United States Department of Labor
Employees' Compensation Appeals Board

A.T., Appellant	)	
and	)	**Docket No. 19-0294**
	)	**Issued: May 29, 2019**
U.S. POSTAL SERVICE, QUEENS VEHICLE PLANT FACILITY, Jamaica, NY, Employer	)	

Appearances:
Stephen Larkin, Esq., for the appellant[1]
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 November 24, 2018 appellant, through counsel, filed a timely appeal from an August 16, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP).[2] Pursuant to the Federal Employees' Compensation Act[3] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[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] The Board notes that counsel did not appeal an October 1, 2018 merit decision which denied authorization of appellant's request to undergo total knee arthroplasty or an OWCP merit decision dated October 16, 2018, which denied modification of the October 1, 2018 decision. Counsel appealed only the merit OWCP decision dated August 16, 2018. Therefore, the Board lacks jurisdiction to review the October 1 and 16, 2018 OWCP merit decisions on this appeal. *See* 20 C.F.R. § 501.3.

[3] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met his burden of proof to establish that the acceptance of his claim should be expanded to include bilateral conditions of knee osteoarthritis, tear of the meniscus, and sprain of the ACL, and a right condition of knee rupture of the ACL causally related to his accepted March 24, 2017 employment injuries.

FACTUAL HISTORY

On March 24, 2017 appellant, then a 50-year-old auto technician mechanic, filed a traumatic injury claim (Form CA-1) alleging that on that same day he sustained injuries to his knees, shin, and chest while in the performance of duty. He stopped work on March 27, 2017 and has not returned to work. In an accompanying narrative statement dated March 29, 2017, appellant noted that on March 24, 2017 he and a coworker had loaded a vehicle bumper into his truck and as he went to move his truck, his pants caught onto the bumper. He claimed that he went flying down onto the bumper hitting both of his knees, the left side of his chest, and right shin. Appellant reported the incident and his injuries to his supervisor on the date of injury.

In support of his claim, appellant submitted a medical report dated March 28, 2017 from Dr. Kioomars Moosazadeh, a Board-certified physiatrist. Dr. Moosazadeh noted that appellant was treated for employment-related bilateral knee injuries sustained on March 24, 2017. He advised that appellant was totally disabled and was unable to return to work until further notice.

OWCP subsequently received additional reports dated March 28 and May 4 and 8, 2017 by Dr. Moosazadeh. In his reports, Dr. Moosazadeh discussed physical examination findings, diagnosed sprain of the anterior cruciate ligament of both knees, and again found that appellant was totally disabled and could not return to work until further notice. In the May 8, 2017 attending physician's report (Form CA-20) he checked a box marked "yes" indicating that the diagnosed condition was caused or aggravated by the claimed March 24, 2017 employment injury.

In a development letter dated June 2, 2017, OWCP notified appellant of the deficiencies of his claim. It advised him of the type of factual and medical evidence needed to establish his claim and provided a questionnaire for his completion. OWCP afforded appellant 30 days to respond.

In a June 1, 2017 report, Dr. Moosazadeh continued to indicate that appellant was totally disabled and that he was unable to work until further notice.

A magnetic resonance imaging (MRI) scan of appellant's left knee was performed on May 24, 2017 by Dr. David Milbauer, a Board-certified diagnostic radiologist. Dr. Milbauer provided impressions of nondisplaced peripheral tear of the body of the medial meniscus, segments of chondral thinning and fissuring involving the medial femoral condyle and lateral tibial plateau, diffuse patellar chondral thinning and deep fissuring involving the medial and lateral patellar facets and segment of full-thickness chondral loss within the femoral trochlea centrally, and small joint effusion, synovitis beneath the ITB and minimal inflammatory changes of the pes anserine bursa. He also performed a right knee MRI scan on the same date. Dr. Milbauer provided impressions of peripheral undersurface tear of the posterior horn of the medial meniscus, torn anterior cruciate ligament, segments of patellofemoral chondral loss including full-thickness chondral loss along the medial patellar facet, localized segment of chondral thinning/fissuring involving the medial

femoral condyle and small focal chondral defect of the lateral tibial plateau centrally, and small joint effusion/synovitis and popliteal cyst.

In a report dated June 6, 2017, Dr. Stephen J. Nicholas, a Board-certified orthopedic surgeon, noted a history that appellant was injured on the job when he fell off a truck. He provided examination findings and reviewed diagnostic test results. Dr. Nicholas also provided assessments of severe osteoarthritis and tear of the meniscus of the bilateral knees and rupture of the anterior cruciate ligament (ACL) of the right knee.

On June 15, 2017 appellant responded to OWCP's development letter. He explained his delay in seeking medical treatment. Appellant claimed that he had contusions on his bilateral knees, right shin, and the left side of his chest. He treated his conditions with ice and ibuprofen. Appellant maintained that he had no prior injury or symptoms.

Appellant submitted reports dated March 28 through June 19, 2017 by Dr. Moosazadeh who again noted the March 24, 2017 work incident, provided examination findings, reviewed diagnostic test results, and addressed appellant's treatment plan.

On July 12, 2017 OWCP accepted appellant's claim for abrasion and contusion of the left knee.

By decision dated July 13, 2017, OWCP denied expansion of the acceptance of appellant's claim to include additional conditions of bilateral knee osteoarthritis, tear of the meniscus, and sprain of the ACL, and right knee rupture of the ACL. It found that the medical evidence of record was insufficient to establish that these conditions were causally related to the accepted March 24, 2017 employment-related incident.

In a July 11, 2017 report, Dr. Moosazadeh continued to opine that appellant was totally disabled from work and that he could not return until further notice.

Dr. Steven Touliopoulos, an attending Board-certified orthopedic surgeon, in a July 11, 2017 report, requested authorization for bilateral knee synvisc-one injections. He noted that appellant remained totally disabled. Dr. Touliopoulos further noted that, if he did not respond appropriately to conservative treatment, then he would likely be a candidate for bilateral total knee arthroplasty. In an August 15, 2017 report, he noted a history of the accepted March 24, 2017 employment injuries and examination findings. Dr. Touliopoulos provided impressions of left knee meniscal tear, chondral injuries, and aggravation of underlying degenerative joint disease; right knee ACL and medial meniscal tears, chondral injuries, and aggravation of underlying degenerative joint disease; right shin injury rule out muscle fascial defect *versus* post-traumatic fibroma *versus* further derangement; and consequential right shoulder impingement syndrome rule out labral, capsule, and rotator cuff injuries consequentially related to a fall caused by right knee dysfunction resulting from appellant's work accident.

OWCP, by decision dated August 25, 2017, denied appellant's claims for leave without pay commencing May 8, 2017 causally related to his accepted March 24, 2017 employment injuries. It found that the medical evidence of record was insufficient to establish disability commencing May 8, 2017.

On August 29, 2017 appellant requested reconsideration of OWCP's July 13, 2017 decision which had denied expansion of the acceptance of his claim.

In an October 10, 2017 report, Dr. Touliopoulos found that appellant was totally disabled and that he was unable to work until further notice. In a report dated November 10, 2017, he reiterated his prior diagnoses.

Undated reports from appellant's physical therapist indicated that appellant was evaluated in October 2017.

By decision dated November 27, 2017, OWCP denied modification of its July 13, 2017 decision. It found that the medical evidence submitted did not contain a rationalized opinion causally relating appellant's additional diagnosed medical conditions to the accepted March 24, 2017 employment injury.

In reports dated November 28, 2017 and January 15, 2018, Dr. Touliopoulos reiterated his prior bilateral knee, right shin, and right shoulder diagnoses and his opinion that the conditions were causally related to the accepted March 24, 2017 employment injuries. In a separate report of the same date and in a January 15, 2018 report, he also reiterated that appellant was totally disabled and was unable to return to work until further notice.

In a letter dated January 18, 2018, OWCP referred appellant, together with a statement of accepted facts (SOAF), the medical record, and a set of questions, to Dr. Timothy Henderson, a Board-certified orthopedic surgeon, for a second opinion to determine whether he continued to suffer from residuals of his accepted work-related conditions.

In a report dated February 2, 2018, Dr. Henderson reviewed appellant's history of injury and medical records, and noted examination findings. He advised that his work-related conditions had not resolved as there was evidence to support that these conditions were still active and causing noted objective findings. Dr. Henderson advised that additional medical recovery should be expected as maximum medical improvement (MMI) had not been obtained. He indicated that appellant's prognosis was fair and that he was a candidate for left total knee replacement followed by six weeks of postoperative physical therapy treatment, three times a week if medical clearance could be obtained as he was overweight. Dr. Henderson found that, based on clinical presentation, he was not currently capable of returning to his date-of-injury job as an auto technician mechanic. Appellant could return to work with restrictions in a sedentary position. Dr. Henderson completed a work capacity evaluation (Form OWCP-5c), which set forth appellant's work restrictions.

OWCP requested, by letter dated February 13, 2018, that Dr. Henderson submit a supplemental report with detailed medical rationale in support of his opinion that appellant continued to suffer from residuals of his accepted conditions. In a letter dated February 14, 2018, Dr. Henderson advised that appellant was not currently suffering from the accepted conditions of left knee contusion and abrasion. He had a severe exacerbation or aggravation of preexisting left knee osteoarthritis and compensatory aggravation of right knee osteoarthritis. Dr. Henderson related findings of a left knee MRI scan. He determined that appellant had reached MMI from his March 24, 2017 injury, however, appellant had a severe exacerbation or aggravation of left knee osteoarthritis and now required a left total knee replacement. Dr. Henderson maintained that he was not able to perform the full duty of his employment due to preexisting and nonwork-related

osteoarthritis. He indicated that appellant had a history of osteoarthritis of both knees and was previously able to perform the full duty of his employment, although the work-related injury had severely exacerbated or aggravated his left knee osteoarthritis.

On March 1, 2018 appellant, through counsel, requested reconsideration of OWCP's July 13, 2017 decision and submitted medical evidence. In a report dated January 3, 2018, Dr. Touliopoulos continued to note a history of the accepted March 24, 2017 employment injuries. He also noted that at the end of June 2017 appellant's right knee buckled at home, which caused him to fall and develop right shoulder derangement. Dr. Touliopoulos related that the right knee would not have buckled if not for his March 24, 2017 right knee injury. He reiterated his prior clinical impressions. Dr. Touliopoulos opined that the diagnosed conditions were causally related to the accepted employment injury. He explained that the knee was comprised of four major ligaments which were critical to the stability of the knee as they attached bones of the knee joint together, the femur and the tibia. Dr. Touliopoulos explained that ACL injuries occurred when the tibia was pushed forward in relation to the femur or a twisting injury. He maintained that this was consistent with appellant banging his right knee into the metal floor. Dr. Touliopoulos related that an acute tear occurred when the knee was bent and forcefully twisted, while the leg was in a weight-bearing position. A torn meniscus could occur because of trauma caused by forceful twisting or hyperflexing of the knee joint. Dr. Touliopoulos maintained that this was consistent with the injury described by appellant where his knee was bent when his pants were caught on the metal bumper causing him to fall and hit his right knee on the metal floor and his left knee on the metal bumper resulting in hyperextension of both knees.

Dr. Touliopoulos noted the definition of arthritis and related that the most common type was the wearing out of joint surface cartilage (osteoarthritis). He related that while the wearing away process did not result from appellant's accident when he hyperextended his knees and the right knee banged into the metal floor and the left knee banged into the metal bumper, that incident could aggravate and accelerate the osteoarthritic condition in his knees. Dr. Touliopoulos further related that the right shoulder injuries were consequentially related to his intervening injury that occurred at the end of June 2017. He noted that as he had noted above, an injury to a ligament could cause articular cartilage to break off and float around in the knee as loose bodies causing the knee to lock. Dr. Touliopoulos maintained that, in appellant's case, the locking of his knee caused it to buckle and fall onto his right shoulder as he was descending steps by his home. When appellant fell and landed on his shoulder an intervening injury occurred resulting in right shoulder derangement. Dr. Touliopoulos described impingement syndrome of the shoulder and maintained that this was consistent with appellant's June 2017 fall resulting from his knee locking up due to his March 24, 2017 employment injury. He advised that double knee replacement was medically necessary due to the extent of injury to his knees.

OWCP received additional reports dated February 27 and March 27, 2018 by Dr. Touliopoulos who continued to reiterate his clinical impressions and opinions regarding causal relationship of additional medical conditions and appellant's total disability.

In a letter dated April 4, 2018, OWCP requested that Dr. Henderson clarify his February 14, 2018 opinion that the accepted March 24, 2017 employment injury had aggravated appellant's preexisting left knee osteoarthritis. On April 16, 2018 it was informed that Dr. Henderson was no longer practicing.

On April 17, 2018 OWCP referred appellant to Dr. Andrew E. Farber, a Board-certified orthopedic surgeon, for a second opinion.

In a report dated April 30, 2018, Dr. Farber reviewed the SOAF and appellant's history of injury and medical records, and noted examination findings. He indicated that appellant fell onto both of his knees. Appellant related to him that he had a subsequent injury a few months later. He was walking down steps when his right knee locked. Appellant fell onto a concrete floor injuring his shoulder. He had been advised that he required a total knee arthroplasty. Appellant related that he had prior right shoulder injury approximately 18 years ago, but he had no issue after that injury. Dr. Farber noted that he denied any other knee injuries. He related that the medical records revealed underlying degenerative change in his knees and that his fall resulted in worsening or aggravation of this pathology. Dr. Farber noted that his examination revealed diffuse tenderness about both knees. There was a palpable effusion about both knees and no gross instability. Flexion and extension was 5/5 bilaterally globally. There was 0 degrees of extension and 100 degrees of flexion on the right, 0 to 95 degrees on the left with discomfort in just about any motion (normal was 0 to 150). A Lachman test did not reveal a firm end point on either knee, although the examination was somewhat limited secondary to discomfort. A McMurray's test was equivocal due to discomfort. At the conclusion of the examination appellant stepped down with discomfort from the examination table and did not use a cane for ambulation. He was unsuccessfully treated with a significant course of conservative treatment, including physiotherapy and visco-supplementation. Dr. Farber indicated that appellant's subjective complaints corresponded with his objective findings. He discussed the results of a left knee MRI scan. Dr. Farber opined that the accepted work-related condition of left knee contusion and left knee abrasion had resolved. He maintained that there was no evidence to support that the work conditions were still active and causing objective findings. Dr. Farber also maintained that no further treatment was indicated for the accepted work conditions. He noted that appellant was not currently working in any capacity, but that he could perform sedentary work. Dr. Farber related that he had moderate disability that was related to his preexisting osteoarthritis and not to his accepted work conditions. He completed an OWCP-5c form, which set forth appellant's work restrictions.

On May 29, 2018 OWCP requested that Dr. Farber submit a supplemental report clarifying whether the additional conditions of osteoarthritis, meniscus tear, and ACL sprain of the bilateral knees, and rupture of the ACL of the right knee were caused or aggravated by the March 24, 2017 work injury.

In a May 29, 2018 report, Dr. Touliopoulos continued to opine that appellant was indefinitely totally disabled from work.

In a letter dated June 1, 2018, Dr. Farber opined that, based on the history provided and the SOAF, appellant fell on his left knee loading a bumper into a truck. He related that there was no objective evidence to support additional diagnosis other than left knee contusion and left knee abrasion. Dr. Farber noted that appellant had a history of prior left knee arthroscopy and additional work injuries involving the left knee with a diagnosis of sprain. He concluded that an additional diagnosis would not be in relation to this work injury.

Dr. Touliopoulos, in a June 26, 2018 report, reiterated his opinion that appellant was indefinitely totally disabled from work.

On July 19, 2018 OWCP requested that Dr. Farber review an updated SOAF[4] and provide a supplemental report indicating whether it impacted his prior responses.

Dr. Farber, in a letter dated July 26, 2018, related that upon his review of the updated SOAF, medical records, and appellant's history, his previously submitted determination remained unchanged. He noted that appellant had preexisting osteoarthritis. There were underlying degenerative changes in his knees. Dr. Farber continued to opine that appellant's work-related conditions had resolved and that he could return to work in a sedentary position.

By decision dated August 16, 2018, OWCP denied modification of its July 13, 2017 decision. It found that the weight of the medical opinion evidence rested with the opinion of Dr. Farber and established that appellant had not sustained additional medical conditions causally related to his accepted March 24, 2017 employment injuries.

LEGAL PRECEDENT

An employee seeking benefits under FECA[5] has the burden of proof to establish the essential elements of his or her claim, including the fact that he or she is an employee of the United States within the meaning of FECA, that the claim was filed within the applicable time limitation, that an injury was sustained while in the performance of duty as alleged, and that any disability or specific condition for which compensation is claimed is causally related to the employment injury.[6] 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.[7]

When an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.[8] To establish causal relationship between the condition, as well as any attendant disability claimed and the employment event or incident, the employee must submit rationalized medical opinion evidence based on a complete factual and medical background, supporting such a causal relationship.[9] 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

[4] The updated SOAF noted, among other things, appellant's prior claims. In appellant's claim assigned OWCP File No. xxxxxx447, OWCP accepted that he sustained left knee strain on September 10, 2004. It accepted that he sustained a lumbar sprain on September 8, 2009 under his assigned OWCP File No. xxxxxx468. OWCP accepted appellant's claim assigned OWCP File No. xxxxxx804 for a left shoulder impingement and cervical strain sustained on June 2, 2012.

[5] *Supra* note 3.

[6] *See F.H.*, Docket No. 18-1238 (issued January 18, 2019); *Tracey P. Spillane*, 54 ECAB 608 (2003).

[7] *K.M.*, Docket No. 15-1660 (issued September 16, 2016); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

[8] *See T.F.*, Docket No. 17-0645 (issued August 15, 2018); *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[9] *See S.A.*, Docket No. 18-0399 (issued October 16, 2018).

between the diagnosed condition and the specific employment factors identified by the claimant.[10] The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[11]

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."[12] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[13]

ANALYSIS

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

OWCP accepted that appellant sustained an abrasion and a contusion of the left knee on March 24, 2017 when his knees struck a vehicle bumper. In reports dated August 15, 2017 through February 27, 2018 Dr. Touliopoulos, appellant's attending physician, noted a history of the accepted March 24, 2017 employment injuries. He examined appellant and provided impressions of left knee meniscal tear, chondral injuries, and aggravation of underlying degenerative joint disease, right knee ACL and medial meniscal tears, chondral injuries, and aggravation of underlying degenerative joint disease, right shin injury rule out muscle fascial defect versus post-traumatic fibroma versus further derangement, and consequential right shoulder impingement syndrome rule out labral, capsule, and rotator cuff injuries. Dr. Touliopoulos opined that appellant's conditions were a consequence of the accepted employment injuries. In his January 3, 2018 report, he explained how the accepted work injuries caused or aggravated the diagnosed conditions. Dr. Touliopoulos maintained that bilateral knee replacement surgery was medically warranted.

By contrast Dr. Farber, an OWCP referral physician, opined in his report dated April 30, 2018 that appellant's employment-related left knee contusion and abrasion had resolved and that appellant could return to sedentary work with restrictions. He further concluded, in reports dated June 1 and July 26, 2018, that appellant had not sustained additional medical conditions as a result of the March 24, 2017 work injuries.

Both Dr. Touliopoulos and Dr. Faber provided a description of the employment injuries and both provided rationale for their respective findings based on their review of the medical evidence and their physical findings. The Board, therefore, finds that a conflict in medical opinion exists regarding whether appellant's bilateral knee osteoarthritis, tear of the meniscus, and sprain

[10] *See P.M.*, Docket No. 18-0287 (issued October 11, 2018).

[11] *F.H., supra* note 6.

[12] 5 U.S.C. § 8123(a).

[13] *See Darlene R. Kennedy*, 57 ECAB 414 (2006).

of the ACL, and right knee rupture of the ACL were causally related to the accepted work injuries of March 24, 2017.[14]

OWCP's regulations provide that, if a 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.[15] The Board will thus remand the case to OWCP for referral to an impartial medical examiner regarding whether the acceptance of appellant's claim should be expanded to include bilateral knee osteoarthritis, tear of the meniscus, and sprain of the ACL, and right knee rupture of the ACL.[16] Following this and any such further development as may be deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the August 16, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: May 29, 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

[14] *See E.C.*, Docket No. 18-0780 (issued October 11, 2018); *W.B.*, Docket No. 17-1994 (issued June 8, 2018).

[15] 5 U.S.C. 8123(a); *see also G.K.*, Docket No. 16-1119 (issued March 16, 2018).

[16] *See E.C.*, *supra* note 14; *P.S.*, Docket No. 17-0802 (issued August 18, 2017).