

impairment of the left lower extremity, for which she received schedule awards; and (2) whether an OWCP hearing representative properly denied appellant's request for a subpoena.

FACTUAL HISTORY

This case has previously been before the Board. The facts and circumstances of the case as set forth in the Board's prior decision and order are incorporated by reference. The relevant facts of the prior appeal are included below.

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 knelt on a floor to change a post office box lock. On the date of injury, emergency room physicians diagnosed patellar tendinitis and degenerative joint disease.³

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.⁴

On August 8, 2011 appellant claimed a schedule award (Form CA-7). In a November 3, 2011 letter, OWCP advised her of the evidence needed to establish her claim, including a report from her attending physician confirming 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 response, appellant provided a September 16, 2011 letter from Dr. Chmell, opining that the December 20, 2002 employment injury caused chronic "effusion, tenderness, crepitus and diminished range of motion" of both knees. Dr. Chmell noted that imaging studies showed chondromalacia, traumatic arthritis, and torn medial menisci in both knees. He 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, Dr. Chmell found 10 percent impairment according to Table 16-23⁵ due to range of motion limited to 5 to 100 degrees, 10 percent impairment according to Table 16-

³ 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.

⁴ 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.

⁵ Table 16-23, page 549 of the sixth edition of the A.M.A., *Guides* is entitled "Knee Motion Impairments."

6⁶ and Table 16-7⁷ for physical findings including knee tenderness, chronic effusion, crepitus and a limp, 25 percent impairment according to Table 16-3⁸ 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 16-22.⁹ He added these impairments to equal 52 percent. Dr. Chmell 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, 2009.¹⁰

In a January 17, 2012 report, an OWCP medical adviser noted that Dr. Chmell had not correctly applied 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 as the medical evidence failed to establish more than 10 percent impairment of each leg.

On July 22, 2012 appellant requested an oral hearing, held before an OWCP hearing representative on November 27, 2012. At the hearing, she contended that the medical evidence substantiated permanent impairment to all extremities. Following the hearing, appellant provided a December 23, 2012 statement contending that OWCP had not fully considered 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. August 6, 2012 EMG and NCV studies showed bilateral L5 radiculopathy and polyneuropathy of both lower extremities.

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

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

⁸ Table 16-3, pages 509-511 of the sixth edition of the A.M.A., *Guides* is entitled "Knee Regional Grid -- Lower Extremity Impairments."

⁹ Table 16-22, page 549 of the sixth edition of the A.M.A., *Guides* is entitled "Ankle Motion Impairments."

¹⁰ Appellant appealed the February 3, 2009 schedule award under File No. xxxxxx862 to the Board. By decision and order issued May 28, 2010, the Board affirmed the February 3, 2009 schedule award for 10 percent permanent impairment of each leg due to limited bilateral hip motion. Docket No. 09-2007 (issued September 13, 2010).

On February 11, 2013 an OWCP hearing representative affirmed OWCP's June 27, 2012 decision, finding that appellant had not established more than 10 percent impairment of each leg. She found that Dr. Chmell misapplied the A.M.A., *Guides*, whereas the medical adviser had provided a well-rationalized opinion properly using the A.M.A., *Guides*. Appellant then appealed to the Board.

By decision and order issued April 11, 2014,¹¹ the Board set aside OWCP's February 11, 2013 decision and remanded the case to obtain a more detailed analysis of permanent impairment to the lower extremities.

On July 14, 2014 OWCP referred appellant to Dr. James P. Elmes, a Board-certified orthopedic surgeon for a second opinion examination. Dr. Elmes reviewed the medical record and a statement of accepted facts (SOAF). On examination, he found diminished sensation in the right anterior thigh, lateral calf, and medial foot, flexion of the right knee limited to 112 degrees based on an average of three trials measured with a goniometer, left knee flexion limited to 117 degrees. Appellant demonstrated full ankle and foot ranges of motion bilaterally. Dr. Elmes diagnosed bilateral medial meniscal tears, post-traumatic arthropathy of both knees, and nonspecific bilateral hip and ankle pain. He found that appellant had reached maximum medical improvement on November 25, 2011.

Regarding the right knee, Dr. Elmes referred to Table 16-3 to find a class 3 Class of Diagnosis (CDX) for arthritis, with a one millimeter cartilage interval on July 8, 2014 knee x-rays. He assigned default grade of C, equaling 30 percent impairment. Dr. Elmes found a Functional History (GMFH) grade modifier of 2, and Physical Examination (GMPE) grade modifier of 1 due to limited motion. He explained that no Clinical Studies (GMCS) grade modifier was applicable as the x-rays were used to establish the CDX. Applying the net adjustment formula, or (GMFH-CDX) + (GMPE-CDX), or (2-3) + (1-3) resulting in a modifier of -3, moving the default C to A, equaling 26 percent impairment of the right lower extremity.

Regarding the left knee, Dr. Elmes found no joint space narrowing on July 8, 2014 x-rays. He applied a class 1 CDX for meniscal injury, with a default value of two percent. Dr. Elmes found a GMFH of 2 for a lower limb score of 35, and a GMPE of 1 for moderate medial joint tenderness on palpation, he explained that there was no applicable GMCS as there was no joint space narrowing by x-ray. Applying the net adjustment formula, or (2-1) + (1-1), Dr. Elmes calculated a net modifier of +1, moving the default grade of C upward to D, equaling two percent impairment of the left lower extremity.

An OWCP medical adviser reviewed Dr. Elmes' report on August 4, 2014, and concurred with his assessment for the right lower extremity. He noted, however, that there was no impairment under the sixth edition of the A.M.A., *Guides* for meniscal injury in the absence of a frank tear or meniscectomy. Therefore, appellant did not have any additional impairment of the left lower extremity. The medical adviser noted that using the Combined Values Chart on page 604 of the A.M.A., *Guides*, appellant had a total of 33 percent impairment of the right lower extremity, and 10 percent impairment of the left lower extremity.

¹¹ Docket No. 13-1902 (issued April 11, 2014).

By decision dated August 19, 2014, OWCP granted appellant a schedule award for an additional 23 percent permanent impairment of the right leg, for a total of 33 percent. It found that appellant did not establish that she sustained greater than the 10 percent impairment of the left leg previously awarded.

In a September 9, 2014 letter, appellant requested a hearing and asked that the Branch of Hearings and Review subpoena Dr. Elmes and the x-ray films on which he relied. She alleged that OWCP had failed to consider all impairments to her legs in calculating the August 19, 2014 schedule award. Appellant submitted a February 19, 2014 x-ray report noting progression of moderate tricompartmental osteoarthritis of the right knee with narrowing of the compartments and patellofemoral joint space, and a grossly normal left hip. At the hearing, held February 12, 2015, she contended that imaging studies of record demonstrated that she had additional impairments of both lower extremities. Appellant contended that Dr. Chmell should have been given an additional opportunity to perform an assessment. Following the hearing, she submitted a March 7, 2015 letter reiterating her contentions.

By decision dated April 21, 2015, an OWCP hearing representative affirmed the August 19, 2014 schedule award. He found that, although OWCP had not doubled appellant's various lower extremity claims, Dr. Elmes had performed a thorough clinical examination and described the many studies from those claims that were part of the case record under File No. xxxxxx089. The hearing representative therefore found that Dr. Elmes had sufficient evidence to perform his impairment rating. He formally denied appellant's request to subpoena Dr. Elmes and the x-ray films, finding that the films and testimony were "not considered necessary in resolving the impairment issue." The hearing representative noted that Dr. Elmes provided an extensive discussion of all diagnostic evidence and the weight accorded to various reports and clinical findings. Therefore, Dr. Elmes' direct testimony and the x-ray films were not needed to determine the percentage of permanent impairment.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA¹² 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 of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of the 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*.¹⁴

¹² 5 U.S.C. § 8107.

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

¹⁴ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *see also* Part 3 -- *Medical, Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

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, which is then adjusted by grade modifiers based on functional history, physical examination, and clinical studies.¹⁶ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

In some instances, an OWCP's medical adviser's opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the A.M.A., *Guides*. In this instance, a detailed opinion by OWCP's medical adviser which gives a percentage based on reported findings and the A.M.A., *Guides* may constitute the weight of the medical evidence.¹⁷

ANALYSIS -- ISSUE 1

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 10 percent permanent impairment of each lower extremity due to restricted bilateral hip motion.

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 leg due to limited knee and ankle motion, examination findings, 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. However, an OWCP medical adviser opined on January 17, 2012 that appellant had only 10 percent impairment of each leg. Pursuant to the first appeal, the Board remanded the case for additional development regarding the appropriate percentage of permanent impairment.

On remand of the case, OWCP obtained a second opinion from Dr. Elmes, a Board-certified orthopedic surgeon, who provided a July 14, 2014 impairment rating. Dr. Elmes based his opinion on a SOAF and the medical record. He performed a thorough clinical examination, obtaining range of motion measurements after three trials and using a goniometer. Dr. Elmes found that appellant had 33 percent impairment of the right leg due to class 3 osteoarthritis with a one millimeter cartilage interval, with a GMFH of 2 and GMPE of 1. Regarding the left knee, he found no joint space narrowing on July 8, 2014 x-rays. Dr. Elmes calculated two percent impairment of the left leg due to meniscal injury.

¹⁵ A.M.A., *Guides* (6th ed. 2009), page 3, Section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

¹⁶ A.M.A., *Guides* (6th ed. 2009), pp. 494-531.

¹⁷ See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.8(j) (September 2010).

An OWCP medical adviser reviewed Dr. Elmes' assessment. He found that appellant had no additional impairment of the left leg as the A.M.A., *Guides* did not allow impairments for meniscal injury in the absence of a tear. The medical adviser concurred, however, with Dr. Elmes' evaluation of appellant's right leg. Based on Dr. Elmes' opinion as reviewed by the medical adviser, OWCP issued the August 19, 2014 schedule award for an additional 23 percent impairment of the right leg.

The Board finds that OWCP properly relied on Dr. Elmes' clinical findings and impairment rating regarding the lower extremities, as reviewed by its medical adviser. Dr. Elmes applied the appropriate portions of the A.M.A., *Guides* to his clinical findings regarding the right leg.¹⁸ The medical adviser made a minor modification to the left lower extremity rating, but concurred with all other elements of Dr. Elmes' rating methodology and calculations. Therefore, OWCP's April 21, 2015 decision affirming the August 19, 2014 determination of 33 percent permanent impairment of the right lower extremity and 10 percent permanent impairment of the left lower extremity was proper in this regard.

On appeal, appellant asserts that OWCP developed her lower extremity schedule award claims in a piecemeal fashion to lower the percentage of permanent impairment awarded. As explained above, Dr. Elmes' opinion was based on a SOAF, and a medical record which included reports from appellant's other lower extremity claims.

Appellant may request a schedule award or increased schedule, based on evidence of a new exposure or medical evidence showing progression of an employment-related condition, resulting in permanent impairment or increased impairment.

LEGAL PRECEDENT -- ISSUE 2

Section 8126 of FECA provides that the Secretary of Labor, on any matter within his jurisdiction under this subchapter, may issue subpoenas for and compel the attendance of witnesses within a radius of 100 miles.¹⁹ The implementing regulations provide that a claimant may request a subpoena, but the decision to grant or deny such a request is within the discretion of the hearing representative, who may issue subpoenas for the attendance and testimony of witnesses and for the production of books, records, correspondence, papers, or other relevant documents. Subpoenas are issued for documents only if they are relevant and cannot be obtained by other means and for witnesses only where oral testimony is the best way to ascertain the facts.²⁰ In requesting a subpoena, a claimant must explain why the testimony is relevant to the issues in the case and why a subpoena is the best method or opportunity to obtain such evidence because there is no other means by which the testimony could have been obtained.²¹ Section 10.619(a) of the implementing regulations provides that a claimant may request a subpoena only

¹⁸ See *supra* note 17.

¹⁹ 5 U.S.C. § 8126(1).

²⁰ 20 C.F.R. § 10.619; *Gregorio E. Conde*, 52 ECAB 410 (2001).

²¹ *Id.*

as a part of the hearings process and no subpoena will be issued under any other part of the claims process.

To request a subpoena, the requestor must submit the request in writing and send it to the hearing representative as early as possible, but no later than 60 days (as evidenced by postmark, electronic marker or other objective date mark) after the date of the original hearing request.²² The hearing representative retains discretion on whether to issue a subpoena. The function of the Board on appeal is to determine whether there has been an abuse of discretion.²³ Abuse of discretion is generally shown through proof of manifest error, a clearly unreasonable exercise of judgment or actions taken which are clearly contrary to logic and probable deduction from established facts.²⁴

ANALYSIS -- ISSUE 2

In the present case, appellant requested that the hearing representative subpoena Dr. Elmes and the July 8, 2014 x-rays he obtained. The hearing representative denied the request, finding that Dr. Elmes' testimony and the x-ray films were not necessary to the adjudication of the case.

As noted above, the hearing representative has discretion with respect to the issuance of subpoenas. Appellant argued that the x-ray films and testimony were crucial to establishing the appropriate percentage of permanent impairment, without providing any valid explanation as to why they were necessary. The hearing representative reasonably determined that the evidence was not needed as Dr. Elmes provided a thorough and comprehensive report. There was no evidence presented that subpoenas were necessary with respect to the development of the relevant evidence in this case. The Board finds no abuse of discretion related to the denial of a subpoena request.²⁵

CONCLUSION

The Board finds that OWCP properly determined that appellant had no more than 33 percent permanent impairment of the right lower extremity and 10 percent permanent impairment of the left lower extremity, for which she received schedule awards. The Board further finds that an OWCP hearing representative properly denied appellant's request for a subpoena.

²² 20 C.F.R. § 10.619(a)(1).

²³ See *Gregorio E. Conde*, *supra* note 20.

²⁴ *Claudio Vazquez*, 52 ECAB 496 (2001).

²⁵ *D.O.*, Docket No. 15-1368 (issued October 22, 2015).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 21, 2015 is affirmed.

Issued: March 16, 2016
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board