United States Department of Labor
Employees' Compensation Appeals Board

D.S., Appellant	)	
	)	**Docket No. 17-1758**
and	)	**Issued: February 6, 2018**
DEPARTMENT OF VETERANS AFFAIRS, WEST LOS ANGELES VETERANS ADMINISTRATION MEDICAL CENTER, Los Angeles, CA, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 14, 2017 appellant, through counsel, filed a timely appeal from a June 19, 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.

[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 met his burden of proof to establish more than three percent permanent impairment of each lower extremity, for which he previously received schedule awards.

On appeal counsel contends that the extent of appellant's injury was minimized rather than maximized. He asserts that appellant is entitled to full benefits under the law.

FACTUAL HISTORY

OWCP accepted that on August 28, 2012 appellant, then a 55-year-old housekeeping aid, sustained a sprain and unspecified internal derangement of the bilateral knees and temporary aggravation of unspecified arthropathy of the right lower leg due to his repetitive work duties. It authorized left knee arthroscopic chondroplasty, medial and lateral plica release, anterior synovectomy, and minimal lateral retinacular release for patella balance. Those initial procedures were performed by Dr. Michael Schiffman, an attending Board-certified orthopedic surgeon, on February 20, 2013. OWCP subsequently authorized right knee arthroscopic minimal lateral retinacular release, anterior synovectomy, debridement of fat pad, and subtotal medial meniscectomy of the posterior horn. Those procedures were performed by Dr. Schiffman on June 5, 2013.

OWCP received a December 12, 2014 medical report from Dr. Schiffman in which he found that appellant had eight percent permanent impairment of each knee and three percent whole person permanent impairment pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of permanent Impairment* (A.M.A., *Guides*).[3] Dr. Schiffman diagnosed status post June 5, 2013 right knee arthroscopy with subtotal medial meniscectomy, anterior synovectomy, chondroplasty medial femoral condyle, fat pad debridement, and lateral release. He also diagnosed status post February 20, 2013 left knee arthroscopy, chondroplasty medial femoral condyle, medial and lateral plica release, anterior synovectomy, and minimal lateral retinacular release. Under Table 16-3, Knee Regional Grid, page 509 of the A.M.A., *Guides,* Dr. Schiffman identified a right knee meniscal injury as a class 1 diagnosis-based impairment (DBI) (mild) for total (medial or lateral) meniscectomy, meniscal tear, or meniscal repair. He assigned a grade modifier 1 for Functional History (GMFH) and Physical Examination (GMPE) and a grade modifier 2 for Clinical Studies (GMCS). Dr. Schiffman then used the net adjustment formula and calculated a net adjustment of +1 or grade D, eight percent impairment of the right leg, which converted to three percent permanent impairment of the whole person under Table 16-10, Impairment Values Calculated from Lower Extremity Impairment, page 530. For the left knee, he also identified the diagnosis of meniscal injury which fell under a class 1 DBI (mild problem) for total (medial or lateral) meniscectomy, meniscal tear, or meniscal repair. Dr. Schiffman assigned a grade modifier 1 for functional history and physical examination and a grade modifier 2 for clinical studies. He then applied the net adjustment formula and calculated a net adjustment of +1 or grade D, eight percent permanent impairment of the left leg, which converted to three percent whole person

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

impairment under Table 16-10. Dr. Schiffman opined that appellant's impairment was 100 percent related to the accepted work-related injury.

Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), reviewed the medical record, including Dr. Schiffman's impairment ratings, on March 6, 2015 and determined that appellant had three percent permanent impairment of each lower extremity. He advised that appellant had reached maximum medical improvement (MMI) on December 12, 2014, the date of Dr. Schiffman's evaluation.

On March 10, 2015 appellant filed a claim for a schedule award (Form CA-7).

By decision dated March 18, 2015, OWCP granted appellant schedule awards for three percent permanent impairment of each lower extremity. The award ran from December 12, 2014 to April 11, 2015, for a total of 17.28 weeks of compensation.

On March 26, 2015 appellant, through counsel, requested a telephone hearing with an OWCP hearing representative. In a November 13, 2015 decision, an OWCP hearing representative set aside the March 18, 2015 schedule award decision and remanded the case for OWCP to obtain clarification from Dr. Harris with regard to the extent of any permanent impairment to the bilateral lower extremities. She noted that while Dr. Harris concurred with Dr. Schiffman's findings, it appeared that he relied on the physician's whole person impairment ratings rather than his lower extremity impairment ratings.

On November 24, 2015 OWCP referred Dr. Schiffman's December 12, 2014 report to a DMA for review. In a November 30, 2015 report, Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a DMA, recommended a second opinion impairment evaluation as Dr. Schiffman's June 5, 2013 operative report indicated that he had performed a partial meniscectomy rather than a total meniscectomy of the right knee, which would result in a lesser degree of permanent impairment. He noted that, because Dr. Schiffman's February 20, 2013 operative report failed to indicate that a total left knee meniscectomy was performed, there was no support for rating the left knee for that surgical procedure.

On March 1, 2016 QTC Medical Services, OWCP's scheduler, referred appellant, along with a statement of accepted facts (SOAF), the medical record, and a set of questions, to Dr. Kevin J. Pelton, a Board-certified orthopedic surgeon, for a second opinion on whether appellant had permanent impairment due to his accepted work injuries.

In a March 21, 2016 report, Dr. Pelton noted his review of the SOAF and medical record. He noted appellant's history and current complaints of frequent left plantar foot pain which appellant described as 4 on a scale of 0 to 10 and a 6 with prolonged walking, standing, and ascending or descending stairs. Appellant had a slight right leg limp. On neurological examination, Dr. Pelton found symmetrical deep tendon reflexes. There was normal sensation over the bilateral anterior lateral thighs, anterior lower leg, and dorsal feet. There was no evidence of motor deficits. Appellant had mild palpable tenderness over the bilateral medial and lateral joint lines. A patellofemoral grind test was positive bilaterally. Muscle strength was normal. Valgus and varus stress test was negative bilaterally. Bilateral negative McMurray's, negative anterior and posterior drawer, negative Lachman's, and negative pivot shift test were

also noted. Dr. Pelton diagnosed bilateral knee sprain; status post left knee arthroscopy with chondroplasty, medial and lateral plica release, anterior synovectomy and minimal lateral retinacular release for patellar balance; status post right knee arthroscopy with minimal lateral retinacular release, anterior synovectomy, debridement of the fat pad, and subtotal medial meniscectomy of the posterior horn; and radiographic evidence of three-millimeter joint space of the medial compartment bilaterally.

Dr. Pelton advised that appellant's left knee regional impairment was consistent with a class 1 mild soft tissue injury with a default permanent impairment rating of two percent.[4] He opined that appellant had only mild residuals after surgery and that there was no evidence of a DBI estimated impairment based on the surgery. Dr. Pelton assigned a grade modifier 1 for mild functional history, mild physical examination, and mild clinical studies. He applied the net adjustment formula and found a net adjustment of zero, for a default grade C, two percent impairment of the left leg, which converted to one percent whole person permanent impairment. Dr. Pelton determined that appellant's right knee arthroscopy diagnoses represented a class 1 subtotal medial meniscectomy with default leg permanent impairment of two percent.[5] He advised that appellant had continued slight residual functional losses and assigned a grade modifier 2 for slight functional history, moderate physical examination, and positive clinical studies. Dr. Pelton used the net adjustment formula and calculated a net adjustment of 2, which moved the default, grade C impairment to grade E, for three percent permanent impairment of the right leg. He determined that appellant had reached MMI on December 12, 2014, the date of Dr. Schiffman's evaluation.

On May 17, 2016 Dr. Katz, again serving as DMA, reviewed the updated medical record, including Dr. Pelton's second opinion report, and concurred with his findings and calculations.

By decision dated October 19, 2016, OWCP found that the weight of the medical evidence rested with the opinions of Drs. Pelton and Katz and concluded that appellant was not entitled to additional schedule awards for either lower extremity.

On October 24, 2016 appellant, through counsel, requested a telephone hearing with an OWCP hearing representative. The hearing was held on April 25, 2017.

By decision dated June 19, 2017, the hearing representative affirmed the October 19, 2016 decision as to the lower extremity schedule awards. She found that the weight of the medical evidence rested with the opinion of Dr. Katz serving as OWCP's DMA and concluded that appellant was not entitled to schedule awards greater than that which was previously awarded for the right and left lower extremities.

LEGAL PRECEDENT

5 U.S.C. § 8107 provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the

[4] A.M.A., *Guides* 509, Table 16-3.

[5] *Id*.

permanent impairment of the scheduled member or function.[6] Neither FECA,[7] nor its implementing regulations[8] specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[9] For schedule awards after May 1, 2009, permanent impairment is evaluated under the sixth edition.[10]

With respect to knee impairment, the A.M.A., *Guides* provides a regional grid at Table 16-3. The Class of Diagnosis (CDX) impairment is determined based on specific diagnosis, and then the default value for the identified CDX is determined. The default value (grade C) may be adjusted by using grade modifiers for functional history, Table 16-6, physical examination, Table 16-7, and clinical studies, Table 16-8. The adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[11]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than three percent permanent impairment of each lower extremity.

OWCP accepted appellant's claim for sprain and unspecified internal derangement of the bilateral knees and temporary aggravation of unspecified arthropathy of the right lower leg. On February 20, 2013 appellant underwent an authorized left knee arthroscopic chondroplasty, medial and lateral plica release, anterior synovectomy, and minimal lateral retinacular release for patella balance. He underwent an authorized right knee arthroscopic minimal lateral retinacular release, anterior synovectomy, debridement of fat pad, and subtotal medial meniscectomy of the posterior horn on June 5, 2013. On March 18, 2015 OWCP awarded three percent permanent impairment of each lower extremity. On November 13, 2015 an OWCP hearing representative remanded the matter to OWCP for clarification on the extent of appellant's permanent impairment.

Following remand of the case by OWCP's hearing representative OWCP requested that Dr. Katz, a DMA, review the December 12, 2014 report of appellant's physician, Dr. Schiffman, who had found that appellant had eight percent permanent impairment of each leg under the sixth edition of the A.M.A., *Guides*. On November 30, 2015 Dr. Katz recommended a second opinion

[6] 5 U.S.C. § 8107. This section enumerates specific members or functions of the body for which a schedule award is payable and the maximum number of weeks of compensation to be paid; additional members of the body are found at 20 C.F.R. § 10.404(a).

[7] *Id.*

[8] 20 C.F.R. § 10.404.

[9] *A. George Lampo*, 45 ECAB 441 (1994).

[10] FECA Bulletin No. 09-03 (issued March 15, 2009).

[11] The net adjustment is up to +2 (grade E) or -2 (grade A).

impairment evaluation as the surgical procedures described in Dr. Schiffman's February 20 and June 5, 2013 operative reports failed to support his permanent impairment ratings.

Appellant was then referred to Dr. Pelton for a second opinion. In his March 21, 2016 report, Dr. Pelton found that he had three percent permanent impairment of the right leg and two percent permanent impairment of the left leg under the sixth edition of the A.M.A., *Guides*. He reviewed appellant's history, conducted a physical examination, and stated diagnoses. In calculating impairment for the right leg, Dr. Pelton selected the diagnosis of subtotal medial meniscectomy, which represented a class 1 impairment.[12] He assigned a grade modifier 2 for slight functional history, moderate physical examination, and positive clinical studies. Dr. Pelton applied the net adjustment formula and found a net adjustment of 2, class E, for a permanent impairment rating of three percent for the right lower extremity. Regarding the left lower extremity, he selected the diagnosis of mild soft tissue injury.[13] Dr. Pelton assigned a grade modifier 1 for mild functional history, mild physical examination, and mild clinical studies. He applied the net adjustment formula and found a net adjustment of zero, class E, for a permanent impairment rating of two percent for the left lower extremity. In his May 17, 2016 report, Dr. Katz concurred with the permanent impairment ratings calculated by Dr. Pelton.

The Board finds that Dr. Pelton properly applied the A.M.A., *Guides* and determined that appellant had three percent right lower extremity permanent impairment and two percent left lower extremity permanent impairment.

As stated above, Dr. Schiffman, in his December 12, 2014 report, found that appellant had eight percent permanent impairment each of the right and left knee based on a total medial or lateral meniscectomy. He improperly based his impairment ratings on this surgical procedure. Dr. Schiffman's June 5, 2015 operative report noted that a subtotal medial meniscectomy of the posterior horn of the right knee was performed and his February 20, 2013 operative report did indicate that a left knee total meniscectomy was performed. The Board finds, therefore, that his opinion is of diminished probative value and insufficient to establish greater permanent impairment as it does not conform to the procedures of the A.M.A., *Guides*.[14]

The Board finds that appellant has not demonstrated greater than three percent permanent impairment of the right and left lower extremities, for which he previously received a schedule award.

On appeal counsel contends that the extent of appellant's injury was minimized rather than maximized. He asserts that appellant is entitled to full benefits under the law. However, for the reasons set forth above, the Board finds that, the weight of the medical evidence does not establish that appellant has greater than the three percent permanent impairment of each lower extremity previously awarded. There is no medical evidence of record, in conformance with the A.M.A., *Guides*, which supports any greater impairment.

[12] *Supra* note 4.

[13] *Id.*

[14] *See J.G.*, Docket No. 09-1128 (issued December 7, 2009) (an attending physician's report is of little probative value where the A.M.A., *Guides* are not properly followed).

Appellant may request a schedule award or 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 failed to meet his burden of proof to establish more than three percent permanent impairment of each lower extremity, for which he previously received schedule awards.

ORDER

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

Issued: February 6, 2018
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