

FACTUAL HISTORY

This case has previously been before the Board. In a May 3, 2012 decision, the Board found that the case was not in posture for decision regarding appellant's entitlement to disability compensation for the period March 12 to April 28, 2011. The Board directed OWCP to refer her to an appropriate specialist for a rationalized opinion as to whether she was disabled from work for the period March 12 to April 28, 2011 due to the accepted conditions.² In a July 29, 2013 decision, the Board found that a conflict in medical evidence existed between OWCP referral physician Dr. Zvi Kalisky, a Board-certified physiatrist, and appellant's attending physicians, Dr. Tom G. Mayer, a Board-certified orthopedic surgeon, and Dr. Gregory Powell, a Board-certified physiatrist. The Board remanded the case to OWCP for an impartial evaluation regarding appellant's entitlement to disability compensation for the period March 12 to April 28, 2011.³ The facts and findings of the previous Board decisions are incorporated herein by reference.

Following the Board's July 29, 2013 remand order on August 13, 2013 Dr. Mayer diagnosed chronic left knee and wrist pain and advised that appellant could work six hours of modified duty daily. On November 5, 2013 he advised that she could work eight hours of modified duty daily, effective November 11, 2013. Dr. Mayer continued to submit reports and noted on January 30, 2014 that appellant was working eight hours of modified duty daily.

In April 2014, OWCP referred appellant to Dr. Dale R. Allen, a Board-certified orthopedic surgeon, for an impartial evaluation.⁴ In a May 29, 2014 report, Dr. Allen reviewed the history of injury and medical record, and noted her complaints of pain, stiffness, numbness, and burning in her right arm and left knee. Physical examination of the left knee demonstrated moderate patellofemoral joint crepitus with range of motion and compression which limited walking, standing, and bending of the right knee. Examination of the right elbow demonstrated

² Docket No. 11-2095 (issued May 3, 2012). On August 7, 2008 appellant, a city letter carrier, injured her right elbow and left knee when she tripped and fell while delivering mail. OWCP initially accepted that she sustained a right arm and elbow sprain and later also accepted left patellofemoral dysfunction. Appellant was working limited duty at the time she claimed compensation beginning March 12, 2011. A job description indicated that she was to case mail for delivery for one to two hours, deliver mail for one to six hours, stand for one to four hours, drive to deliver mail for one to six hours, walk to prepare and deliver mail for one to six hours, and lift to prepare and deliver mail for one to eight hours daily.

³ Docket No. 13-105 (issued July 29, 2013). Subsequent to the Board's May 3, 2012 decision, on May 8, 2012 Dr. Larry T. Johnson, Board-certified in surgery and orthopedic surgery, performed left knee arthroscopy for patellofemoral dysfunction. Appellant, who had been working part time and receiving intermittent compensation, was placed on the periodic compensation rolls at a full-time rate thereafter. In June 2012, she was referred to Dr. Kalisky for a second opinion evaluation. In a July 24, 2012 report, Dr. Kalisky advised that appellant was not totally disabled from work for the period March 12 through April 26, 2011. In an August 9, 2012 decision, OWCP denied her claim for compensation for this period. On March 12, 2013 Dr. Johnson performed additional left knee surgery to remove hardware. On May 14, 2013 Dr. Mayer advised that appellant could return to full-time modified duty on June 1, 2013. Appellant returned to work for four hours a day on June 3, 2013. She continued to receive intermittent compensation.

⁴ The statement of accepted facts provided to Dr. Allen advised that the accepted conditions were sprain of elbow and forearm; sprain of knee, lateral collateral ligament, left; other derangement of left knee; enthesopathy of left knee; and fracture patella, closed, left.

tenderness over the lateral epicondyle consistent with lateral epicondylitis which she could tolerate with medication. Dr. Allen advised that appellant could work full time with restrictions. In an attached work capacity evaluation, he limited walking to three hours daily and lifting to 20 pounds. Dr. Allen suggested that appellant might need a hinged knee brace and elbow pad.

On June 6, 2014 appellant filed a schedule award claim and submitted an impairment evaluation dated May 9, 2014 in which Dr. Gregory Powell, a Board-certified physiatrist, described her right elbow and left knee injuries. Dr. Powell examined the right elbow and left knee and diagnosed post-traumatic effusion with chronic postoperative pain left knee, and chronic lateral epicondylitis of the right elbow, after injury. He rated appellant's impairments in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).⁵ Dr. Powell noted that, under Table 16-3, Knee Regional Grid, the most appropriate category would be for the diagnosis of a cruciate ligament injury. He advised that appellant had a class 1 impairment due to mild laxity, with a default value of 10 percent. Dr. Powell found grade modifiers 2 for clinical studies and physical examination and a modifier 1 for functional history. He then applied the net adjustment formula and concluded that appellant had 13 percent left lower extremity impairment. Dr. Powell evaluated her right upper extremity under Table 15-4, Elbow Regional Grid, finding the most appropriate soft tissue diagnosis would be elbow contusion or crush injury with healed minor soft tissue or skin injury, for a class 1 impairment with a two percent default value. He found grade modifiers 1 for clinical studies, 2 for physical examination, and 2 for functional history. Dr. Powell then applied the net adjustment formula and found that appellant had three percent right upper extremity impairment. He concluded that she had reached maximum medical improvement on the date of his examination, May 9, 2014.

In a July 1, 2014 report, Dr. Ronald Blum, a Board-certified orthopedic surgeon and OWCP medical adviser, reviewed the medical record including Dr. Powell's report. He agreed that maximum medical improvement was reached on May 9, 2014. Dr. Powell calculated appellant's right upper extremity and left lower extremity impairments in accordance with Table 15-4 and Table 16-3 of the A.M.A., *Guides*, and agreed with Dr. Powell's conclusion that she had 3 percent permanent impairment of the right arm and 13 percent permanent impairment of the left leg.

On September 12, 2014 OWCP sent Dr. Allen a description of the position appellant was performing when she stopped work on March 12, 2011. On December 8, 2014 Dr. Allen certified that she could perform the duties of the modified position for the period March 12 to April 28, 2011.

By decision dated December 23, 2014, OWCP found that the weight of the medical evidence rested with the opinion of Dr. Allen, the impartial examiner, and concluded that appellant was not entitled to disability compensation for the period March 12 to April 28, 2011.

On March 20, 2015 OWCP granted appellant a schedule award for three percent permanent impairment of the right upper extremity, for 9.36 weeks, to run from January 27 to April 2, 2015. In a second March 20, 2015 decision, appellant was granted a schedule award for

⁵ A.M.A., *Guides* (6th ed. 2009).

13 percent permanent impairment of the left lower extremity, for 37.44 weeks, to run from May 9 to September 20, 2014.

LEGAL PRECEDENT -- ISSUE 1

Under FECA, the term “disability” is defined as incapacity, because of employment injury, to earn the wages that the employee was receiving at the time of injury.⁶ Disability is thus not synonymous with physical impairment which may or may not result in incapacity to earn the wages. An employee who has a physical impairment causally related to a federal employment injury, but who nonetheless has the capacity to earn wages he or she was receiving at the time of injury has no disability as that term is used in FECA.⁷ The test of “disability” under FECA is whether an employment-related impairment prevents the employee from engaging in the kind of work he or she was doing when injured.⁸ Whether a particular injury causes an employee to be disabled for work and the duration of that disability, are medical issues that must be proved by a preponderance of the reliable, probative, and substantial medical evidence.⁹

Monetary compensation benefits are payable to an employee who has sustained wage loss due to disability for employment resulting from the employment injury.¹⁰ The Board will not require OWCP to pay compensation for disability in the absence of any medical evidence directly addressing the specific dates of disability for which compensation is claimed. To do so would essentially allow employees to self-certify their disability and entitlement to compensation.¹¹ Causal relationship is a medical issue. 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 states 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. This is called a referee examination, and

⁶ See *Prince E. Wallace*, 52 ECAB 357 (2001).

⁷ *Cheryl L. Decavitch*, 50 ECAB 397 (1999); *Maxine J. Sanders*, 46 ECAB 835 (1995).

⁸ *Corlisa Sims*, 46 ECAB 963 (1995).

⁹ *Tammy L. Medley*, 55 ECAB 182 (2003).

¹⁰ *Laurie S. Swanson*, 53 ECAB 517 (2002).

¹¹ *William A. Archer*, 55 ECAB 674 (2004); *Fereidoon Kharabi*, 52 ECAB 291 (2001).

¹² *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

¹³ 5 U.S.C. § 8123(a); see *Y.A.*, 59 ECAB 701 (2008).

OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.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 -- ISSUE 1

The Board finds that appellant did not establish that she was disabled for the period March 12 to April 28, 2011 due to the accepted conditions. Appellant's claim was accepted for sprain of elbow and forearm; sprain of knee, lateral collateral ligament, left; other derangement of left knee; enthesopathy of left knee; and fracture patella, closed, left.

In its July 29, 2013 decision,¹⁶ the Board found that a conflict in medical evidence existed between OWCP referral physician Dr. Kalisky and appellant's attending physicians, Drs. Mayer and Powell. The Board set aside an August 9, 2012 OWCP decision and remanded the case to OWCP for an impartial evaluation regarding whether appellant was entitled to disability compensation for the period March 12 to April 28, 2011.

OWCP thereafter referred appellant to Dr. Allen for an impartial evaluation. In his comprehensive report dated May 29, 2014, Dr. Allen reviewed the history of injury and medical record, noted her complaints, and discussed his physical examination findings regarding the left knee and right elbow. He advised that appellant could work full time with restrictions, limiting her walking to three hours daily and lifting to 20 pounds. On September 12, 2014 OWCP sent Dr. Allen a description of the position appellant was performing when she stopped work on March 12, 2011. On December 8, 2014 Dr. Allen certified that she could perform the duties of the modified position for the period March 12 to April 28, 2011.

The Board has carefully reviewed the opinion of Dr. Allen and finds that it has reliability, probative value, and convincing quality with respect to its conclusions regarding the relevant issue in the present case, *i.e.*, whether appellant met her burden of proof to establish that she was entitled to disability compensation for the period March 12 to April 28, 2011. Dr. Allen's opinion is based on a proper factual and medical history and he thoroughly reviewed the factual and medical history and accurately summarized the relevant medical evidence.¹⁷ He reviewed the description of appellant's job duties when she stopped work on March 12, 2011 and certified that she could perform these duties. Dr. Allen's opinion is entitled to special weight as the impartial medical examiner and establishes that she is not entitled to wage-loss compensation for the period March 12 to April 28, 2011.¹⁸

¹⁴ 20 C.F.R. § 10.321.

¹⁵ *V.G.*, 59 ECAB 635 (2008).

¹⁶ *Supra* note 3.

¹⁷ *See Melvina Jackson*, 38 ECAB 443 (1987).

¹⁸ *See P.D.*, Docket No. 12-1690 (issued February 21, 2013).

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.

LEGAL PRECEDENT -- ISSUE 2

The schedule award provision of FECA,¹⁹ and its implementing federal regulation,²⁰ set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.²¹ For decisions issued after May 1, 2009, the sixth edition is used to calculate schedule awards.²²

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).²³ Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).²⁴ The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).²⁵ The A.M.A., *Guides* also provides that, under certain circumstances, range of motion may be selected as an alternative approach in rating impairment. An impairment rating that is calculated using range of motion may not be combined with a diagnosis-based impairment and stands alone as a rating.²⁶

Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.²⁷ The net adjustment formula is (GMFH - CDX) +

¹⁹ 5 U.S.C. § 8107.

²⁰ 20 C.F.R. § 10.404.

²¹ *Id.* at § 10.404(a).

²² Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *see also id.* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 Exhibit 1 (January 2010).

²³ A.M.A., *Guides*, *supra* note 2 at 5, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

²⁴ *Id.* at 385-419.

²⁵ *Id.* at 411.

²⁶ *Id.* at 390. The A.M.A., *Guides* explains that diagnoses in the grid that may be rated using range of motion are followed by an asterisk.

²⁷ *Id.* at 494-531.

(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 procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.³⁰

ANALYSIS -- ISSUE 2

On March 20, 2015 appellant was granted a schedule award for 3 percent permanent impairment of the right upper extremity, and in a second decision that day, she was granted a schedule award for 13 percent permanent impairment of the left lower extremity.

In an impairment evaluation dated May 9, 2014, Dr. Powell provided an impairment rating in accordance with the sixth edition of the A.M.A., *Guides*. He noted that the most appropriate diagnosis for appellant's left knee under Table 16-3 would be a cruciate ligament injury. Dr. Powell found that she had a class 1 impairment due to mild laxity, with a default value of 10 percent, and grade modifiers 2 for clinical studies and physical examination and a modifier 1 for functional history. He then applied the net adjustment formula and concluded that appellant had 13 percent left lower extremity permanent impairment. Dr. Powell evaluated her right upper extremity under Table 15-4, finding the most appropriate soft tissue diagnosis would be elbow contusion or crush injury with healed minor soft tissue or skin injury, for a class 1 impairment with a two percent default value. He found grade modifiers 1 for clinical studies, 2 for physical examination, and 2 for functional history. Dr. Powell then applied the net adjustment formula and concluded that appellant had three percent right upper extremity impairment. He concluded that she had reached maximum medical improvement on the date of his examination, May 9, 2014.

Pursuant to OWCP procedures, on July 1, 2014, Dr. Blum, an OWCP medical adviser, reviewed the medical record including Dr. Powell's report. He agreed that maximum medical improvement was reached on May 9, 2014. The medical adviser calculated appellant's right upper extremity and left lower extremity impairments in accordance with Table 15-4 and Table 16-3 of the A.M.A., *Guides*, respectively and agreed with Dr. Powell's conclusion that she had 3 percent impairment of the right upper extremity and 13 percent impairment of the left lower extremity. There is no evidence of record showing greater impairment.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

²⁸ *Id.* at 521.

²⁹ *Id.* at 23-28.

³⁰ *See supra* note 22 at Chapter 2.808.6(f) (February 2013).

CONCLUSION

The Board finds that appellant did not establish that she was entitled to disability compensation for the period March 12 to April 28, 2011 and that she has no greater than 3 percent permanent impairment of the right upper extremity and 13 percent permanent impairment of the left lower extremity for which she received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated March 20, 2015 and December 23, 2014 are affirmed.

Issued: October 22, 2015
Washington, DC

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

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

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