United States Department of Labor
Employees' Compensation Appeals Board

K.P., Appellant	)	
and	)	**Docket No. 12-302**
	)	**Issued: June 25, 2012**
DEPARTMENT OF AGRICULTURE, FOREST SERVICE, Albuquerque, NM, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
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 November 28, 2011 appellant, through his attorney, filed a timely appeal from the October 24, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP) denying his claim for work-related right knee arthrofibrosis and authorization of right knee arthroscopic surgery. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 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 met his burden of proof to establish work-related arthrofibrosis of his right knee or that a repeat arthroscopic surgery of his right knee should be authorized.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

OWCP accepted that on February 4, 2007 appellant, a 34-year-old social service assistant, sustained injury to his right knee due to an incident at work. On February 4, 2007 he was walking up stairs, slipped on salt used for winter weather and, while recovering his balance, felt pain in his right knee. Appellant did not fall to the ground. The claim was accepted for a torn medial meniscus of the right knee. OWCP authorized a May 9, 2007 right knee arthroscopy with medial shelf plica excision and minor synovectomy by Dr. Michael R. Magoline, an attending Board-certified orthopedic surgeon. It was later accepted that appellant sustained thrombosis of his right leg as a result of the authorized surgery. Appellant received wage-loss compensation for periods of disability.[2]

To determine the nature of appellant's work-related residuals and his need for further medical treatment, OWCP scheduled a second opinion examination. In an October 19, 2009 report, Dr. Manhal A. Ghanma, a Board-certified orthopedic surgeon, reviewed the medical evidence of record, listed a history of appellant's injury and detailed findings of his medical examination. Upon physical examination, the right knee range of motion was from 0 to 120 degrees of flexion, the right knee measured 38 centimeters and the left knee measured 39 centimeters. The right calf measured 35 centimeters, the left calf measured 34 centimeters, both thighs were equal at 42 centimeters and the knees were nine degrees of valgus bilaterally, with no evidence of popliteal cysts. Dr. Ghanma noted that there was no evidence of any discoloration or swelling of the right knee and no evidence of any localizing tenderness on examination. He reported there was no abnormality of gait, stance, balance or motor strength. Dr. Ghanma advised that there were no current findings to support evidence of the work-related right medial meniscus tear that was still active or causing objective symptoms. He stated that there were no residuals from appellant's work injury and that he could return to his date-of-injury job in a full-duty capacity. Dr. Ghanma advised that no additional medical treatment was necessary.

In an October 26, 2009 report, Dr. Magoline requested that OWCP authorize another arthroscopy of appellant's right knee due to persistent pain. Upon examination on the right knee, appellant had tenderness over the lateral retinaculum and crepitus with range of motion and that he also had mild pain anteriorly. Dr. Magoline diagnosed chondromalacia patella with patellofemoral mal tracking and possible painful scar tissue, *i.e.*, arthrofibrosis. He stated that the surgical plan would be to inspect the patellofemoral joint and to possibly perform a lateral release and resect scar tissue, as necessary.

On December 7, 2010 OWCP sent Dr. Ghanma's report to Dr. Magoline for his review and comments. On January 18, 2010 Dr. Magoline responded that he had read and reviewed Dr. Ghanma's report. He noted that, while there was no lymphadenopathy present, appellant continued to complain of right anterior knee pain with some peripatellar tenderness over both the lateral aspect and the medial aspect of the knee. Dr. Magoline felt that these findings were consistent with the existence of scar tissue in the right knee. He diagnosed status post right knee

[2] Appellant stopped work on February 4, 2007 and did not return to work.

arthroscopy with excision of medial shelf plica, ongoing on the right. Dr. Magoline again recommended a repeat arthroscopy of the right knee.

Due to the difference in medical opinion regarding the nature of appellant's medical condition and the need for surgery, OWCP found a conflict in medical opinion between Dr. Magoline and Dr. Ghanma. It referred appellant to Dr. Robert Kleinman, a Board-certified orthopedic surgeon, for an impartial medical examination.

Dr. Kleinman performed an impartial medical examination on February 23, 2010. In a March 1, 2010 report, he detailed his review of the case file and described appellant's medical history and findings on physical examination. Appellant did not exhibit right knee effusion, but there was positive crepitation with active range of motion of both knees which was painful on the right but not on the left. Dr. Kleinman noted free range of motion in the right hip, no varus or valgus instability and negative Lachman's, anterior drawer and McMurray's tests. He stated that appellant's thighs showed no difference in circumference, but that the right calf measured two centimeters larger in circumference compared to the left calf. There was minimal tenderness on palpation in the calf region and pain on palpation over the anteromedial joint line, anterolateral joint line and the medial and lateral parapatellar regions, medial greater than lateral. Dr. Kleinman stated that there was a positive patellar inhibition test, that appellant could perform 2/3 of a squat before it became too painful and that he could walk on his heels and toes. Appellant had 0 to 120 degrees active range of motion in his right knee and that, while doing a McMurray's test, he could get to 130 degrees. Dr. Kleinman diagnosed a right medial meniscus tear by history, thrombosis of the right lower extremity, chondromalacia of the right knee patella and medial plica by history.

Dr. Kleinman advised that the right knee torn medial meniscus and thrombosis of the right leg were work related, but that the other two diagnoses were not work related. He explained that, despite an initial magnetic resonance imaging (MRI) scan test that showed an abnormality in the medial meniscus, arthroscopic evaluation indicated that the medial meniscus was intact and the September 9, 2009 MRI scan showed that there was no evidence of internal derangement.[3] Dr. Kleinman found there was no further residual related to the medial meniscal tear and posited that appellant's symptoms did not appear related to the medial meniscus as he demonstrated minimal pain in the region of the posterior horn of the medial meniscus and had a negative McMurray's test. He noted that there were no objective findings to support residuals of the right lower extremity arthrosis as still being present and active. Appellant was capable of returning to his duties as a social service assistant with the limitation of no standing or walking for greater than two hours at a time and no greater than four hours in a shift. Dr. Kleinman noted this restriction was based strictly on the residual of the thrombosis. He stated that no further treatment was required for the allowed condition of the tear of the medial meniscus of the right knee and that the venous thrombosis could be treated with periodic elevation and the use of nonsteroidal anti-inflammatory medication. Dr. Kleinman stated that no surgical treatment was required for the allowed conditions in appellant's claim and that the proposed surgical treatment was directed at medical conditions that were not work related.

[3] Dr. Kleinman indicated that arthroscopic evaluation was the most accurate method of assessing a meniscal tear.

Dr. Kleinman's report was sent to Dr. Magoline on March 24, 2010 for review. On April 12, 2010 Dr. Magoline responded that appellant likely had parapatellar adhesions that were definitely related to his original surgery and that he required surgery for this condition. On May 17, 2010 he provided a further diagnosis of arthrofibrosis of the right knee and advised that this condition should be allowed in the claim due to the long-standing postoperative troubles appellant experienced with his right knee.

The reports of Dr. Magoline were sent to Dr. Kleinman for review and comment. Dr. Kleinman provided an addendum report dated June 16, 2010, stating that in his medical opinion, appellant did not have right knee arthrofibrosis. He noted that arthrofibrosis was typically a complication of either a knee injury or a surgical procedure on the knee leading to excessive scar tissue and painful loss of motion in that knee. Dr. Kleinman stated that during the February 23, 2010 physical examination appellant demonstrated actively 0 to 120 degrees of right knee motion and passively he could get appellant to 130 degrees of motion of the knee. These findings were inconsistent with the diagnosis of arthrofibrosis and he concluded there was insufficient objective medical evidence to support the diagnosis of arthrofibrosis.

Dr. Kleinman advised that appellant's current knee complaints were related to chondromalacia of the patellofemoral joint along with thinning of the retropatellar cartilage. He explained that the surgery performed on May 9, 2007 included a minor synovectomy and that a medial plica was resected. Dr. Magoline had noted a lateral tilt of the patella on radiographic studies, a radiographic finding which was often associated with chondromalacia patella and thought to be one of the possible causes of chondromalacia patella. He opined that, if scar tissue had formed from the synovectomy and excision of the medial plica, it would have resulted in scarring along the medial side of the patellofemoral joint and compressed the medial side of the patella. Such findings would be inconsistent with a lateral patellar tilt. Dr. Kleinman opined that this lateral tilt preexisted the injury and it was noted upon examination that both knees demonstrated crepitation with active flexion and extension, findings consistent with chondromalacia of the patella. He concluded that arthroscopic surgery to address adhesions in the right knee was not medically necessary and posited that there was no further treatment necessary for the allowed knee conditions related to the February 4, 2007 work injury.

In a November 16, 2010 decision, OWCP denied appellant's claim finding that he did not sustain work-related arthrofibrosis of his right knee or establish that repeat arthroscopic surgery of his right knee should be authorized. It found that the special weight of the medical opinion evidence rested with the impartial opinion of Dr. Kleinman.

Appellant requested a hearing with an OWCP hearing representative. During a telephone hearing held on March 15, 2011, counsel contended that the opinion of Dr. Kleinman was not sufficiently well rationalized to constitute the weight of the medical evidence. He argued that there was no conflict in medical opinion as to the existence of arthrofibrosis and, therefore, Dr. Magoline's opinion should be accepted.

In a May 4, 2011 decision, OWCP's hearing representative affirmed the November 16, 2010 decision. He found that the weight of the medical evidence with respect to appellant's claimed conditions and request for additional surgery was with the opinion of Dr. Kleinman.

In an August 3, 2011 report, Dr. Magoline stated that he had been following appellant with regards to his right knee for over a year. Appellant had a prior work-related injury to his right knee and underwent a right knee arthroscopy complicated by deep vein thrombosis and hemarthrosis within the right knee. He had persistent right knee pain since that time. Dr. Magoline stated that appellant suffered postoperative adhesions in his right knee related to his initial right knee surgery which occurred as a result of his work-related injury. He posited that appellant suffered complications postoperatively as a result of his right knee surgery which was performed due to his work-related injury and therefore it should be acceptable to be able to treat him for these complications. Dr. Magoline stated:

> "[Appellant] has failed all conservative management for this and the only thing that I can offer him at this point in time is a repeat arthroscopy of the right knee with lysis of adhesions and examination of his patellofemoral joint. I feel this is reasonable given the circumstances. It is my strong feeling that this should be also included in [appellant's] workers' compensation claim as these complications have occurred as a direct result of the surgery which was performed to address his work[-]related injury."

In an October 24, 2011 decision, OWCP affirmed its May 4, 2011 decision denying appellant's claim for work-related arthrofibrosis and additional right knee surgery.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of establishing the essential elements of his claim including the fact that the individual is an "employee of the United States" within the meaning of FECA, that the claim was timely filed within the applicable time limitation period of FECA, that an injury was sustained in the performance of duty as alleged and that any specific condition for which compensation is claimed is causally related to the employment injury.[4] The medical evidence required to establish a causal relationship between a specific claimed condition and an accepted employment injury is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there was a causal relationship between the claimant's diagnosed condition and the compensable employment factors. 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 claimant.[5]

Section 8103(a) of FECA states in pertinent part: "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 or the period of disability or aid in lessening the

[4] *J.F.*, Docket No. 09-1061 (issued November 17, 2009).

[5] *See E.J.*, Docket No. 09-1481 (issued February 19, 2010).

amount of the monthly compensation."[6] The Board has found that OWCP has great discretion in determining whether a particular type of treatment is likely to cure or give relief.[7] The only limitation on OWCP's authority is that of reasonableness.[8] 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.[9]

Section 8123(a) of FECA provides in pertinent 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."[10] In situations where 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.[11]

ANALYSIS

OWCP accepted that on February 4, 2007 appellant sustained a torn medial meniscus of his right knee when he slipped on stairs at work. It authorized a May 9, 2007 right knee arthroscopy with medial shelf plica excision and minor synovectomy by Dr. Magoline, an attending Board-certified orthopedic surgeon. It was later accepted that appellant sustained thrombosis of his right leg as a result of the authorized surgery. In October 2009, Dr. Magoline requested that OWCP authorize another arthroscopy of appellant's right knee due to persistent pain. He stated that appellant had painful scar tissue, *i.e.*, arthrofibrosis, which was related to the May 2007 surgery. OWCP denied appellant's claim for an additional right knee condition and his request for further right knee surgery based on the opinion of Dr. Kleinman, a Board-certified orthopedic surgeon, who served as an impartial medical specialist.

OWCP properly determined that a conflict in medical opinion arose between Dr. Magoline and Dr. Ghanma, a Board-certified orthopedic surgeon, who served as an OWCP referral physician. Their medical opinions differed in whether appellant had work-related

[6] 5 U.S.C. § 8103.

[7] *Vicky C. Randall*, 51 ECAB 357 (2000).

[8] *Lecil E. Stevens*, 49 ECAB 673, 675 (1998).

[9] *Rosa Lee Jones*, 36 ECAB 679 (1985).

[10] 5 U.S.C. § 8123(a).

[11] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

arthrofibrosis of the right knee and whether right knee surgery was necessary to treat a work-related condition.[12] In order to resolve the conflict, OWCP properly referred appellant, pursuant to section 8123(a) of FECA, to Dr. Kleinman, for an impartial medical examination and an opinion on these matters.[13]

In a March 1, 2010 report, Dr. Kleinman reported the findings of his February 23, 2010 physical examination and diagnosed a right medial meniscus tear by history, thrombosis of the right lower extremity, chondromalacia of the right knee patella and medial plica by history. He advised that the right knee torn medial meniscus and the thrombosis of the right leg were work related, but that the other two diagnoses were not work related. In a supplemental June 16, 2010 report, Dr. Kleinman concluded that appellant did not have work-related arthrofibrosis of the right knee. He stated that during the February 23, 2010 physical examination appellant demonstrated actively 0 to 120 degrees of right knee motion and passively he could get appellant to 130 degrees of motion of the knee. Dr. Kleinman opined that these findings were inconsistent with the diagnosis of arthrofibrosis and, therefore, there was insufficient objective medical evidence to support the diagnosis of arthrofibrosis. He indicated that Dr. Magoline noted a lateral tilt of the patella on radiographic studies, a radiographic finding which was often associated with chondromalacia patella. Dr. Kleinman further noted that Dr. Magoline had opined that if scar tissue had formed from the synovectomy and excision of the medial plica, it would have resulted in scarring along the medial side of the patellofemoral joint and compressed the medial side of the patella. He explained that these findings would be inconsistent with a lateral patellar tilt and opined that this lateral tilt preexisted the work injury. Dr. Kleinman concluded that arthroscopic surgery to address adhesions in the right knee was not medically necessary and posited that there was no further treatment necessary for the allowed knee conditions related to the February 4, 2007 work injury.

The Board has carefully reviewed the opinion of Dr. Kleinman and notes that it has reliability, probative value and convincing quality with respect to its conclusions regarding the relevant issues of the present case. Dr. Kleinman provided a thorough factual and medical history and accurately summarized the relevant medical evidence.[14] He provided medical rationale for his opinion by providing a detailed explanation of how the physical examination and diagnostic testing findings did not support the existence of work-related arthrofibrosis or the need for additional right knee surgery due to a work-related condition. Dr. Kleinman further explained that appellant's current knee complaints were related to nonwork-related chondromalacia of the patellofemoral joint along with thinning of the retropatellar cartilage.

[12] In October 26, 2009 and January 18, 2010 reports, Dr. Magoline provided an opinion that appellant had work-related arthrofibrosis of the right knee and that additional right knee surgery should be performed to treat this work-related condition. In contrast, Dr. Ghanma found in his October 19, 2009 report that appellant had no residuals of a work-related condition and that no additional treatment was required for treatment of a work-related condition. Appellant, through counsel, argued that there was no conflict in the medical opinion evidence between Dr. Magoline and Dr. Ghanma regarding the existence of work-related arthrofibrosis, but such a conflict existed because Dr. Magoline posited that such a condition existed and Dr. Ghanma found that appellant did not have any residuals of a work-related condition.

[13] *See supra* note 10.

[14] *See Melvina Jackson*, 38 ECAB 443, 449-50 (1987); *Naomi Lilly*, 10 ECAB 560, 573 (1957).

After Dr. Kleinman provided his opinion, Dr. Magoline submitted reports dated August 12, 2010 and August 3, 2011, in which he reiterated his opinion that appellant had work-related arthrofibrosis of the right knee which required additional surgery. As he was on one side of the conflict, his additional reports essentially duplicated his previous opinion and are insufficient to give rise to a new conflict.[15]

For these reasons, appellant did not meet his burden of proof to establish that he sustained work-related arthrofibrosis of his right knee or that repeat arthroscopic surgery of his right knee should be authorized. With respect to the denial of repeat right knee surgery, there is no evidence that OWCP abused its discretion in denying his request for such additional medical treatment.

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 did not meet his burden of proof to establish that he sustained work-related arthrofibrosis of his right knee or that repeat arthroscopic surgery of his right knee should be authorized.

[15] *See Richard O'Brien*, 53 ECAB 234 (2001).

ORDER

IT IS HEREBY ORDERED THAT the October 24, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 25, 2012
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