

ISSUE

The issue is whether appellant met his burden of proof to establish more than 21 percent permanent impairment of the left lower extremity and 21 percent permanent impairment of the right lower extremity for which he previously received schedule awards.

On appeal counsel asserts that the report of the attending physician should carry the weight of the medical evidence because OWCP's referral physician performed a very cursory physical examination and did not sufficiently explain his findings and conclusions.

FACTUAL HISTORY

On June 3, 2011 appellant, then a 47-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that years of carrying mail and other job duties caused bilateral knee arthritis. On March 30, 2012 OWCP accepted bilateral degenerative joint disease of the knees. Appellant stopped work on June 14, 2012 when Dr. David L. Chalnick, a Board-certified orthopedic surgeon, performed bilateral total knee replacement surgery, which had been authorized by OWCP. He returned to full-time modified duty on February 1, 2013.

On November 14, 2013 appellant, through counsel, requested a schedule award (Form CA-7).³ In a September 25, 2013 report, Dr. Arthur Becan, an orthopedic surgeon, related appellant's history, reviewed medical evidence including preoperative x-rays, and provided physical examination findings noting no effusion or tenderness, and diminished range of motion bilaterally. There was no evidence of varus or valgus instability of either knee, and anterior drawer sign and posterior drop back were negative. Quadriceps strength was 4/5 and gastrocnemius 5/5. Dr. Becan diagnosed cumulative and repetitive occupational trauma, severe varus deformity of the knees bilaterally, advanced osteoarthritis of the right knee, moderately advanced osteoarthritis of the left knee, and status post bilateral total knee arthroplasty. He advised that his impairment rating was based on subjective factors of daily bilateral knee pain, with intermittent swelling and instability, and restrictions to activities of daily living. Objective factors were a mildly guarded gait pattern, diminished range of motion, and diminished quadriceps strength. Dr. Becan found that, in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),⁴ under Table 16-3, Knee Regional Grid, appellant had a class 3 bilateral impairment for a diagnosis of total knee arthroplasty with instability, for 37 percent permanent impairment of each leg. He found bilateral grade modifiers of 2 for functional history and physical examination, and a grade modifier of 3 for clinical studies. Dr. Becan then applied the net adjustment formula, finding an adjustment of minus two. He concluded that appellant had 34 percent permanent impairment of each leg.

On December 13, 2013 Dr. Chalnick reported that appellant had continued bilateral pain, but was greatly improved from his preoperative condition. He noted that x-rays revealed that the implants were in good position with no signs of loosening. Dr. Chalnick provided permanent

³ Appellant filed a schedule award claim (Form CA-7) on July 14, 2014.

⁴ A.M.A., *Guides* (6th ed. 2009).

restrictions of no squatting, kneeling, and climbing. On February 14, 2014 he reported that appellant had fallen on ice four days previously, which caused pain and a click. On examination Dr. Chalnick noted excellent bilateral knee motion and no gross signs of instability. X-rays again demonstrated that the implants were in good position with no signs of loosening. Dr. Chalnick diagnosed a strain and contusion, and advised that appellant could continue restricted duty.

On August 15, 2014 Dr. Henry J. Magliato, an OWCP medical adviser who is a Board-certified orthopedic surgeon, reviewed the record including Dr. Becan's September 25, 2013 report. The medical adviser advised that maximum medical improvement (MMI) was reached on September 25, 2013, the date of Dr. Becan's report, and agreed with his conclusion that appellant had 34 percent permanent impairment of each knee.

OWCP referred appellant to Dr. Stanley Askin, a Board-certified orthopedic surgeon, for a second opinion medical examination and impairment evaluation. In an October 17, 2014 report, Dr. Askin noted the history of present injury, appellant's complaint that exertion caused some knee discomfort, and his review of the statement of accepted facts and medical record. Lower extremity examination revealed bilateral knee scars, and that muscle function of the hip abductors, hip adductors, hip flexors, hip extensors, quadriceps, hamstrings, and ankle and toe motors was preserved bilaterally. Other than an area of decreased sensation lateral to surgical scars, sensation was otherwise preserved about both lower extremities. Deep tendon reflexes at the knees were symmetrical and straight leg raising was negative. Dr. Askin advised that appellant had excellent smooth range of motion from 0 to 120 degrees and that neither knee demonstrated significant instability, although effusion was present bilaterally. He reviewed February 14, 2014 x-rays which showed bilateral satisfactory implants. Dr. Askin diagnosed status post bilateral total knee replacements. He advised that, in accordance with Table 16-3 of the A.M.A., *Guides*, appellant had a class 2 impairment for a diagnosis of total knee replacement. Dr. Askin found a grade modifier of 0 for functional history, noting that appellant had no gait derangement, a grade modifier of 1 for physical examination for minimal findings of swelling, and a grade modifier of 0 for clinical studies because appellant's x-rays confirmed successful knee replacements. He applied the net adjustment formula, finding an adjustment of minus five which corresponded to class A for 21 percent permanent bilateral lower extremity impairment under Table 16-3. Dr. Askin indicated that he could not account for Dr. Becan's findings and would give more credit to Dr. Chalnick's description of appellant. He concluded that he based his evaluation on appellant's presentation on October 17, 2014.

OWCP asked its medical adviser, Dr. Magliato, to again review the record, including Dr. Askin's October 17, 2014 report and Dr. Chalnick's finding of no instability. In an October 30, 2014 report, Dr. Magliato noted that, while Dr. Becan found instability in each knee on September 25, 2013, on February 4, 2014 Dr. Chalnick found no instability. He advised that Dr. Askin also found no instability and reported that appellant demonstrated a good result on examination and on x-ray studies. Dr. Magliato concluded that he agreed with Dr. Askin's calculations under the A.M.A., *Guides* and his conclusion that appellant had 21 percent permanent impairment of the right lower extremity and 21 percent permanent impairment of the left lower extremity.

In a report dated November 18, 2014, Dr. Chalnick noted appellant's complaint of right knee pain that caused limping. Right knee physical examination demonstrated motion from 0 to 130 degrees. There was no pain on palpation of the implant, and no pain of motion of the hip, with pain present proximal to the implant in the quadriceps tendon. No defect was palpable and appellant could perform a straight leg raise. X-rays demonstrated that the implant was in good position with no signs of loosening. Dr. Chalnick diagnosed right quadriceps tendinitis. He opined that he did not believe that there was an issue with the implant in and of itself.

On July 23, 2015 OWCP granted appellant a schedule award for 21 percent permanent impairment of each lower extremity, for a total of 120.96 weeks, to run from October 17, 2014, which was the date of Dr. Askin's report, to February 9, 2019.

Appellant, through counsel, timely requested a hearing before an OWCP hearing representative. At the hearing, held on November 20, 2015, he described letter carrier job duties and maintained that his knees were unstable and painful. Appellant generally asserted that Dr. Askin's evaluation was cursory. Counsel argued that Dr. Askin's opinion was insufficient to carry the weight of the medical evidence, and that Dr. Becan's report and Dr. Chalnick's recent evaluation established instability.

In a December 1, 2015 report, Dr. Chalnick noted appellant's report of discomfort in each knee, right greater than left. He indicated that appellant continued to work as a letter carrier, and walking his route and going up and down stairs aggravated his knees. Physical examination demonstrated that the knees were stable to varus/valgus, flexion and extension, with motion approximately 0 to 140 degrees in each knee. There was no swelling or tenderness, and the calves were soft. The incisions had healed well. Dr. Chalnick concluded that appellant's knees looked good, but advised that his work activity caused worsening discomfort, and opined that he should consider changing his job to a driving route or other more sedentary work.

In a decision dated December 21, 2015, OWCP corrected the term of the schedule award to reflect that the period of the award was October 17, 2014 to February 9, 2017. The remainder of the award, including impairment ratings, was unchanged.

By decision dated January 19, 2016, an OWCP hearing representative affirmed OWCP's July 23, 2015 decision, finding that appellant had no more than 21 percent permanent impairment of each lower extremity, for which he previously received schedule awards. The hearing representative found that Dr. Askin provided a thorough review of the medical evidence, examined appellant, and provided excellent rationale for his opinion.

LEGAL PRECEDENT

It is the claimant's burden of proof to establish a permanent impairment of a scheduled member or function as a result of any employment injury.⁵

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

The schedule award provision of FECA⁶ 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 identifies the impairment class for the diagnosed condition 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 OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's 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

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); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

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

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 2.808.6f (February 2013).

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

Section 8123(a) 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

ANALYSIS

The Board finds that this case is not in posture for decision as a conflict in the medical evidence has been created between the opinions of Dr. Becan, appellant's physician, and Dr. Askin, an OWCP referral physician, regarding the extent of impairment of appellant's bilateral lower extremities.

The accepted condition in this case is bilateral degenerative joint disease of the knees. Appellant had bilateral total knee replacement surgery on June 14, 2012. The sixth edition of the A.M.A., *Guides* classifies the lower extremity impairment by diagnosis, which is then adjusted by grade modifiers.¹⁸ Section 16.2a includes instructions for performing an impairment analysis using the regional grids. This includes identifying a diagnosis and applying the grade modifiers.¹⁹

Both Dr. Becan and Dr. Askin based their impairment analysis on Table 16-3, Knee Regional Grid, of the A.M.A., *Guides*,²⁰ for a diagnosis of total knee arthroplasty.

While Dr. Becan concluded that appellant had a class 3 impairment, described under Table 16-3 as a fair result with fair position, mild instability, and/or mild motion deficit. Dr. Askin found a class 2 impairment described as a good result with good position, stable, and functional.

In his report dated September 25, 2013, Dr. Becan reported physical examination findings of no effusion, tenderness, and diminished range of motion bilaterally. There was no evidence of varus or valgus instability of either knee and anterior drawer sign and posterior drop back were negative. Quadriceps strength was 4/5 and gastrocnemius 5/5. Dr. Becan diagnosed cumulative and repetitive occupational trauma, severe varus deformity of the knees bilaterally, advanced osteoarthritis of the right knee, moderately advanced osteoarthritis of the left knee, and status post bilateral total knee arthroplasty. He advised that his impairment rating was based on subjective factors of daily bilateral knee pain, with intermittent swelling and instability, and restrictions to activities of daily living. Objective factors were a mildly guarded gait pattern, diminished range of motion, and diminished quadriceps strength. Dr. Becan found that, under Table 16-3, Knee Regional Grid, appellant had a class 3 bilateral impairment for a diagnosis of total knee arthroplasty with instability, for 37 percent permanent impairment of each leg. He found bilateral grade modifiers of 2 for functional history and physical examination, and a modifier of 3 for clinical studies. Dr. Becan then applied the net adjustment formula, finding an

¹⁷ 5 U.S.C. § 8123(a); see *Geraldine Foster*, 54 ECAB 435 (2003).

¹⁸ A.M.A., *Guides*, *supra* note 4 at 497-500.

¹⁹ *Id.* at 499-500.

²⁰ *Id.* at 509-11.

adjustment of minus two. He concluded that appellant had 34 percent permanent impairment of each leg.

In his October 17, 2014 report, Dr. Askin noted lower extremity physical examination findings of bilateral knee scars and that muscle function of the hip abductors, hip adductors, hip flexors, hip extensors, quadriceps, hamstrings, and ankle and toe motors was preserved bilaterally. Other than an area of decreased sensation lateral to surgical scars, sensation was otherwise preserved about both lower extremities. Deep tendon reflexes at the knees were symmetrical and straight leg raising was negative. Dr. Askin advised that appellant had excellent smooth range of motion from 0 to 120 degrees and that neither knee demonstrated significant instability although effusion was present bilaterally. He reviewed February 14, 2014 x-rays which showed bilateral satisfactory implants. Dr. Askin diagnosed status post bilateral total knee replacements and advised that, in accordance with Table 16-3, appellant had a class 2 impairment for a diagnosis of total knee replacement. Dr. Askin found a grade modifier of 0 for functional history, noting that appellant had no gait derangement, a grade modifier of 1 for physical examination for minimal findings of swelling, and a grade modifier of 0 for clinical studies because appellant's x-rays confirmed successful knee replacements. He applied the net adjustment formula, finding an adjustment of minus five which corresponded to class A for 21 percent permanent bilateral lower extremity impairment under Table 16-3. Dr. Askin indicated that he could not account for Dr. Becan's findings, and would give more credit to Dr. Chalnack's description of appellant. He concluded that he based his evaluation on appellant's presentation on October 17, 2014.

As previously noted, when there is disagreement between an OWCP physician and the employee's physician, OWCP will appoint a third physician who shall make an examination.²¹ For a conflict to arise, the opposing physician's viewpoints must be of virtually equal weight and rationale.²² The Board finds the differing physical examination findings and conclusions found by Dr. Becan and Dr. Askin to be of equal weight. Thus, a conflict in medical opinion evidence has been created regarding the extent of appellant's bilateral lower extremity impairments. The Board will set aside the January 19, 2016 decision and remand the case for OWCP to refer appellant to an appropriate impartial medical specialist to resolve the conflict. After such further development as it deems necessary, OWCP shall issue a *de novo* decision regarding the extent of appellant's bilateral lower extremity impairments.

CONCLUSION

The Board finds this case is not in posture for decision as a conflict in medical evidence has been created regarding the extent of appellant's bilateral lower extremity impairments.

²¹ *Supra* note 15.

²² *Darlene R. Kennedy*, 57 ECAB 414 (2006).

ORDER

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

Issued: March 14, 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