

**United States Department of Labor
Employees' Compensation Appeals Board**

P.S., Appellant

and

**U.S. POSTAL SERVICE, POST OFFICE,
Cherry Hill, NJ, Employer**

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Docket No. 17-0802
Issued: August 18, 2017

Appearances:

*Thomas R. Uliase, Esq., for the appellant¹
Office of Solicitor, for the Director*

Case Submitted on the Record

DECISION AND ORDER

Before:

PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On February 27, 2017 appellant, through counsel, filed a timely appeal from a November 16, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act² (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of this case.

ISSUE

The issue is whether appellant has met his burden of proof to establish a right knee injury causally related to an October 4, 2014 employment incident.

¹ In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; see also 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

² 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On October 4, 2014 appellant, then a 45-year-old city carrier, filed a traumatic injury claim (Form CA-1) alleging that, on the same date while walking to deliver the mail on his route, his knee “popped.” He stopped work on October 19, 2014 and was separated from employment on October 31, 2014 for unsatisfactory attendance.

Appellant submitted the first page of an October 4, 2014 form requesting authorization for examination and/or treatment (Form CA-16) in which his customer service supervisor authorized treatment for his injury described as “right knee buckled” which occurred on October 4, 2014. The supervisor noted with a checked box authorizing the health care provider to furnish treatment as medically necessary for the effects of the injury.

Appellant submitted emergency room records, dated October 4, 2014, where he was treated for right medial knee pain that started suddenly while walking at work. He reported hearing a “pop” and was unable to bear weight on the right leg. Appellant was treated by Dr. Robert E. Soper, an osteopath, who diagnosed knee sprain. An x-ray of the right knee revealed small to moderate joint effusion with no acute displaced fracture.

Appellant came under the treatment of Dr. Enrique J. Garcia Pena, a Board-certified orthopedist, on October 10, 2014 for a right knee injury. He reported to Dr. Pena that while working as a letter carrier walking to deliver mail, he felt his knee giving way, he heard a loud pop, and pain ensued. Appellant indicated that he had difficulty ambulating afterward and was treated in the emergency room where x-rays were taken. He indicated that he was put in an immobilizer brace. Dr. Pena found limited range of motion of the right knee and tenderness over the medial joint line. He diagnosed right knee pain, possible meniscal injury and placed appellant in a hinged knee brace. A November 25, 2014 magnetic resonance imaging (MRI) scan of the right knee revealed mild medial compartment osteoarthritis with tears of the medial meniscus. On December 1, 2014 Dr. Pena related that appellant reported an injury while performing his mail carrier duties. He noted tenderness to palpation over the medial compartment, positive McMurray sign medially, and full range of motion. Dr. Pena diagnosed right knee pain with medial meniscus tear resultant from injury that he sustained while performing his work duties. He advised that appellant failed conservative management and he recommended arthroscopic debridement of his right knee.

By letter dated January 7, 2015, OWCP advised appellant that his claim had originally been handled as a simple, uncontested case which resulted in minimal or no time loss from work. The claim was administratively handled to allow limited medical payments, but the merits of the claim were not formally adjudicated. OWCP advised that, because the medical bills now exceeded \$1,500.00, the claim would be formally adjudicated. It requested that he submit a comprehensive medical report which contained a reasoned explanation as to how the specific work factors contributed to his claimed injuries. No additional evidence was received.

In a February 9, 2015 decision, OWCP denied appellant’s claim for compensation because the medical evidence of record was insufficient to establish a medical condition causally related to the accepted work incident. On February 11, 2015 it reissued the February 9, 2015 decision. On February 25, 2015 appellant requested an oral hearing.

Appellant submitted an October 10, 2014 workers' compensation update form from Dr. Pena who diagnosed right knee pain and possible ligament tear. Dr. Pena recommended an MRI scan. He noted that appellant could not return to work until his symptoms improved. In workers' compensation update forms dated December 1, 2014 and February 17, 2015, Dr. Pena diagnosed right knee medial meniscus tear, recommended surgery, and advised that appellant could not work. On May 18, 2015 he noted that appellant sustained a work-related medial meniscus tear while working as a mail carrier. Dr. Pena noted conservative measures failed and he recommended surgery. He noted significant symptoms in the medial compartment and diagnosed right knee medial meniscus tear.

In a September 10, 2015 report, Dr. Pena noted first treating appellant on October 10, 2014 where he related that in appellant's work as a mail carrier he was walking and felt his knee give way. Appellant heard a loud pop and had pain. A November 25, 2014 MRI scan revealed mild medial compartment osteoarthritis and an irregular vertical tear of the medial meniscus. Appellant reported not having these symptoms before the October 4, 2014 work event. Dr. Pena noted that appellant had some mild degenerative joint disease, but advised that the meniscal tear was not degenerative. He opined that appellant had a medial meniscal tear to his right knee as a consequence of his October 4, 2014 work activities. Dr. Pena advised that appellant failed conservative care and the arthroscopic surgery was indicated for treatment of his work-related right knee injury. He opined that appellant had an acute onset of symptomatology in the course of his work with a pop and subsequent swelling of the right knee injury with corroborating MRI scan confirming medial meniscal tear. Dr. Pena advised that the findings and history were all consistent with appellant's knee complaint and injury being causally related to his work incident of October 4, 2014.

By decision dated November 18, 2015, an OWCP hearing representative set aside the decision dated February 9, 2015 and remanded the matter for further medical development.

On November 24, 2015 OWCP referred appellant to Dr. Lawrence I. Barr, a Board-certified orthopedist, to determine if appellant's medical condition was causally related to the accepted work incident. In a December 22, 2015 report, Dr. Barr indicated that he reviewed the records provided and examined appellant. He noted that the November 25, 2014 MRI scan revealed mild medial compartment osteoarthritis with a tear of the medial meniscus while an October 4, 2014 right knee x-ray showed degenerative changes around the medial compartment with a small effusion. Right knee examination showed medial and lateral joint line tenderness, pain with range of motion, marked crepitus with motion of the right knee, no McMurray's sign, negative Drawer sign, negative Lachman's test, and intact strength. Appellant pointed to his medial thigh as opposed to any joint line areas when complaining of pain. He diagnosed degenerative medial meniscal tear and degenerative joint disease and right knee. Dr. Barr opined that appellant reached maximum medical improvement and no further treatment was indicated. He opined that he did not find causation and noted that appellant simply took two steps, there was no twisting injury and he was not on an uneven surface. Dr. Barr indicated that just taking two steps did not establish causal relationship for an injury. He noted that the reported mechanism of injury would be unlikely to cause a meniscal tear. Dr. Barr indicated that asymptomatic tears, particularly of the posterior horn of the medial meniscus, were common and could be serendipitously found on MRI scan and degenerative tears could be found without any trauma history. He further indicated that there were signs of abnormal illness behavior on examination of

appellant's right knee. Dr. Barr opined that appellant had degenerative changes on his right knee MRI scan. He noted that based on examination findings he did not recommend work restrictions or a functional capacity evaluation. In a work capacity evaluation (Form OWCP-5c) Dr. Barr noted that appellant was capable of performing his usual job without restrictions and had reached maximum medical improvement.

In a decision dated January 6, 2016, OWCP denied appellant's claim for compensation because the medical evidence did not demonstrate that the claimed medical condition was causally related to the accepted work event.

On January 11, 2016 appellant requested an oral hearing before an OWCP hearing representative which was held on April 18, 2016.

Appellant submitted a January 26, 2016 report from Dr. Pena, who treated appellant for chronic right knee pain with mechanical episodic giving way symptoms. Dr. Pena diagnosed tear of the posterior horn of the medial meniscus. He noted findings of painful right knee localized over the medial joint line. Dr. Pena reviewed Dr. Barr's report and noted that some parts of the report appeared to be inconsistent. He concurred with Dr. Barr's description of degeneration of the medial compartment with irregularity/thinning of the articular cartilage. Dr. Pena disagreed with his description of a degenerative meniscus tear, as the tear pattern, after reviewing imaging studies on November 25, 2014, indicated that the meniscus tear was indeed a vertical pattern in the posterior horn and irregular vertical tear, which was not a typical tear seen in a degenerative knee. He noted that degenerative meniscal tears are more typically complex in nature and the appearance of the vertical tear would suggest traumatic etiology. Dr. Pena opined that due to appellant's persistent symptoms and previous imaging findings, he recommended hyaluronic injections. On March 4, 2016 he diagnosed mild chondromalacia with degenerative joint changes with posterior horn tear of the medial meniscus, radial pattern, by MRI scan. Dr. Pena recommended a repeat MRI scan. In a March 18, 2016 report, he advised that a new MRI scan showed progression of the medial meniscus tear. Dr. Pena diagnosed right knee pain with medial meniscus tear showing progressive changes as compared to the previous MRI scan. He recommended arthroscopic surgery. On April 6, 2016 Dr. Pena performed a right knee arthroscopy, chondroplasty of trochlear groove, medial femoral condyle, partial medial meniscectomy, and medial meniscus repair. He diagnosed right knee chondromalacia of trochlear groove, medial femoral condyle, and complex tear of the posterior horn of the medial meniscus that extends into the meniscal body of the radial component.

In a decision dated July 1, 2016, an OWCP hearing representative affirmed the decision dated January 6, 2016.

On August 19, 2016 appellant requested reconsideration. He submitted reports dated April 12 and July 12, 2016 from Dr. Pena, who noted that appellant was progressing well postoperatively. In reports dated August 12 and September 23, 2016, Dr. Pena noted that appellant was status post right knee arthroscopy, medial meniscus repair of the posterior horn, and had good and bad days. He recommended reordering an MRI scan and MR arthrogram to rule out any underlying pathology that might have progressed from the last evaluation. With regard to whether his underlying pathology was traumatic or degenerative in origin, he noted it was unusual for a patient to have a meniscus tear through ambulation, but with a sharp pain, audible pop, and swelling and discomfort that ensued afterwards, it was a typical meniscal tear presentation.

Dr. Pena indicated that the diagnostic arthroscopy showed the appearance of the meniscus in the medial compartment to be of vertical origin, which was not consistent with degenerative etiology. He further noted that the very mild chondral wear on the medial compartment also indicates that it was not a longstanding degenerative condition. Dr. Pena opined that he understood that other examining physicians might consider it a rare occurrence that meniscus tear might occur through this mechanism of injury, but appellant's clinical examination, his description of the symptoms, MRI scan findings, and intraarticular diagnostic operative findings were consistent with traumatic etiology.

In a decision dated November 16, 2016, OWCP denied modification of the decision dated July 1, 2016.

LEGAL PRECEDENT

An employee seeking benefits under FECA³ has the burden of proof to establish the essential elements of his or her claim including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was filed within the applicable time limitation of FECA, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed is causally related to the employment injury. These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.⁴

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether fact of injury has been established. There are two components involved in establishing fact of injury. First, the employee must submit sufficient evidence to establish that he actually experienced the employment incident at the time, place, and in the manner alleged. Second, the employee must submit medical evidence to establish that the employment incident caused a personal injury.⁵

Rationalized medical opinion evidence is generally required to establish causal relationship. The opinion of the physician must be based on a complete factual and medical background, 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.⁶

Section 8123(a) of FECA provides that, 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.⁷ The implementing regulations state that, if a conflict exists between the medical opinion of the employee's physician and the

³ *Id.*

⁴ *Gary J. Watling*, 52 ECAB 357 (2001).

⁵ *T.H.*, 59 ECAB 388 (2008).

⁶ *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

⁷ 5 U.S.C. § 8123(a); see *Y.A.*, 59 ECAB 701 (2008).

medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination.⁸ 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.⁹

ANALYSIS

On October 4, 2014 appellant filed a traumatic injury claim alleging that, while delivering mail on that date, he felt a pop in his right knee. In a decision dated November 16, 2016, OWCP denied modification of the July 1, 2016 decision denying his claim finding that medical evidence did not demonstrate that he sustained the diagnosed injuries as a result of the work incident.

The Board finds that the case is not in posture for a decision as there is a conflict in medical opinion between Dr. Barr, OWCP's referral physician, and Dr. Pena, appellant's treating physician, both of whom are Board-certified specialists in their respective fields, regarding whether appellant sustained a right knee condition as a result of his work incident on October 4, 2014.

In his December 22, 2015 report, Dr. Barr diagnosed degenerative medial meniscal tear and degenerative joint disease, right knee. He opined that he did not find causation and noted that appellant simply took two steps, there was no twisting injury, and he was not on an uneven surface. Dr. Barr noted that the reported mechanism of injury would be unlikely to cause a meniscal tear. He advised that asymptomatic tears, particularly of the posterior horn of the medial meniscus, were common and degenerative tears could be found without any history of trauma. Dr. Barr further indicated that with regard to appellant's right knee, there were signs of abnormal illness behavior on examination. He advised that appellant has reached maximum medical improvement and no further treatment was indicated.

By contrast, a January 26, 2016 report from Dr. Pena reflected treatment for chronic right knee pain with mechanical episodic giving way symptoms and a diagnosis of tear of the posterior horn of the medial meniscus. He noted reviewing Dr. Barr's report and noted that some parts of the report appeared to be inconsistent. Dr. Pena disagreed with Dr. Barr regarding his description of a degenerative meniscus tear, as the tear pattern on the November 25, 2014 imaging indicated that the meniscus tear was a vertical pattern in the posterior horn and irregular vertical tear, which was not typical of a degenerative knee. He noted that the appearance of the vertical tear suggested traumatic etiology. Dr. Pena diagnosed mild chondromalacia with degenerative joint changes with posterior horn tear of the medial meniscus, radial pattern by MRI scan and performed arthroscopic surgery on April 6, 2016. In other reports, as noted, he continued to indicate that appellant's meniscal tear was traumatic and consistent with the October 4, 2014 work incident.

The Board therefore finds that a conflict in medical opinion has been created regarding whether appellant's right knee condition is causally related to the accepted work incident of October 4, 2014.

⁸ 20 C.F.R. § 10.321.

⁹ V.G., 59 ECAB 635 (2008).

Section 8123 of FECA provides that, if there is a disagreement between the physician making the examination for the United States and the employee's physician, OWCP shall appoint a third physician who shall make an examination.¹⁰

The case will be remanded to OWCP to refer appellant, the medical record, and a statement of accepted facts to an appropriate specialist, to obtain an impartial opinion regarding whether the October 4, 2014 work injury caused or aggravated the diagnosed right knee conditions. Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision in the case.

CONCLUSION

The Board finds that the case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the November 16, 2016 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for further action consistent with this decision.

Issued: August 18, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

¹⁰ *Supra* note 7.