United States Department of Labor
Employees' Compensation Appeals Board

B.T., Appellant	)	
and	)	**Docket No. 15-0956**
	)	**Issued: August 4, 2015**
U.S. POSTAL SERVICE, FORT DEARBORN STATION, Chicago, IL, Employer	)	

Appearances:
Stephen V. Barszcz, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 25, 2015 appellant, through counsel, filed a timely appeal from a January 15, 2015 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 the case.

ISSUE

The issue is whether appellant established that she has more than 23 percent permanent impairment of the left lower extremity for which she received a schedule award.

On appeal counsel asserts that OWCP erred in not relying on the impairment rating of the attending physician or, in the alternative, that it erred by not finding a conflict in the medical evidence regarding appellant's degree of left lower extremity impairment.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On September 28, 2009 appellant, then a 41-year-old letter carrier, filed an occupational disease claim alleging that work duties caused pain and swelling of her left knee. On December 30, 2009 OWCP accepted temporary aggravation/exacerbation of the following preexisting conditions of the left knee medial meniscus tear, lateral meniscus tear, and degenerative joint disease.[2] On March 11, 2010 appellant had arthroscopic repair of torn menisci and anterior collateral ligament with chondroplasty. On February 8, 2011 Dr. Scott M. Sporer, a Board-certified orthopedic surgeon, performed a left total knee arthroplasty.

In a February 15, 2012 report, Dr. Sporer noted appellant's pain had markedly improved and that she had returned to bowling and would like to begin roller skating. Physical examination demonstrated a well-healed surgical incision, full extension, flexion to 125 degrees, and the knee was stable to varus and valgus stresses. There was no effusion, and appellant's calves were soft and nontender with no clinical signs of deep vein thrombosis. Dr. Sporer indicated that left knee x-ray showed well-fixed components with a centrally tracking patella and a restored mechanical axis. He concluded that appellant was doing well. On February 27, 2013 Dr. Sporer reported that she had no pain or discomfort in her left knee and was very happy with the surgical outcome. On examination, surgical sites had healed. Appellant had full extension, flexion to 125 degrees, and was stable to varus and valgus stresses with no effusion present. Dr. Sporer advised that a left knee x-ray demonstrated the components were well fixed, and there had been no interval change. He concluded that appellant was doing well and recommended reevaluation in three years.

A May 26, 2013 left knee x-ray demonstrated a stable appearance when compared to a June 25, 2012 study. The prosthesis remained in satisfactory alignment with no radiographic evidence of loosening.

On September 25, 2013 appellant filed a schedule award claim and submitted a September 9, 2013 report in which Dr. Anatoly M. Rozman, a Board-certified physiatrist, noted his review of medical records. Dr. Rozman advised that she had reached maximum medical improvement. He noted that appellant had a long course of rehabilitation and work conditioning, and was eventually able to return to work but continued to have significant pain and problems ambulating, especially walking up stairs. Physical examination demonstrated a mildly swollen left knee with mild valgus deviation and flexion of 95 to 100 degrees with full extension. Strength was 5-/5 on extension and flexion, sensation mildly decreased in the saphenous nerve distribution, and there was no muscle atrophy. Plantar and dorsiflexion strengths were close to normal. Appellant could not walk on toes on the left but could walk on heels. Left hip strength was preserved. Dr. Rozman indicated that she walked with a slight left-sided limp. He advised that he evaluated appellant's left lower extremity in accordance with Table 16-3, Knee Regional Grid, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*)[3] and found that she had a class 3, grade C

[2] In a separate claim, adjudicated by OWCP under file number xxxxxx347, accepted conditions are bilateral knee sprains, sprains of the cervical, thoracic, and lumbar spines, lateral meniscus tear of the right knee, and contusion of the left knee. The instant case was adjudicated by OWCP under file number xxxxxx455.

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

impairment with a fair result for 35 percent permanent impairment due to fair position and mild motion deficit with mild valgus, mildly decreased flexions, and mild weakness in the left knee. Dr. Rozman found a grade modifier of two for Functional History (GMFH), based on antalgic limp with asymmetric shortening of stance, and a grade modifier of two for Physical Examination (GMPE), based on moderate palpatory findings consistent with documented and supportive observed abnormalities. He applied the net adjustment formula and concluded that appellant had 31 percent permanent impairment of the left leg.

In a January 12, 2014 report, Dr. Christopher Gross, an OWCP medical adviser, advised that he used Dr. Sporer's physical examination findings rather than those of Dr. Rozman because Dr. Sporer had arthroplasty expertise with significantly more experience regarding appellant's condition than Dr. Rozman. He indicated that maximum medical improvement was reached on March 13, 2012 and, based on Table 16-3, appellant had a class 2 diagnosis, a good result after total knee arthroplasty, which had a 25 percent median rating. Dr. Gross found a grade 1 modifier for functional history, based on a mild deficit, no modifier for physical examination because her examination was relatively normal without tenderness, no alignment deformity, and no muscle atrophy. He applied the net adjustment formula and concluded that appellant had a 23 percent left lower extremity impairment.

By decision dated May 27, 2014, appellant was granted a schedule award for 23 percent impairment of the left lower extremity, for a period 66.24 weeks, to run from March 13, 2012 to June 19, 2013.

On October 17, 2014 appellant, through counsel, requested reconsideration. Counsel asserted that the opinion of Dr. Rozman should be credited because it was based on physical examination findings that were more recent than those of Dr. Sporer.

In a September 22, 2014 report, Dr. Rozman, who did not reexamine appellant, reiterated the findings and conclusions of his September 9, 2013 examination. He noted his disagreement with Dr. Gross' evaluation, stating that appellant's left knee condition had deteriorated. Dr. Rozman continued to maintain that appellant had 31 percent left lower extremity impairment.[4]

By report dated November 24, 2014, Dr. David H. Garelick, an OWCP medical adviser and a Board-certified orthopedic surgeon, noted his review of record, including Dr. Rozman's September 22, 2014 report. He stated that he could not discount Dr. Sporer's report describing knee flexion to 125 degrees, stating that in the absence of significant failure of the replacement as would occur with trauma, aseptic loosening, or infection, it was very atypical that the knee range of motion would decrease so much from 125 degrees to 95 to 100 degrees. Dr. Garelick concluded that he would credit Dr. Sporer's opinion as an orthopedic surgeon over that of Dr. Rozman and would recommend no change in appellant's impairment rating.

In a merit decision dated January 15, 2015, OWCP denied modification and affirmed the May 27, 2014 schedule award decision.

[4] Appellant also submitted a June 26, 2014 functional capacity evaluation that does not include an impairment rating.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing federal regulations[6] 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.[7] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

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).[9] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment class for the Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on functional history, physical examination and Clinical Studies (GMCS).[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11] 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.[12] Section 16.2a of the A.M.A., *Guides*, provides that if the class selected is defined by physical examination findings or clinical studies results, these same findings may not be used as grade modifiers to adjust the rating.[13]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the 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.[14]

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id*. at § 10.404(a).

[8] FECA Bulletin No. 09-03 (issued March 15, 2009).

[9] *Supra* note 3 at 4, section 1.3, "ICF: A Contemporary Model of Disablement."

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

[11] *Id*. at 521.

[12] *Id*. at 23-28.

[13] *Id*. at 500.

[14] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

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.[15]

ANALYSIS

The Board finds that this case is not in posture for decision as a conflict in medical evidence has been created between the opinions of Dr. Rozman, appellant's physician, and Drs. Gross and Garelick, the medical advisers, regarding the degree of impairment of appellant's left lower extremity.

The accepted conditions in this case are temporary aggravation/exacerbation of the following preexisting conditions of the left knee: medial meniscus tear, lateral meniscus tear, and degenerative joint disease. On February 8, 2011 Dr. Sporer performed a left total knee arthroplasty.

Dr. Rozman and Drs. Gross and Garelick evaluated appellant's left lower extremity based on the diagnosis of total knee arthroplasty, found in Table 16-3, Knee Regional Grid, of the sixth edition of the A.M.A., *Guides.*[16] This table indicates that in rating a total knee arthroplasty, for a class 2 impairment, moderate problem, the procedure should have a good result with good position, be stable and functional, and for a class 3 impairment, severe problem, there should be a fair result with fair position, mild instability, and/or mild motion deficit.[17]

In a September 9, 2013 report, Dr. Rozman advised that appellant suffered from significant pain and had problems ambulating. He reported examination findings of a mildly swollen left knee, mild valgus deviation, flexion of 95 to 100 degrees, and full extension. Strength was 5-/5 on extension and flexion, and sensation was mildly decreased in the saphenous nerve distribution. Dr. Rozman further indicated that appellant walked with a slight left-sided limp. He advised that, in accordance with Table 16-3, she had a class 3 impairment for 35 percent impairment and, after applying the net adjustment formula, concluded that she had 31 percent permanent impairment of the left lower extremity.

Dr. Gross advised on January 12, 2014 that he used Dr. Sporer's examination finding rather than Dr. Rozman's because Dr. Sporer had arthroplasty expertise with significantly more experience regarding appellant's condition than Dr. Rozman. He advised that under Table 16-3, appellant had a class 2 impairment which had a 25 percent default value. After applying the net adjustment formula, Dr. Gross concluded that she had 23 percent left lower extremity impairment. On the basis of Dr. Gross' report, appellant was granted a schedule award for 23 percent left leg impairment. On November 24, 2014 Dr. Garelick recommended no change in her rating, stating that he would credit Dr. Sporer's opinion as an orthopedic surgeon over that of Dr. Rozman.

[15] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

[16] *Supra* note 3 at 511.

[17] *Id*.

The Board finds the opinions of Dr. Rozman, for appellant, and Drs. Gross and Garelick, for OWCP, to be of equal weight. Thus, a conflict in medical opinion evidence has been created regarding the extent of appellant's left leg impairment. The Board will set aside the January 15, 2015 decision and remand the case for OWCP to refer appellant to an appropriate impartial medical specialist to resolve the conflict. After such further development as it deems necessary, OWCP shall issue a *de novo* decision regarding the extent of permanent impairment to appellant's left lower extremity.

CONCLUSION

The Board finds this case is not in posture for decision as a conflict in medical evidence has been created regarding the extent of impairment of appellant's left lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the January 15, 2015 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for proceedings consistent with this decision of the Board.

Issued: August 4, 2015
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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