United States Department of Labor
Employees' Compensation Appeals Board

R.B., Appellant	)	
and	)	**Docket No. 16-0815**
	)	**Issued: October 25, 2016**
U.S. POSTAL SERVICE, POSTAL SERVICE, Detroit, MI, 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 March 15, 2016 appellant, through counsel, filed a timely appeal from a January 11, 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.

ISSUE

The issue is whether appellant has more than 31 percent permanent impairment of the right lower extremity for which she had 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 April 21, 2008 appellant, then a 43-year-old letter carrier, filed a Form CA-2, notice of occupational disease, alleging that she had developed bilateral knee osteoarthritis as a result of work duties, which included prolonged standing, squatting, and stair climbing.[3] On August 3, 2009 OWCP accepted permanent aggravation of right knee osteoarthritis. It later expanded appellant's claim to include generalized osteoarthrosis, multiple sites, and bilateral localized primary osteoarthritis bilateral legs. OWCP authorized a total right knee replacement, which was performed on June 20, 2008. Appellant did not stop work, but returned to a light-duty position. She was granted disability retirement, effective February 19, 2010.

Appellant came under the treatment of Dr. Ronald Little, a Board-certified orthopedist on February 18, 2008 for significant right knee pain. She reported that her job consisted of sitting practically eight hours per day. On June 20, 2008 Dr. Little performed total knee arthroplasty on the right knee and diagnosed degenerative arthritis of the right knee. Appellant submitted a November 13, 2009 report from Dr. Little who diagnosed right lower extremity radicular pain likely from the back. Dr. Little noted range of motion of the right knee of 5 to 120 degrees and on the left of 0 to 130 degrees.

Appellant was treated by Dr. Carla E. Morton, a Board-certified physiatrist, from August 19, 2009 to February 16, 2010, for injuries sustained to her right knee at work. She reported undergoing a total right knee replacement in 2008. Dr. Morton diagnosed right knee pain by history, status post right total knee arthroplasty, status post osteoarthritis of the right knee, and right knee swelling. On February 16, 2010 she noted range of motion of 0 to 120 degrees. Dr. Morton noted that appellant could work subject to restrictions. An electromyogram dated December 3, 2009 revealed no evidence of a right or left lower extremity radiculopathy, plexopathy, or mononeuropathy.

On June 3, 2010 appellant filed a claim for a schedule award (Form CA-7). She submitted a report dated May 16, 2010 from Dr. William N. Grant, a Board-certified internist. Dr. Grant diagnosed right general osteoarthritis. He noted the history of injury, reviewed the medical record, and presented his findings. Dr. Grant opined that appellant had 36 percent permanent impairment of the right lower extremity pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[4] (A.M.A., *Guides*). He noted examination of the right knee revealed synovial change, a well-healed surgical scar, and tenderness to palpation. Dr. Grant noted range of motion for the right knee revealed flexion contracture of 15 degrees for a 20 percent lower extremity impairment and flexion of 70 degrees for a 20 percent lower extremity impairment. He used the Combined Values Chart of the A.M.A., *Guides* to calculate that 20 percent lower extremity impairment for flexion contracture

[3] Appellant filed a claim for muscle spasms in her right knee on February 25, 2005 which was accepted for sprains and strains of the right knee and leg under File No. xxxxxx126. On March 3, 2009 OWCP consolidated File No. xxxxxx126 and the current claim before the Board, File No. xxxxxx939, for administrative case management purposes.

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

and 20 percent lower extremity impairment for flexion results in 36 percent impairment of the right lower extremity.

In a June 28, 2010 report, an OWCP medical adviser reviewed the medical records provided and disagreed with Dr. Grant's impairment rating. Dr. Grant opined that appellant had 36 percent right lower extremity impairment based on the range of motion impairment rating method. He noted range of motion for flexion contracture was 15 degrees and for flexion 70 degrees. The medical adviser noted, however, that he could not provide a well-reasoned assessment of the true impairment based on range of motion because the examination recorded by Dr. Grant was not consistent with the medical evidence documented elsewhere in the record. He noted on May 16, 2010, Dr. Grant had reported 15 degrees of flexion contracture and 70 degrees for flexion; on February 16, 2010 Dr. Morton had noted 0 degrees for flexion contracture and 85 degrees for flexion; and on November 23, 2009 Dr. Little noted 5 degrees for flexion contracture and 120 degrees for flexion. The great degree of variation in evaluation had a significant impact on an impairment rating and, therefore, range of motion could not be assumed to provide any reliable measure of impairment. The medical adviser noted the diagnosis-based impairment method would be used with no grade modifier for physical examination. Pursuant to the A.M.A., *Guide*s, Table 16-3, page 511, he noted a class 3 right total knee replacement with fair results, which has a default rating of 37 percent. The medical adviser assigned a grade 2 modifier for functional history adjustment under Table 16-6, page 516. He assigned a grade 2 modifier for clinical studies adjustment under Table 16-8, page 519. The medical adviser utilized the net adjustment formula to find a net adjustment of -2. He opined the final right lower extremity impairment after net adjustment was 31 percent.

In a decision dated March 30, 2011, OWCP granted appellant a schedule award for 31 percent permanent impairment of the right lower extremity. The period of the award was from August 18, 2009 to May 4, 2011.

In a report dated October 16, 2012, Dr. Little diagnosed status post right total knee arthroplasty in June 2008 and left knee degenerative joint disease. He noted that appellant reported left knee pain which became unbearable. Dr. Little recommended a left total knee arthroplasty. The medical adviser concurred in Dr. Little's assessment and approved the left knee arthroplasty as work related. On September 9, 2013 Dr. Little performed a left total knee arthroplasty and diagnosed osteoarthritis of the left knee.

Appellant continued to be treated by Dr. Morton from January 14 to September 3, 2014, for bilateral knee pain. She reported an improvement in her bilateral knee pain, but continued to complain of intermittent knee swelling, warmth, and popping with increased activity. On September 3, 2014 Dr. Morton noted that appellant reached maximum medical improvement for her bilateral knee pain.

On September 24, 2014 appellant filed a Form CA-7, claim for an additional schedule award. In an October 15, 2014 letter, OWCP requested that she obtain a medical report from her

treating physician and evaluate the extent of permanent impairment of the bilateral lower extremities under the A.M.A., *Guides.*[5]

Appellant submitted a January 23, 2015 report from Dr. Catherine Watkins Campbell, Board-certified in occupational therapy and family medicine. Dr. Campbell noted that appellant developed osteoarthritis of both knees as a result of multiple falls during her employment and cumulative trauma due to many years walking as a letter carrier. She noted that appellant had her right knee replaced in 2008. Dr. Campbell noted that appellant's lower extremity assessment scale was a score of 80 for no functional deficits. She noted that appellant ambulated with a moderately antalgic gait, no localized tenderness of the right knee, and ballotable patella on the left with tenderness and warmth. Dr. Campbell noted that range of motion for the right knee was -12, -13, -12 degrees and for flexion range of motion was 110, 104, 100 degrees with mild anterior/posterior laxity. She noted maximum medical improvement occurred on September 3, 2014. For the right leg, Dr. Campbell assigned under Table 16-3, page 511, 34 percent impairment for a class 3 right total knee replacement. Based on bilateral total knee replacements and continued use of a wheeled walker, she assigned a grade 3 modifier for Functional History (GMFH) adjustment under Table 16-6, page 516. Based on the degree of flexion contracture documented, she assigned a grade 2 modifier for Physical Examination (GMPE) adjustment under Table 16-7, page 517. Dr. Campbell noted that there were no applicable clinical studies so the Clinical Studies (GMCS) adjustment under Table 16-8, page 519 was not used. She utilized the net adjustment formula to find a net adjustment of -1. Dr. Campbell opined that the final right lower extremity permanent impairment after net adjustment was 34 percent.[6]

In an April 1, 2015 report, the medical adviser reviewed the medical record and disagreed with Dr. Campbell's impairment rating. He noted that the date of maximum medical improvement was October 23, 2014. The medical adviser found that the most impairing diagnosis in the knee region was arthroplasty with a fair result, which would be used for final impairment calculations. He noted that appellant was status post right knee arthroscopy with good hardware placement, mild laxity, and mild motion loss. The medical adviser assigned under Table 16-3, page 511, 31 percent impairment for a class 3 right total knee replacement with fair results. He assigned a grade 3 modifier for a GMFH adjustment under Table 16-6, page 516 based on his observation that appellant still had symptoms in the knee joint and the rating report documents that she used a walker for ambulation. Based on the medical adviser's observation and palpatory findings, he assigned a grade 1 modifier for GMPE adjustment under Table 16-7, page 517. He noted that Dr. Campbell used range of motion deficits to assign GMPE, but range of motion was used to place appellant into the correct diagnostic class and cannot be used again to assign a GMPE. The medical adviser noted tightness, but no other objective deficits were documented. He noted that GMCS were used to place appellant in the right diagnostic class and may not be used again to assign GMCS. The medical adviser utilized

[5] *Id*.

[6] Dr. Campbell also rated left leg permanent impairment. However, OWCP's January 11, 2016 decision did not make a final decision on left leg impairment. Matters regarding left leg impairment are not before the Board on the present appeal. *See* 20 C.F.R. § 501.2(c).

the net adjustment formula to find a net adjustment of -2 for a final grade A. He noted the final right lower extremity permanent impairment after net adjustment was 31 percent.

In a decision dated April 8, 2015, OWCP denied appellant's claim for an additional schedule award.

On April 14, 2015 appellant requested an oral hearing that was held on October 22, 2015.

In a decision dated January 11, 2016, an OWCP hearing representative affirmed the April 8, 2015 decision.[7]

LEGAL PRECEDENT

The schedule award provision of FECA[8] and its implementing federal regulations,[9] 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.[10] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[11]

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).[12] Under the sixth edition, the evaluator identifies the impairments class for the diagnosed condition, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14] Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[15]

[7] With respect to permanent impairment of the left leg, the hearing representative directed OWCP to refer the matter to an OWCP medical adviser for review. As noted, this aspect of the claim is not before the Board on the present appeal. *See id*.

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] *Id.* at § 10.404(a).

[11] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); and Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2003).

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

[13] *Id.* at 385-419.

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

[15] *Id*. at 23-28; *see also R.V.*, Docket No. 10-1827 (issued April 1, 2011).

In determining impairment of the lower extremities, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the knee, the relevant portion of the leg for the present case, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[16] After the Class of Diagnosis (CDX) is determined from the Knee Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the grade modifier for functional history, grade modifier for physical examination, and grade modifier for clinical studies.[17]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical consultant for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with the medical consultant providing rationale for the percentage of impairment specified.[18]

ANALYSIS

OWCP accepted appellant's claim for permanent aggravation of right knee osteoarthritis, generalized osteoarthrosis, multiple sites, and bilateral localized primary osteoarthritis of the bilateral legs. It authorized a total right knee replacement, which was performed on June 20, 2008. On March 30, 2011 appellant was granted a schedule award for 31 percent permanent impairment of the right lower extremity using the applicable table of the sixth edition of the A.M.A., *Guides*. She claimed an additional award and submitted a new medical report.

Dr. Campbell opined that appellant sustained 34 percent permanent impairment of the right leg in accordance with the A.M.A., *Guides.* She explained that, under Table 16-3, page 511, Knee Regional Grid, Total Knee Replacement, appellant was a class 3 for fair results with a default, grade C, impairment rating of 37 percent. Based on bilateral total knee replacements and continued use of a wheeled walker, Dr. Campbell assigned a grade 3 modifier for GMFH adjustment under Table 16-6, page 516. Based on the degree of flexion contracture documented, she assigned a grade 2 modifier for GMPE adjustment under Table 16-7, page 517. Dr. Campbell utilized the net adjustment formula to find a net adjustment of -1, which moved the default grade C rating one place to the left, to grade B, for 34 percent impairment of the right leg. She opined that the final right lower extremity permanent impairment after net adjustment was 34 percent.

In an April 1, 2015 report, the medical adviser reviewed Dr. Campbell's January 23, 2015 report. He agreed with her diagnosis and class utilized. The medical adviser also agreed that appellant's GMFH was 3 and that GMCS was not applicable. His only difference was with Dr. Campbell was for GMPE, which he found was 1 while she found it to be 2. The medical adviser disagreed with her GMPE finding of 2 stating that, as range of motion was used to place appellant into the diagnostic class, it could not be used again to assign GMPE.[19] He noted

[16] *See id.* at 509-11.

[17] *Id*. at 515-23.

[18] *See supra* note 11 at Chapter 2.808.6(f) (February 2013).

[19] *See* A.M.A., *Guides* 521.

tightness warranting GMPE of 1, but no other documented objective deficits. Using the net adjustment formula the medical adviser noted an adjustment of -2 for a final grade A, which yields 31 percent permanent impairment of the right leg. He noted the final right lower extremity impairment after net adjustment was 31 percent.

The Board finds that the medical adviser properly calculated permanent impairment under the sixth edition of the A.M.A., *Guides,* and explained why GMPE of 1 was warranted based on Dr. Campbell's findings. There is no current medical evidence in accordance with the A.M.A., *Guides,* which supports that appellant sustained more than 31 percent permanent impairment for the right lower extremity for which she has already received a schedule award.

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 no more than 31 percent impairment of the right lower extremity for which she received a schedule award.

ORDER

IT IS HEREBY ORDERED that the January 11, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 25, 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