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

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| **W.H., Appellant** | ) | |
| **and** | ) | **Docket No. 16-0806** |
| | ) | **Issued: December 15, 2016** |
| **U.S. POSTAL SERVICE, POST OFFICE, Cleveland, OH, Employer** | ) | |

*Appearances:*
*Alan J. Shapiro, Esq.*, for the appellant[1]
*Office of Solicitor*, for the Director

## DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

### ***JURISDICTION***

On March 10, 2014 appellant, through counsel, filed a timely appeal from a December 21, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 the case.

### ***ISSUE***

The issue is whether appellant has more than two percent permanent impairment of the right leg for which he received a schedule award.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

## ***FACTUAL HISTORY***

On December 1, 2006 appellant, then a 49-year-old letter carrier, injured his right knee when he pivoted to retrieve mail for casing. OWCP accepted his claim for right knee sprain and expanded it to include internal derangement of the posterior horn of the medial meniscus of the right knee and medial meniscus tear of the right knee. Appellant did not stop work, but returned to a light-duty position.

A December 1, 2006 x-ray of the right knee revealed no fractures or dislocations. Appellant was treated by Dr. Steven P. Combs, a Board-certified orthopedist, on December 7, 2006, for a right knee injury sustained at work. He reported that on December 1, 2006 while casing mail, he pivoted and felt a snap in his right knee. Dr. Combs noted tenderness over the anteromedial aspect of the right knee with mild laxity. On January 11, 2007 he noted a magnetic resonance imaging (MRI) scan of the right knee revealed a tear of the posterior horn of the medial meniscus. Dr. Combs diagnosed a torn posterior horn of the medial meniscus. Appellant submitted an April 17, 2007 MRI scan of the right knee, which revealed a horizontal tear involving the posterior horn of the medial meniscus, no evidence of ligamentous injury, and a small Baker's cyst. On July 5, 2007 Dr. Combs performed an authorized arthroscopic right medial meniscectomy.

On May 11, 2009 appellant filed a claim for a schedule award (Form CA-7).

In a December 17, 2009 letter, OWCP requested that appellant obtain a medical report from his treating physician evaluating the extent of his permanent impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*).[3]

Appellant submitted reports from Dr. Combs. These included a July 2, 2009 report noting that the right knee was essentially normal with full range of motion. The knee was nontender with no effusion, erythema, or induration. X-rays were normal.

In an October 6, 2010 report, Dr. William N. Grant, a Board-certified internist, opined that appellant had 28 percent impairment of the right leg. He found right knee weakness, stiffness, and discomfort, occasional swelling, and mild tenderness to palpation. Dr. Grant diagnosed right knee sprain and right derangement post medial meniscus surgery. Utilizing Table 16-23 on page 549 of the A.M.A., *Guides,* he found flexion contracture was 5 degrees for 10 percent impairment and flexion was 75 degrees for 20 percent leg impairment. Dr. Grant combined these values to yield total right leg permanent impairment of 28 percent.

In a January 27, 2010 report, an OWCP medical adviser reviewed the medical record and Dr. Grant's October 6, 2010 findings. He noted that he was unable to provide an impairment rating because Dr. Grant's report contained inaccurate information. The medical adviser noted that appellant sustained a torn medial meniscus of the right knee. Under the A.M.A., *Guides,* Table 16-3, page 509 of the knee regional grid, the default rating for a medial meniscus tear was class C, or two percent impairment of the right leg with a maximum of three percent impairment

[3] A.M.A., *Guides* (6th ed. 2009).

with grade modifiers. The medical adviser noted that Dr. Grant's finding of 28 percent impairment was inaccurate. He recommended referring appellant to a second opinion physician for an impairment rating.

On October 26, 2011 OWCP referred appellant to Dr. Robert J. Nickodem, Jr., a Board-certified orthopedic surgeon, for a second opinion evaluation of appellant's permanent impairment under the A.M.A., *Guides*. In a report dated October 26, 2011, Dr. Nickodem noted a history of appellant's December 1, 2006 injury and the subsequent July 5, 2007 surgery. He noted findings that included no erythema, no swelling, no instability, intact muscle strength, and intact sensation. Range of motion for the right knee was to 135 degrees. Dr. Nickodem diagnosed surgically corrected internal derangement of the posterior horn. He noted that appellant reached maximum medical improvement. Dr. Nickodem noted that appellant had normal range of motion of the right knee and was unable to explain Dr. Grant's findings of significant loss of range of motion. Under Table 16-3, Knee Regional Grid, Meniscal Injury, of the A.M.A., *Guides*, he calculated that appellant had two percent right leg impairment. Dr. Nickodem noted that appellant's AAOS score was 73, which constituted a functional history grade modifier of 1, physical examination noted minimal findings for a grade modifier of 1, and clinical studies were a grade modifier of 1 for the findings on the MRI scan. He applied the net adjustment formula, which yielded zero adjustment. Dr. Nickodem noted that appellant was a class 1, grade C, partial medial meniscectomy for two percent right leg impairment.[4]

In a report dated December 30, 2011, an OWCP medical adviser concurred with Dr. Nickodem's determination. He noted that pursuant to the A.M.A., *Guides* appellant had two percent impairment of the right lower extremity.

OWCP determined that there was a conflict of opinion between Dr. Grant, appellant's treating physician who found 28 percent impairment of the right leg, and Dr. Nickodem, the second opinion physician, who opined that appellant had 2 percent right leg impairment due to the accepted conditions. It prepared questions for the selected specialist advising that a conflict of medical opinion was present concerning the percentage of permanent impairment caused by the work injury of December 11, 2006.[5]

On May 14, 2012 OWCP referred appellant to Dr. Nasimullah Rehmatullah, a Board-certified orthopedic surgeon selected to act as a referee physician. Dr. Rehmatullah indicated, in a June 4, 2012 report, that he reviewed the record and examined appellant. He noted that appellant had reached maximum medical improvement. Dr. Rehmatullah noted appellant's complaints of pain in the medial side of the right knee. Physical examination revealed that appellant walked without a limp and was able to squat down with some discomfort over the medial side of the right knee. The right quadriceps was ½ inch smaller than the left side. Appellant had no gross knee instability, but had tenderness in the medial joint line.

[4] A.M.A., *Guides* 509.

[5] OWCP asked that the referee specialist respond to its questions with as much detail as possible. It advised that the specialist must use the A.M.A., *Guides*, sixth edition and that the report must: "reference all pertinent objective and subjective findings, including any diagnostic evidence, and show how you applied the criteria/tables in the A.M.A., *Guides*, [sixth] [e]dition" and that it must "provide a clear explanation regarding your calculations. If any information is missing to correctly calculate the percentage, please indicate the specific evidence that is needed."

Dr. Rehmatullah diagnosed twisting injury to the right knee on December 1, 2006 with a tear of the medial meniscus and status postsurgery on July 5, 2007. He noted that appellant had quadriceps atrophy on the right side, full range of motion of the right knee, and residual pain on the medial side of the right knee, in the medial joint line. Dr. Rehmatullah noted pursuant to Table 16-3, page 509 of the A.M.A., *Guides* appellant had seven percent permanent impairment of the right lower extremity.

In a report dated March 19, 2013, an OWCP medical adviser reviewed Dr. Rehmatullah's June 4, 2012 report and determined that an impairment rating could not be calculated due to incomplete information. He noted that Dr. Rehmatullah did not cite the applicable table in the A.M.A., *Guides* and failed to provide any of the required information necessary for a complete rating. The medical adviser recommended that OWCP refer appellant to a skilled examiner to obtain an accurate impairment rating.

On March 29, 2013 OWCP referred appellant to a new independent medical specialist, Dr. Manhal A. Ghanma, a Board-certified orthopedic surgeon, to resolve the conflict. Dr. Ghanma indicated, in an April 26, 2013 report, that he reviewed the record and examined appellant. He noted right knee active range of motion from 0 to 140 degrees of flexion, which differed considerably from the findings of Dr. Grant on October 6, 2010. Range of motion was equal in both knees, there was no instability of either knee, negative drawer signs, and no crepitation on either side. Dr. Ghanma noted that appellant reached maximum medical improvement on August 27, 2007 and found that his current right knee examination was normal. He noted that the lower limb questionnaire score was 13 and that appellant complained of mild stiffness in his right knee during the past week and pain when going up and down stairs. Dr. Ghanma noted that, pursuant to the A.M.A., *Guides*, Table 16-3 Knee Regional Grid -- Lower Extremity Impairments, page 509, appellant was a class 1, default impairment of two percent right lower extremity impairment for a partial meniscectomy. Dr. Ghanma further noted pursuant to Table 16-6 on page 516, the grade modifier for functional history adjustment was based on the lower limb questionnaire score indicating a mild deficit. He noted that appellant's grade modifier for physical examination was zero pursuant to Table 16-7 on page 517. Dr. Ghanma noted that appellant's grade modifier for clinical studies was 1 as an MRI scan confirmed the diagnosis and mild pathology. Using the net adjustment formula on page 521, appellant's net adjustment was equal to -1, grade B for two percent permanent impairment of the right leg.

In a report dated July 2, 2013, an OWCP medical adviser concurred in Dr. Ghanma's determination. Pursuant to the A.M.A., *Guides* appellant had two percent permanent impairment of the right lower extremity.

In a September 23, 2013 decision, OWCP granted appellant a schedule award for two percent permanent impairment of the right leg. The award ran from April 26 to June 5, 2013.

On September 27, 2013 appellant requested an oral hearing which was held on January 14, 2014.

In a decision dated May 14, 2014, an OWCP hearing representative vacated the September 23, 2013 decision and remanded the matter for further medical development. The

hearing representative noted that OWCP should have sought to clarify the referee physician's examination report of Dr. Rehmatullah prior to making the determination that appellant should be referred for a new referee examination. The hearing representative instructed OWCP to request clarification from Dr. Rehmatullah regarding his schedule award evaluation.

On September 25, 2014 OWCP requested clarification from Dr. Rehmatullah with respect to his schedule award impairment rating. It prepared questions for the selected specialist advising that a conflict of medical opinion was present concerning the percentage of permanent impairment caused by the work injury of December 11, 2006.

In a report dated November 4, 2014, Dr. Rehmatullah noted that, based on his examination of June 12, 2012 and review of the records, appellant reached maximum medical improvement on July 5, 2008. Using the A.M.A., *Guides* diagnosis-based impairment criteria, appellant was class 1 impairment to the right knee (page 509, Table 16-3) with a range of impairment from 1 percent to 13 percent. Dr. Rehmatullah noted that appellant had seven percent permanent impairment of the right lower extremity.

In a report dated December 29, 2014, an OWCP medical adviser reviewed Dr. Rehmatullah's November 4, 2014 report. He determined that the referee physician did not properly utilize the A.M.A., *Guides* in calculating an impairment range under Table 16-3 and Table 16-6 for a partial medial or lateral meniscectomy. The medical adviser noted pursuant to the net adjustment formula appellant was a grade B for two percent right lower extremity permanent impairment.

In a decision dated March 13, 2015, OWCP denied appellant's schedule award claim.

On March 20, 2015 appellant requested an oral hearing, which was held on October 14, 2015.

In a decision dated December 21, 2015, the hearing representative affirmed the March 13, 2015 decision.

## ***LEGAL PRECEDENT***

The schedule award provision of FECA[6] and its implementing federal regulations,[7] 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

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants.[8] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[9]

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).[10] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] The grade modifiers are used on the net adjustment formula described above to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down the default value C, by the calculated net adjustment.[13]

Section 8123 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.[14] When 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.[15]

When OWCP obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to correct the defect in his original report. However, when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, the OWCP must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[16]

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[8] *Id.* at § 10.404(a).

[9] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id.* at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

[10] A.M.A., *Guides* 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

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

[12] *Id.* at 521.

[13] *Id*. at 497.

[14] 5 U.S.C. § 8123(a).

[15] *James F. Weikel*, 54 ECAB 660 (2003).

[16] *Talmadge Miller*, 47 ECAB 673 (1996); *Harold Travis*, 30 ECAB 1071, 1078 (1979); *see also supra* note 9 at Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.11(c)(1)-(2) (April 1993).

## ***ANALYSIS***

OWCP accepted the claim for right knee sprain, internal derangement of the posterior horn of the medial meniscus of the right knee, and medial meniscus tear of the right knee. Appellant underwent an authorized arthroscopy of the right knee on July 5, 2007 to repair a medial meniscus tear.

The Board finds that this case is not in posture for a decision as to whether appellant has more than two percent permanent impairment of the right lower extremity, as there remains an unresolved conflict in the medical evidence.

OWCP found that a conflict in the medical evidence existed between appellant's attending physician, Dr. Grant, who found 28 percent permanent impairment of the right lower extremity and OWCP referral physician, Dr. Nickodem who found that appellant had two percent permanent impairment of the right lower extremity. In order to resolve the conflict, it referred appellant to Dr. Rehmatullah for an impartial medical examination.

OWCP noted that Dr. Rehmatullah, in his June 4, 2012 report provided seven percent lower extremity impairment, but he did not cite to the applicable tables in the A.M.A., *Guides* and did not provide required information necessary for an acceptable rating report. It determined that his initial report of June 4, 2012 was of diminished value and referred appellant to second referee physician, Dr. Ghanma, to resolve the conflict of medical opinion and obtain an accurate impairment rating. OWCP did not seek clarification from Dr. Rehmatullah regarding his impairment rating.

The Board has held that the exclusion of a medical report obtained from a designated impartial medical specialist is required under specific circumstances. In *Joseph R. Alsing*,[17] the Board excluded the medical report from a second impartial medical specialist, which was obtained prior to any attempt to have the original medical referee clarify his medical opinion. The Board stated: "Since the report … was improperly obtained, it will not be given any weight on review by the Board and should not be considered by [OWCP]." The Board in *Alsing* remanded the case to OWCP to obtain a clarification report from the first impartial medical specialist and to issue a *de novo* decision.[18] OWCP procedures also direct exclusion of a report where "a second referee specialist's report is requested before [OWCP] has attempted to clarify

[17] *Joseph R. Alsing*, 39 ECAB 1012 (1988); *Jeannine E. Swanson*, 45 ECAB 325 (1994).

[18] *See also Kim Law-Jackson*, Docket No. 03-2075 (issued November 26, 2003) (where the Board found that OWCP erred when it failed to follow the instructions of the Board and obtain clarification of a report from the first impartial medical adviser prior to referring appellant to another impartial medical examiner).

the original referee specialist's report."[19] Consequently, Dr. Ghanma's report must be excluded from consideration as it was obtained before OWCP sought clarification from Dr. Rehmatullah.[20]

OWCP eventually sought clarification from Dr. Rehmatullah. In a report dated November 4, 2014, Dr. Rehmatullah noted that, based on his examination of June 12, 2012 and review of the records, appellant reached maximum medical improvement. Using the A.M.A., *Guides* diagnosis-based impairment criteria, he advised that appellant had a class 1 impairment to the right knee under Table 16-3, on page 509, with a range of impairment of 1 percent to 13 percent. Dr. Rehmatullah noted that appellant had seven percent impairment to the right leg.

The Board notes that Dr. Rehmatullah reiterated his opinion as noted in his initial report of June 4, 2012, and opined that appellant had seven percent impairment to the right lower extremity. Dr. Rehmatullah failed to provide any further explanation of his opinion as requested by OWCP. Although it appears that he used the diagnosis-based impairment for a meniscal injury on page 509, he did not explain how he arrived at his calculation under the A.M.A., *Guides*. For example, Dr. Rehmatullah did not explain how he used grade modifiers and the net adjustment formula to determine the rating.[21] The Board finds that he did not furnish sufficient rationale to support his stated conclusion that appellant had seven percent permanent impairment of the right leg. For these reasons, the Board finds that Dr. Rehmatullah's report is of diminished probative value and is insufficient to resolve the conflict.

When a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of the specialist, if sufficiently well rationalized, must be given special weight.[22] When the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative, or lacking in rationale, as is the case here, OWCP should refer the claimant to a second impartial specialist.[23]

The case will be remanded to OWCP for further development of the medical evidence and referral of appellant to a second referee physician to resolve the now existing conflict of opinion. After such further development as OWCP deems necessary, an appropriate decision should be issued regarding this matter.

[19] OWCP's procedures state that OWCP should request a supplemental report from the referee physician to clarify inadequacies in the initial report. Only if the referee physician does not respond or does not provide a sufficient response after being asked, should OWCP request a new referee examination; *see E.M.*, Docket No. 13-1876 (issued March 26, 2014); *see also supra* note 16 at Chapter 2.810.11(e) (September 2010).

[20] *See Terrance R. Stath*, 45 ECAB 412 (1994) (where the Board distinguished situations where medical reports were excluded because OWCP might have influenced the opinion of an impartial medical specialist from circumstances in which the medical report obtained was defective for other procedural reasons). *See also id*. at Chapter 2.810.12 (September 2010).

[21] *See* A.M.A., *Guides* 497 (explains the process of how a diagnosis-based impairment is determined).

[22] *See supra* note 15.

[23] *See supra* note 16.

## ***CONCLUSION***

The Board finds that the case is not in posture for decision. The case shall be remanded for further development of the medical evidence, to be followed by an appropriate merit decision.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the Office of Workers' Compensation Programs' December 21, 2015 decision is set aside. The case is remanded for action consistent with this decision of the Board.

Issued: December 15, 2016
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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