United States Department of Labor
Employees' Compensation Appeals Board

F.A., Appellant	)	
and	)	**Docket No. 09-1049**
	)	**Issued: November 10, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Mobile, AL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 12, 2009 appellant filed a timely appeal of the Office of Workers' Compensation Programs' merit decision dated December 31, 2008. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has met his burden of proof in establishing that he required a right knee arthroplasty due to his accepted employment injury.

FACTUAL HISTORY

On November 22, 2006 appellant, then a 42-year-old letter carrier, filed an occupational disease claim for a right knee condition due to climbing stairs in the performance of duty on September 1, 2006.

Dr. Mark Goddard, a Board-certified radiologist, performed a magnetic resonance imaging (MRI) scan on October 13, 2006 which demonstrated a complex complete tear of the posterior horn of the medial meniscus with a small parameniscal cyst as well as patellar

contusion and chondromalacia along the medial patellar facet. Dr. Manuel P. Daugherty, Jr., a Board-certified orthopedic surgeon, performed a video arthroscopy of the right knee with partial medial meniscectomy on November 3, 2006.

By decision dated March 2, 2007, the Office denied appellant's claim for an employment-related injury. Appellant requested a review of the written record on March 3, 2007. By decision dated May 4, 2007, the Branch of Hearings and Review reversed the March 2, 2007 decision and accepted his claim for tear of the medial meniscus of the right knee.

In a report dated August 20, 2007, Dr. Daugherty found that appellant had moderate effusion of the right knee with course patellofemoral crepitus. He diagnosed pain in the right knee, chondromalacia patella and status postmedial meniscectomy of the right knee. On September 5, 2007 Dr. Daugherty diagnosed osteoarthritis of the right knee and found mild swelling with tenderness medially and laterally. In a note dated September 13, 2007, he again diagnosed osteoarthritis of the knees, right worse than the left.

On January 29, 2008 appellant requested authorization for right knee arthroplastic surgery. Dr. Daugherty examined appellant on May 9, 2008 and found audible patellofemoral crepitus in the right knee and weakness in appellant's right quadriceps. He diagnosed pain in the right knee and moderately severe osteoarthritis of the right knee. Dr. Daugherty made similar findings on June 10 and 17, 2008. He noted that x-rays confirmed medial compartment narrowing in the right knee and on June 17, 2008 stated that appellant wanted to consider undergoing a total knee replacement. Dr. Daugherty stated that he would consult with his colleagues regarding this proposal.

The Office requested that the district medical adviser consider appellant's request for a total knee arthroplasty. In a report dated August 5, 2008, the Office medical adviser denied his request finding that appellant did not submit a medical report with results of Dr. Daugherty's consultations with his colleagues. In a letter dated August 7, 2008, the Office requested that appellant submit additional evidence establishing that the total knee arthroplasty was medically necessary and causally related to his accepted employment injury. It allowed 30 days for a response.

On July 29, 2008 Dr. Daugherty stated that appellant was troubled by a severely degenerated right knee with severe patellofemoral crepitance in the right knee with mild quadriceps wasting and tenderness. He noted that appellant wanted to undergo the total knee arthroplasty because he was unable to take nonsteroidal anti-inflammatory drugs (NSAIDS) for pain. Dr. Daugherty stated that appellant had failed the injection regimen and "really there is nothing else to do, except the replacement…."

In a report dated September 2, 2008, Dr. Daugherty related appellant's course of treatment including the 2006 video arthroscopy with partial medial meniscectomy and injections of Visco supplementation. He noted that the time of appellant's video arthroscopy he "did not appear contrary to clinical impression, to have much in the way of articular cartilaginous damage." Dr. Daugherty noted that appellant was severely incapacitated by knee pain and unable to use NSAIDS and that appellant requested a total knee arthroplasty. He stated,

"[B]ecause of his significant difficulty he is having and really having no other alternatives, he felt this would be an avenue that he wanted to pursue." Dr. Daugherty opined that appellant had substantially increased pain following the partial meniscectomy as part of the stabilizing structure was removed. He stated that the increased pain and the inability to take appropriate medications were the reasons that the total knee arthroplasty was being considered.

In a letter dated September 8, 2008, the Office informed appellant that a second opinion evaluation was necessary to determine whether the proposed total knee arthroplasty was medically necessary and related to his accepted employment injury. Dr. Charlton Barnes, a Board-certified orthopedic surgeon, completed a second opinion evaluation on December 3, 2008. He noted appellant's history of injury and performed a physical examination finding that appellant had right knee flexion of 105 degrees and lacked 5 degrees of extension. Dr. Barnes noted that appellant had a markedly underdeveloped right thigh and numbness in his right calf in a glove-like distribution. He diagnosed chondromalacia of the patella which was work related. Dr. Barnes stated that appellant's employment injury had not resolved and recommended physical therapy. He opined:

> "Clinically, I do not feel he needs a total knee at this time. What he really needs is an arthroscopy to determine how severe damage inside his knee is. He may have fairly severe damage to his right patellar area and intercondylar notch and he might be justified in having an Avon procedure, but I do not see evidence of cartilaginous loss significant enough to do a unicompartmental or bicompartmental knee replacement. My overall impression is patient that is postmedial meniscectomy, right knee, with some limitation of full extension of his right knee and questionable chondromalacia of the right patellar intercondylar notch area."

By decision dated December 31, 2008, the Office denied appellant's request for right knee arthroplasty. It found that the weight of the medical opinion evidence rested with Dr. Barnes.

LEGAL PRECEDENT

Section 8103(a) of the Federal Employees' Compensation Act provides for the furnishing of services, appliances and supplies prescribed or recommended by a qualified physician which the Office, under authority delegated by the Secretary, considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation.[1] In interpreting section 8103(a), the Board has recognized that the Office has broad discretion in approving services provided under the Act to ensure that an employee recovers from his or her injury to the fullest extent possible in the shortest amount of time.[2] The

[1] 5 U.S.C. §§ 8101-8193, 8103(a).

[2] *R.L.*, 60 ECAB ___ (Docket No. 08-855, issued October 6, 2008); *Dale E. Jones*, 48 ECAB 648, 649 (1997).

Office has administrative discretion in choosing the means to achieve this goal and the only limitation on the Office's authority is that of reasonableness.[3]

While the Office is obligated to pay for treatment of employment-related conditions, appellant has the burden of establishing that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[4] Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[5] Therefore, in order to prove that the surgical procedure is warranted, appellant must submit evidence to show that the procedure was for a condition causally related to the employment injury and that the surgery was medically warranted. Both of these criteria must be met in order for the Office to authorize payment.[6]

ANALYSIS

The Board finds that the Office did not abuse its discretion in denying appellant's request for right knee arthroplasty. Although the requested procedure was deemed to be work related, appellant did not meet his burden to establish that it was medically warranted.

Appellant's attending physician, Dr. Daugherty, a Board-certified orthopedic surgeon, noted that appellant had a severely degenerated right knee with severe patellofemoral crepitance in the right knee with mild quadriceps wasting and tenderness. He noted that appellant's knee pain had increased following the partial meniscectomy and that appellant was unable to use NSAIDS to control his pain. However, Dr. Daugherty also noted that at the time of appellant's video arthroscopy the visual signs of articular cartilaginous damage did not correlate with appellant's clinical findings. His reports suggest that appellant requested the surgery and that appellant believed that the total knee replacement surgery was his best treatment option. Dr. Daugherty did not clearly offer an opinion that this surgery was medically warranted. His report states that the total knee arthroplasty was being considered not that he was recommending this course of treatment.

The medical evidence of record does not establish that the requested surgery is the best or only reasonable treatment available. Dr. Barnes, a Board-certified orthopedic surgeon, and Office second opinion physician, disagreed that a total knee replacement was currently appropriate for appellant. He recommended an arthroscopy to determine how severe his internal knee damage was and suggested that an Avon procedure might be appropriate. However, Dr. Barnes concluded that he did not see evidence of cartilaginous loss significant enough to do a unicompartmental or bicompartmental knee replacement.

[3] *Daniel J. Perea*, 42 ECAB 214, 221 (1990) (holding that abuse of discretion by the Office is generally shown through proof of manifest error, clearly unreasonable exercise of judgment or administrative actions which are contrary to both logic and probable deductions from established facts).

[4] *See Debra S. King*, 44 ECAB 203, 209 (1992).

[5] *Id.; see also Bertha L. Arnold*, 38 ECAB 282 (1986).

[6] *See Cathy B. Millin*, 51 ECAB 331, 333 (2000).

The only limitation on the Office's authority in approving, or disapproving, services under the Act is that of reasonableness. In the instant case, appellant requested authorization of a total knee arthroplasty. The Office obtained the opinions of a second-opinion examiner and consulted with its medical adviser to ascertain whether or not the proposed surgery was medically necessary. After considering all of the medical evidence of record, the Office concluded that authorization for the requested surgery should be denied. The Board finds that the Office's refusal to authorize the total knee arthroplasty was reasonable and did not constitute an abuse of discretion.[7] Appellant has not met his burden of showing that the proposed total knee arthroplasty was medically warranted.

CONCLUSION

The Board finds that the Office did not abuse its discretion in refusing to authorize appellant's request for total knee arthroplasty.

ORDER

IT IS HEREBY ORDERED THAT the December 31, 2008 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 10, 2009
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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

[7] *Daniel J. Perea, supra* note 3.