United States Department of Labor
Employees' Compensation Appeals Board

D.B., Appellant	)	
and	)	**Docket No. 18-0219**
	)	**Issued: August 17, 2018**
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, Oxford, WI, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On November 7, 2017 appellant filed a timely appeal from a June 28, 2017 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 OWCP abused its discretion when it denied authorization of appellant's left knee surgery.

FACTUAL HISTORY

On January 20, 2015 appellant, then a 33-year-old correctional officer, filed a traumatic injury claim (Form CA-1) alleging that on January 15, 2015 he twisted his left foot, ankle, calf, and knee when he slipped off the concrete pavement while walking in the snow near a fence at

[1] 5 U.S.C. § 8101 *et seq.*

work. He stopped work on the date of injury and returned to limited-duty work later on January 21, 2015.

On March 6, 2015 OWCP accepted the claim for tear of the medial meniscus of the left knee. It authorized left knee arthroscopy with partial lateral meniscectomy at the anterior horn and partial synovectomy and chondroplasty of medial femoral condyle performed on March 11, 2015 by Dr. James J. Foskett, appellant's attending Board-certified orthopedic surgeon. On March 25, 2015 appellant returned to full-duty work.

In an April 23, 2015 medical report, Dr. Foskett noted that appellant was status post the authorized March 11, 2015 surgery and still had debilitating left knee pain. He also noted appellant's medical history, which included acute left knee pain, left knee anterior cruciate ligament (ACL) reconstruction performed in 2004, repair of a failed left knee ACL, meniscus, ligament repair, removal of hardware, *etc.*, and removal of an abscess on the left knee in 2014. Dr. Foskett provided a review of systems and discussed examination findings. He provided an impression of persistent and debilitating left knee pain with post-traumatic arthritic changes. Dr. Foskett also provided an impression of history of prior trauma and ACL reconstruction. He noted that appellant reinjured his knee on January 15, 2015 and that, prior to this injury, he had been doing satisfactorily. Appellant's pain had been significantly accelerated by this injury and he had persistent debilitating pain despite arthroscopy injection and physical therapy. Dr. Foskett advised that, although appellant was relatively young for a total knee replacement, this was likely the only salvage procedure which would appreciably relieve his pain. He related that appellant was not a good candidate for unicompartmental knee arthroplasty due to his weight, age, and having an incompetent ACL. On May 19, 2015 Dr. Foskett requested authorization to perform a total left knee arthroplasty.

On May 29, 2015 OWCP referred the case to an OWCP medical adviser, Dr. Michael Hellman, an orthopedic surgeon, for an opinion with respect to the requested surgery.

On June 10, 2015 Dr. Foskett performed a total left knee arthroplasty and an open lateral retinacular release of the left knee for patellofemoral maltracking and dislocation. The preoperative diagnoses were left knee severe osteoarthritis and cystic mass on the left anterior knee. The postoperative diagnoses were left knee severe osteoarthritis and cystic subfascial mass on the left knee, rule out sterile abscess, inclusion with foreign body reaction *versus* infection.

In a note dated June 11, 2015, Dr. Hellman reviewed the relevant medical evidence, which indicated that appellant had preexisting post-traumatic arthritis of the left knee. He concluded that surgery should not be authorized. Dr. Hellman explained that appellant's accepted employment-related injury was a ground level low-energy twist of the left knee and that this type of injury would not cause any permanent aggravation of his preexisting condition. He reasoned that this type of injury was a temporary aggravation of his post-traumatic arthritis. Dr. Hellman further reasoned that appellant's preexisting condition was already severe before the accepted injury occurred.

OWCP, by letter dated August 12, 2015, referred appellant, along with a statement of accepted facts (SOAF), the medical record, and list of questions, to Dr. Mysore S. Shivaram, a Board-certified orthopedic surgeon, for a second opinion to determine whether appellant's

June 10, 2015 left knee surgery was medically necessary to treat his January 15, 2015 employment injury.

By decision dated August 27, 2015, OWCP denied authorization for the June 8, 2015 left knee surgery based on Dr. Hellman's opinion. It noted that appellant had been scheduled for a second opinion evaluation to determine whether the surgery should be authorized.

Appellant was unable to attend the scheduled appointment with Dr. Shivaram. OWCP rescheduled the examination for October 28, 2015. In an October 28, 2015 report, Dr. Shivaram reviewed the SOAF and the medical record and reported findings on physical examination. He diagnosed severe degenerative arthritis of the left knee and status post left total knee replacement followed by removal of the total knee prosthesis and subsequent surgical procedure with antibiotic spacer in the left knee. Dr. Shivaram noted that x-rays and a magnetic resonance imaging (MRI) scan performed following appellant's January 15, 2015 employment injury revealed the presence of a moderate degree of degenerative arthritis of the left knee. The MRI scan revealed no evidence of a medial meniscal tear. The lateral meniscus had only an anterior horn of the lateral meniscus and there was a questionable tear in the anterior horn of the lateral meniscus. Arthroscopic surgery of the left knee revealed no evidence of a medial meniscus tear. There were peripheral degenerative changes as shown on the arthroscopic pictures of the knee. The ACL was still intact even though it was somewhat lax as indicated in the description of an operative report. Based on the above findings, Dr. Shivaram found that the nature of the January 15, 2015 left knee injury was not exactly clear. He advised that appellant had a severe injury to the knee in the past and also had ACL reconstruction, lateral ligament reconstruction, and patellar ligament repair prior to the January 15, 2015 employment injury. Dr. Shivaram maintained that there was no evidence to indicate that the accepted work injury aggravated or accelerated appellant's preexisting severe left knee degenerative arthritis. He further maintained that, based on the above discussion, no further medical treatment was required for the January 15, 2015 work-related injury. Dr. Shivaram advised that no further improvement could be expected since appellant had a left total left knee replacement and was awaiting revision of this surgical procedure. He opined that the accepted injury did not cause any permanent aggravation or acceleration of appellant's osteoarthritis of the left knee and further opined that OWCP should not approve appellant's total left knee replacement surgery since he had significant degenerative arthritis of the knee prior to the January 15, 2015 employment injury.

By decision dated March 31, 2016, OWCP denied authorization for further left knee surgery based on the opinions of Drs. Hellman and Shivaram.

On April 19, 2016 appellant requested an oral hearing before an OWCP hearing representative. On December 7, 2016 he requested that his request for an oral hearing be converted into a request for a review of the written record by an OWCP hearing representative due to a scheduling conflict.

Appellant submitted a December 17, 2016 report from Dr. Foskett, who reviewed Dr. Shivaram's October 28, 2015 findings and disagreed with his opinion that the June 10, 2015 left knee surgery should not be authorized. Dr. Foskett noted that appellant's knee condition was complex in nature and nuanced. Prior to the January 15, 2015 work-related injury, appellant suffered an ACL injury, which was successfully treated by ACL reconstruction. He also had

preexisting arthritis, which was significant in his left knee prior to the accepted work injury. Dr. Foskett indicated that this was documented at the subsequent arthroscopy he performed and at the prior repeat ligamentous reconstruction he performed before the employment injury. He related that Dr. Shivaram's evaluation did not consider that given the nature of appellant's previously injured and compromised left knee, an additional lateral meniscal tear could further significantly accelerate arthritic degeneration of such a knee. Dr. Foskett opined, with a high degree of medical certainty and assurance, that appellant's January 15, 2015 work injury likely contributed to significantly and accelerated his underlying arthritic left knee condition. He maintained that the accepted work injury then partially and significantly contributed to his need to undergo the 2015 left total knee arthroplasty. Dr. Foskett concluded that, based on the above-reviewed evaluations and findings, it was clear that the accepted employment injury significantly contributed to appellant's need to undergo subsequent total knee arthroplasty.

By decision dated January 27, 2017, an OWCP hearing representative set aside the March 31, 2016 decision and remanded the case for further development of the medical evidence. She found that, while Dr. Foskett's December 17, 2016 report was insufficiently rationalized, it presented *prima facie* evidence of a causal relationship between the need to undergo left knee surgery and the accepted January 15, 2015 employment injury. On remand the hearing representative directed OWCP to obtain the medical records referenced by Dr. Foskett in his report. Upon receipt of these medical records, OWCP was directed to prepare an updated SOAF and provide the records to Dr. Shivaram for review and to obtain a supplemental report concerning whether appellant had a material worsening of a preexisting condition causally related to the January 15, 2015 employment injury and, if so, whether the left total knee replacement performed on June 10, 2015 by Dr. Foskett was appropriate medical treatment and medically warranted for the accepted work injury.

On remand Dr. Foskett submitted his reports and diagnostic test reports performed on his behalf dated January 13, 2010 through August 11, 2015, which addressed appellant's left knee conditions, including a large lateral meniscus tear, instability, an ACL tear, and a cystic mass. These records also addressed surgeries appellant underwent to treat these conditions and his work capacity.

OWCP, by letter dated April 20, 2017, requested that Dr. Shivaram review the accompanying additional reports from Dr. Foskett, reexamine appellant, and provide an opinion as to whether he had a material worsening of his preexisting left knee condition due to the January 15, 2015 employment injury and whether the total left knee replacement surgery was warranted.

In a report dated May 31, 2017, Dr. Shivaram reviewed the SOAF and medical records that accompanied OWCP's April 20, 2017 letter. He noted that, unfortunately, appellant had a severe left knee injury as early as 2004. Appellant also had chronic instability of the knee and early arthritic changes were seen as early as 2010. He underwent reconstruction of the lateral ligaments and revision of the ACL due to chronic instability of the knee. Dr. Shivaram indicated that, with long-standing instability of the knee, abnormal joint mechanics would lead to degenerative changes of the knee. He further indicated that appellant was seen on several occasions for continued knee pain over the course of years and had repeat arthroscopic evaluation of the knee for instability and continued knee pain. Dr. Shivaram related that the January 15, 2015

employment injury was not very significant based on the presence of mild effusion in the knee and no significant changes on a left knee MRI scan and subsequent arthroscopic evaluation of the knee. However, he related that subsequent arthroscopy in 2015 revealed significant degenerative changes involving the medial compartment and lateral and patellofemoral joint. Dr. Shivaram related that appellant was frustrated with his long-standing left knee pain and problems and that a total knee replacement was recommended since he had end-stage arthritis. He maintained that, based on all these findings, his opinion remained that the accepted January 15, 2015 work injury did not cause any permanent aggravation or acceleration of appellant's left knee osteoarthritis. Dr. Shivaram related that, as indicated above, appellant had severe degenerative arthritis of the left knee at the time of the accepted injury. He reiterated his prior opinion that the left total knee replacement should not be approved by OWCP since appellant had significant degenerative arthritis of the knee prior to the January 15, 2015 employment injury. Dr. Shivaram noted that, as indicated in the medical records, he had ongoing left knee problems with significant pain for several years, which ultimately led to further surgical procedure. He indicated that, following the left total knee replacement, revision of the left total knee replacement was performed for an infected left total knee replacement. Dr. Shivaram reported that appellant was quite satisfied with his recovery following the surgical procedure. He also reported that his left knee was stable for examination. An examination revealed a well-healed scar and the knee was not warm to touch. There was 1+ effusion in the joint and 0 to 110 degrees of range of motion. Alignment of the left leg and left knee were satisfactory. Dr. Shivaram related that, at present, appellant advised that he could walk for long distances and did not require the use of an assistive device for ambulation. He maintained that overall appellant appeared to have a good result following revision arthroplasty of the left knee. Appellant had no pain in the left knee. Dr. Shivaram advised that appellant experienced left knee pain with constant movement and weather changes. In addition, kneeling, excessive climbing, running, etc. aggravated his left knee pain. Ice and rest would resolve appellant's symptoms.

By decision dated June 28, 2017, OWCP again denied authorization for appellant's left knee surgery. Based on Dr. Shivaram's May 31, 2017 opinion, it found that the June 10, 2015 total left knee replacement surgery was not necessitated by the accepted January 15, 2015 work injury.

LEGAL PRECEDENT

Section 8103 of FECA 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 OWCP considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation.[2] While OWCP is obligated to pay for treatment of employment-related conditions, the employee has the burden of proof to establish that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[3]

[2] 5 U.S.C. § 8103; *see L.D.*, 59 ECAB 648 (2008).

[3] *Kennett O. Collins, Jr.*, 55 ECAB 648 (2004).

In interpreting this section of FECA, the Board has recognized that OWCP has broad discretion in approving services provided under section 8103, with the only limitation on OWCP's authority being that of reasonableness.[4] 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.[5] To be entitled to reimbursement of medical expenses, a claimant has the burden of proof to establish that the expenditures were incurred for treatment of the effects of an employment-related injury or condition. Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[6] In order for a surgical procedure to be authorized, a claimant must submit evidence to show that the surgery is for a condition causally related to an employment injury and that it is medically warranted. Both of these criteria must be met in order for OWCP to authorize payment.[7]

ANALYSIS

The Board finds that OWCP did not abuse its discretion in denying authorization for appellant's June 10, 2015 total left knee surgical procedure.

OWCP accepted that appellant sustained a tear of the medial meniscus of the left knee while in the performance of duty on January 15, 2015. It authorized left knee arthroscopy with partial lateral meniscectomy at the anterior horn and partial synovectomy and chondroplasty of medial femoral condyle performed on March 11, 2015 by Dr. Foskett, an attending physician.

On May 19, 2015 Dr. Foskett requested authorization for a total left knee arthroplasty due to preexisting severe osteoarthritis and a cystic mass on the left anterior knee that were aggravated by the accepted injury. He performed the surgery on June 10, 2015. Subsequently, in a December 17, 2016 report, Dr. Foskett opined that the accepted work-related injury significantly contributed to and accelerated appellant's underlying left knee arthritis which necessitated surgery on June 10, 2015.

By decision dated March 31, 2016, OWCP denied the request for authorization of surgery based on the opinions of Dr. Hellman, an OWCP medical adviser, and Dr. Shivaram, an OWCP referral physician, who opined that appellant's June 10, 2015 surgery was not necessitated by the accepted employment injury. On January 27, 2017 an OWCP representative set aside the March 31, 2016 decision, finding that, while Dr. Foskett's December 17, 2016 opinion was not sufficiently rationalized, it was *prima facie* evidence of a causal relationship between the January 15, 2015 employment injury and the June 10, 2015 left knee surgery. She remanded the case to OWCP to further develop whether the June 10, 2015 left knee surgery should be authorized. On remand OWCP received a response to a request for further opinion from Dr. Shivaram

[4] *See D.K.*, 59 ECAB 141 (2007).

[5] *Minnie B. Lewis*, 53 ECAB 606 (2002).

[6] *M.B.*, 58 ECAB 588 (2007).

[7] *R.C.*, 58 ECAB 238 (2006).

regarding whether appellant had a material worsening of his preexisting left knee arthritis due to the accepted work injury that required surgery. By decision dated June 28, 2017, OWCP denied authorization for the June 10, 2015 left knee surgery based on Dr. Shivaram's report.

In his May 31, 2017 supplemental report, Dr. Shivaram found that appellant's preexisting left knee condition which warranted total left knee replacement surgery was not caused or aggravated by the accepted January 15, 2015 employment-related injury. He noted appellant's medical history which revealed a severe left knee injury dating back to 2004, and chronic instability and early arthritic changes were seen as early as 2010 resulting in reconstruction of the lateral ligaments and revision of the ACL and repeat arthroscopic evaluation for instability and continued knee pain. On physical examination of the left knee, Dr. Shivaram reported essentially normal findings with the exception of limited range of motion. Appellant informed him that, although he experienced left knee pain with constant movement and weather changes, he could walk for long distance and did not require the use of an assistive device for ambulation. Dr. Shivaram noted that he appeared to have a good result following revision arthroplasty of the left knee. He explained that the January 15, 2015 employment injury was not very significant based on the presence of mild effusion in the knee and no significant changes on a left knee MRI scan and subsequent arthroscopic evaluation of the knee. Dr. Shivaram related that, although the 2015 arthroscopy revealed significant degenerative changes involving the medial compartment and lateral and patellofemoral joint, his opinion remained that the accepted employment-related injury did not cause any permanent aggravation or acceleration of appellant's left knee osteoarthritis.

The Board finds that Dr. Shivaram's opinion that appellant did not sustain a material worsening of his preexisting left knee arthritis that necessitated surgery on June 10, 2015 due to the January 15, 2015 employment injury represents the weight of the medical evidence in this case. Dr. Shivaram provided a well-rationalized medical opinion based on a complete factual and medical background.

OWCP has discretion with respect to authorization for surgery. As previously noted, 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.[8] Based on the medical evidence of record, the Board finds that it did not abuse its discretion in this case.[9]

On appeal appellant contends that his physician's opinion is sufficient to warrant authorization of his surgery. An OWCP hearing representative set aside the denial of authorization for the June 10, 2015 surgery, finding that, while Dr. Foskett's opinion that the January 15, 2015 employment injury significantly contributed to and accelerated appellant's underlying left knee arthritis, which necessitated surgery on June 10, 2015, was not sufficiently rationalized, it established *prima facie* evidence of causal relationship requiring further development of the medical evidence. OWCP properly developed the medical evidence to resolve this issue by

[8] *Supra* note 5

[9] *See L.C.*, Docket No. 16-1797 (issued March 10, 2017).

obtaining additional medical records from Dr. Foskett and referring appellant to Dr. Shivaram for another second opinion. Thus, the Board finds that appellant's argument is not substantiated.

Appellant further contends on appeal that an OWCP referral physician did not perform a complete physical examination, and spent only 20 minutes during his first evaluation and 5 minutes during his second evaluation. Dr. Shivaram provided detailed examination findings and a well-rationalized medical opinion based on these findings. The Board finds, therefore, that appellant's argument is not substantiated.

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 OWCP did not abuse its discretion when it denied authorization for appellant's left knee surgery.

ORDER

IT IS HEREBY ORDERED THAT the June 28, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 17, 2018
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board