United States Department of Labor
Employees' Compensation Appeals Board

J.M., Appellant	)	
and	)	**Docket No. 17-1056**
	)	**Issued: November 3, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Detroit, MI, Employer	)	

Appearances:
Appellant, pro se
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 April 20, 2017 appellant filed a timely appeal from a November 4, 2016 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 appellant has established more than two percent permanent impairment of his right lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On March 27, 2014 appellant, then a 58-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that he developed right knee pain as a result of walking, standing, and climbing in and out of vehicles in the performance of duty. He first became aware

[1] 5 U.S.C. § 8101 *et seq.*

of his condition and realized it resulted from his federal employment on February 10, 2014. Appellant stopped work on March 4, 2014 and returned to full-time light duty on March 5, 2014. OWCP accepted his claim for right knee strain.

On January 28, 2015 appellant filed a claim for a schedule award (Form CA-7). He retired from federal service on July 31, 2015. After development of the medical evidence, OWCP issued an October 21, 2015 decision granting appellant a schedule award for two percent permanent impairment of his right lower extremity.

On January 26, 2016 appellant filed a claim for an increased schedule award (Form CA-7) due to his accepted right knee condition. In a February 5, 2016 statement, he explained that according to Dr. Peter E. Metropoulos, Board-certified in occupational medicine, his accepted right knee sprain had continued to worsen. Appellant explained that, after a recent magnetic resonance imaging (MRI) scan, he decided to file a second schedule award claim.

Appellant submitted a January 11, 2016 report from Dr. Metropoulos, who related that appellant complained of progressively increasing pain with decreased function. Upon examination of appellant's right knee and lower leg, Dr. Metropoulos reported tenderness to the right knee diffusely and anteriorly, greatest along the lateral aspect of the patella, tenderness to the popliteal fossa without obvious fullness or masses, and tenderness to the right joint line medially and laterally. Range of motion was decreased to the right knee with flexion and extension. Dr. Metropoulos indicated that a December 2, 2015 right knee MRI scan showed tricompartmental osteoarthritis, most pronounced in the patellofemoral joint, small knee joint effusion, mild medial collateral ligament bursitis, tendinosis and superimposed interstitial tearing involving the tendon origin of the medial head of the gastrocnemius muscle, and small Baker's cyst. He diagnosed right knee strain with progressive pain and loss of function and decreased range of motion with MRI scan evidence of tricompartmental osteoarthritis most pronounced in the patellofemoral joint.

Dr. Metropoulos opined that appellant had 22 percent permanent impairment of the right lower extremity. He explained that this rating was based upon Table 16-3, class 1, page 509, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (hereinafter A.M.A., *Guides*) (6th ed., 2009). Dr. Metropoulos noted that appellant's claim was accepted for right knee sprain and he related that maximum medical improvement (MMI) was reached on January 21, 2015. He explained that the impairment rating range provided for a class 1 with mild motion deficits was five to nine percent. Dr. Metropoulos assigned grade modifiers of 1 for functional history and physical examination, which resulted in no adjustment. He calculated that appellant had seven percent right lower extremity impairment. Dr. Metropoulos also indicated that, according to Table 16-3, page 509, appellant had two percent permanent impairment for his medial meniscal tear.[2] He further noted that appellant had

[2] Dr. Metropoulos indicated that appellant was class 1 with provided for a range of one to three percent impairment. He assigned grade modifiers of 1 for functional history and physical examination, which resulted in no adjustment.

seven percent permanent impairment for tear of the gastrocnemius muscle tendon.[3] For the condition of tricompartmental osteoarthritis, Dr. Metropoulos opined that appellant had seven percent permanent impairment of the lower extremity.[4] He utilized the combined values chart on pages 604 to 605, Appendix A, and calculated that appellant had a total of 22 percent permanent impairment of his right lower extremity.

In a February 11, 2016 report, Dr. Michael M. Katz, a Board-certified orthopedic surgeon and OWCP medical adviser, reviewed the medical evidence of record, including Dr. Metropoulos' January 11, 2016 report. He noted his disagreement with Dr. Metropoulos' impairment rating because he applied Table 16-3, Knee Regional Grid, for separate diagnoses, which was duplicative and inconsistent with the methodology set forth by the sixth edition of the A.M.A., *Guides.* Dr. Katz further reported that the medical evidence of record lacked sufficient detail to permit assignment of an impairment rating on the basis of a records review. He recommended that OWCP refer appellant's schedule award claim for a second-opinion evaluation.

On April 28, 2016 OWCP requested that Dr. Metropoulos respond to Dr. Katz' February 11, 2016 report. In a May 18, 2016 supplemental medical report, Dr. Metropoulos reiterated his medical findings and explanation for why appellant had 22 percent permanent impairment of the right lower extremity. He agreed with Dr. Katz that the sixth edition of the A.M.A., *Guides* suggests that a medical examiner identify the most impairing diagnosis when there is more than one diagnosis being assessed and to opine as to whether the other diagnoses were duplicative or not. Dr. Metropoulos contended, however, that the A.M.A., *Guides* also instructed the medical examiner to determine whether the impairments were duplicative or whether the examiner may combine them within a single region if the most impairing diagnosis did not adequately reflect the losses. He opined that, in appellant's case, the most impairing diagnosis did not adequately reflect appellant's permanent impairment. Dr. Metropoulos explained that, because appellant's functional impairment could not be fully attributed to a singular diagnosis present in appellant's right knee, it was more reasonable to combine the values of the two diagnoses to more accurately reflect the impairment present in his right knee.

In a June 2, 2016 report, Dr. Katz reviewed Dr. Metropoulos' May 18, 2016 addendum report and asserted that his position remained unchanged with respect to Dr. Metropoulos' impairment rating based on various right knee diagnoses. He cited to page 497 of the A.M.A., *Guides*: "If a patient has [two] significant diagnoses … the examiner should use the diagnosis with the highest impairment rating in that region that is causally-related for the impairment calculation." Dr. Katz explained that the existence of multiple conditions could be accounted for by adjusting the grade modifiers and net adjustment upwards. He again recommended a second

[3] Dr. Metropoulos reported class 1, Tier 2, for a range of five to nine percent impairment. He assigned grade modifiers of 1 for functional history for functional history and physical examination, which resulted in no adjustment.

[4] Dr. Metropoulos explained that appellant was a class 1 for moderate to severe articular cartilage thinning along the lateral aspect of the patellofemoral joint compartment, a knee joint effusion, bursitis, and inflammation of the superolateral aspect of the infrapatellar fat pad and mild instability. He assigned grade modifiers of 1 for functional history for functional history and physical examination, which resulted in no adjustment.

opinion impairment evaluation from a Board-certified specialist in physical medicine and rehabilitation or orthopedic surgery.

Dr. Katz provided a June 28, 2016 addendum report and explained that he was unable to provide a date of MMI because the medical records that he reviewed lacked sufficient detail to permit assignment of impairment based on a records review. He contended that, because there was no probative examination record upon which impairment could be calculated, he was unable to assign a date of MMI.

OWCP found a conflict in medical opinion between Dr. Metropoulos, appellant's treating physician, and Dr. Katz, an OWCP medical adviser, regarding the degree of permanent impairment to appellant's right lower extremity as a result of his accepted right knee condition. It referred appellant's case, along with a statement of accepted facts (SOAF) and a copy of the medical record, to Dr. Paul J. Drouillard, an osteopath Board-certified in orthopedic surgery, for an impartial medical examination and opinion to resolve the conflict pursuant to 5 U.S.C. § 8123(a).

In a September 27, 2016 report, Dr. Drouillard reviewed appellant's history, including the SOAF, and noted that appellant had worked for the employing establishment since August 1985 until he retired in July 2015. He reviewed the medical record of evidence and related that a December 2, 2015 right knee MRI scan showed tricompartmental osteoarthritis, worse in the patellofemoral joint, degenerative tear in the posterior horn of the medial meniscus, and a small Baker's cyst. Dr. Drouillard opined that Dr. Metropoulos' impairment rating was a result of adding ratings together, which did not appear to be the correct way to use the formula. Upon physical examination of appellant's right knee, he reported neutral alignment of both knees with no inflammation, swelling, erythema, or skin discoloration. Dr. Drouillard noted some palpable crepitus under the patellofemoral joint of both knees, consistent with chondromalacia. Drawer, Lachman, pivot shift, and McMurray's tests were negative. Dr. Drouillard diagnosed right knee degenerative joint disease. He related that appellant's claim was accepted for right knee strain and had previously been granted a schedule award for two percent permanent impairment of the right lower extremity. Dr. Drouillard indicated that he agreed with the assessment. He opined that appellant's right knee strain appeared to have resolved. Dr. Drouillard explained that appellant's current problems were degenerative in nature and unrelated to his employment.

In an October 13, 2016 report, Dr. Arthur S. Harris, a Board-certified orthopedic surgeon and OWCP medical adviser, reviewed Dr. Drouillard's September 27, 2016 report. He noted that a SOAF was not contained within the case file. Dr. Harris reported that according to Table 16-3, page 509, of the sixth edition of the A.M.A., *Guides* appellant had two percent lower extremity permanent impairment "for residual problems status post straining injury right knee." He noted a date of MMI of September 27, 2016. Dr. Harris explained that, as appellant was previously awarded two percent right lower extremity impairment, he was not entitled to an increased schedule award.

In a decision dated November 4, 2016, OWCP denied appellant's claim for an increased schedule award. It found that the medical evidence of record failed to establish that he was entitled to more than the two percent permanent impairment of his right lower extremity

previously awarded. OWCP determined that the special weight of the medical evidence rested with the opinion of Dr. Drouillard as the impartial medical examiner.

LEGAL PRECEDENT

A claimant seeking compensation under FECA[5] has the burden of proof to establish the essential elements of his or her claim.[6] With respect to a schedule award, it is the claimant's burden of proof to establish a permanent impairment of the scheduled member as a result of his or her employment injury.[7]

The schedule award provision of FECA and its implementing regulations 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. FECA, however, does not specify the manner in which the percentage of 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.[8] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[9]

In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, 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.[10] 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 (GMFH), grade modifier for Physical Examination (GMPE), and grade modifier for Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11] 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.[12]

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[5] *Supra* note 1.

[6] *John W. Montoya*, 54 ECAB 306 (2003).

[7] *Edward Spohr*, 54 ECAB 806, 810 (2003); *Tammy L. Meehan*, 53 ECAB 229 (2001).

[8] 20 C.F.R. § 10.404 (1999); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.806.6.6a (January 2010); *id*., at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[10] *See* A.M.A., *Guides* (6th ed. 2009) 509-11.

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

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

A claim for an increased schedule award may be based on new exposure.[13] Absent any new exposure to employment factors, a claim for an increased schedule award may also be based on medical evidence indicating that the progression of an employment-related condition has resulted in a greater permanent impairment than previously calculated.[14]

ANALYSIS

OWCP accepted appellant's occupational disease claim for right knee strain as a result of his employment duties as a letter carrier. It subsequently granted him a schedule award for two percent permanent impairment of his right lower extremity. On January 26, 2016 appellant filed claim for an increased schedule award (Form CA-7).

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

OWCP found a conflict between Dr. Metropoulos and Dr. Katz with respect to the extent of appellant's right lower extremity permanent impairment and referred his case to Dr. Drouillard to resolve the conflict pursuant to 5 U.S.C. § 8123(a). The Board finds, however, that the medical evidence of record was not of equal weight to create a conflict under 5 U.S.C. § 8123(a). In January 11 and May 18, 2016 reports, Dr. Metropoulos opined that appellant had 22 percent permanent impairment of the right lower extremity. In reports dated February 11 to June 28, 2016, Dr. Katz noted his disagreement with Dr. Metropoulos' calculations, but he did not provide his own opinion on the extent of appellant's right lower extremity impairment. Instead, Dr. Katz recommended that OWCP refer appellant's schedule award claim to a second-opinion examiner. As there was no conflict under 5 U.S.C. § 8123(a), the referral to Dr. Drouillard was for a second opinion examination.[15]

In his September 27, 2016 report, Dr. Drouillard provided an accurate history of injury and provided physical examination findings. He diagnosed right knee degenerative joint disease. Dr. Drouillard opined that appellant's right knee strain appeared to have resolved and explained that appellant's current symptoms were degenerative in nature and unrelated to his employment. He noted that appellant had previously been granted an impairment rating of two percent and that he agreed with the assessment. Dr. Drouillard, however, did not reference any specific tables in the A.M.A., *Guides* or explain the protocols that he used in making the impairment determination. The Board has found that a physician must support his impairment rating by specifically referencing the tables or other provisions of the A.M.A., *Guides* and explaining the

[13] *A.A.*, 59 ECAB 726 (2008); *Tommy R. Martin*, 56 ECAB 273 (2005); *Rose V. Ford*, 55 ECAB 449 (2004).

[14] *James R. Hentz*, 56 ECAB 573 (2005); *Linda T. Brown*, 51 ECAB 115 (1999).

[15] *See Cleopatra McDougal-Saddler*, 47 ECAB 480 (1996) (the Board found that, as there was no conflict in medical opinion evidence, the report of the physician designated as the impartial medical examiner was not afforded the special weight of the evidence but was considered for its own intrinsic value as he was a second opinion specialist); *see also B.T.*, Docket No. 16-1319 (issued April 25, 2017) (the Board found that at the time of the referral for a permanent impairment rating there was no conflict in medical opinion evidence; therefore, the referral was for a second opinion examination).

application of the provisions.[16] As Dr. Drouillard's report does not properly conform to the A.M.A., *Guides*, his opinion is of diminished probative value.

OWCP procedures further provide that, if a second opinion report is equivocal, lacks rationale, or fails to address the specific medical issues, the claims examiner should seek clarification or further rationale from the physician.[17] It is required to seek clarification from the second opinion physician and request a supplemental report to clarify inadequacies in the initial report.[18] Consequently, the Board finds that the opinion of Dr. Drouillard, the second opinion physician, requires further clarification on the issue of additional permanent impairment to appellant's right lower extremity.

The Board also notes that Dr. Harris, OWCP's medical adviser, indicated that a SOAF was not contained within the case file. When an OWCP medical adviser, second opinion specialist, or referee physician renders an opinion based on a SOAF which is incomplete or inaccurate, or does not use the SOAF as a framework in forming his medical opinion, his opinion is seriously diminished or negated altogether.[19]

The case is remanded for proper application of the A.M.A., *Guides* and further development of the evidence. Following such further development as OWCP deems necessary, it should issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for decision and is remanded to OWCP for further development.

[16] *E.L.*, Docket No. 13-0894 (issued July 8, 2013); *Mary L. Henninger*, 52 ECAB 408 (2001).

[17] *G.C.*, Docket No. 16-1109 (issued December 7, 2016); *supra* note 8 Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.9(j) (June 2015).

[18] *Id.*, *see also Ayanle A. Hashi*, 56 ECAB 234 (2004).

[19] *Supra* note 9 at Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.0600.3a (October 1990).

ORDER

IT IS HEREBY ORDERED THAT the November 4, 2016 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: November 3, 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