United States Department of Labor
Employees' Compensation Appeals Board

M.G., Appellant	)	
and	)	**Docket No. 15-1793**
	)	**Issued: May 5, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Palatine, IL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 31, 2015 appellant, through counsel, filed a timely appeal from an April 1, 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 this case.

ISSUE

The issue is whether OWCP properly found that appellant had two percent permanent impairment of the right lower extremity, for which she received a schedule award.

FACTUAL HISTORY

This case has previously been before the Board. By decision and order issued October 2, 2014,[2] the Board affirmed a February 12, 2014 OWCP decision finding that a June 10, 2013

[1] 5 U.S.C. § 8101 *et seq.*

[2] Docket No. 14-1127 (issued October 2, 2014).

schedule award for two percent permanent impairment of the right leg was proper under the facts of the case. The facts and circumstances of the case as set forth in the Board's prior decision and order are incorporated herein by reference.

OWCP accepted that on February 22, 2011 appellant, then a 33-year-old city carrier in transitional status, sustained a sprain of the right knee and leg and derangement of the right meniscus when she slipped and fell on an icy sidewalk. Appellant stopped work on the date of injury and was separated from the employing establishment effective March 4, 2011. She received compensation for total disability commencing February 25, 2011.

Dr. Samuel S. Park, an attending Board-certified orthopedic surgeon, treated appellant beginning on March 9, 2011. He noted that she had previously undergone reconstructive surgery of the right anterior cruciate ligament in 2003 with screw fixation. Appellant did well until her work injury on February 22, 2011. Dr. Park diagnosed a right knee sprain superimposed on osteoarthritis of the right knee.[3]

On May 13, 2011 Dr. Park performed arthroscopic repair of a right medial meniscal tear and right anterior cruciate ligament tear, approved by OWCP. He also diagnosed grade 2 to 3 chondromalacia. In periodic reports through November 5, 2012, Dr. Park found that appellant attained maximum medical improvement as of July 12, 2012, with good stability, no atrophy, and continued pain. He noted that x-rays showed severe osteoarthritis of the right knee. Dr. Park administered cortisone injections.[4]

On October 18, 2012 appellant claimed a schedule award. She submitted a December 8, 2012 impairment rating from Dr. Neil Allen, an attending Board-certified internist and neurologist. Referring to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, the A.M.A., *Guides*), Dr. Allen noted a class 1 diagnosis-based impairment Class of Diagnosis (CDX) according to Table 16-3 with a default value of 10 percent.[5] He found a grade modifier for Functional History (GMFH) for a lower limb questionnaire score of 63, a grade modifier 1 for findings on Physical Examination (GMPE) due to mild lateral instability and moderate palpatory findings as consistently documented and observed, mild flexion deficit, and no grade modifier for Clinical Studies (GMCS) as he used the studies as a key factor in class placement. Applying the net adjustment formula of (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX),[6] or (1-1) + (1-1), Dr. Allen found that no adjustment in the default 10 percent value. He concluded that appellant had 10 percent permanent impairment of the right lower extremity.

[3] An April 12, 2011 magnetic resonance imaging (MRI) scan of the right knee showed degenerative changes, chondromalacia, a Baker's cyst, and a possible medial meniscal tear.

[4] By pretermination notice dated August 23, 2012 and finalized November 5, 2012, OWCP terminated appellant's wage-loss and medical compensation benefits effective that day as the accepted right knee injury had resolved without residuals, based on Dr. Park's opinion. Following a February 12, 2013 telephonic hearing, a hearing representative affirmed the termination by May 7, 2013 decision.

[5] Table 16-3, pages 509-11 of the sixth edition of the A.M.A., *Guides* is entitled "Knee Regional Grid -- Lower Extremity Impairments." Dr. Allen, however, did not specify upon which diagnosis he had based his impairment rating.

[6] The net adjustment formula is set forth at page 521 of the A.M.A., *Guides*.

On April 21, 2013 an OWCP medical adviser found that appellant had reached maximum medical improvement as of November 12, 2012. He explained that Dr. Allen misapplied the A.M.A., *Guides* as he assessed 10 percent impairment applicable to multiple partial meniscectomies. The medical adviser concluded that appellant's partial medial meniscectomy equaled two percent diagnosis-based impairment of the right lower extremity, with no net adjustment.

By decision dated June 10, 2013, OWCP issued a schedule award for two percent impairment of the right leg, based on the medical adviser's interpretation of Dr. Park's and Dr. Allen's clinical findings. It found that Dr. Allen had misapplied the A.M.A., *Guides*, but only referred to the medical adviser's report without explaining how the A.M.A., *Guides* had been misapplied.

In a June 20, 2013 letter, counsel requested a telephonic hearing, which was held before an OWCP hearing representative on November 26, 2013. At the hearing, he contended that the medical adviser had not considered all relevant clinical findings. Counsel submitted November 13, 2013 reports from Dr. Park recommending removal of a right proximal tibial screw and washer as appellant had end-stage medial joint space collapse and the device was too large for the decreased space. OWCP approved the procedure, which Dr. Park performed on December 10, 2013.

By decision dated February 12, 2014, the OWCP hearing representative affirmed OWCP's June 10, 2013 schedule award. She found that OWCP properly accorded the medical adviser's opinion the weight of the medical evidence as Dr. Allen had misapplied the A.M.A., *Guides* noting she considered the medical adviser an expert in application of the A.M.A., *Guides*.

Appellant then appealed to the Board, resulting in the October 2, 2014 decision and order affirming the February 12, 2014 decision.[7]

In a January 12, 2015 letter to OWCP, counsel requested reconsideration. He submitted a January 1, 2015 report from Dr. Allen, responding to OWCP's June 10, 2013 finding that he misapplied the A.M.A., *Guides*. Dr. Allen explained that he rated appellant based on the anterior cruciate ligament tear and not the medial meniscectomy. He noted that in his December 8, 2012 report, he misstated that he relied on page 511 of the A.M.A., *Guides* instead of page 510. Dr. Allen noted that a diagnosis-based impairment for an anterior cruciate ligament tear was the most appropriate as it reflected the injury resulting in the greatest functional loss. He reiterated his assessment of a GMFH and GMPE of 1, resulting in no net adjustment of the default grade C. Dr. Allen therefore found 10 percent impairment of the right leg.

On February 11, 2015 OWCP requested that an OWCP medical adviser review Dr. Allen's January 1, 2015 addendum and determine the appropriate percentage of permanent impairment. The medical adviser responded on February 23, 2015 noting that the anterior

[7] Docket No. 14-1127 (issued October 2, 2014). During the pendency of the prior appeal, appellant submitted January 13 and May 5, 2014 reports from Dr. Park noting continuing right knee symptoms treated with cortisone injections.

cruciate ligament tear was a preexisting condition. He noted that if appellant was hired after 2003, "then the ACL tear should be factored into the impairment rating."

In a February 22, 2011 memorandum, OWCP informed the medical adviser that appellant began work at the employing establishment on February 12, 2011 after the 2003 anterior cruciate ligament injury. It provided a copy of the April 21, 2013 OWCP medical adviser's report for review. The medical adviser responded on March 12, 2015 that although the anterior cruciate ligament tear was preexisting and should therefore be factored into the impairment rating, Dr. Allen was not qualified to assess the impairment as he was not a Board-certified orthopedist. He opined that unless an orthopedic surgeon found ligamentous laxity on examination on appellant's right knee, the April 21, 2013 impairment rating of two percent impairment of the right lower extremity should remain unmodified. Dr. Allen's December 8, 2012 report noted LCL street test, on the right knee, positive for mild (grade 1) laxity at 20 degrees of flexion, but negative at 0 degrees of flexion.

By decision dated April 1, 2015, OWCP affirmed the Board's October 2, 2014 decision, finding that Dr. Allen's January 1, 2015 report was insufficient to support an increase in permanent impairment beyond the two percent previously awarded.

LEGAL PRECEDENT

The schedule award provisions of FECA[8] 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 matter 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.[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, the evaluator identifies the impairment class for the diagnosed condition, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[11] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

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

[8] 5 U.S.C. § 8107.

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

[10] 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."

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

impairment using the A.M.A., *Guides*.[12] 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.[13]

ANALYSIS

Appellant claimed a schedule award for permanent impairment of the right lower extremity caused by an accepted right knee sprain with meniscal derangement. She submitted a December 8, 2012 impairment rating from Dr. Allen, an attending physician Board-certified in neurology and internal medicine. Dr. Allen found that appellant had reached maximum medical improvement. Referring to Table 16-3 of the A.M.A., *Guides*, he found 10 percent diagnosis-based impairment of the right lower extremity, with no grade modifier adjustments. On April 21, 2013 an OWCP medical adviser opined that Dr. Allen had not applied the appropriate elements of Table 16-3. He explained that status post partial mensicectomy with no instability equaled two percent impairment for either the medial or lateral meniscus. Based on the medical adviser's report, OWCP issued a June 20, 2013 schedule award for two percent permanent impairment of the right leg, affirmed by a hearing representative on a decision dated and finalized February 12, 2014. The Board affirmed the June 20, 2013 schedule award in its prior decision and order of October 2, 2014.

Pursuant to the present appeal, appellant submitted a January 1, 2015 addendum report from Dr. Allen, in which he explained that he had intended to find 10 percent permanent impairment of the right leg due to the preexisting anterior cruciate ligament tear and not the partial medial meniscectomies. An OWCP medical adviser reviewed Dr. Allen's report and opined that he was not qualified to rate impairment due to an anterior cruciate ligament tear as he was not a Board-certified orthopedist. He explained that, unless a Board-certified orthopedic surgeon found ligamentous laxity in the right knee due to the anterior cruciate ligament tear, the June 20, 2013 schedule award for two percent permanent impairment of the right lower extremity should stand undisturbed. OWCP then issued the April 1, 2015 decision affirming prior schedule award. The Board finds, however, that the case is not in posture for a decision.

In affirming the June 20, 2013 schedule award, OWCP relied on the medical adviser's March 12, 2015 impairment rating. The medical adviser asserted that Dr. Allen had improperly based his rating on anterior cruciate ligament tear rather than the partial medial meniscectomy. He noted that the grid used by Dr. Allen was proper only if there was evidence of ligamentous laxity in the right knee. However, Dr. Allen's December 28, 2012 report documented laxity of

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013); *see also L.R.*, Docket No. 14-674 (issued August 13, 2014); *D.H.*, Docket No. 12-1857 (issued February 26, 2013).

[13] *See* Federal (FECA) Procedure Manual, *id*., *Developing and Evaluating Medical Evidence*, Chapter 2.810.8(j) (September 2010).

the right knee on physical examination. He confirmed this finding in his supplemental report. The medical adviser has not addressed this error in his review of the medical record.

Additionally, the medical adviser questioned Dr. Allen's competence to rate appellant's impairment as he was not a Board-certified orthopedic surgeon. The Board finds, however, that Dr. Allen is a Board-certified internist and neurologist and therefore qualified to offer an impairment rating.

On remand of the case, OWCP shall refer appellant, an updated statement of accepted facts, and the medical record to an appropriate specialist for a second opinion examination regarding the appropriate percentage of impairment. In particular, the specialist should specifically designate upon which diagnosis the impairment rating is based. Following this examination and any other development deemed necessary, OWCP shall issue a *de novo* decision in the case.

On appeal, counsel contends that OWCP's April 1, 2015 decision is "contrary to law and fact." As set forth above, the case will be remanded for additional development.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 1, 2015 is set aside, and the case remanded for additional development in accordance with this decision and order.

Issued: May 5, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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