United States Department of Labor
Employees' Compensation Appeals Board

C.H., Appellant	)	
and	)	**Docket No. 18-1065**
	)	**Issued: November 29, 2018**
DEPARTMENT OF THE INTERIOR, BUREAU OF RECLAMATION, Grand Coulee, WA, Employer	)	

Appearances:
Stephanie Leet, 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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On May 1, 2018 appellant, through counsel, filed a timely appeal from an April 10, 2018 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 has met his burden of proof to establish more than 28 percent permanent impairment of his right lower extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

This matter has previously been before the Board.[3] The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are set forth below.

On August 20, 2008 appellant, then a 56-year-old mechanic, filed a traumatic injury claim (Form CA-1) alleging that he sustained a right knee injury at work on August 13, 2008. He asserted that his right knee twisted and popped when he stepped on a steam cleaner hose. Appellant did not stop work.[4]

OWCP accepted appellant's claim for medial meniscus tear and medial collateral ligament sprain of his right knee.

Appellant stopped work on October 21, 2008 and, on the same date, Dr. James M. Lamberton, an attending Board-certified orthopedic surgeon, performed OWCP-approved partial medial and lateral meniscectomies, and medial and lateral femoral condyle chondroplasties.

On December 8, 2008 appellant returned to regular duty on a full-time basis.

In a September 15, 2009 report, Dr. Lamberton determined that appellant had 35 percent permanent impairment of his right lower extremity due to right knee deficits related to arthritis and partial medial and lateral meniscectomies. He calculated appellant's permanent impairment under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5]

OWCP requested that Dr. Kenneth D. Sawyer, a Board-certified orthopedic surgeon, evaluate appellant's permanent impairment in his role as an OWCP medical adviser. On October 7, 2009 Dr. Sawyer determined that, under the sixth edition of the A.M.A., *Guides*, appellant had 26 percent permanent impairment of his right lower extremity based on deficits from right knee arthritis, a condition that he deemed to be the most impairing right knee diagnosis.

By decision dated November 3, 2009, OWCP granted appellant a schedule award for 26 percent permanent impairment of his right lower extremity. The award ran for 74.88 weeks from

[3] Docket No. 16-0968 (issued August 8, 2016).

[4] In 2005, OWCP accepted an employment-related left knee condition under a separate claim file. Appellant underwent OWCP-approved total left knee replacement surgery and received schedule award compensation for the condition, but the permanent impairment of appellant's left lower extremity is not the subject of the present appeal.

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

September 15, 2009 to February 21, 2011 and was based on the October 7, 2009 report of Dr. Sawyer.

Appellant stopped work on January 23, 2012 and, on that same date, Dr. Lamberton performed OWCP-approved total right knee replacement surgery.

In a September 30, 2013 report, Dr. Lamberton determined that, under the sixth edition of the A.M.A., *Guides*, appellant had 21 percent permanent impairment of his right lower extremity due to deficits related to his January 23, 2012 total right knee replacement surgery.

OWCP requested that Dr. L.J. Weaver, a Board-certified internist, evaluate appellant's permanent impairment in his role as an OWCP medical adviser. On December 12, 2013 Dr. Weaver expressed his agreement with Dr. Lamberton's permanent impairment rating.

By decision dated January 16, 2014, OWCP granted appellant a schedule award for 21 percent permanent impairment of his right lower extremity. The award ran for 74.88 weeks from September 15, 2009 to February 21, 2011 and was based on Dr. Lamberton's September 30, 2013 report and Dr. Weaver's December 12, 2013 report.

By decision dated March 9, 2015, OWCP rescinded its January 16, 2014 schedule award because the compensation awarded for 21 percent permanent impairment of appellant's right lower extremity was duplicative of previously-awarded compensation for his right lower extremity permanent impairment.[6]

In January 2015, OWCP expanded appellant's accepted conditions to include trochanteric bursitis of the right hip.

On May 11, 2015 appellant filed a claim for compensation (Form CA-7) seeking increased schedule award compensation due to his August 13, 2008 employment injury.

In support of his schedule award claim, appellant submitted an April 12, 2015 report from Dr. Lamberton who noted that appellant continued to complain of right knee soreness with recurrent reproducible popping in the medial aspect upon flexion/extension motion. He also reported walking with a limp most of the time and Dr. Lamberton opined that appellant's increasing right trochanteric bursa pain was secondary to his abnormal gait. Dr. Lamberton detailed the findings of the physical examination he conducted on February 10, 2015, noting that he observed appellant walking with a mild-to-moderate limp.[7] Examination of appellant's right knee showed mild swelling without effusion and stability both anteriorly and posteriorly. Dr. Lamberton indicated that range of motion testing of appellant's right knee showed full

[6] By decision dated January 5, 2016, OWCP's hearing representative affirmed OWCP's March 9, 2015 rescission decision. By separate decision dated January 5, 2016, the hearing representative determined that appellant received a $62,032.20 overpayment of compensation, due to receipt of duplicative schedule award compensation, which was not eligible for waiver of recovery of the overpayment. By decision dated August 8, 2016, the Board affirmed both January 5, 2016 decisions. Docket No. 16-0968 (issued August 8, 2016); *see supra* note 3.

[7] Dr. Lamberton indicated that appellant had an antalgic gait favoring his left lower extremity, but noted that he also had a hint of a Trendelenburg gait favoring his right hip.

extension and flexion limited to about 110 to 115 degrees. He found that appellant had tenderness to palpation over the medial side of his right knee and popping upon flexion/extension. The range of motion testing of appellant's right hip showed flexion to 95 degrees, internal rotation to 10 degrees, external rotation to 20 degrees, and abduction to 20 degrees with a negative Patrick's test. Appellant had very exquisite point tenderness over his greater right hip trochanter.[8] Dr. Lamberton diagnosed status post total right knee replacement/arthroplasty (fixed and stable with a fair result) and severe chronic trochanteric bursitis of the right hip secondary to abnormal gait pattern due to the August 13, 2008 injury.

Dr. Lamberton advised that appellant's right lower extremity permanent impairment had increased since the last rating evaluation due to his development of an employment-related right hip trochanteric condition and deterioration of his right knee condition evidenced by persistent mild-to-moderate limp, recurrent swelling, recurrent popping, and some loss of range of motion. He applied the diagnosis-based impairment rating method of the sixth edition of the A.M.A., *Guides*.[9] Under Table 16-3 (Knee Regional Grid) beginning on page 509, appellant's total right knee replacement fell under class 3 with a default value of 37 percent due to a fair result with mild right knee range of motion deficits. Under Table 16-6 through Table 16-8 on pages 516 through 520, Dr. Lamberton determined that appellant had a grade modifier for functional history (GMFH) of 1 (mild antalgic limp), a grade modifier for physical examination (GMPE) of 2 (recurrent tenderness to palpation and painful popping over the medial side), and grade modifier for clinical studies (GMCS) of 2 (total right knee replacement in place). Application of the net adjustment formula on page 520 required movement from the 37 percent default value on Table 16-3 to the 31 percent value two spaces to the left. Dr. Lamberton concluded that appellant had 31 percent permanent impairment of his right lower extremity due to right knee deficits. He further found that, under Table 16-4 (Hip Regional Grid) beginning on page 512, appellant's right hip condition (including heterotopic bone/bursitis) fell under class 1. Dr. Lamberton determined that appellant had a functional history grade modifier of 1 (mild antalgic limp), a physical examination grade modifier of 2 (recurrent tenderness to palpation of the trochanter), and clinical studies grade modifier of 2 (moderate pathology with heterotopic bone). Application of the net adjustment formula meant that appellant had 13 percent permanent impairment of his right lower extremity due to right hip deficits. Dr. Lamberton combined the 31 percent and 13 percent values, using the Combined Values Chart on page 604, and concluded that appellant had 40 percent permanent impairment of his right lower extremity.

On February 2, 2016 OWCP requested that Dr. Eric M. Orenstein, a Board-certified orthopedic surgeon and OWCP medical adviser, review Dr. Lamberton's April 12, 2015 report and provide an opinion on the extent of appellant's permanent impairment.

In a February 6, 2016 report, Dr. Orenstein discussed Dr. Lamberton's April 12, 2015 report and provided his own right lower extremity permanent impairment under the sixth edition of the A.M.A., *Guides.* He noted that, under Table 16-3, appellant's total right knee replacement fell under class 2 with a default value of 25 percent due to a good result. Under Table 16-6 through Table 16-8, Dr. Orenstein determined that appellant had a GMFH of 1 (antalgic limp), a GMPE of

[8] Dr. Lamberton noted that x-ray testing demonstrated mild heterotopic bone over the greater right trochanter.

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

2 (moderate palpatory findings), and a GMCS of 1. Application of the net adjustment formula required movement from the 25 percent default value on Table 16-3 to the 21 percent value two spaces to the left. Dr. Orenstein concluded that appellant had 21 percent permanent impairment of his right lower extremity due to right knee deficits. He further found that, under Table 16-4, appellant's right hip bursitis fell under class 1 with a default value of seven percent for right lower extremity permanent impairment. Dr. Orenstein determined that appellant had a GMPE of 2 (moderate palpatory findings) and a GMCS of 2 (confirmation of heterotopic bone), and that a GMFH was not applicable because functional history was used to determine the diagnosis class. Application of the net adjustment formula required movement two spaces to the right of the seven percent default value on Table 16-3 such that appellant's total right lower extremity permanent impairment due to right hip deficits was nine percent. Dr. Orenstein combined the 21 percent and 9 percent values and concluded that appellant had 28 percent permanent impairment of his right lower extremity. He found that appellant reached maximum medical improvement (MMI) on April 12, 2015, the date of Dr. Lamberton's examination.

On February 10, 2016 OWCP referred appellant for a second opinion examination to Dr. Aleksandar Curcin, a Board-certified orthopedic surgeon, and requested that he provide an assessment of appellant's permanent impairment.

In a March 22, 2016 report, Dr. Curcin discussed appellant's factual and medical history and noted that appellant presented to the March 22, 2016 appointment complaining of right knee pain with occasional popping and right trochantric bursitis symptoms. He reported his findings of the physical examination, noting that he observed appellant walking with full weight on his lower extremities and that he had no significant limp or list. Dr. Curcin indicated that appellant could stand on one leg at a time without significant discomfort, but he declined squatting to the floor for fear of worsening his symptoms. Appellant's right knee produced very mild-to-minor mechanical clunking from knee replacement surgery and there was no tenderness with palpation or evidence of effusion. Dr. Curcin noted that range of motion of the right knee was from 0 to 105 degrees and that the drawer tests of the medial collateral, lateral collateral, and anterior cruciate ligaments were all stable. Regarding the right hip, there was discomfort with palpation over the right greater trochanteric region. Thigh circumference was 55 centimeters on the right and 57 centimeters on the left. Dr. Curcin diagnosed right medial meniscal tear, sprain of right medial collateral ligament, and trochanteric bursitis of the right hip.

Dr. Curcin found that, under Table 16-3 of the sixth edition of the A.M.A., *Guides*, appellant's total right knee replacement fell under class 2 with a default value of 25. He determined that appellant had a GMFH of 0 (no limp or assistive devices used), a GMPE of 1 (thigh atrophy), and a GMCS of 1 (limited imaging findings). Application of the net adjustment formula required movement from the 25 percent default value on Table 16-3 such that appellant had 21 percent permanent impairment of his right lower extremity due to right knee deficits. Dr. Curcin further found that, under Table 16-4, appellant's right hip bursitis fell under class 1 with a seven percent default value for right lower extremity permanent impairment. He determined that appellant had a GMPE of 2 and a GMCS of 2, and that a GMFH was not applicable because functional history was used to determine the diagnosis class. Application of the net adjustment formula required movement two spaces to the right of the seven percent default value on Table 16-3 such that appellant's total right lower extremity permanent impairment due to right hip deficits was nine percent. Dr. Curcin combined the 21 percent and 9 percent values and concluded that appellant

had 28 percent permanent impairment of his right lower extremity. He agreed with both Dr. Lamberton and Dr. Orenstein that appellant reached MMI on April 12, 2015

OWCP requested that Dr. Orenstein review Dr. Curcin's March 22, 2016 report in his role as an OWCP medical adviser and provide an opinion on the extent of appellant's permanent impairment. In a September 10, 2017 report, Dr. Orenstein indicated that he agreed with Dr. Curcin's March 22, 2016 rating evaluation and his own earlier rating evaluation that appellant had 28 percent permanent impairment of his right lower extremity.[10]

By decision dated September 14, 2017, OWCP granted appellant a schedule award for an additional 2 percent permanent impairment of his right lower extremity, for a total of 28 percent permanent impairment of his right lower extremity (2 percent permanent impairment in addition to the 26 percent permanent impairment previously awarded). The award ran for 5.75 weeks from March 22 to May 1, 2016 and was based on the opinions of Dr. Curcin and Dr. Orenstein.

On October 10, 2017 appellant requested a telephone hearing with a representative of OWCP's Branch of Hearings and Review. During the hearing held on February 23, 2018, counsel argued that there was a conflict in the medical opinion evidence between Dr. Lamberton, the attending physician, and Dr. Curcin and Dr. Orenstein, OWCP's physicians, regarding the extent of the permanent impairment of appellant's right lower extremity.

By decision dated April 10, 2018, OWCP's hearing representative denied modification of its September 14, 2017 decision. She found that the weight of the medical evidence rested with the permanent impairment ratings of Dr. Curcin and Dr. Orenstein.

LEGAL PRECEDENT

The schedule award provisions of FECA,[11] and its implementing federal regulations,[12] 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.[13] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[14]

[10] Dr. Orenstein appears to have inadvertently referred to his earlier rating evaluation as occurring on December 4, 2016, but it actually occurred on February 6, 2016. The record does not contain a December 4, 2016 report of Dr. Orenstein.

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404.

[13] *Id.* at § 10.404(a).

[14] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, 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.[15] After the class of diagnosis (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).[16] 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.[17]

FECA provides that if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[18] For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[19] Where OWCP has referred the case to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well-reasoned and based upon a proper factual background, must be given special weight.[20]

ANALYSIS

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

OWCP initially accepted appellant's claim for medial meniscus tear and medial collateral ligament strain of his right knee, and it later expanded the accepted conditions to include trochanteric bursitis of the right hip. It granted appellant schedule awards for 28 percent permanent impairment of his right lower extremity.

The Board finds that there is an unresolved conflict in the medical opinion evidence between Dr. Lamberton, the attending physician, and Drs. Orenstein and Curcin, OWCP's physicians, regarding the extent of the permanent impairment of appellant's right lower extremity.

In an April 12, 2015 report, Dr. Lamberton determined that, under Table 16-3 of the sixth edition of the A.M.A., *Guides*, total right knee replacement fell under class 3 with a default value of 37 percent due to a fair result with mild right knee range of motion deficits.[21] Under Table 16-6 through Table 16-8, Dr. Lamberton found that appellant had a GMFH of 1, a GMPE of 2, and a

[15] *See* A.M.A., *Guides* 509-11 (6th ed. 2009).

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

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

[18] 5 U.S.C. § 8123(a); *Shirley L. Steib*, 46 ECAB 309, 317 (1994).

[19] *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

[20] *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

[21] A.M.A., *Guides* 509-11, Table 16-3.

GMCS of 2.[22] Application of the net adjustment formula required movement from the 37 percent default value on Table 16-3 to the 31 percent value two spaces to the left.[23] Dr. Lamberton concluded that appellant had 31 percent permanent impairment of his right lower extremity due to right knee deficits. He further found that, under Table 16-4, appellant's right hip condition fell under class 1. Dr. Lamberton determined that appellant had a GMPH of 1, a GMPE of 2, and a GMCS of 2. Application of the net adjustment formula meant that appellant had 13 percent permanent impairment of his right lower extremity due to right hip deficits. Dr. Lamberton combined the 31 percent and 13 percent values, using the Combined Values Chart, and concluded that appellant had 40 percent permanent impairment of his right lower extremity.

In contrast both Dr. Orenstein and Dr. Curcin determined that appellant had lesser permanent impairment of his right lower extremity, *i.e.*, 28 percent rather than 40 percent, under the standards of the sixth edition of the A.M.A., *Guides.* The reports of Dr. Orenstein and Dr. Curcin contain numerous calculations that differ from those of Dr. Lamberton. Mostly notably, Dr. Orenstein and Dr. Curcin concluded that appellant's right knee condition fell under class 2 under Table 16-3, whereas Dr. Lamberton found that it fell under class 3.

Consequently, the case must be referred to an impartial medical specialist to resolve the existing conflict in the medical opinion evidence regarding the extent of the permanent impairment of appellant's right lower extremity. On remand OWCP should refer appellant, along with the case file and a statement of accepted facts, to an appropriate specialist for an impartial medical evaluation and report including a rationalized opinion as to the extent of appellant right lower extremity permanent impairment. Following this further development, OWCP should issue a *de novo* decision regarding appellant's increased schedule award claim.

CONCLUSION

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

[22] *Id.* at 516-20, Table 16-6 through Table 16-8.

[23] *Id.* at 520.

ORDER

IT IS HEREBY ORDERED THAT the April 10, 2018 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded to OWCP for further action consistent with this decision.

Issued: November 29, 2018
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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