United States Department of Labor
Employees' Compensation Appeals Board

J.D., Appellant	)	
and	)	**Docket No. 13-1902**
	)	**Issued: April 11, 2014**
U.S. POSTAL SERVICE, ROSELAND POST OFFICE, Chicago, IL, 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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On August 9, 2013 appellant filed a timely appeal from a February 11, 2013 merit decision 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]

ISSUE

The issue is whether appellant sustained more than 10 percent permanent impairment of the left lower extremity and 10 percent impairment of the right lower extremity, for which she received schedule awards.

[1] 5 U.S.C. § 8101 *et seq.*

[2] Appellant also has another appeal, No. 13-1975, that is proceeding separately to adjudication before the Board.

On appeal, appellant asserts that the opinion of her attending physician establishes a greater percentage of impairment than that awarded. She also contends that OWCP did not properly consider the medical evidence.

FACTUAL HISTORY

OWCP accepted that on December 20, 2002 appellant, then a 45-year-old mail processing clerk, sustained medial meniscal tears of both knees and traumatic arthropathy of both lower legs when she kneeled on a floor to change a post office box lock.[3] On the date of injury, emergency room physicians diagnosed patellar tendinitis and degenerative joint disease.[4]

On January 8, 2009 Dr. Samuel J. Chmell, an attending Board-certified orthopedic surgeon, diagnosed an aggravation of osteoarthritis of both hips. He obtained an April 22, 2009 magnetic resonance imaging (MRI) scan of both ankles showing mild post-traumatic edema, an April 23, 2009 MRI scan of both hips that was within normal limits and an April 23, 2009 MRI scan of both knees showing mild bilateral tricompartmental arthritis with no meniscal tears.[5]

On August 8, 2011 appellant claimed a schedule award. In a November 3, 2011 letter, OWCP advised appellant of the evidence needed to establish her claim for a schedule award due to accepted bilateral meniscal tears and traumatic arthropathy of both lower legs. OWCP directed appellant to submit a report from her attending physician opining that her condition had reached maximum medical improvement and providing an impairment rating according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*).

In a September 16, 2011 letter, Dr. Chmell stated that the December 20, 2002 injury caused chronic "effusion, tenderness, crepitus and diminished range of motion" of both knees. He noted that imaging studies showed chondromalacia, traumatic arthritis and torn medial menisci in both knees. In reports through May 3, 2012, Dr. Chmell diagnosed traumatic arthopathy of both lower legs and bilateral ankle and foot derangement. He found appellant totally disabled for work.

Dr. Chmell submitted a November 25, 2011 impairment rating finding 52 percent impairment of each lower extremity according to the A.M.A., *Guides*. For the right knee, he found a 10 percent impairment according to Table 16-23[6] due to range of motion limited to 5 to

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[3] OWCP initially denied the claim by decision dated September 28, 2011 on the grounds that causal relationship was not established.

[4] A January 2, 2003 left knee x-ray showed minimal spur formation and an intact joint space. December 16, 2003 bilateral hip x-rays were negative for arthritis.

[5] February 8, 2010 electromyography (EMG) and nerve conduction velocity (NCV) studies showed isolated findings of right peroneal nerve injury. November 22, 2010 EMG and NCV studies of both lower extremities showed no evidence of radiculopathy.

[6] Table 16-23, page 549 of the sixth edition of the A.M.A., *Guides* is entitled "Knee Motion Impairments."

100 degrees, 10 percent impairment according to Table 16-6[7] and Table 16-7[8] for physical findings including knee tenderness, effusion, crepitus and a limp, 25 percent impairment according to Table 16-3[9] for imaging studies showing osteophytes and cartilage damage, and 7 percent impairment for right ankle motion limited to 0 to 20 degrees according to Table 16-22.[10] Dr. Chmell added these impairments to equal 52 percent. He noted the same percentages of impairment for the left knee for identical findings, other than knee extension limited to 105 degrees.

On December 20, 2011 OWCP referred the medical record to an OWCP medical adviser for an impairment rating of the left and right lower extremities according to the sixth edition of the A.M.A., *Guides*. It noted that, under File No. xxxxxx862, accepted for aggravation of bilateral hip osteoarthritis and bilateral hip strains, appellant received a schedule award for 10 percent impairment of each lower extremity on February 3, 2009.[11]

In a January 17, 2012 report, an OWCP medical adviser noted that Dr. Chmell did not correctly apply the A.M.A., *Guides*, as he included both restricted motion and a diagnosis-based impairment. He noted that an April 2009 MRI scan of both knees showed no meniscal tears and mild tricompartmental arthritis. The medical adviser opined that the arthritis was due to appellant's morbid obesity, as she weighed 240 pounds and stood 5'3. He stated that there was "no basis for any additional lower extremity" impairment beyond the 10 percent awarded.

By decision dated June 27, 2012, OWCP denied appellant's claim for an increased schedule award on the grounds that the medical evidence did not establish more than 10 percent impairment of each lower extremity, for which she received a prior schedule award.

On July 22, 2012 appellant requested an oral hearing, held November 27, 2012. At the hearing, she contended that the medical evidence substantiated permanent impairments to all extremities. Following the hearing, appellant provided a December 23, 2012 statement asserting that OWCP did not fully consider the medical evidence. She submitted additional medical evidence.

In June 21, August 9, September 27 and December 6, 2012 reports, Dr. Chmell noted pain, swelling and diminished reflexes in both lower extremities. He repeated prior diagnoses.

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[7] Table 16-6, page 516 of the sixth edition of the A.M.A., *Guides* is entitled "Functional History Adjustment -- Lower Extremity Impairments."

[8] Table 16-7, page 517 of the sixth edition of the A.M.A., *Guides* is entitled "Physical Examination Adjustment -- Lower Extremity Impairments."

[9] Table 16-3, pages 509-511 of the sixth edition of the A.M.A., *Guides* is entitled "Knee Regional Grid -- Lower Extremity Impairments."

[10] Table 16-22, page 549 of the sixth edition of the A.M.A., *Guides* is entitled "Ankle Motion Impairments."

[11] Appellant appealed the February 3, 2009 schedule award under File No. xxxxxx862 to the Board. By decision and order issued May 21, 2010, the Board affirmed the February 3, 2009 schedule award for 10 percent impairment of each lower extremity due to limited bilateral hip motion. Docket No. 09-2007.

August 6, 2012 EMG and NCV studies showed bilateral L5 radiculopathy and polyneuropathy of both lower extremities.

By decision dated and finalized February 11, 2013, an OWCP hearing representative affirmed OWCP's June 27, 2012 decision, finding that appellant had not established more than 10 percent permanent impairment of each lower extremity. The hearing representative found that Dr. Chmell misapplied the A.M.A., *Guides*, whereas OWCP's medical adviser provided a well-rationalized opinion explaining that appellant did not establish an increased percentage of permanent impairment.

LEGAL PRECEDENT

The schedule award provisions of FECA[12] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a mater which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[13] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[14]

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).[15] Under the sixth edition, the evaluator identifies 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).

ANALYSIS

OWCP accepted that appellant sustained bilateral meniscal tears and bilateral traumatic arthropathy of the lower legs. Appellant claimed a schedule award on August 8, 2011. Under File No. xxxxxx862, she received a February 3, 2009 schedule award for a 10 percent impairment of each lower extremity due to restricted bilateral hip motion.

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[12] 5 U.S.C. §§ 8101-8193.

[13] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[14] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[15] A.M.A., *Guides* (6th ed. 2008), page 3, Section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[16] A.M.A., *Guides* 494-531 (6th ed. 2008).

In support of her claim, appellant submitted reports from Dr. Chmell, an attending Board-certified orthopedic surgeon, diagnosing bilateral ankle and foot derangement and osteoarthritis of both hips and knees. Dr. Chmell provided a November 25, 2011 impairment rating finding 52 percent of each lower extremity due to limited knee and ankle motion, physical findings on examination, and imaging studies showing cartilage degeneration and arthritis. He referenced specific tables in the sixth edition of the A.M.A., *Guides* in calculating the percentage of impairment. An OWCP medical adviser reviewed the medical record and Dr. Chmell's impairment rating on January 17, 2012. He contended that Dr. Chmell misapplied the A.M.A., *Guides* and that the record did not demonstrate more than the 10 percent impairment of each lower extremity previously awarded. The Board finds, however, that the case is not in posture for a decision.

The medical adviser explained that an April 2009 MRI scan of both knees showed no meniscal tears and opined that appellant's condition was due to her morbid obesity. However, this opinion is of diminished probative value as the basis of his opinion of no additional impairment for the knee region is based on his finding that appellant has no bilateral meniscal tears, a condition accepted by OWCP. The Board notes that it is the function of the medical expert to give an opinion only on medical questions, not to find facts.[17] Therefore, the case will be remanded for further medical development. OWCP shall obtain an appropriate medical opinion regarding appellant's lower extremity permanent impairment with appropriate reference to specific tables and grading schemes of the A.M.A., *Guides,* for any impairment found. Following this and any other development deemed necessary, OWCP shall issue an appropriate decision in the case.

On appeal, appellant contends that OWCP did not fully consider the medical evidence and that Dr. Chmell found her entitled to an increased schedule award. As stated, the case is not in posture for a decision. The case will be remanded to OWCP for additional development.

CONCLUSION

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

[17] *C.C.,* Docket No. 13-446 (issued May 15, 2013). *See Jeannine E. Swanson*, 45 ECAB 325 (1994); *Barbara Bush,* 38 ECAB 710 (1987) (a medical expert should only determine the medical question certified to him; determination of the legal standards in regards to such medical questions is outside the scope of his or her expertise); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.8(c) (September 2010) (OWCP's medical adviser has no authority to decide the facts in a case, as this is a function of the claims examiner).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 11, 2013 is set aside. The case is remanded to OWCP for further development in accordance with this decision.

Issued: April 11, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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