board-certified radiologist, stated that a magnetic resonance imaging (MRI) scan showed a complete disruption of the ACL graft in appellant's left knee. In a May 5, 2000 report, Dr. Randolph E. Peterson, a Board-certified orthopedic surgeon, stated that she stepped over a fence and put her foot in some dirt. She hit a berm and slipped off, twisting her left knee. Dr. Peterson reported that an MRI scan showed a possible ACL tear but no menisci tears. He noted that appellant had an ACL reconstruction in 1993 and subsequently returned to full activity.

On June 28, 2000 appellant stepped out of a truck into a hole and twisted her left knee again. She filed another claim for a traumatic injury.[1] In a July 3, 2000 report, Dr. Frederick Oyer, a Board-certified radiologist, stated that an MRI scan showed evidence of bone edema involving the proximal tibia. He reported that there was no evidence of a functioning ACL graft, but that appellant's posterior cruciate and collateral ligaments were intact as were the menisci. In a July 5, 2000 report, Dr. Peterson noted that appellant had a brace on when she stepped off the truck and had a valgus injury. In reviewing her objective findings, Dr. Peterson indicated that a repeat MRI scan showed that the ACL was highly attenuated. He related that the radiologist concluded that appellant had an absent ACL. Finally, Dr. Peterson commented that the MRI scan did not show any evidence of injury to the medial or lateral collateral ligament or medial or lateral meniscus.

In a December 7, 2000 report, Dr. James M. Johnson, a Board-certified orthopedic surgeon, described appellant's October 23, 2000 surgery, wherein he performed a left knee ACL allograft, with patellar tendon reconstruction as well as debridement and microfracture to correct a Grade 4 defect in the femoral condyle. He also performed autologous cartilage harvest for potential autologous cartilage regrowth. Dr. Johnson noted that, in examining the knee, the lateral tibiofemoral joint was normal with an intact lateral meniscus. He indicated that the medial tibiofemoral joint revealed evidence of a previous partial meniscectomy. Dr. Johnson's postoperative diagnoses were a left knee ACL rupture with previous ACL reconstruction and erosion of bone tunnels and a Grade 4 medial femoral condylar chondromalacia.

In a January 26, 2001 report, Dr. Johnson stated that appellant was able to return to light duty and should be able to return to full duty, including her duties as a firefighter in approximately three months. He noted that complications which might affect her potential return to full duty included an area of fairly severe articular damage. Dr. Johnson indicated that, if the area became painful with increasing activity, he might have to consider a very aggressive, very complicated treatment of autologous cartilage implantation. He commented that, if that operation was performed, appellant would probably miss a further six months from full duty.

[1] The Office doubled the case record for these two injuries. The record is unclear as to whether any other left knee condition was accepted as a result of the June 2000 injury.

In a March 9, 2001 letter, Dr. Johnson requested authorization for the proposed surgery of open knee arthrotomy with autologous cultured chondrocyte implantation. He noted that the procedure had been approved by the Federal Drug Administration (FDA). Dr. Johnson pointed out that alternative procedures had an 80 percent failure rate. In a March 14, 2001 memorandum, the Office medical adviser stated that the operation was experimental surgical therapy. He indicated that he could not recommend authorization for the requested procedure.

In an April 11, 2001 report, Dr. Johnson indicated that he was returning appellant to full activities. He stated that, if appellant had increasing pain during the fire fighting season and became unable to perform those duties, he would plan early autologous cartilage implantation.

In an October 16, 2001 report, Dr. Johnson noted that appellant was able to fight forest fires throughout the fire season. He indicated, however, that as the season progressed, she had increasing medial left knee pain and occasional swelling and currently felt restricted in activities. Review of appellant's x-rays showed a Grade 1 femoral condylar defect with some stellate extensions. Dr. Johnson reported that she had been informed of all the risks of an anterior cartilage implantation and wished to proceed with it.

In a November 20, 2001 memorandum, a second Office medical adviser stated that it was not likely that the articular defect of the medial femoral condyle was related specifically to the ACL injury. She commented that it would most likely be related to prior trauma, near in time and subsequent to the medial meniscus injury which was not work related. In evaluating the proposed surgery, the second Office medical adviser noted that autologous cartilage implantation was a potential treatment for cartilage damage in the knee joint, but added that the clinical efficiency was not proven and the long-term side effects, consequences and safety were not known. She concluded that the procedure was not the standard of care and that the treatment was not medically necessary or warranted.

In a November 27, 2001 letter, the Office stated that the operative procedure of antilogous cartilage implantation was not authorized, based on the conclusions of the Office medical adviser. The Office indicated that appellant would be referred to another physician for a second opinion.

In a January 16, 2002 report, Dr. Johnson noted that the Office medical adviser denied coverage because she believed that the efficiency of antilogous cartilage implantation was not proven. Dr. Johnson stated that many sources, including 10-year follow-up studies, showed that the procedure was an effective, proven, Federal Drug Administration (FDA) approved procedure. He pointed out that in his report on the October 23, 2000 operation he had stated that the Grade 4 articular defect of the medial femoral condyle appeared to be acute. Dr. Johnson commented that this wording would not have been used in a seven-year-old or progressive-type articular defect arising from a medial meniscectomy. He concluded that appellant's articular defect was directly related to her employment injuries in 2000. Dr. Johnson added that he and three other orthopedic surgeons in his area performed autologous cartilage implantation and therefore had become the community standard of care.

The Office referred appellant to Dr. Charles P. Schneider, a Board-certified orthopedic surgeon, for a second opinion. In a January 9, 2002 report, he noted that she complained of pain

on the medial side of the left knee with prolonged walking or standing. Dr. Schneider indicated that appellant's range of motion was good but she had soreness when she was up for any length of time. On examination Dr. Schneidere noted crepitance over the medial femoral condyle when appellant's knee went through a range of motion, but good stability in the ACL in both knees. He diagnosed traumatic arthritis of the left knee with an osteochondral defect of the medial femoral condyle and status post revision of the ACL reconstruction. Dr. Schneider mentioned two concerns about the autologous cartilaginous implantation. He commented that the cartilaginous defect on the medial femoral condyle might be related predominately to appellant's prior medial meniscectomy and injury in 1993 because the injuries in 2000 seemed less likely to cause the osteochondral lesion. Finally, he concluded that there were no long-term studies that showed autologous cartilaginous implantation were curative and he could not say with any medical certainty that the procedure would postpone a knee arthroplasty in the future.

The Office sent a copy of Dr. Schneider's report to Dr. Johnson and requested his comments on the report. In an April 19, 2002 reply, Dr. Johnson noted that Dr. Schneider felt that appellant's cartilaginous defect might be due to the prior medial meniscectomy. Dr. Johnson indicated that Dr. Schneider's conclusion was possible but stated that there was no evidence to prove that fact and no articular cartilage defect was noted at that time. He commented that since appellant was fully active up to the time of her employment injury it was difficult to draw a time line for the presence of the articular defect. Dr Johnson also disagreed with Dr. Schneider's opinion that there was no long-term studies that showed autologous cartilaginous implantation was curative. He declared that there was possibly no better procedure for the type of defect appellant had. Dr. Johnson stated that the procedure showed a 93 percent success rate over 10 years in isolated femoral condyle defects. He indicated that there was no other procedure with such a success rate. In response to the statement that autologous cartilage implantation was experimental, Dr. Johnson pointed out that the procedure had been approved by the FDA. He stated that there was no other available procedure for appellant's knee.

The Office referred appellant, together with the statement of accepted facts and the case record, to Dr. George Nicola, a Board-certified orthopedic surgeon, to resolve the conflict in the medical evidence between Dr. Schneider and Dr. Johnson. In an October 17, 2002 report, Dr. Nicola indicated that appellant showed a full range of motion in both knees with no crepitus, pain or limitation. He commented that, both knee joints appeared to be stable, particularly the left knee showing good ACL stability. Dr. Nicola found parapatellar crepitus in both knees with increased crepitus on the left, particularly on the medial side. He noted that there was mildly warmth on the left knee. Dr. Nicola indicated that appellant was noted to have sustained a medial meniscus tear, which indicated that she had a medial joint injury to the left knee which resulted in her 1993 ACL reconstruction. He commented that the surgeon performed a medial meniscectomy at that time. Dr. Nicola stated that a medial meniscectomy could change the load characteristics of the medial compartment of the knee which would predispose her to develop the cartilaginous lesions.

Dr. Nicola indicated that appellant had undergone the microfracture technique which occasionally was very successful but was not successful for appellant. He recommended an arthroscopy, followed either by a mosaicplasty, which involved drilling small holes in the bone and placing plugs of appellant's cartilage into the holes to fill the defect or an autologous

cartilage implantation. Dr. Nicola stated that either procedure would be acceptable and would improve appellant's long-term outlook for her knee.

Dr. Nicola turned to the issue of whether the surgery was necessary for residuals of the 2000 employment injuries. He noted that appellant's MRI scan in May 2000 which did not show a bone bruise which would have suggested a recent bony or cartilaginous injury. Dr. Nicola commented that the MRI scan showed appellant had a prior medial meniscectomy in the 1993 surgery. He concluded that these facts would indicate that her osteochondral defect may have predated her April 2000 and June 2000 injuries. Dr. Nicola concluded that appellant should consider either another operation on her knee for diagnostic arthroscopy or autologous cartilage implantation. He related that Dr. Johnson, in his April 19, 2002 letter, had stated that the issue of causal relationship between the employment injuries and appellant's need for surgery could not be answered with certainty, but noted that she had an absence of symptoms between her arthroscopy and her 2000 injuries. Dr. Nicola, however, pointed out that there was no bone contusion on the May 2000 MRI scan that would suggest that the osteochondral defect was a recent injury.

The Office requested clarification from Dr. Nicola on whether appellant's left knee osteochondral defect was related to the 2000 traumatic injuries, with reference to objective findings that verified his opinion. In a December 31, 2002 response, he stated that appellant had a significant injury in 1990, when she "blew out her knee" while skiing and underwent surgery in 1993 for that condition. Dr. Nicola indicated that there may have been a cartilage injury at that time which manifested itself in April 2000 when appellant twisted her knee. Appellant reported a popping sound which Dr. Nicola interpreted as a flap of cartilage that was in the knee joint. He commented that at the time of appellant's initial patellar tendon allograft by Dr. Johnson, she was noted to have a Grade 4 osteochondral lesion which involved the medial femoral condyle with Grade 2 and Grade 3 changes on the undersurface of the patella. Dr. Nicola concluded that those conditions would not develop in the leg between the time appellant injured her knee and the time of her October 23, 2000 surgery, which suggested that those conditions predated appellant's April 30, 2000 injury.

In a February 23, 2003 decision, the Office denied appellant's request for authorization of the autologous cartilage implantation because the medical evidence of record did not establish that the surgery was medically necessary for appellant's accepted work injury.

Appellant requested reconsideration. In support of her request, she submitted an April 14, 1995 surgery report from Dr. Richard L. Romeyn, a Board-certified orthopedic surgeon. She noted that the physicians had consistently misstated the date of her prior injury due to skiing. Appellant pointed out that Dr. Romeyn indicated that the medial and lateral menisci were fully probed and visually inspected and found to be normal. He reported that the articular surface of the medial femoral condyle, the medial tibial plateau, lateral femoral condyle and the lateral tibial plateau were all essentially pristine. Dr. Romeyn noted that the patellofemoral articulation was without pathology and with no chondrosis on either the patella or the femoral trochear groove. He stated that the ACL still had fibers between the tibial and femoral points of insertion but was severely attenuated.

Appellant also submitted a February 25, 2003 report from Dr. Johnson, who indicated that she continued to have significant chronic medial knee aching with sharp lateral knee pain. He commented that the lateral pain was due to some patellar tightness. Dr. Johnson noted that the medial pain was at the area of appellant's articular defect on the femur. He repeated his conclusion that autologous cartilage implantation was indicated. In a June 9, 2003 note, Dr. Johnson indicated that appellant was one week postoperative of her autologous cartilage implantation.

The Office sent Dr Romeyn's report to Dr. Nicola and requested his comments. In an April 9, 2004 report, Dr. Nicola stated that appellant's Grade 4 osteochondral lesion involving the medial femoral condyle with Grade 2 and 3 changes on the underside of the patella predated her April 27, 2000 injury. He indicated that the Grade 2 and 3 chondromalacia would take longer than a few months to develop. Dr. Nicola stated that Grade 4 osteochondral lesion, which involved the removal of the entire cartilaginous surface, generally did not occur with a twisting injury without preexisting cartilaginous problems such as a flap. He repeated his conclusion that the popping appellant felt in both injuries were due to a flap that got caught in the joint with subsequent denuding of the bony surface. Dr. Nicola commented that a Grade 4 change would not happen over a few months, but should take many months or years to develop.

In an April 30, 2004 merit decision, the Office denied appellant's request for modification of its February 23, 2003 decision.

LEGAL PRECEDENT

Section 8103 of the Federal Employees' Compensation Act[2] 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 or the period of disability or aid in lessening the amount of the monthly compensation. 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.[3] 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.[4] 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.[5]

[2] 5 U.S.C. § 8103.

[3] *James R. Bell*, 52 ECAB 414 (2001).

[4] *Claudia L. Yantis*, 48 ECAB 495 (1997).

[5] *Cathy B. Mullin*, 51 ECAB 331 (2000).

It is well established that when a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background must be given special weight.[6]

ANALYSIS

The Office initially rejected appellant's request for authorization of the autologous cartilage implantation surgery based on the first Office medical adviser's statement that the procedure was experimental even though Dr. Johnson had stated that the surgical procedure had been approved by the FDA. He stated in his October 16, 2001 report that appellant had increased pain and x-rays showed a Grade 1 femoral condylar defect. The second Office medical adviser stated that autologous cartilage implantation was a potential treatment for cartilage damage in the knee joint, but commented that the clinical efficiency had not been proven and the long term side effects, consequences and safety were not known. She added that the procedure was not the standard of care. The Office medical adviser concluded that the treatment was not medically necessary. Dr. Johnson reported that many sources, including 10-year studies, showed that the procedure was effective. He also noted that he and three other orthopedic surgeons performed the procedure and, therefore, the procedure was the standard of care in his area. Dr. Schneider stated that there were no long-term studies showing that showed autologous cartilage implantation was curative. Dr. Johnson responded that the procedure had a 93 percent success rate over 10 years in isolated femoral condyle defects. He declared that no other surgical procedure had better long-term results. The Office properly determined that a conflict existed in the medical evidence as to whether the proposed knee surgery should be performed. Appellant was thereafter referred to Dr. Nicola, the impartial medical specialist. In several reports, he carefully reviewed the evidence of record as well as his own examination findings and concluded that appellant needed additional surgery and indicated that autologous cartilage implantation was one of the choices. Therefore, the weight of the medical evidence, represented by the reports of Dr. Nicola, establishes that autologous cartilage implantation was medically warranted.

The Office also referred appellant to Dr. Nicola, the impartial medical examiner to resolve the conflict between Dr. Johnson and Dr. Schneider as to whether the proposed surgery was in fact for an employment-related condition. The medical evidence of record establishes that appellant had knee injuries which preexisted the work injuries. It is well established that, when a factor of employment aggravates, accelerates or otherwise combines with a preexisting nonoccupational pathology, the employee is entitled to compensation.[7] The question was thus whether the work injuries caused directly or by aggravation, the diagnosed conditions which required surgery.

Dr. Nicola, in his first report, concluded that appellant had a medial meniscectomy at the time of her first knee operation due to a medial joint injury. He stated that her May 3, 2000 MRI scan did not show a bone bruise which would have suggested a recent bony or cartilaginous injury. Dr. Romeyn's report, as noted previously, indicated that, at the time of the 1995 surgery, the medial femoral condyle was pristine. When the Office gave Dr. Nicola an opportunity to

[6] *Gloria J. Godfrey*, 52 ECAB 486 (2001).

[7] *Chris Wells*, 52 ECAB 445 (2001).

comment on the 1995 surgical report, he stated that a Grade 4 osteochondral lesion would not happen over a few months but would take many months to years to develop. Dr. Nicola indicated that a Grade 4 osteochondral lesion, which involved the entire cartilaginous surface, generally did occur with a twisting injury without a preexisting problem such as a flap. He concluded that appellant had a flap which, in both of the employment injuries, was caught in the joint causing a popping sensation with subsequent denuding of the bony surface.

While Dr. Nicola concluded that the articular defect of the medial femoral condyle preexisted the 2000 employment injuries, his description of the mechanism of the injury suggests that the existence of the cartilaginous flap prior to the injuries would have been caught in the left knee joint at the time of each of the employment injuries. Furthermore he stated that appellant then had a subsequent denuding of the bony surface. Dr. Nicola's explanation suggests that the 2000 employment injuries caused an aggravation of the preexisting condition which resulted in further aggravating appellant's left knee condition. An employment-related aggravation of a preexisting condition constitutes an employment injury. If surgery is necessary to correct the effects of an aggravation of a preexisting condition, the surgery would be for the purpose of a condition causally related to an employment injury. The Office, however, when requesting that Dr. Nicola address the cause of the current medical condition did not advise him regarding the legal standards for causation: that aggravation of a prior condition can also establish causal relationship. The record does not indicate that the Office requested that Dr. Nicola address aggravation of the preexisting condition. The Office's failure to clarify this aspect of the case with the impartial medical specialist.

The case must be remanded to the Office for further development. The Office should determine whether the employment injuries of April and June 2000 caused an aggravation of a preexisting condition and resulted in further damage to articular lesion of the medial femoral condyle which had to be corrected by an autologous procedure, which Dr. Nicola indicated was an accepted procedure for the correction of appellant's condition. After further development as it may find necessary, the Office should issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for decision and must be remanded for further development, followed by a *de novo* decision.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 30, 2004 be set aside and the case remanded for further development as set forth in this decision.

Issued: November 22, 2004
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member