United States Department of Labor
Employees' Compensation Appeals Board

P.W., Appellant	)	
and	)	**Docket No. 16-0684**
	)	**Issued: October 3, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Palatine, IL, 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 February 23, 2016 appellant, through counsel, filed a timely appeal from a January 19, 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 the 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 met her burden of proof to establish more than two percent permanent impairment of the left lower extremity for which she received a schedule award and zero permanent impairment of the right lower extremity.

On appeal counsel asserts that OWCP ignored appellant's medical evidence.

FACTUAL HISTORY

OWCP accepted that on August 30, 2010 appellant, then a 51-year-old mail handler/equipment operator, sprained her right knee lateral collateral ligament, and sustained a tear of the medial meniscus of her left knee. She stopped work on September 2, 2010.

Dr. Shawn W. Palmer, a Board-certified osteopath specializing in orthopedic surgery, began treating appellant on September 16, 2010. He described bilateral knee physical examination findings, noting that she was collaterally stable. Dr. Palmer indicated that plane x-rays demonstrated mild narrowing of the medial joint line of both knees. An October 7, 2010 magnetic resonance imaging (MRI) scan of the right knee demonstrated a defect of the anterolateral femoral condyle, tricompartmental arthritis, and moderate joint effusion. The anterior and posterior cruciate ligaments were intact, and the medial and lateral menisci and ligaments, the quadriceps tendon, and patellar ligament were normal. A left knee MRI scan that day demonstrated a tear of the posterior horn of the medial meniscus, chondromalacia, and moderate joint effusion. On October 12, 2010 Dr. Palmer reviewed the MRI scans. Regarding the right knee, he indicated that it showed mild preexisting arthritis, and that the defect of the anterolateral femoral condyle would indicate significant bone bruising from the employment injury.

On December 6, 2010 Dr. Palmer performed arthroscopic knee repair of a partial tear of the medial meniscus on the left and a cortisone injection in the right knee. He submitted follow-up reports, noting on January 6, 2011 that neither knee had effusion and the left knee was healing well. On February 10, 2011 Dr. Palmer advised that appellant could return to work for four weeks working only on the forklift, and thereafter to unrestricted duty. Appellant, who had received wage-loss compensation, returned to full-time full duty on March 11, 2011. In a treatment note dated April 12, 2011, Dr. Palmer advised that he had no further treatment recommendations for appellant other than knee braces for her to wear at work.

On April 9, 2012 appellant filed a schedule award claim (Form CA-7). In support she submitted August 12, 2011 and February 17, 2012 reports from Dr. William N. Grant, a Board-certified internist. Dr. Grant described the history of injury and appellant's medical history. He noted that she had a difficult time performing activities of daily living and that she walked with a limp. Dr. Grant advised that, in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[3] under Table 16-3, Knee Regional Grid, for a diagnosis of right collateral sprain, appellant had a class 2 impairment with modifiers 2 for functional history and physical examination. He

[3] A.M.A., *Guides* (6th ed. 2009) (2nd prtg. 2009).

concluded that she had 16 percent right lower extremity impairment. Regarding the left knee, Dr. Grant advised that for a diagnosis of medial meniscus tear, appellant had a class 2 impairment, with modifiers 2 for functional history and physical examination, for a total two percent left lower extremity impairment.

On July 17, 2012 OWCP asked its medical adviser to comment regarding impairment of appellant's left lower extremity. On July 22, 2012 Dr. Sanjai Shukla, an OWCP medical adviser, who is Board-certified in orthopedic surgery, reviewed the medical record including Dr. Grant's reports. He noted that, while Dr. Grant indicated that appellant had tenderness to palpation of the left knee, physical examination findings were missing from the medical chart. Dr. Shukla indicated that, using Table 16-3, for a partial meniscectomy, she had a class 1 impairment with a default impairment of two percent. He advised that appellant had modifiers 1 for functional history and physical examination, for a net adjustment of zero. Dr. Shukla concluded that she had two percent permanent impairment of the left lower extremity with April 12, 2011 the date of maximum medical improvement.

On September 14, 2012 OWCP requested that an OWCP medical adviser comment regarding impairment of both lower extremities. On September 17, 2012 Dr. David H. Garelick, an OWCP medical adviser, who is a Board-certified orthopedist, noted his review of the reports of Dr. Shukla and Dr. Grant. He advised that Dr. Grant's reports showed little regarding physical examination. Dr. Garelick indicated that on September 16 and 28, 2010 Dr. Palmer advised that appellant's right knee was collaterally stable, and that an MRI scan of the right knee dated October 7, 2010 was described as normal. He concluded that, as there was no objective evidence to support ongoing pathology in the right knee, there was no basis for Dr. Grant's rating of 16 percent permanent impairment. Dr. Garelick concluded that appellant had zero impairment of the right lower extremity and agreed with Dr. Shukla regarding the date of maximum medical improvement and his impairment rating of two percent impairment of the left lower extremity.

On October 12, 2012 OWCP granted appellant a schedule award for two percent left lower extremity impairment, for a total of 5.76 weeks, to run from April 12 to May 22, 2011. The decision also found that she had zero loss of the right lower extremity.

Appellant, through counsel, timely requested a hearing, which was held on February 13, 2013. At the hearing counsel noted that he was submitting a new medical report. In a February 19, 2013 report, Dr. Neil Allen, Board-certified in internal medicine and neurology, reviewed medical evidence and described examination findings. He advised that, for the left knee, under Table 16-3, appellant had a class 1 impairment with default leg impairment of seven percent. Dr. Allen found grade modifiers 1 for functional history and physical examination, and no modifier for clinical studies, as it had been used as a key factor in class placement. He concluded that appellant had seven percent left leg impairment.

For the right knee, Dr. Allen noted that range of motion provided a more accurate impairment for her diagnosis of right knee osteoarthritis. He utilized Table 16-23, Knee Range of Motion, finding that appellant had three percent impairment for 108 degrees of flexion. Dr. Allen then utilized Table 16-17, Functional History Net Modifier, and found a modifier 1 based on pain with strenuous activity, an antalgic gait and an American Academy of Orthopedic Surgeons score of 68. He concluded that appellant had 10 percent right leg impairment.

By decision dated April 30, 2013, an OWCP hearing representative set aside the October 12, 2012 decision and remanded the case to OWCP to have its medical adviser review Dr. Allen's report.

In a September 3, 2013 report, Dr. Christopher Gross, an OWCP medical adviser, noted his review of the medical record including Dr. Allen's report. He indicated that he saw no new evidence to support an additional award. Dr. Gross maintained that Dr. Allen incorrectly rated appellant's right knee range of motion, noting that she no longer had pain over the lateral collateral ligament, and that an October 7, 2010 MRI scan showed the collateral ligaments to be normal. He indicated that her loss of knee range of motion was likely due to preexisting knee degenerative joint disease, as documented by Dr. Palmer.

Regarding the left knee, Dr. Gross noted that Dr. Allen incorrectly based his findings on a total meniscectomy, but appellant has had a partial meniscectomy. He reported that Dr. Shukla correctly rated the partial meniscectomy in his July 22, 2012 report. Dr. Gross concluded that appellant's right lower extremity rating remained at zero percent, and her left lower extremity impairment at two percent, as awarded, with maximum medical improvement at April 21, 2011.

In a decision dated September 9, 2013, OWCP found that appellant had not established additional permanent impairment. Appellant, through counsel, timely requested a hearing, which was held on March 21, 2014. At the hearing counsel argued that she should be referred for a second-opinion evaluation.

By decision dated June 10, 2014, an OWCP hearing representative reviewed all the relevant medical evidence and affirmed the September 9, 2013 decision. On October 22, 2014 appellant, through counsel, requested reconsideration and submitted an addendum report from Dr. Allen dated October 2, 2014. In the October 2, 2014 report, Dr. Allen recognized that, as she only had a partial meniscectomy on the left, the correct impairment rating was two percent, for which she had received a schedule award. Regarding the right knee, he rated appellant under Table 16-3 for a right knee strain, finding a class 1 impairment with a mild loss of knee flexion, which had a default value of seven percent. Dr. Allen found modifiers 1 for functional history, physical examination, and clinical studies, which did not change the default value of seven percent.

OWCP referred Dr. Allen's October 2, 2014 report to Dr. Garelick, an OWCP medical adviser, for review. In his May 18, 2015 report, Dr. Garelick disagreed with Dr. Allen's right knee impairment evaluation. He indicated that the definition of a knee strain was a stretch or tear of one or more ligaments in the knee joint, and physical examination and/or MRI scans were to be used to confirm this. Dr. Garelick discussed Dr. Palmer's reports in which the latter advised that appellant's right knee was "collaterally stable," implying no tearing or stretching of the collateral ligaments. He further noted that the October 7, 2010 right knee MRI scan indicated that the medial and collateral ligaments were normal. Dr. Garelick advised that appellant had no right leg impairment. The date of maximum medical improvement remained the same.

In a merit decision dated May 27, 2015, OWCP found that the weight of the medical evidence rested with the opinion of Dr. Garelick and denied modification of the prior decisions.

Appellant, through counsel, again requested reconsideration on November 16, 2015 and submitted a new report from Dr. Allen dated October 21, 2015. In that report, Dr. Allen disagreed with Dr. Garelick's conclusion regarding appellant's right knee impairment. He maintained that, with a grade 1 sprain, the patient would demonstrate tenderness, but that laxity would not be demonstrated on collateral stress testing, noting that collateral laxity was a sign of a grade 2 or 3 injury. Dr. Allen further noted that it was not surprising that the MRI scan lacked findings of a sprain as the MRI scan was not performed until nearly three months after the employment injury and MRI scan changes would have resolved by that time. He also noted that the MRI scan showed evidence of significant acute bone bruising, which supported measurable injury of the joint. Dr. Allen reiterated that his rating of October 2, 2014 was proper and supported by the medical evidence.

In a merit decision dated January 19, 2016, OWCP denied modification of the prior decisions. It found that the weight of the medical evidence rested with the medical adviser, indicating that Dr. Allen had not provided objective findings to show that an essentially normal MRI scan would result in a grade 2 or 3 injury.[4]

LEGAL PRECEDENT

It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of any employment injury.[5]

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 the A.M.A., *Guides* as the uniform standard applicable to all claimants.[8] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[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

[4] The record also indicates that appellant received a third-party recovery for this injury.

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

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id*. at § 10.404(a).

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

[10] A.M.A., *Guides*, *supra* note 3 at 4, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

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] 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.[13] 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.[14]

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 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.[15] In determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[16]

ANALYSIS

The Board finds that appellant has not established more than two percent left lower extremity permanent impairment. The sixth edition of the A.M.A., *Guides* classifies the lower extremity impairment by diagnosis, which is then adjusted by grade modifiers.[17] Section 16.2a includes instructions for performing an impairment analysis using the regional grids. This includes identifying a diagnosis and applying the grade modifiers.[18]

Each physician who provided an impairment analysis in this case, whether an attending physician or OWCP medical adviser, advised that, in accordance with Table 16-3, Knee Regional Grid, of the A.M.A., *Guides*,[19] for a partial tear of the medial meniscus, appellant had two percent left lower extremity impairment. While Dr. Allen initially found that, based on a diagnosis of a total meniscal tear, she had a seven percent impairment, in an October 2, 2014 report, he acknowledged his diagnostic error and advised that she had two percent permanent impairment of the left lower extremity, based on a diagnosis of partial meniscal tear.

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

[12] *Id*. at 521.

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

[14] *Id*. at 500.

[15] *See supra* note 9 at Chapter 2.808.6(f) (February 2013).

[16] *Peter C. Belkind*, 56 ECAB 580 (2005).

[17] A.M.A., *Guides*, *supra* note 3 at 497-500.

[18] *Id*. at 499-500.

[19] *Id*. at 509-11.

The Board finds that appellant has failed to establish more than two percent permanent impairment of the left lower extremity in accordance with the sixth edition of the A.M.A., *Guides*.

Regarding the right lower extremity, Table 16-3 provides a rating for strain.[20] Dr. Grant, who provided reports dated August 12, 2011 and February 17, 2012, found that appellant had a class 2 impairment for right collateral sprain, which he apparently identified as a ligament/bone and joint injury.[21] He, however, provided no physical examination findings to support his conclusion. As such, Dr. Grant's opinion is of limited probative value as to appellant's right lower extremity impairment.

Dr. Allen, an attending physician, first submitted a report on February 19, 2013. He evaluated appellant's right knee under Table 16-23, Knee Range of Motion, and found seven percent impairment. In an October 2, 2014 report, Dr. Allen found that, under Table 16-3, for a right knee strain with mild loss of knee flexion, appellant had a class 1 impairment of seven percent.

All OWCP medical advisers were consistent in their opinions that appellant had no right lower extremity impairment. On September 17, 2012 Dr. Garelick noted that Dr. Palmer found her right knee to be collaterally stable and that an October 7, 2010 MRI scan was essentially normal. He reiterated this opinion on May 18, 2015 when he reviewed Dr. Allen's October 2, 2014 report. Dr. Gross, who reviewed Dr. Allen's initial February 19, 2013 report, also found no objective evidence to support a right lower extremity schedule award.

Appellant, however, also submitted an October 21, 2015 report from Dr. Allen. In his October 21, 2015 report, Dr. Allen disagreed with Dr. Garelick's conclusion regarding her right knee impairment. He maintained that, with a grade 1 sprain, the patient would demonstrate tenderness, but that laxity would not be demonstrated on collateral stress testing, noting that collateral laxity was a sign of a grade 2 or 3 injury. Dr. Allen further noted that it was not surprising that the MRI scan lacked findings of a sprain as the MRI scan was not performed until nearly three months after the employment injury and MRI scan changes would have resolved by that time. His statement regarding the date of the MRI scan is error as the employment injury occurred on August 30, 2010 and the MRI scan was done on October 7, 2010 less than two months later. Dr. Allen also noted that the MRI scan showed evidence of significant acute bone bruising, which supported measurable injury of the joint. He reiterated that his rating of October 2, 2014 was proper and supported by the medical evidence.

As noted above, 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

[20] *Id*. at 509.

[21] *Id*. at 510.

providing rationale for the percentage of impairment specified.[22] Although not required, the Board finds that only a physician can respond to Dr. Allen's October 21, 2015 report.

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[23] The Board finds in this case that the report of Dr. Allen should be referred for review by an OWCP medical adviser to determine whether the new report would change the impairment rating.[24] On remand, OWCP should refer the case to its medical adviser to review the record regarding appellant's right lower extremity impairment. Following this, and any other further development deemed necessary, it shall issue an appropriate merit decision regarding entitlement to a schedule award for her right lower extremity.

Regarding the left lower extremity, 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 did not meet her burden of proof to establish more than two percent impairment of the left lower extremity and that the case is not in posture for decision regarding whether she established impairment to the right lower extremity.

[22] *Supra* note 15.

[23] *William J. Cantrell*, 34 ECAB 1223 (1983).

[24] *Supra* note 16.

ORDER

IT IS HEREBY ORDERED THAT the January 19, 2016 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part, and the case is remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: October 3, 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