United States Department of Labor
Employees' Compensation Appeals Board

F.V., Appellant	)	
and	)	**Docket No. 18-0230**
	)	**Issued: May 8, 2020**
DEPARTMENT OF THE AIR FORCE, TINKER AIR FORCE BASE, OK, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Deputy Chief Judge
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On November 13, 2017 appellant filed a timely appeal from June 6 and October 23, 2017 merit decisions 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.[2]

ISSUES

The issues are: (1) whether OWCP properly denied appellant's request for authorization of a total left knee replacement; and (2) whether appellant has met his burden of proof to establish greater than seven percent permanent impairment of the left lower extremity, for which he previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that appellant submitted additional evidence to OWCP following the October 23, 2017 decision. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

FACTUAL HISTORY

On March 31, 2015 appellant, then a 50-year-old tractor operator, filed a traumatic injury claim (Form CA-1) alleging that on March 6, 2015 he sustained a left knee injury in the performance of duty while preparing an aircraft for a tow. He did not initially stop work.

On May 27, 2015 OWCP accepted the claim for sprain of other specified sites, left knee and leg. On September 16, 2015 it authorized left knee arthroscopy.[3] Appellant underwent arthroscopy of the left knee with partial medial meniscectomy and resection of the plica, which was performed by Dr. Richard Langerman, a Board-certified orthopedic surgeon, on October 12, 2015. On January 6, 2016 OWCP accepted other spontaneous disruption of medial collateral ligament of the left knee and sprain of other specified sites of the left knee and leg. Appellant's loss of wage-earning capacity was determined and he was placed on the supplemental rolls as of February 1, 2016.

In a January 14, 2016 report, Dr. Langerman advised that appellant had undergone a left knee arthroscopy and meniscectomy on October 12, 2015. He explained that appellant was then 13 weeks status post procedure. Dr. Langerman diagnosed degenerative joint disease of the left knee. He noted that he discussed appellant's treatment options and that appellant wanted to proceed with a left total knee arthroplasty. Dr. Langerman explained that at the time of his arthroscopy in October, appellant was found to have advanced degenerative changes. He indicated that appellant received cortisone injections and anti-inflammatories without relief.

In a January 14, 2016 form entitled "Total Knee Arthroscopy Documentation of Medical Necessity" Dr. Langerman noted that he had treated appellant and all reasonable conservative treatment had failed, which caused pain and influenced function and now required total left knee arthroscopy. He indicated by checkmark that appellant had advanced joint disease demonstrated by x-ray or magnetic resonance imaging (MRI) scan demonstrating perlarticular osteophytes, joint subluxation, and joint space narrowing. Appellant's findings included pain at the knee that increased with activity, weight bearing, passive range of motion, and the pain interfered with activities of daily life; limited range of motion, crepitus, joint effusion, and swelling were also noted. He also noted that conservative treatment including anti-inflammatory medication, physical therapy, home exercise, and cortisone shots had failed.

On May 12, 2016 OWCP forwarded appellant's medical record and a statement of accepted facts (SOAF) to its district medical adviser (DMA) and requested that he address whether a total left knee arthroplasty was medically necessary and causally related to appellant's accepted conditions.

In a May 20, 2016 report, Dr. Nelson Saldua, a Board-certified orthopedic surgeon acting as the DMA, noted appellant's history of injury and medical treatment with his chief complaint of left knee pain that affected his activities of daily living. He examined appellant's left knee and provided physical examination findings. Dr. Saldua found that a left knee MRI scan from March 12, 2015 revealed grade 2 chondromalacia of the patella. He noted that appellant continued to be symptomatic, despite nonoperative treatment with unloader brace, steroid injection,

[3] The record reflects that appellant underwent a prior left knee arthroscopy performed in 2012 and 2014 and other services were performed in connection with a left knee diagnosis unrelated to the work injury.

nonsteroidal anti-inflammatory drugs, and physical therapy, that appellant underwent a knee arthroscopy with medial meniscal debridement on October 12, 2015. Dr. Saldua further noted that the attending surgeon recommended a total left knee arthroplasty, but that in his opinion the proposed total knee arthroplasty was not causally related to the accepted medical conditions of other spontaneous disruption of medial collateral ligament of the left knee and sprain of other specified sites of the left knee. He explained that a total knee arthroplasty was an acceptable treatment option for end-stage knee osteoarthritis and degenerative joint disease, but it was not a known treatment for the accepted conditions and was therefore not medically necessary. Dr. Saldua found that the criteria for total knee arthroplasty had not been met as there was no documentation of knee ROM less than 90 degrees, no radiology reports documenting significant loss of chondral clear space in at least one of the three compartments, and no documentation of night pain and of current functional limitations demonstrating necessity of intervention. He opined that the proposed total knee arthroplasty was not medically necessary.

On June 28, 2016 OWCP determined that a conflict of opinion existed between Dr. Langerman, the treating physician, and Dr. Saldua, the DMA, with regard to whether a total left knee arthroplasty was medically necessary. It referred appellant, along with the medical record and a SOAF to Dr. Michael Kiehn, a Board-certified orthopedic surgeon for an impartial medical evaluation, to resolve the conflict.

In an August 10, 2016 report, Dr. Kiehn noted appellant's history of injury and treatment and that he presented for evaluation of his left knee. He noted that in March 2015 appellant went home after work, his knee became painful and swollen, and appellant denied a significant trauma. Dr. Kiehn indicated that appellant underwent left knee arthroscopy, partial medial menisectomy and excision of plica, and that appellant continued with pain in the medial aspect of the knee. He noted that appellant had a medial off loader brace, which helped him somewhat, and he was working light duty. Dr. Kiehn also noted that appellant had previously undergone knee surgeries in 2012 and 2014 and that he needed to obtain the surgical notes to determine what procedures were performed. He examined appellant and provided physical examination findings relative to appellant's left knee. Dr. Kiehn reviewed x-rays that revealed severe degenerative changes of the medial compartment of the left knee, no fractures, dislocations, or loose bodies. He noted that a left knee MRI scan in March 2015 had showed significant edema within the medial femoral condyle and possible early avascular necrosis (AVN) of the medial femoral condyle. Dr. Kiehn assessed post left knee arthroscopy, partial medial meniscectomy, and excision of plica. He indicated that appellant had a significant amount of edema within the medial femoral condyle which could be an early AVN of that area. Dr. Kiehn opined that appellant might be a candidate for a partial knee replacement of the medial compartment, but that procedure may very well not be causally related to any work injury. He indicated that he would provide a supplemental report once he received additional records.

In an August 19, 2016 addendum, Dr. Kiehn explained that he reviewed appellant's surgical reports from 2012 and 2014, that appellant had a partial medial meniscal tear and a recurrent meniscal tear, the cartilage was intact. He also noted that appellant's records indicated that during the last surgical procedure in 2015, appellant had chondromalacia findings of the knee, which would predate his date of injury. Dr. Kiehn opined that appellant "would possibly benefit from a partial knee replacement versus a full replacement, but I do feel his need for knee replacement is causally related to his previous two surgeries and not work-related injury by at least 51 percent."

On December 2, 2016 appellant filed a schedule award claim (Form CA-7).

In a development letter dated December 6, 2016, OWCP advised appellant of the type of evidence needed to establish his claim for a schedule award utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] It afforded him 30 days to submit the necessary evidence. No response was received.

In a June 6, 2017 decision, OWCP denied authorization for total left knee arthroplasty. It explained that OWCP's medical adviser, in his report of May 20, 2016, was of the opinion that the total knee replacement was not medically necessary. Additionally, Dr. Kiehn's impartial medical evaluation represented the special weight of the medical evidence and established that, while there might be a benefit to a partial knee replacement, such procedure would not be causally related to the employment injury.

On June 22, 2017 OWCP referred appellant to Dr. Michael Smith, Board-certified in physical medicine and rehabilitation, for a second-opinion examination in order to provide a permanent impairment rating in accordance with the A.M.A., *Guides.*

In an August 8, 2017 report, Dr. Smith noted appellant's March 6, 2015 employment injury. He diagnosed degenerative left knee with recurrent partial medial menisectomy, a medial collateral ligament (MCL) sprain, and a medial femoral condyle fracture. Utilizing Table 16-3 of the A.M.A., *Guides*,[5] Dr. Smith indicated that appellant fell into the category for primary joint knee arthritis, which was a class 1 impairment, and reported a grade modifier for physical examination (GMPE) of 1 and a grade modifier for functional history (GMFH) of 1. After applying the net adjustment formula ((1-1) + (1-1) =0), he determined that appellant had a net adjustment score of 0 for a grade C impairment. Dr. Smith calculated seven percent permanent impairment under primary joint arthritis with cartilaginous defect fracture and MCL sprain. He noted that appellant reached maximum medical improvement (MMI) on August 8, 2017.

OWCP routed appellant's schedule award claim to Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a DMA for review.

In a September 27, 2017 report, the DMA reviewed appellant's medical record, including Dr. Smith's August 8, 2017 report, and concurred with Dr. Smith's findings. He indicated that based on the arthroscopic debridements, rating appellant's permanent impairment of the left knee under Table 16-3 for primary knee joint arthritis at class 1 impairment for primary arthritis was reasonable.[6] The DMA noted that a standing knee x-ray dated July 28, 2016, showed fairly good preservation of the cartilage interval, making it reasonable to rate under primary knee arthritis, 3 mm cartilage interval or full-thickness articular cartilage defect. He further explained that the class 1, default value was seven percent and that after applying the GMFH and GMPE, the adjustment was 0, therefore appellant had a class 1, grade C, permanent impairment rating of seven percent. The DMA also explained that diagnosis-based ratings under Table 16-3 were not marked

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

[5] *Id*. at 511.

[6] *Id.*

by an asterisk and were therefore ineligible for an alternate ROM rating. He indicated that appellant reached MMI on August 8, 2017, the date of Dr. Smith's report.

By decision dated October 23, 2017, OWCP granted appellant a schedule award for seven percent permanent impairment of the left lower extremity, finding that the weight of the medical evidence rested with the second opinion physician, Dr. Smith, and the DMA, Dr. Katz, who correctly applied the A.M.A., *Guides* to Dr. Smith's August 8, 2017 examination findings. The date of MMI was found to be August 8, 2017. The award covered a period of 20.16 weeks, from August 8 through December 27, 2017.

LEGAL PRECEDENT -- ISSUE 1

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.[7] 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.[8]

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.[9] 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.[10] 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.[11] 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.[12]

[7] 5 U.S.C. § 8103; *see M.P.*, Docket No. 19-1557 (issued February 24, 2020); *D.B.*, Docket No. 18-0219 (issued August 17, 2018); *L.D.*, 59 ECAB 648 (2008).

[8] *See B.I.*, Docket No. 18-0988 (issued March 13, 2020); *R.M.*, Docket No. 19-1319 (issued December 10, 2019); *Kennett O. Collins, Jr.*, 55 ECAB 648 (2004); *Debra S. King*, 44 ECAB 203, 209 (1992).

[9] *See J.E.*, Docket No. 18-0228 (issued August 8, 2019); *Daniel J. Perea*, 42 ECAB 214 (1990) (abuse of discretion by OWCP is generally shown through proof of manifest error, clearly unreasonable exercise of judgement, or administrative actions, which are contrary to both logic and probable deductions from established facts).

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

[11] *See K.W.*, Docket No. 18-1523 (issued May 22, 2019); *M.B.*, 58 ECAB 588 (2007).

[12] *See K.W.*, *id.*; *R.C.*, 58 ECAB 238 (2006).

FECA provides that if there is disagreement between an OWCP-designated physician and an employee's physician, OWCP shall appoint a third physician who shall make an examination.[13] For a conflict to arise, the opposing physicians' viewpoints must be of virtually equal weight and rationale.[14] Where OWCP has referred the case to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well-rationalized and based upon a proper factual background, must be given special weight.[15]

ANALYSIS -- ISSUE 1

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

OWCP accepted appellant's March 6, 2015 traumatic injury claim for other spontaneous disruption of medial collateral ligament of the left knee and sprain of other specified sites of the left knee and leg. Appellant underwent a left knee arthroscopy with partial medial meniscal debridement on October 12, 2015.

Appellant's treating physician, Dr. Langerman, thereafter sought authorization for total left knee replacement. However, OWCP's referral physician, Dr. Saldua, indicated that the procedure was not a known treatment for the accepted conditions. Dr. Saldua explained that total knee replacement was an acceptable treatment option for end-stage knee osteoarthritis and degenerative joint disease, but those conditions were not work related.

In light of the differing medical opinions, OWCP properly found a conflict of medical opinion, and referred the case to Dr. Kiehn, for an impartial medical evaluation to resolve the conflict.[16]

In an August 10, 2016 report, Dr. Kiehn advised that appellant might be a candidate for a partial knee replacement of the medial compartment, but such procedure might not be causally related to any employment injury. He related that he would have to evaluate appellant's prior medical records, regarding his prior left knee procedures. In an August 19, 2016 addendum report, Dr. Kiehn explained that he reviewed appellant's operative reports from 2012 and 2014. He opined that appellant would possibly benefit from a partial knee replacement versus a full replacement, but he also opined that appellant's need for knee replacement was causally related to his previous two surgeries and not his work-related injury "by at least 51 percent." The Board has previously explained that it is not necessary to prove a significant contribution of factors of employment to a condition for the purpose of establishing causal relationship.[17] An employee is not required to prove that occupational factors are the sole cause of his claimed condition. If work-related exposures caused, aggravated, or accelerated appellant's condition, it is compensable.[18]

[13] 5 U.S.C. § 8123(a); *see* 20 C.F.R. § 10.321; *Shirley L. Steib*, 46 ECAB 309, 317 (1994).

[14] *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

[15] *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

[16] *See supra* note 14.

[17] *C.H.*, Docket No. 19-1315 (issued March 16, 2020); *J.L.*, Docket No. 17-0782 (issued August 7, 2017); *H.C.*, Docket No. 16-0740 (issued June 22, 2016).

[18] *Id.*

The Board notes that insofar as Dr. Kiehn's report indicates that the requested left knee replacement may be partially related to appellant's accepted work injury and may be medically warranted, his opinion is speculative.

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. The claimant has the burden of proof to establish entitlement to compensation. However, OWCP shares responsibility in the development of the evidence to see that justice is done.[19] Once it undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[20] Because further clarification is required with regard to Dr. Kiehn's opinion, the case must be remanded to OWCP.

On remand OWCP shall request a supplemental report from Dr. Kiehn to obtain a rationalized medical opinion as to whether appellant's request for authorization of left knee replacement is medically necessary due to the accepted employment injury. Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

LEGAL PRECEDENT -- ISSUE 2

The schedule award provisions of FECA[21] and its implementing federal regulations[22] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members, functions, and organs of the body. FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[23] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[24] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guide*s (2009).[25] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[26]

In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the knee, reference is made to Table 16-3 (Knee Regional Grid)

[19] *See L.B.*, Docket No. 19-0432 (issued July 23, 2019); *William J. Cantrell*, 34 ECAB 1223 (1983).

[20] *Id.*; *see also S.A.*, Docket No. 18-1024 (issued March 12, 2020).

[21] 5 U.S.C. § 8107.

[22] 20 C.F.R. § 10.404.

[23] *J.H.*, Docket No. 18-1207 (issued June 20, 2019); *K.P.*, Docket No. 18-0777 (issued November 13, 2018); *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[24] *Id.*

[25] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5 (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[26] *Id.*; *Isidoro Rivera*, 12 ECAB 348 (1961).

beginning on page 509.[27] After the class of diagnosis (CDX) is determined from the Knee Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[28] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[29]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of permanent impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[30] OWCP may follow the advice of its DMA or consultant where they have properly utilized the A.M.A., *Guides*.[31]

ANALYSIS -- ISSUE 2

The Board finds that appellant has not met his burden of proof to establish more than seven percent permanent impairment of the left lower extremity, for which he previously received a schedule award.

As appellant did not obtain a permanent impairment rating from Dr. Langerman, his treating physician, OWCP referred him to Dr. Smith for a second opinion permanent impairment evaluation. In his August 8, 2017 report, Dr. Smith calculated seven percent permanent impairment of the left lower extremity for appellant's accepted conditions, based on the DBI methodology and using the A.M.A., *Guides*. He provided clinical findings and explained how those objective elements warranted the percentage assessed.

Dr. Katz, a Board-certified orthopedic surgeon serving as the DMA, concurred with Dr. Smith's permanent impairment rating.

The Board finds that OWCP properly determined that the impairment ratings by Dr. Smith, the second opinion physician, and Dr. Katz, the DMA, constituted the weight of the medical evidence.[32] Dr. Smith's opinion was based on the SOAF and the medical record. He provided an impairment rating utilizing the appropriate portions of the A.M.A., *Guides*. Dr. Smith described how the objective clinical findings and physical examination warranted the specified percentage of impairment. Dr. Katz, the DMA, concurred with Dr. Smith's seven percent left lower extremity permanent impairment rating and the methodology used. The Board therefore finds that OWCP properly determined that appellant had seven percent permanent impairment of the lower

[27] A.M.A., *Guides* 509-11 (6th ed. 2009).

[28] *Id.* at 515-22.

[29] *Id.* at 23-28.

[30] *Supra* note 27.

[31] *See L.R.*, Docket No. 18-0923 (issued December 9, 2019); *see Ronald J. Pavlik*, 33 ECAB 1596 (1982).

[32] *J.H.*, *supra* note 23.

extremity. There is no probative medical evidence of record demonstrating greater impairment than that previously awarded.[33]

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 the case is not in posture for decision regarding appellant's request for authorization of total left knee replacement. The Board also finds that appellant has not met his burden of proof to establish more than seven percent permanent impairment of the left lower extremity, for which he previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the October 23, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

IT IS FURTHER ORDERED THAT the June 6, 2017 decision of OWCP is set aside and the case is remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: May 8, 2020
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

[33] *See J.M.*, Docket No. 18-1334 (issued March 7, 2019).