United States Department of Labor
Employees' Compensation Appeals Board

PATRICIA E. McNALLY, Appellant **and** **DEPARTMENT OF JUSTICE, FEDERAL CORRECTIONAL INSTITUTION, Danbury, CT, Employer**	)	**Docket No. 05-338** **Issued: May 5, 2005**

Appearances:
Katherine Smith, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
DAVID S. GERSON, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On November 23, 2004 appellant filed a timely appeal from the April 14, 2004 merit decision of the Office of Workers' Compensation Programs, which denied authorization for a total left knee replacement. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review this denial.

ISSUE

The issue is whether the Office properly denied authorization for appellant's total left knee replacement.

FACTUAL HISTORY

On June 23, 1992 appellant, then a 45-year-old counselor, sustained an injury in the performance of duty when she stepped into a rodent hole, twisted her left knee and fell. The Office accepted her claim for left knee and lumbar strains. Appellant received compensation for temporary total disability on the periodic rolls. The Office authorized an August 14, 1992 high

tibial osteotomy, left, for medial compartment osteoarthritis. The Office also authorized a follow-up procedure on July 23, 1993 to remove staples, to excise an overgrowth at the osteotomy site and to free the peroneal nerve from scar tissue.

On October 26, 2000 Dr. Ronald A. Ripps, appellant's attending physician and the Board-certified orthopedic surgeon, who performed her previous surgeries, requested authorization for a Zimmer NexGen knee replacement. On December 5, 2000 an Office medical adviser reported that he did not believe the surgery was indicated on the basis of appellant's June 23, 1992 injury. He noted that at the time of injury appellant had an underlying and already well-established osteoarthritis of the left knee and that there was no well-rationalized explanation of whether the injury in question caused a permanent aggravation or acceleration of this underlying condition.

The Office found a conflict in medical opinion and referred the case file, together with a statement of accepted facts, to Dr. Edward M. Staub, a Board-certified orthopedic surgeon, for an impartial medical opinion. On March 5, 2001 Dr. Staub explained that the tibial osteotomy would have been done only for a chronic degenerative condition, not for an acute injury. He stated that the June 23, 1992 injury aggravated this significant preexisting osteoarthritis condition and it was possible the injury aggravated her knee enough to warrant a diagnostic arthroscopic evaluation in August 1992. But he did not feel there should be any causation between the June 1992 injury and the high tibial osteotomy: "That procedure was not due to the June incident, but due to a preexisting degenerative arthritis." Dr. Staub acknowledged that appellant needed a knee replacement but stated it would be done because of her preexisting condition, not because of the June 1992 injury.

In a decision dated April 20, 2001, the Office denied authorization for a total left knee replacement, as the weight of the medical evidence, as represented by the opinion of Dr. Staub, indicated that the knee replacement was not associated with appellant's employment injury.

Appellant underwent a total left knee replacement on June 8, 2001.

On January 14, 2002 Dr. Ripps explained that there would have been no arthroscopy and no high tibial osteotomy absent the fall in June 1992. He stated that the only reason an arthroscopy was performed in August 1992 was to assure that the lateral compartment was sufficiently intact to withstand the biomechanical change that a high tibial osteotomy causes. To a reasonable degree of medical certainty, he stated, "had [appellant] not fallen down in 1992, she would not have required a total knee arthroscopy at this time and young age."

In a decision dated March 7, 2002, an Office hearing representative found that Dr. Staub was not an impartial medical specialist because there was no conflict at the time between Dr. Ripps and the Office medical adviser. He found that Dr. Staub was instead a second-opinion physician. Further, the hearing representative found that Dr. Staub's opinion on causal relationship and Dr. Ripp's later opinion were of approximately equal weight, thereby creating a conflict necessitating referral to an impartial medical specialist. The hearing representative set aside the Office's April 20, 2001 decision and remanded the case for further development.

On remand, the Office referred appellant, together with the case record and a statement of accepted facts, to Dr. Robert C. George, a Board-certified orthopedic surgeon, for an opinion on whether the June 23, 1992 injury aggravated her underlying condition and whether it caused or contributed to the need for the left total knee replacement on June 8, 2001. The Office provided Dr. George with an explanation of "temporary" versus "permanent" aggravation.

In a report dated April 17, 2002, Dr. George related appellant's history. Reviewing x-rays going back to 1992, he stated: "It is clear that at that time the patient had advanced osteoarthritis and if she had been significantly older, the most likely course would have been immediate total knee replacement." It was Dr. George's opinion that the 1992 episode clearly triggered a symptomatic period, but he saw no relationship between the injury and appellant's total knee replacement:

> "However, there is no question in my mind whatsoever that Dr. Staub's opinion is correct, that [appellant] had advanced osteoarthritis for years and it is inconceivable that the total knee replacement should relate back to the 1992 injury. It is a well[-]known fact that patients come in orthopedist's office with bone-on-bone osteoarthritis, *i.e.*, fully ready radiographically for total knee replacement and, when they are asked how long has the knee been bothering you?, the answer is often 5 to 6 months or slightly over a year. This is one of the mysteries of osteoarthritis, as long as patients are wearing congruently, *i.e.*, round peg, round hole, then it is astounding how well many of them will compensate for a significant length of time. Ultimately, there ought to be some trigger event, but often it is not definable. Here, in this case, we can clearly accept the trigger event as initiating a period of symptoms. However, the extent of the disease was so obvious that I think [appellant], given her young age, would have come to high tibial osteotomy sooner or later anyway and I think it was a foregone conclusion that she would eventually need total knee replacement on the left as well as the fact that she will clearly need it on the right in the foreseeable future. I believe that it was fairy generous in fact to support [appellant's] financially from a compensation point of view for her high tibial osteotomy, but I do not believe that there is any basis for supporting the total knee replacement as being [w]ork[ers]' [c]ompensation related."

In a decision dated May 17, 2002, the Office found that the weight of the medical evidence rested with Dr. George's April 17, 2002 report, which failed to establish that appellant's total knee replacement was necessitated by her 1992 employment injury. On February 13, 2003, however, an Office hearing representative set aside the Office's May 17, 2002 decision and remanded the case for clarification from Dr. George on whether the approved 1992 and 1993 surgeries accelerated the necessity of a total knee replacement. The hearing representative directed the Office to provide Dr. George with the definition of "acceleration" and "precipitation."

On March 12, 2003 Dr. George responded:

> "In answer to your letter of March 4, 2003, I do not believe the approved 1992 and 1993 surgeries accelerated and precipitated the necessity for a total knee

> replacement. The high tibial osteotomy was a 'buy time' procedure given [appellant's] relatively young age. She already had significant preexisting osteoarthritis and in fact she did relatively well after the high tibial osteotomy for some time. I, therefore, do not accept either the acceleration paragraph or the precipitation paragraph as being relevant in this case."

In a decision dated April 9, 2003, the Office denied authorization for the surgery performed on June 8, 2001 based on the weight of the medical evidence, which failed to support that surgery was warranted and necessitated by the 1992 employment injury.

In a decision dated April 14, 2004, an Office hearing representative affirmed, finding that Dr. George's opinion was of sufficient probative value to constitute the weight of the medical evidence and to resolve the conflict between Dr. Staub and Dr. Ripps.

LEGAL PRECEDENT

Medical expenses, along with transportation and other expenses incidental to securing medical care, are covered by section 8103 of the Federal Employees' Compensation Act. This section 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 Secretary of Labor considers likely to cure, give relief, reduce the degree of the period of any disability or aid in lessening the amount of any monthly compensation.[1]

The Board has recognized that the Office has broad discretion in approving services provided under section 8103 of the Act, with the only limitation on the Office's authority being that of reasonableness.[2]

ANALYSIS

This case comes to the Board from the Office's denial of authorization for appellant's June 8, 2001 total left knee replacement. The question for determination is whether the Office's denial was reasonable.

The Office denied authorization based on the opinion offered by Dr. George, a Board-certified orthopedic surgeon, selected to resolve a conflict in medical opinion.[3] The reasonableness of the Office's denial is, therefore, dependent on whether Dr. George's opinion can be accorded special weight in resolving the conflict.

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[1] 5 U.S.C. § 8103(a).

[2] *James R. Bell*, 52 ECAB 414 (2001); *Joe E. Williams*, 36 ECAB 494 (1985).

[3] The Office referral physician, Dr. Staub, reported that appellant's knee replacement was needed because of her preexisting condition, not because of the June 1992 injury. Her physician, Dr. Ripps, disagreed. He reported to a reasonable degree of medical certainty that, if appellant had not fallen down in 1992, she would not have required a total knee arthroscopy "at this time and young age."

Section 8123(a) of the Act provides in part: "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."[4] 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.[5]

When the Office referred appellant to Dr. George, it asked him to respond to the following: "Did the injury of June 23, 1992 aggravate the underlying condition? If so, please indicate whether it resulted in a temporary or permanent aggravation. If temporary, please state when the aggravation ceased or will cease. If permanent, please explain how this injury altered the course of the underlying condition with supporting objective findings." Dr. George indicated that the June 23, 1992 incident aggravated appellant's underlying osteoarthritis. He noted that she had advanced osteoarthritis at the time of the 1992 injury and that the 1992 episode "clearly triggered a symptomatic period" leading to evaluation and treatment: "Here, in this case, we can clearly accept the trigger event as initiating a period of symptoms." What Dr. George did not address was whether this injury-related aggravation or period of symptoms was temporary or permanent. He noted that appellant "apparently did fairly well" after the high tibial osteotomy on August 14, 1992, but he gave no indication that the aggravation ceased or that appellant returned to her preinjury status at any time prior to her June 8, 2001 total knee replacement.

This is a significant omission. It is uniformly held that an aggravation of a preexisting disease or defect is as compensable as an original or new injury.[6] Where a person has a preexisting condition that is not disabling but which becomes disabling because of an aggravation causally related to the employment, then regardless of the degree of such aggravation, the resulting disability is compensable. No attempt should be made to apportion the disability between the preexisting condition and the aggravation of that condition.[7]

If the June 23, 1992 incident aggravated appellant's preexisting and advanced osteoarthritis, triggering symptoms, evaluation and treatment, then the Office should accept her claim for an aggravation of preexisting left knee osteoarthritis and determine whether this aggravation was temporary or permanent. The Board finds that it was premature for the Office to deny authorization for a total knee replacement without first obtaining clarification on this issue. If the aggravation of appellant's osteoarthritis was temporary, leaving no residuals, then the Office may reasonably deny authorization for surgery. But if the aggravation was permanent, such that the condition for which surgery was warranted must be considered employment related, then the reasonableness of the Office's denial is no longer apparent.

[4] 5 U.S.C. § 8123(a).

[5] *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

[6] *Charles A. Duffy*, 6 ECAB 470, 471 (1954).

[7] *Henry Klaus*, 9 ECAB 333, 334 (1957) (when the record supports aggravation or acceleration of the underlying condition which precipitated disability, the resultant disability is compensable regardless of the precise quantum of such aggravation directly attributable to the work).

When the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting a defect in the original report. When the impartial medical specialist's statement of clarification or elaboration is not forthcoming or if the specialist is unable to clarify or elaborate on the original report or if the specialist's supplemental report is also vague, speculative or lacks rationale, the Office must submit the case record together with a detailed statement of accepted facts to a second impartial specialist for a rationalized medical opinion on the issue in question.[8] Unless this procedure is carried out by the Office, the intent of section 8123(a) of the Act will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.[9]

The Office has not previously requested clarification from Dr. George on whether the June 23, 1992 aggravation of appellant's preexisting left knee osteoarthritis was temporary or permanent.[10] The Board will, therefore, set aside the Office's April 14, 2004 decision and remand the case for a well-reasoned opinion from Dr. George on the duration of the aggravation and for an appropriate exercise of discretion by the Office on whether to authorize appellant's June 8, 2001 total left knee replacement.

CONCLUSION

The Board finds that the Office unreasonably denied authorization for appellant's total left knee replacement without first obtaining clarification from the impartial medical specialist on whether the injury-related aggravation of appellant's preexisting osteoarthritis was temporary or permanent.

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[8] *See Nathan L. Harrell*, 41 ECAB 402 (1990).

[9] *Harold Travis*, 30 ECAB 1071 (1979).

[10] At the direction of an Office hearing representative, the Office requested that Dr. George clarify whether the approved 1992 and 1993 surgeries accelerated the necessity of a total knee replacement. On March 12, 2003 he responded that the high tibial osteotomy was a "buy time" procedure, given appellant's relatively young age and that she did relatively well after the surgery for some time. The Board finds that this response is sufficiently well reasoned to establish that the authorized surgeries did not accelerate appellant's osteoarthritis condition.

ORDER

IT IS HEREBY ORDERED THAT the April 14, 2004 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: May 5, 2005
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

A. Peter Kanjorski
Alternate Member