United States Department of Labor
Employees' Compensation Appeals Board

S.M., Appellant	)	
	)	**Docket No. 18-0237**
and	)	**Issued: August 6, 2018**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Bloomington, IL, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On November 13, 2017 appellant filed a timely appeal from a September 19, 2017 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 the claim.

ISSUE

The issue is whether appellant has established greater than seven percent permanent impairment of her left lower extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On August 6, 2016 appellant, then a 52-year-old rural carrier, filed a traumatic injury claim (Form CA-1) alleging that on August 5, 2016 she stepped out of her delivery vehicle and fell over a curve, twisting and fracturing her left ankle. She stopped work on August 5, 2016. Appellant

[1] 5 U.S.C. § 8101 *et seq.*

was first treated on August 5, 2016 by a physician assistant who obtained x-rays which demonstrated soft tissue swelling overlying and inferior to the lateral malleolus, and a 2.0 x 0.5 mm bony density adjacent to the lateral aspect of the talus suspicious for a small avulsion fracture.

Dr. Gerald W. Paul, an attending podiatrist, provided an August 10, 2016 report in which he diagnosed a closed avulsion fracture of the lateral process of the left talus, and a grade 2 left ankle sprain. He prescribed a walking boot. Dr. Paul noted that appellant had a history of bilateral patellar reconstruction procedures.

In a September 8, 2016 report, Dr. Brett L. Keller, an attending osteopathic physician Board-certified in orthopedic surgery, noted a history of the claimed August 5, 2016 employment incident, superimposed on a history of left knee injuries and an open medial plication for patellar instability. He diagnosed left knee pain with a possible medial or lateral meniscus tear.[2] Dr. Keller prescribed physical therapy.[3] He submitted periodic progress notes.[4]

OWCP accepted that the August 5, 2016 employment incident caused a nondisplaced fracture of the posterior process of the left talus. It subsequently expanded its acceptance of appellant's claim to include "other tear of medial meniscus, left knee." OWCP paid appellant wage-loss compensation for work absences commencing October 17, 2016.

On January 18, 2017 Dr. Keller performed an arthroscopic left medial meniscectomy of the posterior horn, abrasion and chondroplasty of the patella and trochlea, and debridement/excision of the medial synovial plica. OWCP paid appellant wage-loss compensation for resultant work absences. Dr. Keller returned appellant to limited duty effective February 28, 2017.

Appellant returned to limited work on April 27, 2017.

On May 1, 2017 appellant filed a claim for a schedule award (Form CA-7). In support of her claim, she provided an April 21, 2017 report from Dr. Keller. Dr. Keller related appellant's complaints of continued left knee pain and weakness. On examination, he found well-healed surgical incisions, tenderness at the medial patella, and no instability to varus/valgus stress. Dr. Keller obtained range of motion (ROM) measurements of 0 degrees extension and 110 degrees flexion. He opined that appellant had attained maximum medical improvement (MMI). Dr. Keller discontinued physical therapy and returned appellant to limited duty.

On July 18, 2017 OWCP obtained a second opinion on the nature and extent of any permanent impairment of the left lower extremity from Dr. Michael D. Watson, a Board-certified orthopedic surgeon. Dr. Watson reviewed the medical record and a statement of accepted

[2] A September 22, 2016 magnetic resonance imaging (MRI) scan of the left knee showed a possible medial meniscus tear, bi-compartmental osteoarthritis, distal quadriceps tendinosis, severe thickening of the patellar tendon, an acute grade 1 sprain of the medial collateral ligament, an anterior cruciate ligament (ACL) tear, and distal iliotibial bursitis.

[3] Appellant participated in physical therapy treatments September 2016 through April 2017.

[4] A December 7, 2016 MRI scan of the left ankle showed a chronic lateral ankle sprain with no tendon abnormalities.

facts (SOAF). He related that at age seven, appellant had undergone open surgery on both knees for patellofemoral malalignment, with an additional procedure on the left knee when appellant was in her 30s for patellar realignment. On examination of the left ankle, Dr. Watson observed inversion to 30 degrees, eversion to 15 degrees, plantar flexion to 40 degrees, dorsiflexion to 18 degrees, mild lateral swelling, tenderness to palpation of the lateral ligaments, intact tendons, and good distal pulses. On examination of the left knee, he observed a valgus deformity, mild medial tenderness, 120 degrees of flexion, 0 degrees of extension, significant patellofemoral crepitus, and no significant quadriceps atrophy.

Referring to page 529 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[5] Dr. Watson noted that, if two evaluations were performed on the same extremity, a grade modifier for Functional History (GMFH) was applicable only to the higher diagnosis-based impairment (DBI). As appellant's knee impairment was more significant, there was no applicable GMFH for the left talus fracture. Dr. Watson opined that according to Table 16-2,[6] appellant had a class 1 Class of Diagnosis (CDX) for a nondisplaced talus fracture with minimal findings, equal to a default five percent lower extremity impairment. He found a grade modifier for Physical Examination (GMPE) of 1 for palpatory findings of lateral tenderness, and a grade modifier for Clinical Studies (GMCS) of 1 based on radiologic confirmation of an avulsion fragment from the talus. Applying the net adjustment formula, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (1-1) + (1-1) resulted in a net adjustment of zero. Appellant therefore had five percent impairment of the left lower extremity due to the talus fracture.

With regard to the left knee, Dr. Watson found a class 1 CDX for meniscal injury with partial medial meniscectomy according to Table 16-3,[7] with a default impairment of two percent. He assessed a GMFH of 1 for mild functional deficit, a GMPE of 1 for mild problem with minimal palpatory findings and mild valgus deformity, and GMCS of 1 for a confirmed medial meniscus tear. Applying the net adjustment formula, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (1-1) + (1-1) + (1-1), he calculated a net adjustment of zero, keeping the knee impairment at the default two percent. Dr. Watson combined the two percent impairment for the left knee with the five percent impairment for the left ankle, to equal seven percent permanent impairment of the left lower extremity. He noted that a ROM rating method was not appropriate as appellant had no motion deficits of the left knee or ankle. Therefore, the DBI rating method was the preferred technique to assess the appropriate percentage of permanent impairment.

In a report dated August 12, 2017, an OWCP medical adviser, Dr. David J. Slutsky, a Board-certified orthopedic and hand surgeon, reviewed Dr. Watson's impairment rating and the medical record. The Dr. Slutsky opined that Dr. Watson properly applied the appropriate portions

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

[6] Table 16-2, page 502 of the A.M.A., *Guides* is titled "Foot and Ankle Regional Grid (LEI) [lower extremity impairment]."

[7] Table 16-3, page 509 of the A.M.A., *Guides* is titled "Knee Regional Grid (LEI) [lower extremity impairment]."

of the A.M.A., *Guides* to his clinical findings and the medical record. He concurred with Dr. Watson's calculation of seven percent permanent impairment of the left lower extremity.

By decision dated September 19, 2017, OWCP granted appellant a schedule award for seven percent permanent impairment of the left lower extremity. The period of the award ran from July 18 to December 6, 2017.

LEGAL PRECEDENT

The schedule award provision of FECA[8] and its implementing regulation[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 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 regulation as the appropriate standard for evaluating schedule losses.[10] The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.[11]

In addressing lower extremity impairments, the sixth edition requires identifying the impairment class for the diagnosed condition, which is then adjusted by grade modifiers based on functional history, physical examination, and clinical studies.[12] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[13]

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 percentage of impairment in accordance with the A.M.A., *Guides* with an OWCP medical adviser providing rationale for the percentage of impairment specified.[14]

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] *Id*. *See also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5 (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (January 2010).

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

[12] A.M.A., *Guides* 411.

[13] *Id*.

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

ANALYSIS

The Board finds that appellant has not established that she sustained greater than seven percent permanent impairment of her left lower extremity.

OWCP accepted that appellant sustained a nondisplaced fracture of the posterior process of the left talus and a tear of the left medial meniscus. On January 18, 2017 appellant underwent an arthroscopic medial meniscectomy. On May 1, 2017 she claimed a schedule award for permanent impairment of the left lower extremity. Appellant submitted an April 21, 2017 report from Dr. Keller, an attending Board-certified orthopedic surgeon, who opined that appellant had attained MMI, with residual pain on palpation of the left knee, and full motion of the left knee and ankle. Dr. Keller did not offer an impairment rating.

To ascertain the appropriate percentage of permanent impairment of appellant's left lower extremity, OWCP obtained a July 18, 2017 second opinion from Dr. Watson, a Board-certified orthopedic surgeon. Dr. Watson based his opinion on a thorough clinical examination, a detailed review of the SOAF, and the medical evidence of record. He used the net adjustment formula to calculate a DBI rating of five percent for the accepted left talar fracture, based on the default percentage provided by Table 16-2 with no grade modifiers. Dr. Watson then calculated a DBI rating of two percent for the meniscal tear, based on the default percentage provided by Table 16-3 with no applicable grade modifiers. Additionally, he provided extensive rationale explaining why the DBI rating method was preferable over ROM rating. An OWCP medical adviser, Dr. Slutsky, concurred with all elements of Dr. Watson's rating and methodology.

The Board finds that Dr. Watson properly applied the A.M.A., *Guides* to rate appellant's left lower extremity impairment at seven percent, and that his report constitutes the weight of the medical opinion evidence.

On appeal appellant contends that she sustained greater than seven percent permanent impairment of the left lower extremity as she would require a left knee replacement in a few years and had significant functional limitations. However, for the reasons set forth above, there is no evidence which establishes a greater percentage of permanent impairment at this time.

Appellant may request a schedule award or an 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 not established greater than seven percent permanent impairment of the left lower extremity, for which she previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 19, 2017 is affirmed.

Issued: August 6, 2018
Washington, DC

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

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

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