United States Department of Labor
Employees' Compensation Appeals Board

K.L., Appellant	)	
and	)	**Docket No. 20-0212**
	)	**Issued: October 8, 2020**
U.S. POSTAL SERVICE, WELLESLEY SQUARE POST OFFICE, Wellesley, MA, Employer	)	

Appearances:
John L. DeGeneres, Jr., Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On November 5, 2019 appellant, through counsel, filed a timely appeal from an August 22, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the

[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.

Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of this case.[3]

ISSUE

The issue is whether appellant has met his burden of proof to establish bilateral hip and knee conditions causally related to the accepted factors of his federal employment.

FACTUAL HISTORY

On March 29, 2019 appellant, then a 61-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that he developed bilateral hip and knee osteoarthritis causally related to factors of his federal employment. He indicated that he first became aware of his condition on June 13, 2017 and its relationship to his federal employment on July 16, 2018 based on an examination on that day by Dr. Suzanne L. Miller, an attending Board-certified orthopedic surgeon. In an accompanying narrative statement dated June 27, 2017, appellant attributed his osteoarthritis to daily repetitive movements, which included making 400 deliveries seven or more hours; walking five to nine miles carrying a satchel weighing up to 35 pounds and parcels weighing up to 70 pounds; going up and down thousands of stairs and curbs; lifting, carrying, and delivering several hundred pounds of mail and parcels on foot; getting in and out of his vehicle 125 times; casing mail 1.50 to 2 hours; bending at the hips and knees; and squatting, reaching, stooping, twisting, and pivoting his feet to lift, carry, push, and pull tubs of mail around the office. He performed these duties on a daily basis for 29 years, 5 days per week.

In support of his claim, appellant submitted a March 11, 2019 letter from Dr. Miller who noted a history that in September 2013 appellant experienced right knee pain and received injections in both knees. He had no specific treatment for his hips, but he reported that it was very hard to sleep on his right hip. On June 13, 2017 appellant underwent a right knee replacement, which was performed by Dr. Vivek M. Shah, a Board-certified orthopedic surgeon. He was currently performing full-duty work. Dr. Miller indicated a review of appellant's medical records, reported findings on physical examination, and diagnosed status post right unicompartmental knee replacement, left knee osteoarthritis, and bilateral hip osteoarthritis. She opined that his work duties as a letter carrier, which included repetitive lifting, twisting, bending, walking, and climbing, and excessive walking, bending, stooping, and twisting that he performed for 29 years, contributed to the development and progression of his bilateral hip and knee osteoarthritis and need for right knee arthroplasty. Dr. Miller further opined that appellant's lower extremity osteoarthritis was permanently aggravated by his work. She reasoned that impact loading activities cause repeated local stresses on the hips and knees that accelerate arthritis through a process of chronic inflammation. Dr. Miller noted that walking, squatting, stooping, climbing, bending,

[2] 5 U.S.C. § 8101 *et seq.*

[3] Appellant timely requested oral argument before the Board. 20 C.F.R. § 501.5(b). By order dated October 2, 2020, the Board exercised its discretion and denied the request, finding that the arguments on appeal could adequately be addressed based on the case record. *Order Denying Request for Oral Argument*, Docket No. 20-0212 (issued October 2, 2020). The Board's *Rules of Procedure* provide that an appeal in which a request for oral argument is denied by the Board will proceed to a decision based on the case record and the pleadings submitted. 20 C.F.R. § 501.5(b).

lifting, carrying, and twisting are classic types of impact loading activities. She related that these activities exert repeated local stresses that cause a chronic inflammatory process on the weight-bearing joints of the hips and knees resulting in a chemical change that causes the articular cartilage to become stiffer and less resilient. Dr. Miller indicated that as the less lubricating articular cartilage absorbs stresses from the impact loading activities, the articular cartilage deteriorates. She maintained that, even though it was impossible to parse out percentages, she believed that other factors such as, weight, genetic, non-work stress activities, and others likely also contributed to appellant's arthritis. Dr. Miller also understood, however, that there was no apportionment in these cases and if work activities contributed in any amount, then causation was established. She concluded that, certainly, appellant's work activities of 29 years were a contributing factor to the cartilage of his right knee being degraded to the point where he required a total knee replacement, to the cartilage of his left knee being degraded to two millimeters (mm), and to the cartilage of his hips being degraded to three mm, which was classified as impairing osteoarthritis by the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

Appellant also submitted an official copy of his position description.

OWCP subsequently received medical evidence. A February 1, 2017 bilateral knee x-ray report by Dr. Shah found evidence of moderate-to-advanced osteoarthritis of the right knee, greatest in the medial compartment, mild osteoarthritis of the medial compartment of the left knee, and that both compartments were well maintained with no evidence of medial lateral or anterior posterior subluxation of the femur on the tibia. Additionally, Dr. Shah noted that sunrise views showed that both patellofemoral joint spaces were well maintained without evidence of tilt, subluxation, or fracture of the patella. In an insurance form of even date, he provided an assessment of bilateral knee primary osteoarthritis based on diagnostic imaging.

In an April 7, 2017 progress note, Dr. Andrew W. Chapman, a Board-certified orthopedic surgeon, provided an impression of degenerative joint disease, medial and lateral meniscal tears, and a Baker cyst of the right knee. In a letter of even date, he advised that appellant remain out of work until his next follow-up appointment on May 6, 2015.

Dr. Owen D. Maddox, a Board-certified diagnostic radiologist, indicated in a May 4, 2017 report that a right knee x-ray revealed narrowing of the medial joint compartment space and cortical irregularity of the articular surfaces of the medial joint compartment, and degenerative changes of the patellofemoral joint.

In a report also dated May 4, 2017, a nurse practitioner provided assessments of right knee osteoarthritis as a principal admitting diagnosis; history of atrial flutter on pradaxa, hypertension, and hypertriglyceridemia; and right knee osteoarthritis.

OWCP also received a June 13, 2017 operative report, in which Dr. Shah noted appellant's preoperative and postoperative diagnosis of right knee osteoarthritis. Dr. Shah performed a right medial unicompartmental arthropathy. In a July 12, 2017 report, he indicated that an x-ray of the right knee showed evidence of unicompartmental arthroplasty. Both femoral and tibial components appeared to be well aligned with well-maintained lateral joint space. There was no

[4] A.M.A., *Guides* (6th ed. 2009).

gross medial or lateral and no anterior or posterior subluxation of the femur or tibia. Sunrise views showed well-maintained patellofemoral joint space with no evidence of subluxation or fracture of the patella. In an insurance form of even date, Dr. Shah provided an assessment of right artificial knee joint based on diagnostic imaging. In an August 13, 2017 discharge summary, he noted discharge diagnoses of status post right total knee replacement, history of atrial fibrillation and atrial flutter on chronic anticoagulation, sleep apnea on a continuous positive airway pressure machine, and dyslipidemia.

In a June 16, 2017 letter, Dr. Justin W. Kung, a Board-certified diagnostic radiologist, noted that he had reviewed the May 4, 2017 bilateral knee x-ray results. He reported that, overall, there was a mild degenerative change in both femoroacetabular compartments. Dr. King, in a June 23, 2017 letter, indicated that he had reviewed the findings of the February 1, 2017 bilateral knee x-rays. He advised that, overall, there was a severe degenerative change in the right knee medial compartment and a moderate degenerative change in the left knee medial compartment.

OWCP, in a development letter dated April 25, 2019, informed appellant that the evidence submitted was insufficient to establish his claim. It advised him of the type of medical evidence needed, including a medical diagnosis and a comprehensive narrative report from a qualified physician explaining how factors of his federal employment caused, contributed to, or aggravated his medical condition. OWCP afforded appellant 30 days to respond.

In a response letter dated May 2, 2019, appellant, through counsel, contended that Dr. Miller's March 11, 2019 letter was sufficient to establish his claim as she opined that his employment caused, contributed to, or aggravated his bilateral hip and knee osteoarthritis.

On June 7, 2019 OWCP referred appellant, along with a statement of accepted facts (SOAF) and a copy of the case record, to Dr. Christopher W. Rynne, a Board-certified orthopedic surgeon, for a second opinion examination to determine whether appellant sustained bilateral hip and knee conditions as a result of his employment as a letter carrier.[5]

Dr. Rynne, in a July 22, 2019 report, reviewed the medical record and SOAF. He noted that appellant walked without a limp and did not use ambulatory aids. Dr. Rynne reported that an examination of the hips was unremarkable. He noted that leg lengths were equal. Appellant was asymptomatic. There was 100 degrees of hip flexion with full extension bilaterally. There was 70 degrees of abduction, 10 degrees of internal rotation, and 45 degrees of external rotation of both hips. On examination of the right knee Dr. Rynne found a 4½-inch longitudinal incision just medial to the midline. There was diminished sensation in the typical distribution lateral to the flap consistent with the incision. There was also 110 degrees of flexion and full extension. The right knee was stable to valgus and varus stress. Lachman, anterior drawer, posterior drawer, and flexion rotation drawer tests were negative. On examination of the left knee Dr. Rynne reported the same range of motion measurements and negative Lachman and drawer tests as found on examination of the right knee. He diagnosed osteoarthritis, both hips and knees, and status post right knee hemiarthroplasty. Dr. Rynne opined that appellant had no work-related injury. He reasoned that

[5] Prior to its referral of appellant to Dr. Rynne, OWCP mistakenly referred him to Dr. Miller, as a second opinion physician. In a May 20, 2019 report, Dr. Miller continued to opine that appellant's bilateral osteoarthritis was permanently aggravated by his work duties.

appellant noted a gradual onset of bilateral hip and knee pain. Dr. Rynne further reasoned that his x-rays showed age-related degenerative arthritis. He related that every step that appellant had taken in his life, including leisure time activities and sports, contributed to his age-related degenerative arthritis. Dr. Rynne concluded, therefore, that there was no direct causation between his work and arthritis. He further concluded that there was no temporary or permanent aggravation of a preexisting condition. Additionally, there was no clear-cut evidence that appellant's work accelerated or precipitated his arthritis any more than any other activity he performed during his activities of daily living. Dr. Rynne maintained that his arthritis would likely to continue to progress throughout his natural lifespan whether he continued to work or retire. He further maintained that appellant had age-related osteoarthritis of both hips and knees and was status post right medial compartment hemiarthroplasty with an excellent result. Dr. Rynne advised that he was unable to make a causal relationship between these conditions and appellant's work because the conditions were age related and everything that appellant had done in his entire life contributed to his condition. He concluded that appellant could continue to work in a full-time capacity as a letter carrier with no restrictions.

By decision dated August 22, 2019, OWCP denied appellant's occupational disease claim, finding that the evidence of record was insufficient to establish causal relationship between his diagnosed condition and his accepted factors of federal employment. It accorded the weight of the medical evidence to Dr. Rynne.

LEGAL PRECEDENT

An employee seeking benefits under FECA[6] has the burden of proof to establish the essential elements of his or her claim, including 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 period of FECA,[7] 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.[8] 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.[9]

In an occupational disease claim, appellant's burden requires submission of the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical

[6] *Supra* note 2.

[7] *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

[8] *J.M.*, Docket No. 17-0284 (issued February 7, 2018); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[9] *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).

evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[10]

Causal relationship is a medical issue, and the medical evidence required to establish causal relationship is rationalized medical opinion evidence.[11] 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 between the diagnosed condition and the specific employment factors identified by the claimant.[12]

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.[13] The implementing regulations state 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 a district medical adviser, OWCP shall appoint a third physician to make an examination.[14] 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.[15]

ANALYSIS

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

OWCP referred appellant to Dr. Rynne for a second-opinion evaluation and, in his July 22, 2019 medical report, he opined that appellant's bilateral hip and knee osteoarthritis was age related and not caused, contributed to, or aggravated by his work. Dr. Rynne further opined that appellant had no temporary or permanent aggravation of a preexisting condition. He explained that appellant reported a gradual onset of bilateral hip and knee pain. Dr. Rynne further explained that his x-rays showed age-related degenerative arthritis. He maintained that every step that appellant had taken in his life, including leisure time activities and sports, contributed to his age-related degenerative arthritis. Dr. Rynne advised that his arthritis would likely to continue to progress throughout his natural life span whether he continued to work or retire. He concluded, therefore, that there was no direct causal relationship between appellant's employment and his diagnosed arthritis.

[10] *S.C.*, Docket No. 18-1242 (issued March 13, 2019); *R.H.*, 59 ECAB 382 (2008).

[11] *A.M.*, Docket No. 18-1748 (issued April 24, 2019); *T.H.*, 59 ECAB 388 (2008).

[12] *M.V.*, Docket No. 18-0884 (issued December 28, 2018); *I.J.*, 59 ECAB 408 (2008).

[13] 5 U.S.C. § 8123(a); *see K.F.*, Docket No. 20-0100 (issued June 2, 2020); *Y.A.*, 59 ECAB 701 (2008).

[14] 20 C.F.R. § 10.321.

[15] *K.S.*, Docket No. 19-0082 (issued July 29, 2019); *V.G.*, 59 ECAB 635 (2008); *Gary R. Sieber*, 57 ECAB 414, 416 (2006).

In her March 11, 2019 letter, Dr. Miller, appellant's treating physician, opined that his work duties, which included repetitive lifting, twisting, bending, walking, and climbing, and excessive walking, bending, stooping, and twisting that he performed for 29 years, contributed to and permanently aggravated his bilateral hip and knee osteoarthritis and resulted in the need for right knee arthroplasty. She explained that impact loading activities cause repeated local stresses on the hips and knees that accelerate arthritis through a process of chronic inflammation. Dr. Miller further explained that walking, squatting, stooping, climbing, bending, lifting, carrying, and twisting are classic types of impact loading activities. She noted that these activities exert repeated local stresses that cause a chronic inflammatory process on the weight-bearing joints of the hips and knees resulting in a chemical change that causes the articular cartilage to become stiffer and less resilient. Dr. Miller indicated that, as the less lubricating articular cartilage absorbs stresses from the impact loading activities, the articular cartilage deteriorates. She concluded that appellant's work activities performed for 29 years were a contributing factor to the degradation of the cartilage of his right knee, necessitating a total knee replacement, and the degradation of the cartilage in his left knee and hips, which were classified as an impairing diagnosis of osteoarthritis under the A.M.A., *Guides*.

The Board therefore finds that a conflict in medical opinion has been created between the second opinion physician, Dr. Rynne, and appellant's attending physician, Dr. Miller, regarding whether his bilateral hip and knee osteoarthritis was caused or aggravated by factors of his federal employment.[16] 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.[17]

As there remains an unresolved conflict in medical opinion regarding whether appellant's diagnosed bilateral hip and knee condition is causally related to, or a consequence of, the accepted employment factors, the case shall be remanded to OWCP for creation of an updated SOAF and referral to an appropriate specialist to obtain an impartial medical opinion regarding whether appellant sustained bilateral hip and knee conditions causally related to the accepted factors of his federal employment. Following this and any other further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[16] *K.F., supra* note 13; *S.M.*, Docket No. 19-0397 (issued August 7, 2019).

[17] *Supra* note 13.

ORDER

IT IS HEREBY ORDERED THAT the August 22, 2019 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: October 8, 2020
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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