United States Department of Labor
Employees' Compensation Appeals Board

M.E., Appellant	)	
and	)	**Docket No. 16-1216**
	)	**Issued: December 2, 2016**
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, FEDERAL CORRECTIONAL INSTITUTION, Fort Worth, TX, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On May 23, 2016 appellant, through counsel, filed a timely appeal from an April 1, 2016 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 this case.

[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.*

ISSUE

The issue is whether appellant has met his burden of proof to establish permanent impairment of his right leg warranting a schedule award.

FACTUAL HISTORY

On June 2, 1986 appellant, then a 24-year-old correctional officer, filed a traumatic injury claim (Form CA-1) under File No. xxxxxx926 alleging that he sustained a left knee injury on that date when he lost his footing and landed on his left knee. In a September 29, 1986 decision, OWCP denied the claim as it had not received medical evidence to establish a left knee condition causally related to the established June 2, 1986 employment incident.

Following OWCP's decision, additional medical evidence was received into the record. On June 2, 1986 appellant was seen by Dr. Christian J. Renna, an osteopath specializing in neuro musculoskeletal and preventive medicine. He was seen again by Dr. Renna the next day, June 3, 1986, after x-rays had been taken and a fibula head fracture with peroneal nerve contusion had been diagnosed. Appellant was placed in a full cast on that date and asked to return for removal of the cast in two weeks, with no weight bearing during the two-week period.

On June 27, 1986 Dr. Renna completed a request for examination and/or treatment (Form CA-16). He noted having examined appellant the day after the initial injury and having put appellant into a full leg cast.[3] Dr. Renna reexamined appellant and reported tenderness in the right fibula, numbness, and slight stiffness after he had slipped on water and fell while walking in a tunnelway. He diagnosed a right fibula fracture and checked a box marked "yes" indicating that the diagnosed condition was caused or aggravated by the employment activity described.

In a September 23, 1986 report, Dr. Renna noted a history that appellant fell at work on June 2, 1986 and complained about right knee pain. He reported examination findings which included a right knee x-ray that revealed a fibula head fracture with a peroneal nerve contusion. Dr. Renna found that appellant's fracture had healed satisfactorily and he was released to return to work on June 29, 1986.

Thereafter, the claim was essentially dormant until 2013. By letter dated June 27, 2013, appellant requested reconsideration of the September 29, 1986 decision. He explained that his supervisor had completed his Form CA-1 and incorrectly stated that he had injured his left knee rather than his right knee.

In a July 11, 2013 decision, OWCP vacated the September 29, 1986 decision and found that appellant had sustained a right knee condition causally related to his June 2, 1986 employment incident, based on Dr. Renna's reports. By letter of the same date, it accepted his

[3] Appellant had returned to Dr. Renna on June 6, 2016 and explained that he had fallen over an ant hill and ants had gotten into the cast and were biting him. He then took a tin snips and removed the cast himself, but he noted that he had remained on crutches nonetheless. Dr. Renna replaced the full leg cast at that time. However, on June 16, 1986 appellant again returned with the cast having been broken due to unbearable itching. The cast was completely removed and appellant was placed into a knee immobilizer.

claim for right closed fracture of the upper end tibia and fibula and injury to the right peroneal nerve.[4]

On September 5, 2013 appellant filed a claim for a schedule award (Form CA-7) for his right knee.

In a May 1, 2013 report, Dr. John W. Ellis, a family practitioner, provided a history of the June 2, 1986 employment incident and reviewed appellant's medical records. He noted appellant's complaints of continued pain, instability, and grittiness in his right knee. Dr. Ellis reported findings on examination of appellant's left shoulder, elbow, wrist, and knee, right knee, and emotional conditions. The right knee had a scar over the distal patella, which resulted from a fall in 1982 during his military service. It was a small laceration that was treated topically with no sutures and caused only a mild cosmetic deformity. On the lateral aspect of the right knee, there was a scar at the lateral distal femur from where the fracture of the fibula occurred on June 2, 1986. There was crepitation on movement of the right knee. There was 115 degrees of flexion and full extension. There was also mild laxity of the medial collateral ligament. There were hyperpigmented and reddish birthmarks on the anterior right knee, tibial tuberosity, lateral, and slightly anterior right calf. Dr. Ellis diagnosed a fractured right fibula and internal derangement, traumatic arthritis and chondromalacia, and laxity of the medial collateral ligament of the right knee. He opined that appellant's employment contributed to, aggravated and/or caused his injuries, disabilities, and impairments. Dr. Ellis concluded that appellant had been temporarily totally disabled for 45 days while his right leg was in a cast.

By decision dated September 9, 2013, OWCP denied appellant's claim for a schedule award. It found that his right knee conditions had not reached maximum medical improvement (MMI) based on Dr. Ellis' May 1, 2013 report. In addition, Dr. Ellis' report presented clear evidence of a new work injury in the form of occupational factors affecting the right knee. Thus, OWCP recommended that appellant file an occupational disease claim with supporting medical evidence.

On December 17, 2014 appellant filed another Form CA-7 claim for a schedule award. In an October 27, 2014 report, Dr. Ellis provided a history of appellant's claims for compensation, reviewed his medical records, and reported findings on physical examination. He diagnosed a closed fracture of the upper end tibia and fibula and injury to the peroneal nerve. Dr. Ellis reiterated his diagnoses of traumatic arthritis and chondromalacia and medial collateral ligament laxity of the right knee. He also reiterated his opinion that appellant's conditions, impairment, and disability were caused by his employment. Dr. Ellis advised that appellant may need right knee surgery in the future. He noted that appellant had reached MMI as of the date of his examination. Utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), Dr. Ellis found that appellant had 14

[4] Prior to this claim, OWCP, under File No. xxxxxx772, had accepted that appellant sustained lumbar disc displacement on February 19, 1993. In decisions dated May 30 and December 23, 2014, it denied his claim for a schedule award for the lumbar condition. Under File No. xxxxxx408, OWCP had accepted that appellant sustained a left shoulder tear on September 6, 2003. It subsequently issued schedule award decisions reflecting that he had 18 percent permanent impairment of the left arm. These other claims are not before the Board on the present appeal.

percent permanent impairment of the right lower extremity due to mild laxity of the medial collateral ligament and a peroneal nerve injury.

On February 10, 2015 appellant requested reconsideration of the September 9, 2013 decision.

On May 22, 2015 OWCP forwarded the file to Dr. Morley Slutsky, a Board-certified occupational medicine physician and district medical adviser (DMA), for a review of the medical record and an impairment rating. Dr. Slutsky responded on that same date noting that he had not received all of the medical evidence which Dr. Ellis had reviewed in making his impairment rating.

Dr. Slutsky again asked OWCP on July 6, 2015 that a complete medical record be provided to him in order to complete the impairment rating. OWCP provide him with the additional medical records.

OWCP received Dr. Slutsky's report on July 24, 2015 in which he found that appellant had no right lower extremity impairment and that he had reached MMI. Dr. Slutsky explained that there were no diagnostic test findings or physical examination findings of a peroneal nerve injury, closed fracture of the upper end tibia and fibula, or impairment due to these conditions under File Nos. xxxxxx926 or xxxxxx772. He noted that Dr. Renna had found that the closed fracture of the upper end tibia and fibula had healed and released appellant to return to work. Dr. Slutsky advised that Dr. Ellis' findings of laxity of the medial collateral ligament, crepitation, and loss of range of motion (ROM) were inconsistent with the other providers' findings and, thus, were unrelated to the accepted fracture which had healed in 1986 without significant residual findings.

On December 14, 2015 OWCP referred appellant to Dr. Mysore S. Shivaram, a Board-certified orthopedic surgeon, for a second opinion.

In a January 12, 2016 report, Dr. Shivaram reviewed a statement of accepted facts and appellant's medical records. He noted appellant's chief complaints regarding his left foot and calf. Appellant had no particular complaints regarding his right leg. On examination of the right lower extremity, Dr. Shivaram reported no evidence of swelling or deformity. Appellant's gait was normal and he was able to perform heel and toe gait. A right knee examination revealed no obvious swelling or deformity. Skin condition was normal. There was no evidence of intra-articular effusion. ROM was normal. Extension was 0 degrees and flexion was 135 degrees. The knee was stable for valgus. There was varus stress with the knee in extension and flexion.

Appellant was able to dorsiflex, invert, and evert the ankle without any difficulty. There was no evidence of tingling or numbness in the peroneal nerve distribution. Appellant complained about periodic numbness in his right fifth toe. He had intact sensation in this toe. The dorsalis pedis and posterior tibial pulse were 2+. Right foot sensory examination was normal. Appellant had relatively normal right hip ROM. However, he complained about right knee pain when his hips and knees were flexed. There was no evidence of right knee instability. A Lachman test and anterior drawer sign were negative. There was no evidence of laxity of the medial collateral ligament as indicated by Dr. Ellis. X-rays of the right knee and proximal tibia

and fibula were normal. There was no evidence of deformity of the right proximal fibula. Dr. Shivaram advised that overall appellant had excellent healing of the previously reported fracture of the head of the fibula. He found "absolutely no evidence of peroneal nerve injury to the right leg."

Dr. Shivaram diagnosed a normal right knee examination and advised that appellant had reached MMI on December 2, 1986 approximately six months following his nondisplaced fractured head of the fibula. He noted that he had no preexisting permanent impairment. Dr. Shivaram found no evidence of permanent disability. He noted that "[appellant] had overreaction to pain and there was significant symptom magnification during the proceedings."

Utilizing Table 16-3, page 510 of the sixth edition of the A.M.A., *Guides,* Dr. Shivaram determined that a tibial plateau fracture would most closely match appellant's injury. He found a class 0 impairment for nondisplaced fracture with no significant objective abnormal findings at MMI. This resulted in no impairment. Dr. Shivaram also found a class 0 impairment for peroneal nerve injury under Table 16-12, page 535 as there were no objective sensory or motor deficits. This resulted in no impairment. Dr. Shivaram noted that while Dr. Ellis' clinical right knee examination revealed crepitation on movement, mild laxity of the medial collateral ligament, and -6 degrees to 104 degrees of ROM, his examination did not reveal any of these findings. He reiterated his findings of no instability of the knee, no chondromalacia as described by Dr. Ellis, and no clinical indication of an injury to the peroneal nerve. A review of the medical records indicated that there was only a fracture of the head of the fibula and not a closed fracture of the tibia and fibula. There was no indication that appellant required further right knee surgery. Based on the above findings, Dr. Shivaram concluded that there was no evidence of right knee disability or permanent impairment.

On March 23, 2016 Dr. Eric M. Orenstein, a Board-certified orthopedic surgeon and DMA, reviewed the medical record and agreed with Dr. Shivaram's January 12, 2016 opinion that appellant had no right lower extremity impairment under the sixth edition of the A.M.A., *Guides*. He advised that Dr. Ellis' October 27, 2014 findings were suspect as no other examiner who came in contact with appellant observed Dr. Ellis' findings on physical examination of the right lower extremity. Dr. Orenstein noted that almost every response in a pain disability questionnaire was a 9 or 10, which was consistent with Dr. Shivaram's observation that appellant had overreacted to pain.

In an April 1, 2016 decision, OWCP denied appellant's claim for a schedule award. It found that the weight of the medical evidence rested with the opinions of Drs. Shivaram and Orenstein who determined that appellant had no impairment of the right leg.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing federal regulations 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,

[5] 5 U.S.C. § 8107.

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.[6] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[7] For decisions issued after May 1, 2009, the sixth edition is used to calculate schedule awards.[8] It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[9]

It is the claimant's burden to establish that he or she has sustained a permanent impairment of the scheduled member as a result of any employment injury.[10] OWCP procedures provide that, to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this date occurred (date of MMI), describe the impairment in sufficient detail so that it can be visualized on review and computes the percentage of impairment in accordance with the A.M.A., *Guides*.[11]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a 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.[12]

ANALYSIS

The Board finds that appellant has not established ratable right leg permanent impairment. OWCP accepted his claim for right closed fracture of the upper end tibia and fibula and injury to the right peroneal nerve. The Board finds that the weight of the medical evidence rests with the opinions of Dr. Shivaram, an OWCP referral physician, and Dr. Orenstein, the DMA, who properly applied the sixth edition of the A.M.A., *Guides*.

In an October 27, 2014 report, Dr. Ellis, appellant's treating physician, examined appellant and found that he had 14 percent permanent impairment of the right leg under the sixth

[6] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[7] *Id.*

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

[9] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); *id*. at Chapter 3.700.3.a.3 (January 2010). This portion of OWCP procedures provides that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

[10] *Tammy L. Meehan*, 53 ECAB 229 (2001).

[11] *Supra* note 7 at Chapter 2.808.5 (February 2013).

[12] *Id.* at Chapter 2.808.6(f) (February 2013).

edition of the A.M.A., *Guides* due to the diagnosed mild laxity of the medial collateral ligament and a peroneal nerve injury.

Dr. Slutsky, a DMA, reviewed Dr. Ellis' findings on July 2, 2015 and disagreed with his impairment rating and date of MMI. He found that appellant had no right lower extremity impairment under the sixth edition of the A.M.A., *Guides* and that appellant had reached MMI. Dr. Slutsky reasoned that there were no diagnostic or physical examination findings of a peroneal nerve injury, closed fracture of the upper end tibia and fibula, or impairment due to these conditions. He noted Dr. Renna's finding that the closed fracture of the upper end tibia and fibula had healed and that appellant could return to work. Dr. Slutsky concluded that Dr. Ellis' findings of laxity of the medial collateral ligament, crepitation, and loss of ROM were inconsistent with the other providers' findings and, thus, were not related to the accepted fracture, which had healed in 1986 without significant residual findings.

In a January 12, 2016 report, Dr. Shivaram, a second opinion physician, reviewed the medical record and reported essentially normal findings on examination with the exception of varus stress with the right knee in extension and flexion and appellant's complaint of right knee pain when his hips and knees were flexed. He reported normal right knee x-rays. Dr. Shivaram diagnosed a normal right knee examination and advised that appellant's fracture of the head of the fibula had healed excellently. He determined that appellant had reached MMI on December 2, 1986. Dr. Shivaram found that appellant had overacted to pain and exhibited significant symptom magnification during his examination. He utilized Table 16-3, page 510 of the sixth edition of the A.M.A., *Guides* and determined that a diagnosis of tibial plateau fracture closely matched appellant's injury and resulted in a class 0 impairment for nondisplaced fracture with no significant objective abnormal findings at MMI. Dr. Shivaram found that this represented zero percent impairment. He noted that unlike Dr. Ellis' examination of the right knee, his examination did not reveal crepitation on movement, mild laxity of the medial collateral ligament, -6 degrees to 104 degrees of ROM, and chondromalacia. Dr. Shivaram also found no instability of the knee. He related that his review of the medical records only indicated a fracture of the head of the fibula and not a closed fracture of the tibia and fibula. He advised that there was no indication that appellant required further right knee surgery. Dr. Shivaram concluded that there was no evidence of permanent impairment based on his findings. On March 23, 2016 Dr. Orenstein, a DMA, reviewed Dr. Shivaram's January 12, 2016 report and agreed with his impairment rating.

The Board finds that the weight of the medical evidence is represented by the reports of Drs. Shivaram and Orenstein who reviewed the findings on examination and properly applied the A.M.A., *Guides*. These physicians agreed that appellant has no permanent impairment of his right lower extremity due to his accepted right closed facture of the upper end tibia and fibula and right injury to the peroneal nerve. There is no current medical evidence of record, in conformance with the A.M.A., *Guides*, which supports greater impairment.

On appeal, counsel contends that OWCP's decision is contrary to fact and law. For the reasons stated above, the Board finds that counsel's contentions are not substantiated.

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.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish permanent impairment of his right leg warranting a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the April 1, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 2, 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