United States Department of Labor
Employees' Compensation Appeals Board

F.K., Appellant	)	
and	)	**Docket No. 17-1596**
	)	**Issued: May 2, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Charlotte, NC, 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 July 17, 2017 appellant filed a timely appeal from an April 5, 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 to consider the merits of this case.

ISSUE

The issue is whether appellant has more than three percent permanent impairment of her left lower extremity, for which she previously received schedule awards.

On appeal appellant contests the amount of her schedule award. She alleges that both her physician and the second opinion physician believed that she was entitled to a schedule award for 10 percent permanent impairment of her left lower extremity. Appellant also contended that OWCP erred in combining her previous award with her current one.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On January 11, 2011 appellant, then a 51-year-old rural carrier, filed a traumatic injury claim (Form CA-1) alleging that on that date she slid, fell on her back, and twisted her left knee as she exited her vehicle in the performance of duty. On March 22, 2011 OWCP accepted appellant's claim for a contusion of her back and a tear of medial meniscus of her left knee. It later expanded acceptance of the claim to include localized primary osteoarthritis of the lower left leg. OWCP paid appellant intermittent wage-loss compensation benefits on the supplemental rolls beginning March 11, 2011. Appellant received compensation benefits on the periodic rolls commencing June 1, 2014.

On May 18, 2011 Dr. Robert McBride a Board-certified orthopedic surgeon, performed a left knee arthroscopy with partial meniscectomy.

In a December 22, 2011 report, Dr. McBride opined that appellant had five percent permanent impairment of her left knee and three percent permanent impairment of her lumbar spine.

In a March 6, 2012 report, an OWCP medical adviser found that pursuant to Table 16-3 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[2] appellant had a class 1 impairment due to her partial medial meniscectomy, which equaled two percent permanent impairment rating.[3]

By April 27, 2012 decision, OWCP issued appellant a schedule award for two percent permanent impairment of her left lower extremity based on the opinion of OWCP's medical adviser.

On May16, 2012 appellant requested a review of the written record by an OWCP hearing representative. By decision dated August 29, 2012, the hearing representative affirmed the April 27, 2012 schedule award decision.

OWCP approved appellant's request for left knee arthroscopic surgery with medial meniscal repair, and on May 19, 2014, Dr. McBride performed this surgery.

On September 9, 2014 Dr. McBride diagnosed: (1) left knee status post arthroscopy and medial meniscal repair; and (2) mild synovitis of the left knee. He noted that appellant was not planning to return to work. On October 3, 2014 Dr. McBride reviewed the postsurgical arthrogram and noted that she did have some degenerative fibrillation on the inferior edges of the posteromedial meniscus. He also noted a dysmorphic appearance of the medial meniscal body, most likely related to the meniscal repair.

In an October 1, 2014 report, Dr. Daniel Uri, a Board-certified radiologist, interpreted an October 1, 2014 gadolinium magnetic resonance arthography of the left knee as showing:

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

[3] The physician's signature is illegible.

(1) subtotal medial meniscectomy/medial meniscal repair; (2) degenerative fibrillation to attritional tearing involving articular surface of the posterior horn medial meniscus; (3) dysmorphic appearance of the medial meniscal body may suggest sequelae of surgical repair and interstitial degeneration; (4) cruciate ligaments and collateral support intact; (5) small Baker cyst; and (6) no advanced arthrosis.

By letter dated November 13, 2014, OWCP asked Dr. McBride to respond to questions with regard to appellant's treatment, disability status, and permanent impairment. In a December 23, 2014 report, Dr. McBride noted that appellant stated that physical therapy was not helping, and seemed to be aggravating her condition. Appellant also informed Dr. McBride that her knee brace was causing numbness. Dr. McBride noted that appellant told him that she had been unable to work and could not stand for four hours at a time. He assessed appellant with status post scope left knee with partial medial meniscectomy and post-traumatic arthritis of the left knee. Dr. McBride opined that appellant had reached maximum medical improvement, and had 10 percent permanent impairment of the left lower extremity leg. He related that appellant was not able to stand or walk more than one hour per six-hour shift, and could not perform kneeling, squatting, or climbing.

On April 8, 2015 appellant's application for OPM disability retirement was accepted, effective March 26, 2015.

On April 30, 2015 OWCP referred appellant to Dr. Chason S. Hayes, a Board-certified orthopedic surgeon, for a second opinion. In a May 21, 2015 report, Dr. Hayes discussed appellant's employment injury of January 11, 2011 and discussed the history of appellant's medical treatment. He diagnosed derangement of left knee and low back pain. With regard to appellant's derangement of the left knee, Dr. Hayes indicated that the objective findings included well-healed surgical scars over her left knee, but no evidence of any swelling or effusion stability, crepitus, limitation of motion with regard to her left knee. He noted no evidence of any neurological findings with regards to her lumbar spine. Dr. Hayes opined that there were no objective findings to support the diagnosis of a contusion of the back. He noted no evidence of any bruising or abrasions, muscle spasms, or neurological findings. Dr. Hayes opined that more likely than not, appellant's persistent symptoms were due to some degenerative disc disease.

Dr. Hughes noted that there were no current objective findings to support a diagnosis of a left knee meniscal tear, and that more likely than not the persistent symptoms are due to generalized deconditioning and poor motivation. Dr. Hayes also noted that there were no objective findings to support a diagnosis of osteoarthritis, noting that the October 1, 2014 magnetic resonance imaging scan specifically indicated that there were no findings of osteoarthritis. He opined that appellant had marked evidence of symptom magnification with minimal findings on objective examination.

When asked to rate appellant's permanent impairment according to the A.M.A., *Guides*, Dr. Hayes responded that appellant had reached maximum medical improvement on approximately August 19, 2014. He noted that she had no restriction of movement or evidence of atrophy, anklyosis, or sensory changes. Dr. Hayes opined that appellant had 10 percent permanent impairment to her left knee due to postoperative changes and 0 percent impairment to her lumbar spine.

On January 14, 2016 OWCP terminated appellant's wage-loss compensation, effective January 15, 2016. It noted that it did not terminate appellant's medical benefits.[4]

On December 14, 2016 appellant filed a schedule award claim (Form CA-7).

By development letter dated December 19, 2016, OWCP indicated that appellant must submit a physician's opinion in support of her claim for a schedule award. It afforded her 30 days to submit the necessary medical evidence.

In a July 15, 2016 note, Dr. Raza Ali Khan, a Board-certified thoracic surgeon, noted that he gave appellant an injection of Depomedrol in each knee joint for treatment of bilateral knee degenerative joint disease and osteoarthritis. He gave her a joint injection to the left knee of Hyaluronate mixture on December 9, 2016. Dr. Khan listed his impressions as: (1) lumbar degenerative disc disease with bilateral low back pain; (2) bilateral lumbar spondylosis with facet arthropathy; (3) bilateral sacroilitis with sacroiliac joint dysfunction; (4) greater trochanteric bursitis; (5) knee pain with osteoarthritis; and (6) myofascial pain syndrome.

In an April 22, 2016 report, Dr. McBride noted that appellant fell three weeks ago when her knee gave out and locked up. He diagnosed chronic pain left knee. Dr. McBride suggested that she continue to wear her brace, use ice, and perform her home therapy exercises. He did not believe that she would need any further treatment.

On January 9, 2017 appellant responded to OWCP's letter requesting additional information. She noted that both Dr. McBride and Dr. Haynes gave her ratings of 10 percent permanent impairment, and that per her attorney she had sufficient evidence to receive a schedule award based on these two ratings. Appellant noted that, if OWCP felt that it needed another opinion, she would go to any doctors OWCP felt were necessary.

On December 22, 2016 Dr. Thomas Luke Heil, a Board-certified anesthesiologist, gave appellant a left knee injection.

On March 7, 2017 OWCP referred appellant's record to OWCP's medical adviser for an impairment rating under the sixth edition of the A.M.A., *Guides.* In a March 9, 2017 report, OWCP medical adviser noted that appellant had undergone an arthroscopic partial medial meniscectomy and chondral debridement. He determined that appellant had three percent impairment of the left lower extremity. The medical adviser noted that the maximum impairment allowed for a patient who has undergone an arthroscopic partial medial meniscectomy and/or arthroscopic median meniscal repair under the A.M.A., *Guides* would be three percent.[5] He noted that although Dr. McBride and Dr. Hayes felt that appellant had 10 percent permanent lower extremity impairment, neither physician provided an explanation as to the impairment rating.

[4] By decision dated March 29, 2017, OWCP determined that the new evidence was insufficient to modify the decision dated January 14, 2016 because the new evidence did not support that appellant was totally disabled from performing her date-of-injury position. Appellant did not appeal the March 29, 2017 OWCP decision to the Board.

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

By decision dated April 5, 2017, OWCP issued appellant a schedule award for an additional one percent permanent impairment of the left leg.

LEGAL PRECEDENT

Under section 8107 of FECA[6] and section 10.404 of the implementing federal regulations,[7] 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, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[8] As of May 1, 2009, the sixth edition is used to calculate schedule awards.[9]

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).[10] Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition as Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[11] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[12]

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, the relevant portion of the leg for the present case, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[13] After the CDX is determined from the Knee Regional Grid (including identification of a default grade value), the net adjustment formula is applied using GMPH, GMPE, and GMCS. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[14] Under Chapter 2.3, the evaluators are directed to provide reasons for their

[6] 5 U.S.C. § 8101 *et seq.*

[7] 20 C.F.R. § 10.404.

[8] *Id.* at § 10.404(a).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Exhibit 4 (January 2010).

[10] 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.

[11] *Id.* at 383-419.

[12] *Id.* at 411.

[13] *Id.* at 509-11.

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

impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[15]

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.[16]

ANALYSIS

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

OWCP has issued schedule awards for a total of three percent permanent impairment of appellant's left lower extremity, based upon the opinion of OWCP's district medical adviser (DMA).

In a December 23, 2014 report, Dr. McBride, appellant's treating physician, opined that appellant had 10 percent permanent impairment of the left lower extremity. In an April 30, 2015 report, Dr. Hayes, OWCP's second opinion physician, related that appellant had 10 percent permanent impairment of the left lower extremity due to her knee impairment. However, neither of these physicians explained their ratings and neither referenced the A.M.A., *Guides.* Under OWCP procedures, medical evidence to support a schedule award should include a report that shows a claimant has reached a date of maximum medical improvement, that describes the impairment in sufficient detail for the claims examiner to visualize the character and degree of permanent impairment and that calculates a percentage of impairment pursuant to the A.M.A., *Guides.*[17]

It is well established that proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[18] While appellant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.[19] It undertook development of the medical evidence by referring appellant to Dr. Hayes for a second opinion examination. OWCP has an obligation to secure a report adequately addressing the relevant issue of the extent of appellant's lower extremity permanent impairment.[20]

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

[16] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (March 2017). *See C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 414 (2006).

[17] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(b) (February 2013); *V.P.*, Docket No. 16-0702 (issued July 15, 2016).

[18] *Vanessa Young*, 55 ECAB 575 (2004).

[19] *Richard E. Simpson*, 55 ECAB 490 (2004).

[20] *See M.H.*, Docket No. 10-1035 (issued January 12, 2011).

OWCP's procedures provide that, if the case is referred for a second opinion regarding the issue of permanent impairment, the report should contain a history of clinical presentation, physical findings, functional history, clinical studies or objective tests, analysis of findings, and the appropriate impairment rating based on the most significant diagnosis, as well as a discussion of how the impairment rating was calculated.[21] Only after obtaining all necessary medical evidence, should the file be routed to the DMA for an opinion concerning the nature and percentage of impairment.[22] Since Dr. Hayes' report did not sufficiently describe appellant's impairment and schedule award ratings, OWCP should have obtained a supplemental report before referring the case record to the DMA.

This case will, therefore, be remanded for another second opinion referral. After such further development of the medical evidence as necessary OWCP shall issue a *de novo* decision.

CONCLUSION

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

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 5, 2017 is set aside and the case is remanded for further development of the medical evidence, to be followed by a *de novo* decision.

Issued: May 2, 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

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

[22] *Id.* at 2.808.6(f).