# United States Department of Labor
# Employees' Compensation Appeals Board

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| **S.P., Appellant** | ) | |
| **and** | ) | **Docket No. 17-1628** |
| | ) | **Issued: February 13, 2018** |
| **U.S. POSTAL SERVICE, POST OFFICE BAY VIEW/ST. FRANCIS STATION, Milwaukee, WI, Employer** | ) | |

*Appearances:*
*Doug Teegarden*, for the appellant[1]
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

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

## ***JURISDICTION***

On July 24, 2017 appellant, through his representative, filed a timely appeal from a January 30, 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 to consider the merits of this case.

[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.*

## ***ISSUE***

The issue is whether appellant has established more than 37 percent permanent impairment of the left lower extremity, for which he previously received a schedule award

## ***FACTUAL HISTORY***

On May 3, 1994 appellant, then a 37-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on May 2, 1994, he twisted his left knee while ascending stairs to a school carrying a heavy parcel. He stopped work on May 3, 1994 and returned to full-duty work on July 18, 1994. OWCP accepted the claim for left medial meniscus tear and authorized left knee arthroscopic surgery, which was performed on May 27, 1994.

OWCP accepted appellant's claim for a recurrence of medical treatment (Form CA-2a) on March 1, 2002 and authorized left knee arthroscopy with partial medial meniscectomy and tibial osteotomy, which occurred on August 27, 2002. It paid him wage-loss compensation for periods of disability.

On July 13, 1995 appellant filed a claim for a schedule award (Form CA-7). By decision dated December 7, 1995, OWCP granted appellant a schedule award for two percent permanent impairment of his left lower extremity. The period of the award ran from December 8, 1994 to January 17, 1995.

In a letter dated February 12, 1996, appellant requested reconsideration of the December 7, 1995 schedule award determination. By decision dated April 30, 1996, OWCP granted him a schedule award for an additional six percent permanent impairment of the left lower extremity, resulting in a total of eight percent left lower extremity permanent impairment. The period of the award ran from December 8, 1994 to May 18, 1995.

On July 10, 2003 appellant filed a claim for an additional schedule award (Form CA-7). By decision dated April 21, 2004, OWCP granted him a schedule award for an additional 22 percent permanent impairment of his left lower extremity, resulting in a total 30 percent left lower extremity permanent impairment. The period of the award ran from June 11, 2003 to August 27, 2004.

Appellant underwent two additional left knee surgeries. On January 8, 2008 he underwent total knee arthroscopy with removal of hardware, and on February 17, 2009 he underwent surgical revision of the left knee arthroplasty.

Appellant again requested an additional schedule award on August 14, 2009 (Form CA 7). By decision dated November 18, 2009, OWCP granted a schedule award for an additional 7 percent permanent impairment, resulting in a total of 37 percent left lower extremity permanent impairment. The period of the award ran from September 10, 2009 to January 29, 2010.

On June 13, 2013 appellant again filed a claim for an additional schedule award (Form CA-7).

By letter dated July 10, 2013, OWCP informed appellant that the evidence submitted was insufficient to support his claim for an additional schedule award as there was no narrative report supporting increased impairment.

In response, appellant submitted a September 30, 2011 impairment rating from Dr. M. Stephen Wilson, a family practitioner, opining that appellant had 67 percent left lower extremity permanent impairment. Using Table 16-3, Dr. Wilson assigned class 4 for left knee arthroplasty with moderate-to-severe instability and weakness. He assigned grade 4 for functional history and physical examination using Table 16-6 and Table 16-7 and no grade modifier for clinical studies using Table 16-8. Using the net adjustment formula moved the grade to a C or 67 percent left lower extremity permanent impairment. Dr. Wilson opined that this impairment was in addition to prior impairment awards.

On March 27, 2014 OWCP referred appellant for a second opinion evaluation with Dr. Mysore S. Shivaram, a Board-certified orthopedic surgeon, for an impairment determination.

In an April 24, 2014 report, Dr. Shivaram based upon a review of the medical evidence, statement of accepted facts (SOAF), and physical examination, diagnosed status post left knee arthroplasty, left knee instability due to lateral collateral left knee ligament complex, and no evidence of loosening of left knee total replacement. On May 13, 2014 he determined that appellant had 25 percent left lower extremity permanent impairment. Utilizing Table 16-3, Knee Regional Grid - Lower Extremity Impairments, page 511, Dr. Shivaram determined that appellant had a class 2 impairment for total knee arthroplasty with a default value of 25 percent for good position. He assigned grade modifiers of 2 for functional history under Table 16-6, page 516 and physical examination under Table 16-7, page 517. Dr. Shivaram advised that a grade modifier for clinical studies was not applicable. He then used the net adjustment formula and calculated a net adjustment of 0, which, under Table 16-3 did not move the default grade of C for 25 percent permanent impairment of the left lower extremity.

On February 11, 2015 OWCP referred appellant to Dr. Matthew Jiminez, a Board-certified orthopedic surgeon, to resolve the conflict in the medical opinion evidence.

In a May 12, 2015 report, Dr. Jimenez, based upon review of the medical evidence, SOAF, and physical examination, diagnosed left knee meniscal carnage. A physical examination revealed left knee extension and flexion to 145 degrees, no instability and negative Lachman, drawer and pivot shift. Dr. Jimenez reviewed x-ray interpretations which showed good left knee position with no evidence of loosening. He noted no disagreement with the prior impairment ratings.

On May 18, 2015 an OWCP district medical adviser (DMA) reviewed the SOAF and the medical record, including Dr. Jimenez' March 15, 2015 report. Using Table 16-3, Knee Regional Grid -- Lower Extremity Impairments, page 511, he determined that appellant had a class 2 impairment for total knee arthroplasty with a default value of 25 for a good result (good position, stable, functional). The DMA concluded that appellant had 25 percent left lower extremity permanent impairment based on Dr. Jimenez' findings, which he noted was less than the 37 percent previously awarded.

By decision dated May 27, 2015, OWCP denied appellant's request for an additional schedule award. It found that the medical evidence did not establish greater than the 37 percent left lower extremity permanent impairment previously awarded.

On June 24, 2015 appellant requested a telephonic hearing before an OWCP hearing representative.

By decision dated January 8, 2016, the hearing representative set aside the May 27, 2015 decision as further development of the evidence was required. It found that OWCP had incorrectly found a conflict in the medical opinion evidence as Dr. Shivaram's opinion was based on a current examination and the impairment rating by Dr. Wilson was not based on a current examination. The hearing representative further found Dr. Jimenez' opinion to be of no probative value as he failed to provide an impairment rating using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (6th ed. 2009). In addition, Dr. Jimenez had been incorrectly identified as a second opinion physician rather than as an impartial medical examiner in the May 27, 2015 decision. The hearing representative instructed OWCP to provide the DMA with Dr. Shivaram's report for review and provide an opinion on appellant's impairment.

On March 4, 2016 DMA reviewed a SOAF and the medical record, including Dr. Jimenez' March 15, 2015 report. He used the accepted diagnosis of left knee osteoarthritis with total knee replacement to rate appellant's permanent impairment. Utilizing Table 16-3, page 511, DMA determined that appellant had class 2 impairment for total knee arthroplasty with a default value of 25 for a good result (good position, stable, functional). The DMA assigned a grade modifier 0 for functional history under Table 16-6, page 516 based on no antalgic gait, pain on prolonged standing, and ability to walk more than 10 blocks. He reported a grade modifier 1 for physical examination under Table 16-7, page 517 based on no atrophy, good alignment, and slight instability. The DMA advised that a grade modifier for clinical studies was not used and no clinical studies were mentioned. He then used the net adjustment formula and calculated a net adjustment of -3, which, under Table 16-3, moved the default grade two spots to the left to grade A for 21 percent permanent impairment of the left lower extremity.

By decision dated March 18, 2016, OWCP denied appellant's claim for an additional schedule award.

In a form dated April 6, 2016, appellant requested a telephonic hearing before an OWCP hearing representative. The hearing was held on December 5, 2016.

Appellant subsequently submitted an April 13, 2016 report by Dr. Wilson in support of his claim for an increased schedule award. Dr. Wilson, in the April 13, 2016 report, detailed the injury history and medical reports reviewed. A physical examination revealed left antalgic gait with decreased stride length, stance time, and toe-off, restricted range of motion on extension and flexion, weakness with resisted extension and flexion, distal quadriceps muscle atrophy, chronic knee swell, moderate joint effusion, and tenderness on palpation of the lateral and medial joint lines. Dr. Wilson also observed repentance in the left lateral knee aspect from scar tissue build up, good patella tracking, and instability with rotational motion. A review of x-ray interpretations taken that day showed no evidence of total knee loosening or component failure,

bone growth over the proximal fibula/tibia junction, and lateral inferior patella pole osteophyte. Dr. Wilson advised that, in accordance with Table 16-3 of the A.M.A., *Guides*, appellant had class 4 impairment for a diagnosis of left knee arthroplasty with revision, loss of function and permanent anatomical abnormalities. He found a grade modifier of 2 for functional history using Table 16-6, noting that appellant had moderate instability, no grade modifier for physical examination adjustment as this was used to determine class based on moderate instability on consistent palpation using Table 16-7, and a grade modifier of 2 for clinical studies using Table 16-8. Dr. Wilson applied the net adjustment formula, finding an adjustment of minus four which corresponded to class A for 59 percent permanent bilateral lower extremity impairment under Table 16-3.

By decision dated January 30, 2017, OWCP's hearing representative affirmed the March 18, 2016 decision. He found that the weight of the medical opinion evidence rested with the opinions of the second opinion physicians and DMAs that appellant did not have more than the 37 percent left lower extremity permanent impairment previously awarded.

## ***LEGAL PRECEDENT***

Under section 8107 of FECA[3] and section 10.404 of the implementing federal regulations,[4] schedule awards are payable for permanent impairment of specified body members, functions or organs. FECA, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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.[5]

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).[6] Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition is Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[7] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[8]

In determining impairment for the lower extremities, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the knee,

[3] *Id.* at § 8107.

[4] 20 C.F.R. § 10.404.

[5] *D.J.*, 59 ECAB 620 (2008); *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[6] A.M.A., *Guides* (6th ed., 2009), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[7] A.M.A., *Guides* (6th ed., 2009), pp. 383-419.

[8] *Id.* at 411.

the relevant portion of the leg for the present case, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[9] After the CDX is determined from the Knee Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10] 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.[11]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed through 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.[12]

## ***ANALYSIS***

The Board finds that there remains an unresolved conflict in the medical opinion evidence.

OWCP accepted the condition of left knee medial meniscus tear. Compensation benefits were paid. Appellant underwent several left knee surgical procedures including a May 27, 1994 left knee arthroscopic surgery, an August 27, 2002 left knee arthroplasty with partial medial meniscectomy and tibial osteotomy, a January 8, 2008 total knee arthroscopy with removal of hardware, and a February 17, 2009 surgical revision of the left knee arthroplasty. OWCP issued schedule awards for 2 percent permanent impairment of the left lower extremity on December 7, 1995, an additional schedule 6 percent on April 30, 1996, an additional 22 percent on April 24, 2004, and an additional 7 percent on November 18, 2009, resulting in a total schedule award of 37 percent.

While OWCP had found that a conflict existed in the medical opinion evidence between appellant's treating physician, Dr. Wilson in his September 30, 2011 report and OWCP's second opinion physician Dr. Shivaram in his April 24, 2014 report, this finding was set aside by an OWCP hearing representative on January 8, 2016, who found that the conflict did not exist as Dr. Wilson's report was based upon stale physical examination findings.

Thereafter OWCP received a new report from Dr. Wilson dated April 13, 2016, in which he related that appellant had undergone a new physical examination on that day. In the April 13, 2016 report, Dr. Wilson opined that appellant had 59 percent left lower extremity impairment based on a left knee arthroplasty with revision, loss of function, and permanent anatomical

[9] *Id.* at 509-11

[10] *Id.* at 515-22.

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

[12] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013). *See C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

abnormalities. He placed appellant in a class 4 under Table 16-3, finding that appellant had a poor result from his total knee arthroplasty. In a March 4, 2016 report, the DMA opined that appellant had 21 percent right lower extremity impairment based on a total knee arthroplasty with a good result. Under Table 16-3, page 511 of the A.M.A., *Guides*, a total knee arthroplasty is classified as good result when the knee is in good position, stable, and functional. A poor result is obtained when the knee replacement is a poor result with moderate-to-severe instability, and/or moderate-to-severe motion deficit. The dispute between Dr. Wilson and OWCP's DMA centers on whether appellant's total knee replacement had a good or poor result when rating appellant pursuant to Table 16-3, page 511 of the A.M.A., *Guides*.

If there is disagreement between OWCP's medical adviser and appellant's physician, OWCP will appoint a third physician who shall make an examination.[13] For a conflict to arise, the opposing physician's viewpoints must be of virtually equal weight and rationale.[14] The Board finds that the two medical opinions of Dr. Wilson and OWCP's medical adviser are of equal weight. Accordingly, there remains an unresolved conflict in the medical evidence with regard to the amount of appellant's permanent impairment of his left lower extremity. The Board will, therefore, remand the case for referral to an impartial medical specialist for resolution of the conflict in the medical opinion evidence. After such further development as OWCP deems necessary, it shall issue a *de novo* decision.

## ***CONCLUSION***

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

[13] 5 U.S.C. § 8123(a); *see G.D.*, Docket No. 16-0587 (issued August 23, 2016); *Darlene R. Kennedy*, 57 ECAB 414 (2006).

[14] *Darlene R. Kennedy*, *id*.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated January 30, 2017 is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: February 13, 2018
Washington, DC

Patricia H. Fitzgerald, Deputy 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