United States Department of Labor
Employees' Compensation Appeals Board

G.B., Appellant	)	
and	)	**Docket No. 17-0788**
	)	**Issued: March 14, 2018**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Holtsville, NY, 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 February 28, 2017 appellant filed a timely appeal from a February 17, 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 this case.

ISSUE

The issue is whether appellant has met his burden of proof to establish more than 25 percent permanent impairment of the right lower extremity, for which he previously received a schedule award.

On appeal appellant asserts that the medical evidence of record establishes that he has 31 percent impairment of the right lower extremity.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board. In a January 8, 2009 decision, the Board found that appellant's actual earnings as a part-time, limited-duty tax examining technician fairly and reasonably represented his wage-earning capacity, and that OWCP's Branch of Hearings and Review properly denied his request for a review of the written record.[2] In a January 6, 2010 decision, the Board found that OWCP did not meet its burden of proof to terminate appellant's wage-loss compensation and medical benefits on September 24, 2008.[3] Appellant was returned to the periodic compensation rolls. In an August 23, 2012 decision, the Board affirmed a September 22, 2011 OWCP hearing representative's decision, finding that appellant had not established entitlement to a schedule award because the medical evidence of record did not establish that maximum medical improvement had been reached following a recent surgery. The Board also affirmed OWCP's January 11, 2012 nonmerit decision denying appellant's September 27, 2011 reconsideration request.[4] The facts and circumstances as set forth in the Board's prior decisions are incorporated herein by reference. The relevant facts are as follows.

On August 18, 2005 appellant, then a 51-year-old tax examiner technician, was injured when a chair moved from under him while he was in the performance of duty. OWCP accepted the claim for cervical sprain, cervicalgia, cervicobrachial syndrome, right knee sprain, lumbago, lumbar sprain, and aggravation of knee osteoarthritis of the right knee. Appellant underwent a total right knee replacement on August 17, 2011.

On August 16, 2013 appellant filed a claim for a schedule award (Form CA-7). He submitted treatment notes dated August 8 and September 26, 2013 and January 9, 2014 in which Dr. Bradley D. Gerber, an attending Board-certified orthopedic surgeon, described examination findings, noted that appellant was status post right knee total replacement, and diagnosed knee pain and osteoarthritis of the knee. Dr. Gerber indicated that appellant's left knee was becoming worse and advised that appellant's impairment was total and that he could not return to work.

On January 10, 2014 OWCP referred appellant to Dr. Leon Sultan, Board-certified in orthopedic surgery, for a second opinion evaluation on January 28, 2014. In a February 20, 2014 decision, it suspended appellant's monetary compensation under section 8123(d) of FECA because he did not attend a physical examination scheduled with Dr. Sultan on January 28, 2014. OWCP then referred appellant to Dr. Hormozan Aprin, a Board-certified orthopedic surgeon, for a second opinion evaluation on March 12, 2014.

By decision dated March 4, 2014, OWCP denied appellant's schedule award claim, finding that the medical evidence of record was insufficient to establish permanent impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of*

[2] Docket No. 08-0401 (issued January 8, 2009).

[3] Docket No. 09-1275 (issued January 6, 2010).

[4] Docket No. 12-0588 (issued August 23, 2012).

Permanent Impairment (hereinafter A.M.A., *Guides*).[5] Appellant timely requested a review of the written record with OWCP's Branch of Hearings and Review.

An April 1, 2014 magnetic resonance imaging (MRI) scan of the left knee demonstrated severe tricompartment osteoarthritis. A lumbar spine MRI scan that day demonstrated degenerative disc changes and disc bulging at multiple levels.

In an April 7, 2014 report, Dr. Aprin indicated that he examined appellant on March 12, 2014. He noted his review of the statement of accepted facts (SOAF) and medical record and recorded appellant's complaints of occasional neck pain and constant back pain that radiated into the right leg, with occasional numbness, and pain and swelling in his left knee. On examination Dr. Aprin noted decreased cervical and lumbar range of motion with muscle spasm. Knee flexion was diminished bilaterally. He advised that the accepted conditions continued to be active and maintained that the accepted conditions should be expanded to include left knee osteoarthritis. Dr. Aprin indicated that appellant could return to work four hours daily with restrictions and that he had not reached maximum medical improvement (MMI).

In treatment notes dated April 24 and September 11, 2014, Dr. Gerber reiterated his findings and conclusions.

On September 11, 2014 appellant filed a second schedule award claim (Form CA-7).

By decision dated September 17, 2014, an OWCP hearing representative affirmed the March 4, 2014 decision, finding that, as the medical evidence established that appellant had not reached MMI, he had not established permanent impairment of the right leg.

In December 2014, OWCP again referred appellant to Dr. Aprin for a second opinion evaluation. In a January 13, 2015 report, Dr. Aprin again described physical examination findings of decreased cervical, lumbar, and bilateral knee range of motion. He advised that appellant was totally disabled due to the August 18, 2005 employment injury, noting that he needed a left total knee replacement. Dr. Aprin advised that appellant had reached MMI with regard to his right knee, and needed to see a spine surgeon.

Dr. Gerber continued to submit reports with regard to appellant's knee conditions.

On January 24, 2015 appellant elected to receive retirement benefits from the Office of Personnel Management, effective March 10, 2015. On January 29, 2015 he again filed a schedule award claim (Form CA-7).

In February 2015, OWCP referred appellant to Dr. Ajendra Sohal, a Board-certified physiatrist. In a February 25, 2015 report, Dr. Sohal noted her review of the SOAF and medical record, and appellant's complaints of neck, back, and bilateral knee pain. She described physical examination findings of tenderness in the cervical and lumbosacral areas. Dr. Sohal diagnosed cervical and lumbar sprain/strain, underlying obesity, status post right knee replacement, and left knee osteoarthritis. She advised that appellant could work part time as a tax examiner with

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

restrictions on lifting and that he would likely need left knee replacement surgery. Dr. Sohal opined that he did not need pain management for treatment of his lower back, and that obesity and underlying degenerative joint disease were preventing him from returning to work.

On March 10, 2015 OWCP expanded the acceptance of appellant's claim to include aggravated osteoarthritis of the left knee.

By decision dated April 10, 2015, OWCP denied appellant's claim for a schedule award, finding the medical evidence of record did not establish permanent impairment of a scheduled member or function of the body. Appellant timely requested a review of the written record and submitted additional schedule award claims.

In an April 18, 2015 New York State Workers' Compensation Board (hereinafter New York State) form report of permanent impairment, Dr. Michael DiGiovanna, an osteopath practicing family medicine, advised that appellant had 100 percent permanent impairment of the right knee due to decreased range of motion and decreased strength.

Dr. Gerber continued to submit treatment notes describing appellant's condition. On April 9, 2015 he advised that appellant had 60 percent loss of use of the right leg. On May 28, 2015 Dr. Gerber requested authorization for a total left knee replacement.

In an August 10, 2015 report, Dr. Henry J. Magliato, a Board-certified orthopedic surgeon and OWCP medical adviser, noted his review of the record, including the opinions of Dr. DiGiovanna and Dr. Gerber regarding appellant's right knee impairment. He indicated that, as neither physician referenced the sixth edition of the A.M.A., *Guides*, referral for a second opinion evaluation was warranted.

On August 18, 2015 OWCP again referred appellant to Dr. Aprin for an opinion on permanent impairment of the right lower extremity. In a September 10, 2015 report, Dr. Aprin noted that he examined appellant on September 3, 2015 and described examination findings. With regard to right lower extremity impairment, based on a diagnosis of right total knee replacement, he advised that under Table 16-3, Knee Regional Grid, appellant had a class 2 impairment. Dr. Aprin reported appellant's subjective complaints of mild pain and swelling and decreased range of motion of the right knee with difficulty squatting, kneeling, climbing stairs, rising from a chair after a long period, and standing or walking for extended periods. Objective findings included a healed surgical incision, swelling of the right knee, and decreased knee flexion with positive diagnostic study findings. Dr. Aprin found modifiers of 2 each for functional history, physical examination, and clinical studies. After applying the net adjustment formula, he concluded that appellant had 25 percent loss of use of the right leg, with MMI reached on October 23, 2014.

On September 22, 2015 Dr. Magliato, an OWCP medical adviser, reviewed the medical evidence of record, including Dr. Aprin's report. He agreed that, for a moderate problem with a diagnosis of total knee replacement, under Table 16-3, appellant had 25 percent right lower extremity permanent impairment with MMI reached on October 23, 2014.[6]

[6] On October 6, 2015 OWCP authorized left total knee replacement.

By decision dated October 19, 2015, OWCP granted appellant a schedule award for 25 percent permanent impairment of the right leg, to run for 72 weeks, for the period March 10, 2015 to July 25, 2016. It found that the weight of the medical evidence rested with the opinion of Dr. Aprin.

By decision dated October 23, 2015, OWCP's Chief of the Branch of Hearings and Review found that, as appellant had been issued a schedule award on October 19, 2015, there was no basis for his current hearing request of the April 10, 2015 decision denying entitlement to a schedule award. Appellant was advised that, if he disagreed with the October 19, 2015 decision, he could pursue the appeal rights enclosed with that decision.

Appellant timely requested a review of the written record from the October 19, 2015 decision granting a schedule award. He submitted evidence previously of record and a treatment note dated October 22, 2015 in which Dr. Gerber again advised that appellant had 60 percent impairment of the right lower extremity.

By decision dated March 15, 2016, an OWCP hearing representative noted her review of the written record and affirmed the October 19, 2015 schedule award decision. She found that the medical evidence of record did not support greater permanent impairment than the 25 percent awarded.

On August 9, 2016 appellant requested reconsideration. Relevant medical evidence submitted included a March 31, 2016 New York State form report of permanent impairment in which Dr. DiGiovanna advised that appellant had 50 percent right knee impairment due to decreased range of motion and decreased strength.[7] Dr. Gerber also submitted a New York State form report on April 28, 2016. He advised that appellant had 60 percent right knee impairment and 40 percent impairment for right knee disfigurement. On a May 27, 2016 New York State form report, Dr. DiGiovanna advised that appellant had 100 percent impairment of the right knee.

In a treatment note dated July 28, 2016, Dr. Gerber advised that appellant had a class 3 right knee impairment due to a fair result following total knee replacement and that, after applying adjustments for physical examination, functional history, and clinical studies, had a final right leg impairment of 31 percent. An upper extremity permanent impairment worksheet was attached which indicated that appellant had 81 percent impairment for total knee replacement. It indicated that both knees were considered. In treatment notes dated November 10, 2016 and January 12, 2017, Dr. Gerber reiterated that appellant had 31 percent lower extremity impairment. In the latter report, he reported right knee physical examination demonstrated no effusion, erythema, ecchymosis, scars, or deformities. Flexion was to 110 degrees, with 0 degrees in extension. There was no varus or valgus instability present.

By decision dated February 17, 2017, OWCP found that, as the newly submitted evidence by appellant's treating physicians did not conform to the sixth edition of the A.M.A., *Guides*, appellant was not entitled to an additional schedule award for increased impairment of his right leg.

[7] Dr. DiGiovanna also submitted a report dated March 31, 2016 regarding appellant's left knee.

LEGAL PRECEDENT

It is the claimant's burden of proof to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of any employment injury.[8]

The schedule award provisions of FECA,[9] and its implementing federal regulations,[10] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[11] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[12]

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).[13] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[14] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[15] 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.[16] Section 16.2a of the A.M.A., *Guides*, provides that if the class selected is defined by physical examination findings or clinical studies results, these same findings may not be used as grade modifiers to adjust the rating.[17]

OWCP 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 the medical adviser

[8] *See Tammy L. Meehan*, 53 ECAB 229 (2001).

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

[11] *Id*. at § 10.404(a).

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *see also* at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[13] A.M.A., *Guides*, *supra* note 6 at 4, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

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

[15] *Id*. at 521.

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

[17] *Id*. at 500.

providing rationale for the percentage of impairment specified.[18] In determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[19]

ANALYSIS

The Board finds that appellant has not established greater than the 25 percent right lower extremity permanent impairment previously awarded. The sixth edition of the A.M.A., *Guides* classifies the lower extremity impairment by diagnosis, which is then adjusted by grade modifiers.[20] Section 16.2a includes instructions for performing an impairment analysis using the regional grids. This includes identifying a diagnosis and applying the grade modifiers.[21]

With respect to a diagnosis of total knee replacement, Table 16-3 of the A.M.A., *Guides,* shows three classes of impairment: good result, fair result, and poor result. A good result is characterized by good position of the prosthesis, stability, and functionality. It has a default impairment value of 25 percent of the lower extremity. A fair result is characterized by fair position, mild instability, or mild motion deficit. It has a default lower extremity impairment value of 37 percent.[22]

Dr. Aprin, an OWCP referral physician, and Dr. Magliato, an OWCP medical adviser, evaluated appellant's right lower extremity under Table 16-3 based on the diagnosis of total knee arthroplasty. Table 16-3 indicates that in rating a total knee arthroplasty, for a class 2 impairment, moderate problem, the procedure should have a good result with good position, be stable and functional, and for a class 3 impairment, severe problem, there should be a fair result with fair position, mild instability, and/or mild motion deficit.[23]

In his September 15, 2015 report, with regard to right lower extremity impairment, Dr. Aprin advised that appellant had a moderate problem under Table 16-3. He based his opinion on appellant's subjective complaints of mild pain and swelling and decreased range of motion of the right knee with difficulty squatting, kneeling, climbing stairs, rising from a chair after a long period, and standing or walking for extended periods, and his objective findings included a healed surgical incision, swelling of the right knee, and decreased knee flexion with positive diagnostic study findings, appellant had a class 2 impairment. Dr. Aprin found modifiers of 2 each for functional history, physical examination, and clinical studies and, after applying the net adjustment formula, concluded that appellant had 25 percent loss of use of the right leg, with MMI reached on October 23, 2014.

[18] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6f (February 2013).

[19] *Peter C. Belkind*, 56 ECAB 580 (2005).

[20] A.M.A., *Guides, supra* note 6 at 497-500.

[21] *Id*. at 499-500.

[22] *Id*. at 511.

[23] *Id*.

Dr. Magliato reviewed the medical evidence, including Dr. Aprin's report. He agreed with Dr. Aprin that appellant had 25 percent right lower extremity impairment under Table 16-3, with MMI reached on October 23, 2014.

Contrary to appellant's assertions on appeal, the opinions of Dr. Gerber and Dr. DiGiovanna are insufficient to establish entitlement to an increased schedule award. In treatment notes dated July 28 and November 10, 2016 and January 12, 2017 Dr. Gerber advised that appellant had 31 percent right leg impairment. Both he and Dr. DiGiovanna provided New York State form reports of impairment. While Dr. Gerber made reference to a diagnosis-based impairment in his July 28, 2016 treatment note, neither he nor Dr. DiGiovanna made reference to the sixth edition of the A.M.A., *Guides* in any way. The Board has long held that an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's permanent impairment.[24]

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 not met his burden of proof to establish more than 25 percent permanent impairment of the right lower extremity, for which he previously received a schedule award.

[24] *I.F.*, Docket No. 08-2321 (issued May 21, 2009).

ORDER

IT IS HEREBY ORDERED THAT the February 17, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 14, 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