United States Department of Labor
Employees' Compensation Appeals Board

A.J., Appellant	)	
and	)	**Docket No. 16-1282**
	)	**Issued: August 24, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Oklahoma City, OK, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On June 3, 2016 appellant filed a timely appeal from a February 23, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 her burden of proof to establish a recurrence of a work-related medical condition necessitating her January 4, 2016 left knee surgery.

FACTUAL HISTORY

On August 8, 2011 appellant, then a 43-year-old maintenance support clerk, filed an occupational disease claim (Form CA-2) alleging that she sustained injury to her left knee due to the repetitive knee movements required by her work duties over time. She indicated that she first

[1] 5 U.S.C. § 8101 *et seq.*

became aware of her claimed condition on July 11, 2011 and that she first realized on July 24, 2011 that it was caused or aggravated by her employment.[2] Appellant did not stop work, but she began working in a sedentary, limited-duty position for the employing establishment.

OWCP accepted that appellant sustained lateral and medial meniscus tears of her left knee. Appellant received disability compensation on the daily rolls beginning December 7, 2011.

On December 13, 2011 Dr. James L. Bond, an attending Board-certified orthopedic surgeon, performed surgery on appellant's left knee, including complete synovectomy of the anterior/inferior patella pouches, medial/lateral gutters, and posterior medial aspects of the knee, patellar chondroplasty, medial meniscectomy of the medial meniscus (posterior third), anterior cruciate ligament reconstruction with hamstring autograft, and chondroplasty of the medial and lateral femoral condyles. The procedures were authorized by OWCP.

On February 27, 2012 appellant returned to work as a modified clerk for the employing establishment. In a June 4, 2012 decision, OWCP adjusted her wage-loss compensation based on its determination that her actual wages as a modified clerk fairly and reasonably represented her wage-earning capacity. On June 18, 2012 appellant returned to her regular work on a full-time basis and received no disability compensation after that date.

Appellant filed a schedule award claim (Form CA-7) on July 29, 2012 and, by decision dated February 12, 2013, OWCP granted 10 percent permanent impairment of her left lower extremity.[3]

On December 12, 2012 appellant visited Dr. Bond and reported continued left knee problems. Dr. Bond noted that he thought the anterior cruciate ligament and postoperative course had caused a considerable amount of postoperative scarring and arthritis.

The findings of a March 30, 2013 MRI scan of appellant's left knee contained an impression of postoperative changes of an intact anterior cruciate ligament graft repair, tricompartimental joint space narrowing with significant thinning/irregularity of the articular cartilage throughout, and at least three articular cartilage focal defects (measuring up to five millimeters in diameter), small knee joint effusion, morphologic changes of the medial and lateral menisci (most likely representing postoperative change), and mild thickening and increased signal within the proximal medial collateral ligament without fluid or inflammation (suggesting a chronic ligamentous injury).[4]

[2] The findings of a July 18, 2011 magnetic resonance imaging (MRI) scan of appellant's left knee contained an impression of complete tear of the anterior cruciate ligament and degenerative tears involving the posterior horns of the medial and lateral menisci, communicating to the inferior articular surfaces.

[3] On June 13, 2013 appellant requested reconsideration of OWCP's February 12, 2013 decision and, in a June 26, 2013 decision, OWCP denied modification of its February 12, 2013 decision.

[4] The findings noted that there was loss of the normal volume and morphologic appearance of the posterior horn of the medial meniscus, likely related to a previous partial meniscectomy. There was no evidence of a focal linear tear.

The evidence of record does not contain any medical reports dated between April 2013 and May 2015.

On June 6, 2015 appellant visited Dr. Bond and reported that she worked for the employing establishment and that she was getting up out of a chair when her left knee popped a week prior. She had been on "desk type duty" since the incident, but still had increasing left knee pain. Dr. Bond diagnosed left knee pain secondary to medial meniscus tear and arthrosis of the medial compartment.

The findings of an August 19, 2016 left knee MRI scan contained an impression of intact reconstructed anterior cruciate ligament with somewhat of an undulating course as it crossed through the intercondylar notch and widened fluid signal within the tibial tunnel (measuring up to 1.47 millimeters in diameter), postoperative changes of prior partial meniscectomy within the medial meniscus with no convincing evidence of a recurrent medial meniscus tear, intrasubstance degeneration within the posterior horn of the lateral meniscus, tricompartmental articular cartilage loss throughout the knee, and small joint effusion.[5]

On August 31, 2015 Dr. Bond referenced the findings of the August 19, 2016 MRI scan and opined that, secondary to her increased chondral damage, appellant was a candidate for a left total knee arthroplasty. He noted that she had failed conservative treatment and suggested that, secondary to her age, she should undergo left knee arthroscopy with chondroplasty and possible subchondroplasty/cartilage harvest. In a December 30, 2015 report, Dr. Bond advised that appellant would be undergoing the suggested left knee surgery.

On December 29, 2015 appellant requested authorization from OWCP for left knee arthroscopy surgery (Procedure Code 29877) and left tibial arthroscopy surgery (Procedure Code 29855). In a December 15, 2015 form entitled "Preadmission Surgery Information/Orders" and received on December 29, 2015, Dr. Bond described the surgery scheduled for January 4, 2016 as left knee scope surgery with possible subchondroplasty and possible cartilage harvest. He diagnosed unilateral primary osteoarthritis of the left knee, left knee pain, and other tear of the medial meniscus of the left knee (current injury).

Appellant stopped work on January 4, 2016 to undergo left knee surgery. In a January 4, 2016 report, Dr. Bond detailed the left knee surgery he performed on that date, including extensive synovitis, partial medial meniscectomy, and chondroplasty of the patella, trochlear groove, lateral femoral condyle, and medial femoral condyle.[6] The surgery was not authorized by OWCP.

[5] The findings portion of the report also noted that the posterior cruciate ligament was intact without evidence of injury or pathology, and that the medial/lateral collateral ligament structures, popliteus muscle/tendon, pes anserinus, and semimembranosus tendons were unremarkable. There was increased signal within the posterior horn of the lateral meniscus, which was unchanged in its appearance from the March 30, 2013 MRI scan and likely reflected intrasubstance degeneration.

[6] In the "Indications" portion of the surgery report, Dr. Bond noted that appellant was a 47-year-old who had sustained a work-related injury. He indicated that she had an anterior cruciate ligament tear and then had a continued chondral defect secondary to this injury. Dr. Bond advised that appellant wished for definitive management after risks and benefits of operative and nonoperative treatments were explained to her in detail.

In a January 6, 2016 letter, OWCP advised appellant that it was unable, at the time, to authorize her request for left knee arthroscopy surgery and left tibial arthroscopy surgery because the evidence of record did not explain how the need for the surgery resulted from factors of employment. In a separate January 6, 2016 recurrence claim development letter, OWCP provided appellant 30 days to complete an attached questionnaire posing questions about her work activities and medical symptoms, and to submit additional medical evidence.

On January 11, 2016 OWCP received a claim for compensation (Form CA-7), dated January 8, 2016, alleging entitlement to disability compensation for the period January 4 to 15, 2016.

On January 29, 2016 OWCP received a notice of recurrence (Form CA-2a), dated January 25, 2016, in which appellant asserted that, since returning to work, her left knee condition had progressively worsened. Appellant did not check either the box marked "Recurrence due to Medical Treatment Only" or the box marked "Recurrence due to Time Loss From Work."[7]

Appellant submitted a January 14, 2016 report in which Dr. Bond discussed her postsurgery progress and noted that she was totally disabled, but would be able to perform "desk[-]type work" in four weeks.[8]

In a report dated February 11, 2016, Dr. Bond noted that appellant underwent a left anterior cruciate ligament reconstruction in December 2011, but continued to have increasing pain on the outside of her left knee after the surgery. Appellant had failed all conservative treatment prior to the recommendation for additional left knee surgery. Dr. Bond indicated that his comparison of a left knee MRI scan from July 2011 with an August 2015 left knee MRI scan revealed that she sustained a severe loss of articular cartilage within the lateral, patellofemoral, and medial compartments of her left knee. He indicated that, due to these cartilage losses, appellant had subtle laxity and continued pain/stiffness with ambulation, as well as an altered gait. Appellant also had muscle weakness and atrophy secondary to the pain associated with the cartilage defect. Dr. Bond referenced his prior surgery recommendation for left knee scope with chondroplasty and possible subchondroplasty/cartilage harvest. He reported physical examination findings and diagnosed left knee pain secondary to lateral meniscus tear and arthrosis of knee. Dr. Bond noted that it was his medical opinion, based upon examination of the employee, review of the medical records, and his education, training, and experience, that it was more probable than not that the diagnosed conditions/disability arose out of and in the course of appellant's federal employment. He further noted, "It is also my opinion that the current need for treatment is related to [appellant's] original injury that occurred in 2011. As previously mentioned she sustained a tricompartmental articular cartilage loss with continued pain and stiffness."

[7] On January 29, 2016 OWCP also received appellant's responses to the questionnaire it sent to her on January 6, 2016. Appellant noted that she had been performing "desk[-]type duties" and that she experienced aching, stiffening, and swelling in her left knee.

[8] Appellant also submitted notes of periodic physical therapy sessions beginning January 20, 2016.

In a decision dated February 23, 2016, OWCP denied appellant's claim because she had failed to submit sufficient medical evidence to establish a recurrence of a work-related medical condition necessitating her January 4, 2016 left knee surgery.[9] It found that the reports of Dr. Bond did not contain adequate medical rationale explaining how appellant's January 4, 2016 surgery was related to her accepted work conditions.

LEGAL PRECEDENT

Recurrence of a medical condition means a documented need for further medical treatment after release from treatment for the accepted condition or injury when there is no accompanying work stoppage. Continuous treatment for the original condition or injury is not considered a need for further medical treatment after release from treatment, nor is an examination without treatment.[10] An employee has the burden of proof to establish a recurrence of a medical condition that is causally related to his or her accepted employment injury. To meet this burden, the employee must submit medical evidence from a physician who, on the basis of a complete and accurate factual and medical history, supports that the condition is causally related and supports the conclusion with sound medical rationale.[11]

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 amount of the monthly compensation."[12] The Board has found that OWCP has great discretion in determining whether a particular type of treatment is likely to cure or give relief.[13] The only limitation on OWCP's authority is that of reasonableness.[14] 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.[15]

ANALYSIS

OWCP accepted that appellant sustained lateral and medial meniscus tears of her left knee due to performing her work duties over time. On December 13, 2011 Dr. Bond performed

[9] OWCP interpreted appellant's Form CA-2a as a claim for a recurrence of a medical condition which appellant claimed necessitated the January 4, 2016 left knee surgery.

[10] 20 C.F.R. § 10.5(y); *D.L.*, Docket No. 17-0306 (issued April 25, 2017).

[11] *See K.T.*, Docket No. 15-1758 (issued May 24, 2016).

[12] 5 U.S.C. § 8103.

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

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

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

surgery on her left knee, including complete synovectomy of the anterior/inferior patella pouches, medial/lateral gutters, and posterior medial aspects of the knee, patellar chondroplasty, medial meniscectomy of the medial meniscus (posterior third), anterior cruciate ligament reconstruction with hamstring autograft, and chondroplasty of the medial and lateral femoral condyles. Appellant returned to full-time regular duty on June 18, 2012, but she stopped work on January 4, 2016 to undergo additional left knee surgery.[16] On that date Dr. Bond performed extensive synovitis, partial medial meniscectomy, and chondroplasty of the patella, trochlear groove, lateral femoral condyle, and medial femoral condyle. The surgery was not authorized by OWCP and appellant claimed that she sustained a recurrence of a work-related medical condition which necessitated the January 4, 2016 left knee surgery.[17]

The Board finds that OWCP properly denied appellant's request for authorization of left knee surgery on January 4, 2016 and properly determined that she had not sustained a recurrence of a work-related medical condition necessitating such surgery. OWCP properly exercised its discretion in finding that the evidence of record did not show that the proposed surgery was likely to cure or give relief for her accepted work-related conditions.[18]

In a report dated February 11, 2016, Dr. Bond noted that appellant underwent a left anterior cruciate ligament reconstruction in December 2011, but continued to have increasing pain on the outside of her left knee after the surgery. He noted that his comparison of the left knee MRI scan from July 2011 with the left knee MRI scan from August 2015 revealed that she had sustained a severe loss of articular cartilage within the lateral, patellofemoral, and medial compartments of her left knee. Dr. Bond indicated that, due to these cartilage losses, appellant had subtle laxity, continued pain/stiffness with ambulation, altered gait, muscle weakness, and atrophy. He referenced his prior surgery recommendation for left knee scope with chondroplasty and possible subchondroplasty/cartilage harvest and diagnosed left knee pain secondary to lateral meniscus tear and arthrosis of knee. Dr. Bond noted that it was his medical opinion, based upon examination of the employee, review of the medical records, and his education, training, and experience, that it is more probable than not that the diagnosed conditions/disability arose out of and in the course of appellant's federal employment. He further noted, "It is also my opinion that the current need for treatment is related to her original injury that occurred in 2011. As previously mentioned she sustained a tricompartmental articular cartilage loss with continued pain and stiffness."

In this report, Dr. Bond provides an opinion that appellant sustained work-related tricompartmental articular cartilage loss and that symptoms from this cartilage loss necessitated the left knee surgery he performed on January 4, 2016. However, the Board notes that her claim has only been accepted for the conditions of lateral and medial meniscus tears of her left knee

[16] In early-June 2016, appellant reported to Dr. Bond that she was getting up out of a chair when her left knee popped a week prior and that she had been on "desk[-]type duty" since the incident. She did not clearly indicate whether this incident occurred at work and the evidence of record does not contain any claim for a new work injury.

[17] On December 29, 2015 OWCP received a request for authorization of the surgery later performed on January 4, 2016. On January 29, 2016 it received a Form CA-2a which it interpreted as a claim for recurrence of a work-related medical condition.

[18] *See supra* notes 13 through 15.

and he has not provided a clear opinion that the January 4, 2016 surgery was necessitated by these accepted conditions.[19] Dr. Bond's February 11, 2016 report is of limited probative value because he failed to provide any medical rationale for his opinion that appellant sustained tricompartmental articular cartilage loss in her left knee related to her employment, which in turn necessitated the January 4, 2016 surgery.[20] He did not explain how or why her need for left knee surgery on January 4, 2016 would not have been solely due to natural progression of a degenerative process of her left knee. For these reasons, Dr. Bond failed to explain his conclusion that appellant's January 4, 2016 surgery was related to a work-related condition. The Board has held that a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale.[21]

On appeal, appellant argues that residuals of OWCP-authorized December 13, 2011 surgery caused her to undergo surgery on January 4, 2016. The Board has held that authorization by OWCP for medical examination and/or treatment constitutes a contractual agreement to pay for the services if the services are rendered, regardless of whether a compensable injury/condition exists, and that any medical condition resulting from authorized examination or treatment (such as residuals from surgery) may form the basis of a compensation claim for impairment or disability, regardless of the compensability of the original injury.[22] The Board finds, however, that Dr. Bond did not provide an opinion that the January 4, 2016 surgery was necessary to address the effects of appellant's OWCP-authorized December 13, 2011 surgery.[23]

For these reasons, the Board finds that appellant failed to submit sufficient medical evidence to establish a recurrence of a work-related medical condition necessitating her January 4, 2016 left knee surgery.

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.

[19] An August 19, 2016 MRI scan of appellant's left knee contained an impression which showed, *inter alia*, postoperative changes of the December 13, 2011 surgery within the medial meniscus with no convincing evidence of a recurrent medial meniscus tear and intrasubstance degeneration within the posterior horn of the lateral meniscus. There is no indication in the evidence of record that the intrasubstance degeneration within the posterior horn of the lateral meniscus was in any way related to the medical conditions accepted by OWCP in 2011.

[20] *See supra* note 11.

[21] *C.M.*, Docket No. 14-0088 (issued April 18, 2014).

[22] *See G.C.*, Docket No. 15-0370 (issued December 2, 2015); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Authorizing Examination and Treatment*, Chapter 3.300.2b (February 2012).

[23] On December 12, 2012 Dr. Bond noted that he thought the anterior cruciate ligament and postoperative course had caused a considerable amount of postoperative scarring and arthritis. He did not make any further reference to scarring from the December 13, 2011 surgery or otherwise indicate that effects of the December 13, 2011 surgery contributed to the need for the January 4, 2016 surgery.

CONCLUSION

The Board finds that appellant did not meet her burden of proof to establish a recurrence of a work-related medical condition necessitating her January 4, 2016 left knee surgery.

ORDER

IT IS HEREBY ORDERED THAT the February 23, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 24, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board