United States Department of Labor
Employees' Compensation Appeals Board

S.C., Appellant	)	
and	)	**Docket No. 17-0979**
	)	**Issued: October 11, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Jacksonville, FL, 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:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On April 4, 2017 appellant, through counsel, filed a timely appeal from a January 31, 2017 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 this case.

ISSUE

The issue is whether appellant has established more than two percent permanent impairment of her right lower extremity, for which she previously 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 July 9, 2013 appellant, then a 39-year-old city carrier assistant, filed a traumatic injury claim (Form CA-1) alleging that on that same date she sustained a right leg fracture when she slipped and fell while delivering mail. She stopped work on July 9, 2013 and received continuation of pay benefits. By decision dated August 29, 2013, OWCP accepted the claim for right closed fracture of fibula.

Appellant sought treatment with Dr. Paul J. Rucinski, Board-certified in emergency medicine, who treated her right proximal fibula fracture with a hinged knee brace and crutches.

In a November 5, 2013 diagnostic report, Dr. James B. Vogler III, a Board-certified diagnostic radiologist, reported that a magnetic resonance imaging (MRI) scan of the right knee revealed signal abnormalities in the posterior cruciate suggesting the residuals of a grade 2 sprain and/or intraligamentous mucinous degeneration. He further provided findings of healing nondisplaced fracture of the proximal fibula with adjacent post-traumatic tendinitis of the distal biceps femoris insertion and the origin of the peroneus longus tendon, no discrete tendon tears.

In a November 7, 2013 medical report, Dr. Rucinski reviewed a right knee MRI scan and diagnosed healing nondisplaced fracture of the proximal fibula with adjacent post-traumatic tendinitis. He reported that appellant had reached maximum medical improvement (MMI) with a zero percent impairment rating.

In an October 7, 2014 medical report, Dr. Karen Garvey, Board-certified in internal and occupational medicine, provided findings on physical examination and review of diagnostic testing, noting that appellant reached MMI on November 7, 2013. In accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] Table 16-3 Knee Regional Grid, she noted use of the diagnosis of proximal tibial shaft fracture as the equivalent diagnosis and substitute for the proximal nondisplaced fracture of the fibula.[4] Dr. Garvey determined that proximal tibial shaft fracture resulted in a class 1 grade C default diagnosis-based impairment (DBI) rating of five percent. She assigned a grade modifier of zero for functional history due to normal gait;[5] a grade modifier of one for physical examination due to minimal palpatory findings without observed abnormalities for the swelling of the proximal fibula region on the right leg;[6] and a grade modifier of one for clinical studies which was used to confirm the diagnosis, as well as a mild pathology for the MRI scan report which showed adjacent post-traumatic tendinitis of the distal biceps femoris insertion.[7] Applying the net adjustment formula, Dr. Garvey subtracted 1, the numerical value of the class, from the numerical value of the grade modifier for each applicable component (functional history, physical examination, and clinical studies) and then added those

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

[4] *Id.* at 511.

[5] *Id.* at 516, Table 16-6.

[6] *Id.* at 517, Table 16-7.

[7] *Id.* at 519, Table 16-8.

values, resulting in a net adjustment of negative 1 ((0-1) + (1-1) + (1-1).[8] Application of the net adjustment formula meant that movement was warranted one place to the left of class 1 default value grade C to grade D based on Table 16-3.[9] Therefore, the DBI rating for appellant's right fibula fracture yielded a four percent permanent impairment of the right lower extremity.[10]

OWCP routed Dr. Garvey's report and the case file to Dr. James Dyer, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), for review and a determination on whether appellant sustained a permanent partial impairment of the right lower extremity and for a determination on date of MMI.

In a June 1, 2015 medical report, Dr. Dyer determined that appellant sustained one percent permanent impairment of the right lower extremity. He noted that Dr. Garvey incorrectly applied the A.M.A., *Guides* as she chose the diagnosis of proximal tibial shaft fracture as the equivalent diagnosis to substitute for proximal nondisplaced fracture of the fibula. Dr. Dyer noted that this was not a correct basis for the impairment rating as there was no DBI in the A.M.A., *Guides* for fracture of the fibula. He determined that the rating should be based on class 1 severity for biceps femoris tendinitis, resulting in one percent permanent impairment.[11] Dr. Dyer found that examination findings and complaints were consistent with ongoing distal biceps tendinitis rather than a fibular fracture, resulting in one percent permanent impairment of the right lower extremity. However, he did not explain his calculations when arriving at his lower extremity impairment rating. Dr. Dyer concluded that MMI was reached on November 7, 2013.

On June 17, 2015 appellant filed a claim for a schedule award (Form CA-7).

By letter dated June 24, 2016, OWCP provided appellant a copy of the DMA's report and requested that her treating physician review and comment on his impairment rating. It noted that the DMA found that the A.M.A., *Guides* were used incorrectly when applying a schedule award for her right fibula closed fracture.

By letter dated July 30, 2015, counsel for appellant argued that appellant was not required to submit a report from her physician and it was OWCP's obligation to send her to another physician if they disagreed with her findings.

By decision dated September 9, 2015, OWCP granted appellant a schedule award for one percent permanent impairment of the right lower extremity. It found that the weight of the medical evidence rested with Dr. Dyer serving as OWCP's DMA. The date of MMI was noted as November 7, 2013. The award covered a period of 2.88 weeks from November 7 to 27, 2013.

[8] *Id.* at 521.

[9] *Id.*

[10] *Id.*

[11] *Id.* at 509.

By letter dated September 16, 2015, appellant, through counsel, requested an oral hearing before an OWCP hearing representative.

By decision dated March 10, 2016, an OWCP hearing representative set aside the September 9, 2015 schedule award decision and remanded the case for further development. She noted that the A.M.A., *Guides* provided that, if a specific diagnosis was not listed in the DBI grid, Table 16-3, the examiner should identify a similar listed condition to be used as a guide to the impairment calculation.[12] In this instance, the DMA did not explain why using the diagnosis of proximal tibial shaft fracture was incorrect. The hearing representative remanded the case for a DMA to review the impairment rating completed by Dr. Garvey and offer an opinion concerning why use of the similar diagnosis of proximal tibial shaft fracture could not be substituted as an equivalent diagnosis in determining the impairment rating of the right leg. Following any further development as deemed necessary, OWCP was instructed to issue a *de novo* decision on the claim.

On March 16, 2016 OWCP routed the reports of Dr. Garvey and Dr. Dyer, as well as the case file, to Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as OWCP's DMA, for review and a determination on whether appellant sustained a permanent partial impairment of the right lower extremity and date of MMI.

In a March 16, 2016 report, Dr. Katz noted review of both Dr. Garvey and Dr. Dyer's reports with respect to the right lower extremity impairment rating. He determined that Dr. Dyer utilized the most appropriate method for rating the DBI as tendinitis in Table 16-3.[13] Dr. Katz noted that no grid existed for proximal fibular fracture and that a nondisplaced proximal fibular fracture was not equivalent to a nondisplaced proximal tibia fracture. As such, the most likely source for the ongoing difficulties documented by Dr. Garvey would be distal biceps tendinitis which was documented by MRI scan. Using the Table 16-3 Knee Regional Grid, diagnostic key factor for tendinitis, palpatory and/or radiographic findings resulted in class 1 with a default value at two percent. Dr. Katz assigned a grade modifier of zero for functional history, one for physical examination, and two for clinical studies based on Dr. Garvey's findings. Applying the net adjustment formula resulted in zero ((0-1) + (1-1) + (2-1)), warranting two percent permanent impairment of the right lower extremity under class 1 default value C.[14] Dr. Katz concluded that the date of MMI was October 7, 2014, the date of Dr. Garvey's examination.

By decision dated April 18, 2016, OWCP granted appellant a schedule award for an additional one percent permanent impairment of the right lower extremity, totaling two percent permanent impairment. It found that the weight of the medical evidence rested with Dr. Katz serving as OWCP's DMA. The date of MMI was noted as October 7, 2014. The award covered a period of 2.88 weeks from October 7 to 27 2014.

[12] *Id.* at 500, 16.2c

[13] *Supra* note 11.

[14] *Id.*

By letter dated April 25, 2016, appellant, through counsel, requested a telephone hearing before an OWCP hearing representative.

At the December 7, 2016 hearing, counsel for appellant argued that appellant's claim had not been accepted for bicep tendinitis which was used by the DMA to calculate her impairment rating. As the condition was not accepted by OWCP, counsel argued that the appropriate DBI was that used by Dr. Garvey.

By decision dated January 31, 2017, OWCP's hearing representative affirmed the April 18, 2016 schedule award decision finding that appellant had established two percent permanent impairment of the right lower extremity. He noted that the weight of the medical evidence rested with Dr. Katz serving as OWCP's DMA.

LEGAL PRECEDENT

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.[15] 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 to all claimants, good administrative practice necessitates 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 the implementing regulations as the appropriate standard for evaluating schedule losses.[16]

The A.M.A., *Guides* provide a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF). For lower extremity impairments, the evaluator identifies the impairment of the Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[17] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[18] Evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[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

[15] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[16] *See* 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).

[17] *Supra* note 3 at 493-531.

[18] *Id*. at 521.

[19] *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

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 accepted appellant's claim for right closed fracture of fibula. The Board finds that appellant has not established that she has more than two percent permanent impairment of the right lower extremity, for which she previously received a schedule award.

In an October 7, 2014 medical report, appellant's treating physician, Dr. Garvey reported that appellant sustained four percent permanent impairment of the right lower extremity, using the DBI rating method for a diagnosis for a proximal tibial shaft fracture as a substitute for the accepted condition of proximal nondisplaced fracture of the fibula.[21] She explained that no key diagnostic factor exists under Table 16-3 Knee Regional Grid for a proximal fibular fracture, warranting use of the proximal tibial fracture as it was adjacent to the knee. Dr. Dyer, serving as OWCP's DMA, disagreed with Dr. Garvey's rating finding that the impairment should be based on the diagnosis of biceps femoris tendinitis.

OWCP routed the reports of Dr. Garvey and Dr. Dyer to Dr. Katz, serving as OWCP's DMA, for review and comment. In a March 16, 2016 report, Dr. Katz determined that appellant was entitled to two percent permanent impairment of the right lower extremity based on the diagnostic key factor for tendinitis, palpatory and/or radiographic findings, resulting in class 1 grade C default value. He determined that Dr. Dyer utilized the most appropriate method for rating under tendinitis and Dr. Garvey incorrectly utilized the diagnosis of a nondisplaced proximal tibia fracture as it was not equivalent to a nondisplaced proximal fibular fracture. Based on the opinion of Dr. Katz, OWCP issued a schedule award for two percent permanent impairment of the right lower extremity.

The Board finds that Dr. Katz's report is sufficient to represent the weight of medical evidence.[22] The Board notes that the DMA disagreed with the use of proximal tibial shaft fracture as a substitute for proximal fibula fracture. The DMA noted that the diagnoses were not equivalent. Rather, he explained that the diagnosis should be based on distal biceps tendinitis, as documented by the MRI scan of the right knee, since the Knee Regional Grid contained no diagnostic factor for a fibula fracture.[23] Counsel for appellant argued that Dr. Katz improperly utilized tendinitis to calculate appellant's impairment rating as it was not an accepted condition of the claim. Section 16.2c of the A.M.A., *Guides* provides that, "In the event that a specific diagnosis is not listed in the DBI grid, Table 16-3, the examiner should identify a similar listed condition to be used as a guide to the impairment calculation. The rationale for this decision

[20] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (March 2017).

[21] *Supra* note 4.

[22] *J.S.*, Docket No. 13-2132 (issued July 23, 2014).

[23] *Supra* note 4.

should be described."[24] Dr. Katz provided proper medical rationale by explaining that the diagnosis of distal biceps tendinitis best represented appellant's impairment and that it was in fact a condition that had been documented by MRI scan examination.

The Board also finds that Dr. Katz properly rated appellant's permanent impairment. Dr. Katz used Table 16-3 Knee Regional Grid, diagnostic key factor for tendinitis. He related that appellant's palpatory and/or radiographic findings resulted in class 1 with a default value at two percent. Dr. Katz assigned a grade modifier of zero for functional history, one for physical examination, and two for clinical studies based on Dr. Garvey's findings. He then explained that the net adjustment formula ((0-1) + (1-1) + (2-1)), resulted in the default value of C which reflected a two percent permanent impairment of the right lower extremity.[25] As such, his report represents the weight of the medical evidence.

The Board notes that Dr. Garvey opined that since there was no DBI grid for proximal fibular fracture, appellant's impairment should be rated for proximal tibial fracture as it was adjacent to the knee. Dr. Garvey, however, did not explain why appellant's permanent impairment was properly evaluated by application of a grid for a body part that had no documented findings, but was selected because of proximity to the impaired body part. He therefore did not provide sufficient rationale for his selection of the diagnosis to be used for evaluation of appellant's permanent impairment.[26]

Appellant may request a schedule award or increased schedule award at any time based on evidence of new exposure or medical evidence showing a progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has not established that she has more than two percent permanent impairment of her right lower extremity, for which she previously received a scheduled award.

[24] *Supra* note 12.

[25] *See M.B.*, Docket No. 16-1826 (issued May 15, 2017).

[26] *Id*.

ORDER

IT IS HEREBY ORDERED THAT the January 31, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 11, 2017
Washington, DC

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

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

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board