United States Department of Labor
Employees' Compensation Appeals Board

D.I., Appellant	)	
and	)	**Docket No. 16-1891**
	)	**Issued: December 7, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Amesbury, MA, Employer	)	

Appearances:
Daniel B. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 27, 2016 appellant, through counsel, filed a timely appeal from a September 12, 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.[3]

[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.*

[3] Appellant timely requested an oral argument before the Board. By order dated February 7, 2017, the Board exercised its discretion and denied the request, finding that the issue presented could be addressed based on review of the case record. *Order Denying Request for Oral Argument*, Docket No. 16-1891 (issued February 7, 2017).

ISSUE

The issue is whether appellant has more than 26 percent permanent impairment of the left lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On November 13, 2012 appellant, then a 63-year-old retired letter carrier, filed an occupational disease claim (Form CA-2) alleging that his employment duties aggravated and accelerated his bilateral knee osteoarthritis. OWCP assigned the claim File No. xxxxxx209 and, on December 13, 2012, accepted the claim for aggravation of bilateral knee osteoarthritis.

Appellant has three prior claims for injuries to his knees. Under File No. xxxxxx218, OWCP accepted left knee strain and left medial meniscus tear, which occurred in the performance of duty on August 24, 1996. Appellant underwent left knee arthroscopy on February 28, 1997. Under File No. xxxxxx787, OWCP accepted left patellar tendon rupture due to an October 27, 2006 work-related fall. Appellant underwent left knee patellar tendon repair on October 27, 2006. Under File No. xxxxxx136, appellant filed a claim for a right knee condition that allegedly arose on or about November 6, 2006. OWCP denied that claim by decision dated December 2, 2008. It combined appellant's lower extremity claims and designated File No. xxxxxx209 as the master file.

On February 6, 2013 appellant filed a claim for a schedule award (Form CA-7). In a January 31, 2013 report, Dr. David C. Morley Jr., a Board-certified orthopedic surgeon, advised that appellant had reached maximum medical improvement (MMI) with respect to both knees.[4] He diagnosed bilateral advanced medial compartment knee arthritis, which was causally related to appellant's prior letter carrier duties. Utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (2009) (A.M.A., *Guides*),[5] Dr. Morley calculated 32 percent permanent impairment for each lower extremity for "knee joint arthritis." Appropriate tables and figures in the A.M.A., *Guides* were cited.

On January 2, 2014 an OWCP medical adviser reviewed Dr. Morley's January 31, 2013 report. He opined that appellant sustained temporary aggravation of the bilateral knee osteoarthritis and that his employment factors did not accelerate his preexisting knee condition.

OWCP declared a conflict in medical opinion between Dr. Morley and its medical adviser, and referred appellant to Dr. Robert R. Pennell, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a March 17, 2014 report, Dr. Pennell noted that there was no scientific evidence that appellant's work duties caused or contributed to his developing osteoarthritis in either knee joint.

[4] Dr. Morley noted that appellant tore his right meniscus in 1988, which required arthroscopic surgery. This was reportedly a nonindustrial injury, and appellant subsequently returned to work without significant problems. Dr. Morley also noted appellant's work-related left knee surgery in 2006. He explained that appellant reached MMI within months of the respective knee surgeries.

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

He noted that nonoccupational risk factors for knee osteoarthritis included age and being overweight or obese. Dr. Pennell noted, however, that there was scientific evidence that appellant's prior work-related left knee injuries would be contributing causes to his left knee osteoarthritis. He concluded that the prior left knee injuries and related surgeries resulted in a permanent aggravation of the left knee osteoarthritis. Dr. Pennell noted that appellant did not bring his x-rays with him. He noted that the radiologists who read the December 29, 2010 and May 1, 2012 bilateral knee x-rays concluded that appellant had moderate narrowing of the medial joint space, bilaterally with an assumed joint space measuring two millimeters (mm). Under Table 16-3, Knee Regional Grid, Dr. Pennell assigned class 2 for moderate problem with a two mm cartilage interval for the left knee. He assigned grade modifier 1 for functional history for a mild limp and also based on the American Academy/Association of Orthopedic Surgeons (AAOS) questionnaire. Dr. Pennell noted that the September 27, 2012 questionnaire was inconsistent with appellant's statements provided on examination, where he reported that he was only a "little" tender on the sides of his knees and there was a relatively small joint effusion and no crepitation. There was also only minor laxity of the medial collateral ligament and no other instability. Dr. Pennell also noted a mild varus deformity and good range of motion of the knees with no leg length discrepancy. On that basis, he applied grade modifier 1 for physical examination. Dr. Pennell noted a clinical studies modifier was not applicable as the x-ray findings were used to place appellant in the diagnosis class. Applying the net adjustment formula, he calculated 16 percent permanent impairment of the left lower extremity.

On August 15, 2014 an OWCP medical adviser recommended that Dr. Pennell, as the impartial medical specialist, review recent left knee x-ray images, perform joint space measurements, and document the number of millimeters for each of the left knee comparts and then provide an impairment rating.

On January 13, 2015 OWCP forwarded bilateral knee x-rays from October 2, 2014 to Dr. Pennell for review and an addendum report.

In a January 20, 2015 addendum, Dr. Pennell indicated that the medial joint space of the left and right knees measured one mm. Under Table 16-3, A.M.A., *Guides* 511 (6th ed. 2009),[6] he assigned class 3 for one mm cartilage interval and applied grade modifier 1 for functional history and grade modifier 1 for physical examination. A grade modifier for clinical studies was excluded. Dr. Pennell applied the net adjustment formula and calculated a net adjustment of -4 which yielded 26 percent permanent impairment of the left lower extremity.

On March 19, 2015 OWCP amended the accepted conditions to reflect permanent aggravation of left knee osteoarthritis and temporary aggravation of right knee osteoarthritis.

On October 30, 2015 an OWCP medical adviser concurred with Dr. Pennell's impairment rating for the left lower extremity of 26 percent. He opined that MMI occurred on March 17, 2014, the date of Dr. Pennell's impairment examination. The medical adviser agreed with Dr. Pennell's assignment of grade modifier 1 for functional history as appellant had an antalgic gait, which did not require the use of a single gait aid/external orthotic device for stabilization and there was no documentation of a positive Trendelenburg. He also agreed with a grade

[6] *See* A.M.A. *Guides* 511, Table 16-3.

modifier 1 for physical examination as there was no tenderness to palpation and small joint effusions. The medical adviser further noted that since clinical studies were used to place appellant into the class, they could not be used again to assign a grade modifier.

By decision dated December 21, 2015, OWCP issued a schedule award for 26 percent permanent impairment of the left lower extremity. The period of the award ran for 74.88 weeks of compensation for the period March 17, 2014 to August 23, 2015.

On January 14, 2016 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was scheduled for June 28, 2016.[7]

In a June 17, 2016 letter and at the June 28, 2016 hearing, counsel presented arguments with respect to both the right and left knees. Appellant also testified at the hearing.

New evidence included: a September 27, 2012 AAOS lower limb questionnaire, FECA Circular No. 13-07, articles on knee osteoarthritis; excerpts from the Federal (FECA) Procedure Manual, a June 9, 2016 memorandum from one of appellant's counsels; and documents pertaining to other individuals with FECA claims.[8]

In a June 9, 2016 memorandum, counsel argued that appellant's left lower extremity permanent impairment was 30 percent. He also argued that the finding of temporary aggravation of the right knee arthritis was erroneous.

By decision dated September 12, 2016, an OWCP hearing representative affirmed the December 21, 2015 decision which granted a schedule award for 26 percent permanent impairment of the left lower extremity. Special weight was given to Dr. Pennell's impartial medical evaluation. However, the hearing representative remanded the case for further action with regard to the right knee.

LEGAL PRECEDENT

The schedule award provisions of FECA[9] and its implementing regulations,[10] 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

[7] On January 22, 2016 counsel requested a subpoena to compel attendance and testimony of Dr. Pennell. In a May 25, 2016 letter, an OWCP hearing representative denied his request for a subpoena as it had not been demonstrated that the relevant evidence from Dr. Pennell could not be obtained in writing if further clarification was deemed necessary to resolve the impairment issue. The hearing representative further found that if the decision rendered following the hearing was not favorable, the decision would include a specific finding on the subpoena issue which could then be appealed. The issue of whether a subpoena was properly denied is not before the Board on this appeal.

[8] Per FECA Circular No. 13-07, the documents pertaining to other claimants were not scanned into this case file.

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

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.[11] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* is used.[12]

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).[13] Under the sixth edition, for lower extremity impairments the evaluator 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).[14] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[15] The grade modifiers are used on the net adjustment formula described above to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down the default value C, by the calculated net adjustment.[16]

Section 8123 of FECA provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician, who shall make an examination.[17] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[18] OWCP's medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.[19]

OWCP's 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

[11] *Id.* at § 10.404(a).

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

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

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

[15] *Id.* at 521.

[16] *Id.* at 497.

[17] 5 U.S.C. § 8123(a).

[18] *James F. Weikel*, 54 ECAB 660 (2003).

[19] *V.G.*, 59 ECAB 635 (2008); *Thomas J. Fragale*, 55 ECAB 619 (2004); *see also Richard R. LeMay*, 56 ECAB 341 (2005).

percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[20]

ANALYSIS

OWCP initially accepted appellant's claim for aggravation of bilateral knee osteoarthritis. It later amended the accepted conditions to reflect permanent aggravation of left knee osteoarthritis and temporary aggravation of right knee osteoarthritis. The issue is whether appellant has more than 26 percent permanent impairment of the left lower extremity, for which he previously received a schedule award. The Board finds that appellant has not met his burden of proof to establish more than the 26 percent permanent impairment previously awarded.

In his January 31, 2013 report, Dr. Morley found that MMI had been achieved in both knees and opined that appellant had 32 percent permanent impairment of each knee. An OWCP medical adviser reviewed the case record on January 2, 2014 and opined that appellant sustained temporary aggravation of the bilateral knee osteoarthritis and his employment factors did not accelerate his preexisting knee condition. OWCP thereafter properly declared a conflict in the medical opinion evidence and referred appellant to Dr. Pennell for an impartial medical examination.

In his March 17, 2014 report, Dr. Pennell concluded that appellant's prior left knee injuries and associated surgeries resulted in a permanent aggravation of the left knee osteoarthritis, but not the right knee osteoarthritis. However, without reviewing actual bilateral knee x-rays, he rendered an impairment rating for the left lower extremity. Following a review of the October 2, 2014 bilateral knee x-rays, Dr. Pennell opined in an addendum report of January 20, 2015 that appellant had 26 percent permanent impairment of the left lower extremity. He diagnosed permanent left knee osteoarthritis. Under Table 16-3, Dr. Pennell indicated as the left knee x-rays showed one mm medial joint space, appellant was class 3 or 30 percent default impairment. He excluded clinical studies, but found grade modifiers of 1 for functional history and physical examination. Utilizing the net adjustment formula, (GMFH 1 – CDX 3) + (GMPE 1 – CDX 3) + (GMCS - CDX) (n/a), Dr. Pennell indicated that -4 moved the default impairment of 30 percent to the left 4 times, which yielded 26 percent left lower extremity permanent impairment.

An OWCP medical adviser reviewed Dr. Pennell's findings and concurred with his impairment rating. He opined that MMI occurred on March 17, 2014, the date of Dr. Pennell's examination. Based on Dr. Pennell's examination findings, the medical adviser agreed with his determinations of grade modifiers of 1 for physical examination and functional history. He also agreed that since clinical studies (x-rays) were used to place appellant into the diagnosis class, they could not be used again to assign a grade modifier. Therefore, appellant had a total of 26 percent left lower extremity permanent impairment. The record does not contain a rationalized impairment rating showing that appellant has more than the 26 percent permanent impairment of the left lower extremity previously awarded.

[20] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (February 2013).

On appeal counsel challenges, without providing any arguments or reasons, the hearing representative's affirmance of the December 21, 2015 schedule award for the left lower extremity. As noted, there is no evidence which demonstrates that appellant sustained greater than 26 percent permanent impairment of his left lower extremity.

Appellant may request a schedule award or increased schedule award at any time 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 26 percent permanent impairment of the left lower extremity, for which he previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the September 12, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 7, 2017
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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