United States Department of Labor
Employees' Compensation Appeals Board

C.W., Appellant	)	
and	)	**Docket No. 12-804**
	)	**Issued: October 2, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On February 24, 2012 appellant, through his attorney, filed a timely appeal from the February 21, 2012 decision of the Office of Workers' Compensation Programs (OWCP) denying his request for further merit review of his claim and a February 8, 2012 schedule award decision. 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 the case.

ISSUES

The issues are: (1) whether appellant met his burden of proof to establish that he sustained more than an eight percent permanent impairment to his left leg, for which he received a schedule award; and (2) whether OWCP properly refused to reopen appellant's case for further review of the merits under 5 U.S.C. § 8128(a).

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board. In a January 28, 2010 decision, the Board set aside OWCP's October 22, 2008 schedule award decision.[2] The Board found that the case was not in posture for decision as the report of a second opinion physician, Dr. Steven Valentino, was insufficiently rationalized. The Board remanded the case for further development. In a September 26, 2011 decision, the Board again found the case was not in posture for decision.[3] The Board noted that OWCP's medical adviser used findings provided by Dr. Robert Allen Smith, an OWCP referral physician, to rate permanent impairment due to primary knee arthritis. The Board found that it was unclear where measurements necessary for the rating came from, particularly a finding of a three-millimeter full thickness cartilage defect. The Board noted that Table 16-3, page 511 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (6th ed. 2009), (*hereinafter* A.M.A., *Guides*) provided that the class of impairment for primary knee joint arthritis was dependent on cartilage intervals. OWCP's medical adviser indicated that there were no specific measurements of the thickness of the hyaline cartilage on any of the clinical examinations; but nevertheless rated impairment based on a three-millimeter thickness of the cartilage with no supportive x-ray findings. The Board directed that OWCP request that the examining physician conduct appropriate examination of the extremities, including obtaining appropriate x-rays or other testing needed to document the impairment rating. The facts as contained in the prior appeals are incorporated by reference.

By letter dated November 17, 2011, OWCP referred appellant to Dr. Noubar A. Didizian, a Board-certified orthopedic surgeon for a second opinion. In a November 17, 2011 report, Dr. Didizian, reviewed appellant's history of injury and treatment. He examined appellant and determined that his left leg had not reached maximum medical improvement and his condition was getting progressively worse. Dr. Didizian noted that appellant developed a flexion contracture of five degrees and limited flexion of the left knee. Appellant brought in x-rays from March 23, 2010 that revealed degenerative changes in both knees, most pronounced in the patellofemoral joint. Dr. Didizian explained that he measured the joint line and advised that it showed nine millimeters in the thickness of the hyaline cartilage in the medial joint and three millimeters on the lateral joint. He advised that the patellofemoral joint showed one millimeter of articular surface. Dr. Didizian reiterated that appellant had not reached maximum medical improvement and recommended a total knee replacement. He explained that appellant would reach maximum medical improvement 10 to 12 months postsurgery.

In a letter dated December 8, 2011, appellant informed OWCP that he did not wish to have knee replacement surgery. He requested that OWCP proceed with his request for an increased schedule award. In a letter dated December 12, 2011, appellant's representative requested that OWCP advise him of the status of appellant's schedule award. By letter dated December 16, 2011, OWCP advised Dr. Didizian that appellant did not wish to proceed with surgery and requested that he rate appellant's impairment.

[2] Docket No. 11-546 (issued September 26, 2011). The Board also reversed the October 22, 2008 decision that terminated appellant's compensation benefits.

[3] Docket No. 09-290 (issued January 28, 2010).

In a December 29, 2011 addendum report, Dr. Didizian utilized the A.M.A., *Guides*, and referred to Table 16-3 for knee regional grid, page 511 under arthritis. He explained that the primary diagnosis was primary knee joint arthritis. Dr. Didizian stated that he selected class 2 because appellant had a "two millimeter cartilage interval, four being normal. Class 2 has a default impairment value of letter C or 20 percent." Dr. Didizian advised that the grade modifiers for physical examination, functional history and clinical studies were all grade modifier 2. He utilized the net adjustment formula on page 521 and determined that the net adjustment is (2-2) + (2-2) + (2-2) = 0. Dr. Didizian explained that, as a result, there was no adjustment to the default value of letter C and the final impairment was equal to 20 percent of the leg.

By letter dated January 18, 2012, OWCP referred Dr. Didizian's report to an OWCP medical adviser. In a report dated February 6, 2012, Dr. Christopher Brigham, Board-certified in occupational medicine, reviewed appellant's history and the report of Dr. Didizian. He noted that Dr. Didizian assigned a class 2 rating with a default score of 20 percent leg impairment based on his finding of a two-millimeter cartilage interval. Dr. Brigham explained that, on November 17, 2011, Dr Didizian found "nine millimeters in the hyaline cartilage in the medial joint and thickness of three on the lateral joint." He explained that at most there could only be a class 1 impairment for "three-millimeter cartilage interval," which had a default score of seven percent leg impairment. Dr. Brigham referred to section 16.3a, Adjustment Grid Functional History and Table 16-6, Functional History Adjustment Lower Extremities.[4] He assigned a grade modifier 1 for a limp with no routine use of an external orthotic device or singe gait aid. Regarding physical examination findings, Dr. Brigham referred to Table 16-7 and assigned a grade modifier 1, as the physical examination revealed that appellant had mild motion loss with mild placatory findings.[5] Appellant did not have a grade modifier for clinical studies under Table 16-8 as the clinical studies were used to confirm the diagnosis.[6] Dr. Brigham applied the net adjustment formula to find no net adjustment from the default grade C, or seven percent leg impairment. He determined that appellant reached maximum medical improvement on July 12, 2008.

By decision dated February 8, 2012, OWCP found that appellant had seven percent impairment of the left lower extremity. As appellant had already received a schedule award of eight percent, he was not entitled to an additional award.

On February 12, 2012 appellant's attorney requested reconsideration. He noted that OWCP did not obtain a new x-ray. Counsel asserted that Dr. Brigham's report was not that of an OWCP medical adviser as his company had nonphysicians perform impairment ratings.

In a decision dated February 21, 2012, OWCP denied appellant's request for reconsideration without further merit review.

[4] A.M.A., *Guides* 516.

[5] *Id*. at 517.

[6] *Id*. at 518.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA[7] and its implementing regulations[8] 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. For decisions issued after May 1, 2009, the A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[9]

In addressing lower extremity impairments, the sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[10] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[11]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[12]

ANALYSIS -- ISSUE 1

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

It is well established that proceedings under FECA are not adversarial in nature and, while the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[13] Once OWCP undertakes development of the medical evidence, it has the responsibility to do so in a proper manner.[14] The reports from Dr. Didizian and Dr. Brigham are insufficient to resolve the issue of the extent of impairment to appellants' left leg. In the prior appeal, the Board remanded the case because OWCP's medical adviser provided an impairment rating based on a three millimeter thickness of the hyaline cartilage although there were no specific measurements of the thickness of the hyaline cartilage

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] FECA Bulletin No. 09-03 (issued March 15, 2009). A.M.A., *Guides* (6th ed. 2008).

[10] A.M.A., *Guides* 494-531*; see J.B.*, Docket No. 09-2191 (issued May 14, 2010).

[11] A.M.A., *Guides* 521.

[12] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

[13] *Richard E. Simpson*, 55 ECAB 490 (2004).

[14] *Melvin James*, 55 ECAB 406 (2004).

to support this selection. OWCP was instructed to obtain an opinion from an examining physician who conducted appropriate examination, including obtaining an appropriate x-ray examination or other testing needed to document the impairment rating.

In this case, the Board notes that Dr. Didizian did not obtain new x-rays. Rather, he referred to x-rays from March 23, 2010. The Board notes that the March 23, 2010 x-ray did not provide the required information pertinent to an impairment rating for arthritis. A new x-ray examination was not obtained. The Board notes that Dr. Didizian's two reports noted different cartilage interval values. Without objective test findings of record, the Board is unable to make an informed decision. The Board will remand the case for further development of the medical evidence. On remand OWCP should refer appellant for x-ray testing and request an appropriate specialist to address the left knee joint arthritis. Following this and any other further development as deemed necessary, it shall issue an appropriate merit decision on appellant's schedule award claim.

On appeal, counsel also contends that the report from Dr. Brigham is not that of a physician as the impairment evaluation was prepared by a nonphysician and reviewed by Dr. Brigham. It is well established that a physician's signature is required on a report in order for it to be considered as medical evidence.[15] Dr. Brigham signed the report in question and is a physician, as defined under FECA. The February 6, 2012 impairment evaluation constitutes probative medical opinion from a physician.[16]

CONCLUSION

The Board finds this case not in posture for decision.[17]

[15] *Vickey C. Randall*, 51 ECAB 357 (2000).

[16] *B.M.*, Docket No. 11-725 (issued February 17, 2012).

[17] In light of the Board's finding on the first issue, the second issue is moot.

ORDER

IT IS HEREBY ORDERED THAT the February 21, 2012 decision of the Office of Workers' Compensation Programs is set aside and remanded.

Issued: October 2, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board