United States Department of Labor
Employees' Compensation Appeals Board

J.L., Appellant	)	
and	)	**Docket No. 18-0990**
	)	**Issued: March 5, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Little Rock, AR, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 16, 2018 appellant filed a timely appeal from a December 1, 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 by denying authorization for bilateral knee replacements.

FACTUAL HISTORY

On April 24, 2012 appellant, then a 58-year-old city carrier, filed a traumatic injury claim (Form CA-1) alleging that, on April 14, 2012, he missed a step and fell approximately six steps while delivering mail. He landed on his chin, chest, right knee, and lower leg. Appellant stopped

[1] 5 U.S.C. § 8101 *et seq.*

work on April 14, 2012 and returned to regular-duty work on April 17, 2012. OWCP initially accepted the claim for right knee medial meniscus tear.

Dr. James C. Tucker, Jr., an orthopedic surgeon, performed an authorized arthroscopy of appellant's right knee with partial medial and lateral meniscectomy and chondroplasty of the trochlear groove on September 24, 2012. Appellant returned to full-duty work on November 26, 2012. OWCP subsequently expanded acceptance of the claim to include derangement of the left medial meniscus and temporary aggravation of bilateral knee osteoarthritis.[2]

Dr. Tucker also performed OWCP authorized left knee arthroscopy with partial medial and lateral meniscectomies and removal of loose body on March 29, 2013. Appellant returned to limited-duty work in May 2013 with permanent restrictions.

Due to bilateral knee pain, during 2014 and 2015, appellant received corticosteroid and euflexxa injections in both knees from Dr. Tucker. On October 6, 2015 Dr. Tucker noted that the bilateral corticosteroid injections only provided relief for four weeks and that appellant was having increasing difficulty performing his work and activities of daily living. He referred appellant to Dr. D. Gordon Newbern, an orthopedic surgeon, for an evaluation of possible bilateral total knee replacement.

In a November 4, 2015 report, Dr. Newbern noted that appellant had worked for 28 plus years delivering mail and was currently restricted to a six-mile per day walking limit due to his knee conditions. He indicated that appellant's symptoms noticeably worsened after he fell, from a height of about five feet, while delivering mail on April 14, 2012. Dr. Newbern noted that appellant had four arthroscopies of the left knee and one arthroscopy of the right knee. He reported that the x-rays revealed arthritic narrowing of the medial compartment of both knees, mild narrowing in the patellofemoral compartments with some spurring in both knees, and narrowing of the lateral compartment of the left knee. Dr. Newbern provided an assessment of moderate osteoarthritis of both knees, left more symptomatic than right, which caused appellant constant pain and difficulty walking. He indicated that, in 2012, appellant had grade 3 chondromalacia changes in the femoral trochlea of the right knee and, in March 2013, was found to have grade 3 chondromalacia in the medial femoral condyle of the left knee. Dr. Newbern opined that appellant was a candidate for bilateral knee replacements which he deemed were secondary to his work injury.

On March 18, 2016 OWCP referred the case record and statement of accepted facts (SOAF) to a district medical adviser (DMA) for an opinion regarding the requested bilateral total knee replacements.

[2] The record reflects that, in OWCP File No. xxxxxx993, OWCP accepted a left knee medial meniscus tear that occurred on February 18, 2006. On March 3, 2006 appellant underwent OWCP authorized surgery for complex medial meniscal tear left knee and radial tear of the lateral meniscus of left knee. By decision dated May 9, 2008 OWCP granted appellant a schedule award for 10 percent permanent impairment of the left lower extremity. Under OWCP File No. xxxxxx448, OWCP denied a November 1, 2003 claim for a left knee injury. It combined these claims with the current claim, OWCP File No. xxxxxx848, which serves as the master file.

In an April 21, 2016 report, Dr. William Tontz, a Board-certified orthopedic surgeon serving as a DMA, reviewed the medical evidence of record. He opined that, as there was evidence of a temporal relationship between the April 14, 2012 work injury, the requested bilateral total knee replacements were causally related to the April 14, 2012 work injury. Dr. Tontz further opined, however, that such procedure was not medically necessary as there was insufficient clinical information to support bilateral total knee replacements. He noted that there was no evidence of limited range of motion less than 90 degrees and no evidence of severe osteoarthritis.

OWCP, by letter dated May 3, 2016, referred appellant along with a SOAF, the medical record, and list of questions to Dr. Thomas Rooney, a Board-certified orthopedic surgeon, for a second opinion evaluation. Although appellant attended the June 8, 2016 appointment with Dr. Rooney, OWCP did not receive a medical report from Dr. Rooney and was subsequently advised that Dr. Rooney had passed away.

OWCP referred appellant to another second opinion evaluation, this time with Dr. William F. Blankenship, a Board-certified orthopedic surgeon, to determine whether the proposed bilateral total knee replacement surgery was medically necessary. In an October 4, 2016 report, Dr. Blankenship noted the accepted conditions, his review of the medical records, including appellant's past history for arthroscopies for meniscal tears of the left knee and his right knee arthroscopy. He noted appellant's physical examination findings and provided an impression of bilateral knee arthritis. Dr. Blankenship opined that, although the proposed bilateral knee replacements were causally related to the accepted medical conditions, they were not medically necessary.

On January 24, 2017 OWCP declared a conflict in medical opinion between Dr. Newbern and Dr. Blankenship regarding whether the April 14, 2012 work incident caused the degenerative conditions for which bilateral total knee replacements were medically necessary. Appellant was referred to Dr. Charles D. Varela, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a February 13, 2017 report, Dr. Varela, as a referee physician, reviewed a SOAF and the medical record. On physical examination, he noted that appellant's knees revealed no evidence of swelling and had full range of motion. Appellant was noted to have some parapatellar crepitus with range of motion of both knees, with no ligamentous laxity. There was minimal tenderness to either medical or lateral compartments of both knees and mild parapatellar tenderness bilaterally. Dr. Varela noted that the February 13, 2017 x-ray revealed varus deformities bilaterally and decreased joint space of both medial compartments, left greater than right. He indicated that appellant's joint space was maintained and, with weight bearing, the joint space was decreased, especially on the left side. Dr. Varela provided an impression of bilateral medial compartment arthritis, left greater than right, with varus deformities.

Dr. Varela opined that there was no evidence to support that the April 14, 2012 work injury was the cause of appellant's proposed bilateral knee arthroplasties. He indicated that appellant's condition was degenerative in nature and had been ongoing for some time. Dr. Varela noted that appellant had known preexisting degenerative changes in his left knee. He further indicated that the mechanism of injury did not correlate with the current degree of arthritis present in his right knee. Dr. Varela further opined that there is no evidence to support that his work-related injury

on April 4, 2012 is the cause of his presumed need for bilateral arthroplasties. He also noted that most of appellant's symptoms were not located over areas of his arthritis and that his pain was not over the typical areas of degenerative arthritis. In addition, the x-ray findings showed maintained joint spaces, especially on the right side. While appellant had less joint space present on the left side, his symptoms did not correlate with decreased joint space.

By decision dated March 8, 2017, OWCP denied authorization for bilateral knee replacements. Special weight was accorded to the opinion of Dr. Varela, serving as a referee physician.

On March 15, 2017 appellant notified OWCP that he had obtained Dr. Rooney's second opinion report. On April 3, 2017 he requested a telephonic hearing before an OWCP hearing representative, which was held on September 18, 2017.

OWCP received a copy of a June 8, 2016 report from Dr. Rooney, which noted the history and symptoms reported by appellant and presented physical examination findings. He also reported findings of standing x-rays of both knees performed in his office. Dr. Rooney opined that, while the proposed surgical procedure was within the realm of accepted medical practice, he could not say for sure that the surgical procedure was medically necessary for and causally related to appellant's accepted conditions. He noted that appellant had preexisting degeneration in both knees and that the torn menisci described in Dr. Tucker's right knee operative note of September 24, 2012 were degenerative type tears.

OWCP also received a statement from appellant and medical evidence from Dr. Tucker. In a March 29, 2017 report, Dr. Tucker indicated that he had reviewed appellant's operative report from 2012. He noted that, although there was meniscal damage and some minor changes in the trochlear curve articular surface, appellant did not have signs of significant degenerative change. Dr. Tucker indicated that the degenerative changes did not begin until after his injury and subsequent meniscectomy. Therefore, he believed that the requested total knee replacements were secondary to appellant's work injury. Ongoing treatment notes from Dr. Tucker diagnosing bilateral knee arthritic pain were also provided. A copy of the 2010 operative report was resubmitted.

OWCP referred Dr. Rooney's report to Dr. Varela for review. In a June 14, 2017 supplemental report, Dr. Varela reviewed Dr. Rooney's report and noted that his opinion had not changed, and that a total knee replacement on either knee remained unwarranted. He noted that on physical examination, Dr. Rooney had described mild tenderness and full range of motion of the knee with full pulses. Thus, the indications for total knee arthroplasty (*i.e.*, significant pain which significantly impacts daily activities) was not present. Dr. Varela noted that, in his examination, appellant's described location of pain was not in the area of his knee arthritis. He indicated that while Dr. Rooney had noted that appellant had multiple left knee surgeries and documented degenerative changes prior to his injury date, there was no evidence to suggest with a reasonable degree of certainty that appellant's work injury was the cause of his degenerative condition and any presumed need for surgery that he may or may not have in the future. Rather, appellant's knee conditions were degenerative in nature, had been going on for some time, and most likely had been aggravated by his normal daily activities as well as his multiple previous

surgeries. Dr. Varela opined that a single injury to his right knee in April 2012 would not be the sole cause of his degenerative conditions in either knee.

By decision dated December 1, 2017, an OWCP hearing representative affirmed OWCP's March 8, 2017 decision denying authorization for appellant's bilateral knee replacements. The hearing representative found that Dr. Tucker had not provided sufficient medical reasoning to overcome the special weight of the evidence afforded to Dr. Varela.

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.[3] 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.[4]

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.[5] 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.[6] 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.[7] 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.[8]

Section 8123(a) provides that, if there is a 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.[9] The implementing regulations state that, if a

[3] 5 U.S.C. § 8103; *see L.D.*, 59 ECAB 648 (2008).

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

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

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

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

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

[9] *R.C.*, Docket No. 12-0437 (issued October 23, 2012).

conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[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

The Board finds that OWCP has not abused its discretion in denying authorization for bilateral knee replacements.

OWCP properly found that a conflict in medical opinion evidence arose between Dr. Newbern, appellant's attending physician, and Dr. Blankenship,[12] an OWCP referral physician as to whether the proposed bilateral knee replacements were medically necessary. It thereafter referred appellant to Dr. Varela to resolve the conflict in medical opinion.

For a surgical procedure to be authorized, the evidence must establish 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.[13]

In his February 13, 2017 report, Dr. Varela reviewed appellant's history of injury and treatment, and the SOAF. He provided an impression of bilateral medial compartment arthritis, left greater than right, with varus deformities. Dr. Varela opined that there was no evidence to support that his work-related injury on April 4, 2012 is the cause of his presumed need for bilateral arthroplasties. However, he also found that the proposed surgery was not currently medically necessary. Dr. Varela explained that the bilateral total knee arthroplasties were not medically necessary as appellant was still very functional, had good range of motion, was of a relatively young age, and was only minimally symptomatic and limited from his knee pain. He also noted that most of appellant's symptoms were not located over areas of his arthritis or over the typical areas of degenerative arthritis. In addition, the x-ray findings showed maintained joint spaces, especially on the right side. While appellant had less joint space present on the left side, his symptoms did not correlate with decreased joint space.

In his June 14, 2017 supplemental report, Dr. Varela reviewed Dr. Rooney's second opinion report. Dr. Rooney reported that he could not opine unequivocally that the surgical procedure was medically necessary for and causally related to appellant's accepted conditions. He

[10] 20 C.F.R. § 10.321.

[11] *F.C.*, Docket No. 14-0560 (issued November 12, 2015).

[12] Appellant was referred to Dr. Blankenship as Dr. Rooney, the first referral physician selected, had passed away and OWCP had not received a report from Dr. Rooney.

[13] *Supra* note 8.

noted that appellant had preexisting degeneration of both knees and that the right knee torn menisci described in Dr. Tucker's September 24, 2012 operative note were degenerative-type tears. In his supplemental report, Dr. Varela found that there was no evidence to suggest with any reasonable certainty that appellant's work injury was the cause of his current degenerative condition and the presumed need for any surgery.

The Board finds that Dr. Varela accurately summarized the relevant medical evidence, provided detailed findings on examination, and reached conclusions about appellant's proposed bilateral total knee replacement surgery which comported with his findings.[14]

The evidence from Dr. Tucker, an attending physician, provided subsequent to Dr. Varela's report is insufficient to overcome the special weight accorded to the reports of Dr. Varela as the impartial medical examiner. In his March 29, 2017 report, Dr. Tucker, an attending physician, indicated that appellant's right knee did not have signs of any significant degenerative change in his 2012 operative report. He opined that the degenerative changes did not begin until after his injury and subsequent meniscectomy. Therefore Dr. Tucker believed that the need for total knee replacements were secondary to appellant's work injury. However, he did not provide a rationalized explanation, based upon medical findings, that the proposed bilateral knee replacements were in fact medically necessary.[15]

The Board thus finds that OWCP did not abuse it discretion in denying the proposed surgical procedure. As noted above, the only restriction on OWCP's authority to authorize medical treatment is one of reasonableness.[16] As Dr. Varela explained that the proposed surgery was not medically necessary, the Board finds that OWCP acted reasonably in denying appellant's request for bilateral total knee replacements.[17]

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 of appellant's bilateral total knee replacements.

[14] *Manuel Gill*, 52 ECAB 282 (2001).

[15] *Supra* note 9.

[16] *See D.C.*, 58 ECAB 629 (2007).

[17] *B.L.*, Docket No. 15-1452 (issued September 20, 2016).

ORDER

IT IS HEREBY ORDERED THAT the December 1, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 5, 2019
Washington, DC

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

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

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