# United States Department of Labor
# Employees' Compensation Appeals Board

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| **G.G., Appellant** | ) | |
| **and** | ) | **Docket No. 12-1168** |
| | ) | **Issued: February 25, 2013** |
| **U.S. POSTAL SERVICE, DALLAS BULK MAIL CENTER, Dallas, TX, Employer** | ) | |

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

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

### ***JURISDICTION***

On May 3, 2012 appellant filed a timely appeal of an April 19, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this schedule award case.

### ***ISSUE***

The issue is whether appellant has more than 38 percent impairment to the right lower extremity and 49 percent impairment to the left lower extremity, for which he received schedule awards.

On appeal, appellant contends that the medical opinion of Dr. Ronnie D. Shade, an attending Board-certified orthopedic surgeon, is sufficient to establish that his knee problems

[1] Appellant did not appeal a January 23, 2012 OWCP decision denying disability compensation for the period November 22 to December 1, 2011. Thus, the Board will not review this decision on appeal. 20 C.F.R. § 501.3.

[2] 5 U.S.C. § 8101 *et seq.*

were directly related to his accepted employment-related foot injury. He further contends that OWCP improperly refuted Dr. Shade's opinion with the opinions of two of its hand-picked second opinion physicians who failed to conduct a thorough medical examination.

## ***FACTUAL HISTORY***

This case has previously been before the Board.[3] In the March 26, 2008 decision, the Board set aside a January 11, 2007 OWCP decision and remanded the case for further development of the medical evidence to determine the extent of permanent impairment to appellant's left lower extremity. The facts and history as set forth in the prior decision are incorporated by reference.[4] The relevant facts are delineated below.

On remand, OWCP issued a June 18, 2008 decision granting appellant a schedule award for an additional 10 percent impairment to each lower extremity, totaling 38 percent impairment of the right lower extremity and 49 percent impairment of the left lower extremity.

On July 11, 2011 appellant filed a claim for an additional schedule award. In a June 16, 2011 medical report, Dr. Shade noted the accepted conditions including, bilateral general osteoarthritis. He listed findings on physical examination and diagnosed chondromalacia patella of the bilateral knees. Dr. Shade suspected a meniscal tear of the right knee and bilateral healed stress fractures of the proximal tibias. He advised that appellant reached maximum medical improvement on the date of his examination. Dr. Shade determined that he had nine percent impairment to each lower extremity under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) due to arthritis in both knees.

On September 30, 2011 Dr. Ronald Blum, a Board-certified orthopedic surgeon and an OWCP medical adviser, reviewed Dr. Shade's analysis under the sixth edition of the A.M.A., *Guides* and agreed with the nine percent impairment to each lower extremity due to bilateral knee arthritis and date of maximum medical improvement.

Also, on September 30, 2011 Dr. Henry B. Mobley, a Board-certified internist serving as an OWCP medical adviser, reviewed the medical record, including the findings of

[3] Docket No. 07-1257 (issued March 26, 2008).

[4] On August 12, 1991 appellant, then a 41-year-old mailhandler, filed an occupational disease claim alleging that he developed degenerative joint disease and arthritis in his right foot as a result of constant standing and walking at work. OWCP accepted his claim for an aggravation of his preexisting right foot conditions, which included degenerative joint disease, subtaler joint and ankle arthritis, *pes planus* and posterior tibial tendinitis. It also accepted that appellant sustained left flat foot and tibia tendinitis as consequential injuries. OWCP found that he sustained a recurrence of disability on or about September 28, 1999 and accepted his claim for bilateral posterior tibial tendinitis and *pes planus*. It subsequently accepted that appellant sustained bilateral ankle general osteoarthritis and abnormality of gait. On April 8, 2005 OWCP authorized triple arthrodesis and fusion of bones of the right foot which was performed the next day. On August 30, 2005 it authorized the same surgery for the left foot and revision of the left calf tendon. On May 5, 1993 OWCP granted appellant a schedule award for 28 percent impairment to his right lower extremity. On May 22, 1996 it granted a schedule award for 29 percent impairment to his left lower extremity. In the January 11, 2007 decision, OWCP granted 10 percent impairment for an additional schedule award for the left lower extremity, totaling 39 percent.

Drs. Shade and Blum. He determined that under the sixth edition of the A.M.A., *Guides* appellant had an additional six percent impairment to each lower extremity. Dr. Mobley questioned whether bilateral knee arthritis was work related, noting that this condition was previously accepted by OWCP with regard to appellant's accepted ankle injury.

By letter dated November 10, 2011, OWCP referred appellant, together with a statement of accepted facts and the medical record, to Dr. Robert E. Holladay, IV, a Board-certified orthopedic surgeon, for a second opinion. In a December 28, 2011 report, Dr. Holladay diagnosed osteoarthritis of both feet and nonwork-related bilateral knee arthritis. He opined that there was no basis in medical literature or objective evidence to support a conclusion that the development of osteoarthritis of the knee was caused by standing on concrete floors.

On January 18, 2012 Dr. Shade reviewed Dr. Holladay's December 28, 2011 findings. He opined that, based on his review of the medical literature, altered biomechanics along with prolonged standing and walking on hard concrete floors directly caused appellant's bilateral knee osteoarthritis.

On January 26, 2012 Dr. Mobley reviewed Dr. Holladay's December 28, 2011 report and agreed with his opinion that the record did not establish that appellant's bilateral knee arthritis was work related and opined that he did not sustain any additional permanent impairment.

On February 3, 2012 OWCP found that a conflict existed in the medical opinion evidence between Dr. Shade and Dr. Holladay as to whether appellant's bilateral knee general osteoarthritis was causally related to the accepted ankle injury and his employment. By letter dated February 15, 2012, it referred him, together with a statement of accepted facts and the medical record, to Dr. Bernie L. McCaskill, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the conflict, pursuant to 5 U.S.C. § 8123(a).

In a March 20, 2012 report, Dr. McCaskill obtained a history of the accepted employment injuries and appellant's medical treatment and employment background. He noted appellant's complaints of continuous bilateral mid-foot pain equally severe on the left and right, greater right anteromedial knee pain and popping and greater left anteromedial foot pain. Appellant's foot symptoms had decreased by 40 percent since their onset. His knee symptoms had worsened. Appellant rated his current symptoms as 5 to 7 out of 10 in severity. He performed sedentary work with limited standing and walking. Appellant's knee and foot symptoms were aggravated by walking and standing and somewhat relieved by rest. Dr. McCaskill provided a detailed review of the medical records. On physical examination, he reported essentially normal findings except that appellant walked with a slow and somewhat careful, but essentially normal gait. Dr. McCaskill noted that appellant had restricted ankle motion when asked to toe or heel walk on either lower extremity. Mid-thigh circumferences measured 10 centimeters above the superior pole of each patella which were 40 centimeters bilaterally. Maximum mid-calf circumferences were 32 centimeters on the right and 31 centimeters on the left. Dr. McCaskill diagnosed bilateral *pes planus*, chronic symptomatic osteoarthritis of the bilateral knees and persistent chronic bilateral mid-foot pain postbilateral triple arthrodesis.

Dr. McCaskill advised that appellant's knee symptoms appeared to be related to mild nonspecific degenerative changes. Such changes were commonly seen in individuals his age that

did not have significant foot problems. Dr. McCaskill noted that available medical records did not describe significant long-term gait problems. He further noted that, prior to appellant's 2005 bilateral triple arthrodesis, he walked with a calcaneal gait. This implied that appellant bore more weight on his heels than on his forefeet. Dr. McCaskill did not believe that a symmetrical calcaneal gait would likely result in significant abnormal stresses to either knee or in the development of osteoarthritis that otherwise would not have occurred. While appellant certainly had some degree of an abnormal gait in the month following his bilateral foot surgery, when evaluated by Dr. Shade on April 7, 2008 he specifically noted that appellant had a normal gait. Based on his performance of sedentary work since 1991 and limited ability to walk significant distances since that time due to his bilateral foot problems, Dr. McCaskill advised that he was less likely to develop osteoarthritis in either knee than the average individual. He concluded that there was no clear or objective basis in the medical records or history to find that appellant's knee problems which were associated with mild degenerative changes had any direct relationship to his accepted work-related bilateral foot problems. Dr. McCaskill further concluded that although appellant could not perform his usual work duties, he could work eight hours a day with restrictions.

On March 29, 2012 OWCP requested that Dr. Mobley review the medical record, including his prior findings dated September 30, 2011 and January 26, 2012 and the findings of Drs. McCaskill, Shade and Holladay to determine the extent of permanent impairment to appellant's bilateral lower extremities. It also requested that Dr. Mobley convert impairment calculations made on January 24, 2007 to an impairment rating under the sixth edition of the A.M.A., *Guides* as this award had not been paid.[5]

On April 13, 2012 Dr. Mobley advised that appellant reached maximum medical improvement on January 24, 2007. He noted Dr. Strain's July 21, 2006 finding that appellant had 17 percent impairment to each lower extremity due to ankylosis in the plantar flexion of the ankles under the fifth edition of the A.M.A. *Guides*. Dr. Mobley further noted his prior schedule awards for 38 percent impairment to the right lower extremity and 49 percent impairment to the left lower extremity due to surgical ankylosis in the plantar flexion of the bilateral ankles. He, therefore, advised that the award proposed by his evaluation of Dr. Strain's report on January 24, 2007 did not result in any additional impairment as it would be a duplication of the previous

[5] The Board notes that on January 24, 2007 Dr. Mobley reviewed a July 21, 2006 report of Dr. Byron E. Strain, a Board-certified physiatrist, who found that appellant, had 17 percent impairment to each lower extremity due to surgical ankylosis in the plantar flexion of the ankles. He noted Dr. Strain's finding that appellant had bilateral ankle triple arthrodesis and occasional pain in the right ankle, ankle fusion in the plantar flexion on right to 17 degrees and on the left to 16 degrees and neutral inversion and eversion and appellant wore ankle braces and foot inserts. Dr. Mobley determined that under Table 17-24 on page 541 of the fifth edition of the A.M.A., *Guides*, appellant's bilateral ankle ankylosis represented 10 percent impairment. He added this impairment to 16 to 17 degrees of plantar flexion -- 17 percent, resulted in 27 percent impairment to each lower extremity. Dr. Mobley noted the February 11, 1996 opinion of Dr. R. Meador, an OWCP medical adviser, who found that appellant had 29 percent impairment of the left lower extremity based on range of motion deficits of the ankle and hindfoot. He subtracted his 27 percent impairment from the 29 percent impairment to calculate -2 percent impairment to the left lower extremity impairment. Dr. Mobley concluded that appellant had no additional impairment to the left lower extremity, but appellant had 27 percent impairment to the right lower extremity under the fifth edition of the A.M.A., *Guides*. Dr. Mobley noted that this determination did not take into account Dr. Meador's July 26, 2006 determination that appellant had l0 percent impairment to each lower extremity.

awards. Dr. Mobley concluded that conversion under the sixth edition of the A.M.A., *Guides* was not indicated as it would not affect the outcome of the conversion, *i.e.*, it would be a duplication and, therefore, no additional schedule award was warranted.

In an April 19, 2012 decision, OWCP found that the weight of the medical evidence rested with Dr. McCaskill's impartial medical opinion and established that appellant's bilateral knee osteoarthritis was not caused by his employment. It further found that he was not entitled to any additional schedule award for his lower extremities based on Dr. Mobley's April 13, 2012 opinion.

## ***LEGAL PRECEDENT***

A claim for an increased schedule award may be based on new exposure.[6] Absent any new exposure to employment factors, a claim for an increased schedule award may also be based on medical evidence indicating that the progression of an employment-related condition has resulted in a greater permanent impairment than previously calculated.[7]

In determining entitlement to a schedule award, preexisting impairment to the scheduled member should be included.[8] Any previous impairment to the member under consideration is included in calculating the percentage of loss except when the prior impairment is due to a previous work-related injury, in which case the percentage already paid is subtracted from the total percentage of impairment.[9]

The schedule award provision of FECA[10] and its implementing federal regulations,[11] 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.[12] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[13] Effective May 1, 2009,

[6] *A.A.*, 59 ECAB 726 (2008); *Tommy R. Martin*, 56 ECAB 273 (2005); *Rose V. Ford*, 55 ECAB 449 (2004).

[7] *James R. Hentz*, 56 ECAB 573 (2005); *Linda T. Brown*, 51 ECAB 115 (1999).

[8] *Carol A. Smart*, 57 ECAB 340 (2006); *Michael C. Milner*, 53 ECAB 446 (2002).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.7(a)(2) (January 2010).

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

[12] *Ausbon N. Johnson*, 50 ECAB 304 (1999).

[13] *Supra* note 11; *Mark A. Holloway*, 55 ECAB 321, 325 (2004).

FECA adopted the sixth edition of the A.M.A., *Guides*[14] as the appropriate edition for all awards issued after that date.[15]

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).[16] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[17]

OWCP's 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 the medical adviser providing rationale for the percentage of impairment specified.[18]

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.[19] In situations where 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.[20]

## ***ANALYSIS***

OWCP accepted appellant's claim for bilateral flat foot, posterior tibial tendinitis, *pes planus* and bilateral ankle general osteoarthritis and abnormal gait. It authorized triple arthrodesis of the right foot, which was performed on April 6, 2005 and the same surgery for the left foot and revision of the left calf tendon which were performed on September 1, 2005. By June 18, 2008 appellant had received schedule awards totaling 38 percent of the right lower extremity and 49 percent of the left lower extremity. In an April 19, 2012 decision, OWCP denied his claim for an additional schedule award. The Board finds that appellant did not meet his burden of proof to establish greater permanent impairment.[21]

[14] A.M.A., *Guides* (6th ed. 2008).

[15] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[16] A.M.A., *Guides* 494-531.

[17] *Id.* at 521.

[18] *See* Federal (FECA) Procedure Manual, *supra* note 9, Chapter 2.808.6(d) (January 2010).

[19] 5 U.S.C. § 8123(a).

[20] *L.S.*, Docket No. 12-139 (issued June 6, 2012); *Gloria J. Godfrey*, 52 ECAB 486 (2001); *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

[21] An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his claim. *Amelia S. Jefferson*, 57 ECAB 183, 187 (2005).

Due to a conflict between appellant's physician, Dr. Shade, who found that appellant had work-related bilateral knee osteoarthritis and Dr. Holladay, an OWCP referral physician, who found that appellant's bilateral knee arthritis was not work related, OWCP referred appellant to Dr. McCaskill, selected as the impartial medical specialist to resolve the conflict in medical opinion. The Board finds that the special weight of the medical evidence is represented by the thorough, well-rationalized opinion of Dr. McCaskill, the impartial medical specialist selected to resolve the conflict in the medical opinion.[22] Dr. McCaskill opined that appellant's bilateral knee osteoarthritis was not causally related to his accepted employment-related bilateral foot problems. The Board has carefully reviewed the opinion of Dr. McCaskill and finds that it has reliability, probative value and convincing quality with respect to whether appellant sustained work-related bilateral knee osteoarthritis. He noted that appellant's examination was essentially normal. Dr. McCaskill advised that his knee symptoms were related to mild nonspecific degenerative changes which were commonly seen in individuals his age that did not have significant foot problems. He further advised that the medical record did not describe significant long-term gait problems; rather it indicated that he had a normal gait following his 2005 bilateral foot surgery.

Dr. McCaskill further stated that, prior to this surgery, appellant walked with a calcaneal gait which implied that he bore more weight on his heels than on his forefeet. He related that a symmetrical calcaneal gait would not likely result in significant abnormal stresses to either knee or in the development of osteoarthritis that otherwise would not have occurred. Dr. McCaskill indicated that appellant was less likely to develop osteoarthritis in either knee than the average individual based on the sedentary work he performed since 1991 and his limited ability to walk significant distances since that time due to his bilateral foot problems. He concluded that there was no clear or objective basis in the medical records or history to find that the mild degenerative changes in appellant's knees were directly related to the accepted work-related bilateral foot problems.

Regarding the extent of appellant's bilateral lower extremity impairment, Dr. Mobley, an OWCP medical adviser, determined that appellant had no additional permanent impairment. He noted Dr. Strains' July 21, 2006 findings that appellant had 17 percent impairment to each lower extremity due to ankylosis in the plantar flexion of the ankles under the fifth edition of the A.M.A. *Guides*. Dr. Mobley also noted appellant's previous schedule awards for 38 percent impairment to the right lower extremity and 49 percent impairment to the left lower extremity due to his bilateral ankle condition. He advised that the conversion of his January 24, 2007 findings regarding Dr. Strain's report under the sixth edition of the A.M.A., *Guides* was not warranted as this would not result in any additional impairment, but rather a duplication of the bilateral ankle impairment for which appellant previously had received schedule awards. The Board finds that Dr. Mobley's opinion is sufficient to represent the weight of the medical evidence in this case.[23] There is no medical evidence in the record that establishes that appellant has a greater impairment under the sixth edition of the A.M.A., *Guides*. Accordingly, the Board finds that appellant has no greater than 38 percent impairment to his right lower extremity and 49 percent impairment to his left lower extremity, for which he received schedule awards.

[22] *See* cases cited, *supra* note 20.

[23] *See Bobby L. Jackson*, 40 ECAB 593, 601 (1989).

On appeal, appellant contended that Dr. Shade's opinion was sufficient to establish that he sustained a knee condition directly related to his accepted employment-related foot injury. As stated, the special weight of the medical evidence, as represented by Dr. McCaskill's impartial opinion, establishes that appellant's bilateral knee condition was not causally related to his accepted employment-related bilateral foot conditions. Further, appellant's contention that OWCP improperly refuted Dr. Shade's opinion with the opinions of two of its hand-picked second opinion physicians who failed to conduct a thorough medical examination is not supported by the record on appeal. Appellant submitted no evidence establishing bias of any OWCP referral physician.

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. On appeal, he submitted new evidence; but, the Board is precluded from reviewing evidence which was not before OWCP at the time it issued its final decision.[24]

## ***CONCLUSION***

The Board finds that appellant has failed to establish that he has more than 38 percent impairment to the right lower extremity and 49 percent impairment to the left lower extremity, for which he received schedule awards.

[24] *See* 20 C.F.R. § 501(c)(1); *J.T.*, 59 ECAB 293 (2008); *G.G.*, 58 ECAB 389 (2007); *Donald R. Gervasi*, 57 ECAB 281 (2005); *Rosemary A. Kayes*, 54 ECAB 373 (2003).

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the April 19, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 25, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board