United States Department of Labor
Employees' Compensation Appeals Board

L.R., Appellant	)	
and	)	**Docket No. 14-674**
	)	**Issued: August 13, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Tampa, FL, Employer	)	

Appearances:
Lenin V. Perez, for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 3, 2014 appellant, through his representative, filed a timely appeal from a December 18, 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 established that he sustained more than a two percent permanent impairment of the right lower extremity, for which he received a schedule award.

On appeal, appellant's representative contends that a conflict in the medical opinion evidence warrants a referral to an impartial medical examiner.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the issuance of the December 18, 2013 OWCP decision, appellant submitted new evidence. The Board is precluded from reviewing evidence which was not before OWCP at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c)(1).

FACTUAL HISTORY

OWCP accepted that appellant, then a 56-year-old city letter carrier, sustained a neck sprain, bilateral shoulder sprain, lumbosacral sprain, right knee lateral meniscus tear and chondromalacia of the right patellae in the performance of duty on April 9, 2012. It authorized right knee surgery which appellant underwent on May 21, 2012. Appellant received appropriate disability compensation. He returned to work on February 11, 2013, stopped working due to another injury under OWCP File No. xxxxxx401 and subsequently retired.

On May 10, 2013 appellant, through his representative, filed a claim for a schedule award and submitted an April 9, 2013 report from his attending physician Dr. Samy Bishai, an orthopedic surgeon, who diagnosed internal derangement, torn lateral meniscus, status post partial lateral meniscectomy and weakness of the quadriceps muscle group of the right knee joint and chondromalacia of the right patella. Upon examination, Dr. Bishai found some swelling of the right knee joint and tenderness overlying the lateral joint line and also overlying the patella. Appellant had healed scars of a previous surgical procedure of the arthroscopic surgery that was performed recently on his right knee joint. Range of motion of the right knee joint was from 0 to 100 degrees. Appellant had audible and palpable crepitations overlying the patella during the movements of the knee joint during flexion/extension. Dr. Bishai opined that appellant had reached maximum medical improvement and had a 10 percent permanent impairment of the right lower extremity based on Table 16-23,[3] on page 549, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). He explained that his rating was based on appellant's knee joint "range of motion of [0 to 100] degrees of flexion which placed him in the mild category, giving him an impairment rating of 10 percent of the lower extremity according to Table 16-23."

On May 13, 2013 Dr. Howard P. Hogshead, a Board-certified orthopedic surgeon and OWCP medical adviser, reviewed the medical evidence of record and a statement of accepted facts. He reviewed Dr. Bishai's April 9, 2013 report and explained that he erroneously recommended a 10 percent impairment rating of the right lower extremity based on a range of motion test that was taken too soon after appellant's right knee surgery indicating that the duration of "time [was] not sufficient in order to recover range of motion or strength." Dr. Hogshead concluded that range of motion in a recent postoperative knee was not medically credible for purposes of rating an impairment and placed appellant in class 1, grade C for a meniscus injury under Table 16-3,[4] page 509, equating to a two percent permanent impairment of the right lower extremity. He noted that although numerous other tests had been carried out, including upper and lower extremity electrodiagnostic studies, there was no statement regarding impairment of the upper extremities or left lower extremity.

By decision dated May 14, 2013, OWCP granted appellant a schedule award for two percent permanent impairment of the right lower extremity. The award ran for 5.76 weeks for the period February 11 through March 23, 2013.

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

[4] Table 16-3, pages 509-11 of the sixth edition of the A.M.A., *Guides* is entitled *Knee Regional Grid -- Lower Extremity Impairments.*

On May 20, 2013 appellant, through his representative, requested an oral hearing before an OWCP hearing representative, which was held *via* telephone on October 29, 2013.

By decision dated December 18, 2013, OWCP's hearing representative affirmed the May 14, 2013 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[5] 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.[6] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[7]

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).[8] 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).[9] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX). Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[10]

The sixth edition of the A.M.A., *Guides* also provides that range of motion may be selected as an alternative approach in rating impairment under certain circumstances. A rating that is calculated using range of motion may not be combined with a diagnosis-based impairment and stands alone as a rating.[11]

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[5] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

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

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5 (February 2013); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[8] A.M.A., *Guides* (6th ed. 2009), page 3, section 1.3, The of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[9] *Id*. at 494-531.

[10] *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[11] *See L.B.*, Docket No. 12-910 (issued October 5, 2012).

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 percentage of impairment using the A.M.A., *Guides*.[12]

ANALYSIS

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

The sixth edition of the A.M.A., *Guides* states that diagnosis-based impairment is the primary method of evaluation for the upper[13] and lower[14] extremities and the method of choice for calculating impairment. On the other hand, range of motion based impairment may be used as a stand-alone rating when other grids refer the evaluator to this method or when no other diagnosis-based sections are applicable for impairment rating of a condition.[15] A range of motion impairment stands alone and is not combined with diagnosis impairment.[16] Utilizing Table 16-23, Dr. Bishai found that appellant had reached maximum medical improvement and evaluated appellant based on range of motion. He determined that appellant had a 10 percent permanent impairment of the right lower extremity based on his knee joint "range of motion of [0 to 100] degrees of flexion which placed him in the mild category." Dr. Bishai did not, however, provide any explanation for using the range of motion as opposed to the diagnosis-based estimate.

OWCP's medical adviser, Dr. Hogshead, disagreed and opined that applying Table 16-3 was the best way to determine appellant's impairment on the grounds that range of motion in a recent postoperative knee was not medically credible for purposes of rating an impairment. He placed appellant in class 1, grade C for a meniscus injury, equating to a two percent permanent impairment of the right lower extremity.

The Board finds, however, that Dr. Hogshead's impairment rating is not sufficiently thorough or well-reasoned. Dr. Hogshead did not adequately explain his rating of impairment in the May 13, 2013 report. He did not set forth findings from examination in sufficient detail to allow the Board to fully understand the nature and extent of permanent impairment. It is well established that a physician's opinion should include a description of impairment, including the loss in degrees, range of motion of affected members, any atrophy or deformity, decreases in strength or disturbance of sensation in such detail as those reviewing the file will be able to clearly visualize the impairment with all its limitations.[17] Additionally, Dr. Hogshead noted that

[12] Federal (FECA) Procedure Manual, *supra* note 7 at Chapter 2.808.6(f) (February 2013); *see also D.H.*, Docket No. 12-1857 (issued February 26, 2013).

[13] A.M.A., *Guides* 387, 461

[14] *Id*. at 497, 543.

[15] *Id.* at 461, 543. *See also id.* at 387, 497 (Range of motion is used primarily as a physical examination adjustment factor and is only used to determine actual impairment values when a grid permits its use as an option or it is not possible to otherwise define impairment).

[16] *Id.* at 405.

[17] *See Peter C. Belkind*, 56 ECAB 580 (2005).

numerous tests had been carried out, including upper and lower extremity electrodiagnostic studies, yet he did not evaluate any impairment related to appellant's accepted neck sprain, bilateral shoulder sprain and lumbosacral sprain conditions.

Accordingly, the Board will set aside OWCP's December 18, 2013 decision and remand the case for an OWCP referral physician to conduct a physical examination and determine the nature and extent of appellant's permanent impairment. Following this and such further development of the evidence as may be necessary, OWCP shall issue a *de novo* decision on appellant's claim for a schedule award.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the December 18, 2013 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion of the Board.

Issued: August 13, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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