United States Department of Labor
Employees' Compensation Appeals Board

W.W., Appellant	)	
and	)	**Docket No. 18-0093**
	)	**Issued: October 9, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Locust Valley, 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 October 10, 2017 appellant filed a timely appeal from an April 14, 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 established more than two percent permanent impairment of his left lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On September 28, 2006 appellant, then a 52-year-old clerk, filed a traumatic injury claim (Form CA-1) alleging that, on that date, his left leg got caught on an exposed surge protector wire while at work, causing injury to his left knee. He stopped work on September 29, 2006. OWCP

[1] 5 U.S.C. § 8101 *et seq.*

accepted the claim for tear of medial meniscus of left knee and sprain of left knee and leg. Appellant returned to light-duty work for four hours a day on November 1, 2006, but stopped work the same day. OWCP accepted a recurrence of total disability commencing November 1, 2006.

Appellant underwent OWCP-authorized arthroscopic debridement of torn left medial meniscus and removal of a pathological medial patellar plica on January 11, 2007, which was performed by Dr. Steven M. Erlanger, a Board-certified orthopedic surgeon. Dr. Erlanger noted that "there was a large area of complete thickness, articular cartilage loss on the medial femoral condyle involving a large portion of the weight bearing area." The postoperative diagnosis was torn left medial meniscus, pathological medial patellar plica, and extensive medial femoral osteoarthritis. Appellant returned to full-duty regular work on March 12, 2007.

On October 20, 2010 appellant filed a claim for a schedule award (Form CA-7). OWCP advised him, by development letter dated November 5, 2010, of the requirements necessary for establishing permanent impairment to a scheduled member based on the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2]

In a November 22, 2010 report, Dr. Erlanger noted that appellant had "20 percent permanent disability secondary to the torn medial meniscus with associated arthritis."

By decision dated May17, 2011, OWCP denied appellant's schedule award claim. It found that the medical evidence of record did not establish that he had reached maximum medical improvement (MMI), nor did it contain an impairment rating based on the A.M.A., *Guides*.

On May 10, 2012 appellant requested reconsideration.

In a June 6, 2011 report, Dr. Erlanger provided an impression of status post left partial medial meniscectomy with osteoarthritis and permanent 20 degrees loss of flexion. He opined that appellant reached MMI and had 20 percent permanent impairment of the left leg.

In an April 23, 2012 report, Dr. Erlanger opined that appellant was "25 percent disabled."

By decision dated August 6, 2012, OWCP denied modification of its May 17, 2011 schedule award denial. It found that the medical evidence was insufficient to establish that the accepted conditions had reached a fixed and permanent state. OWCP further found that there was insufficient evidence of permanent impairment to a scheduled member or function of the body under 5 U.S.C. § 8107 or 20 C.F.R. § 10.404.

On August 5, 2013 appellant requested reconsideration.

In a July 22, 2013 report, Dr. Erlanger noted the history of the September 29, 2006 work injury and that he underwent arthroscopic partial medial meniscectomy and chondroplasty for grade 3 arthritic changes in the medial compartment. He opined that appellant had 15 percent permanent impairment of the left lower extremity. Under Table 16-3, Dr. Erlanger advised that

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

appellant was class 1 grade E for 13 percent loss of use of the lower extremity for meniscal injury. He further opined that appellant had an additional two percent impairment for primary osteoarthritic change three millimeter cartilage under Table 15-3 class 1.

On August 23, 2013 OWCP referred a statement of accepted facts (SOAF) and the medical record to its medical adviser to determine whether appellant attained MMI and established permanent impairment under the sixth edition of the A.M.A., *Guides.*

In a September 7, 2013 report, an OWCP district medical adviser (DMA) reviewed the SOAF. He indicated that Dr. Erlanger's July 22, 2013 impairment report made no sense. First, the DMA noted that, under Table 16-3, a class 1 grade E impairment rating of 13 percent was for both partial medial and lateral menisectomy. However, appellant only had a partial medial menisectomy. The DMA noted that, under Table 16-3, the highest impairment for a partial medial menisectomy was three percent. Second, under Table 16-3, page 511, there was no two percent impairment listed for a primary knee joint osteoarthritis, class 1. Rather, the impairment range under class 1 was five through nine percent, dependent on the grade modifiers. The DMA advised that the A.M.A., *Guides* used only the diagnosis which yielded the highest impairment value. He recommended that either OWCP secure a supplemental opinion from Dr. Erlanger, or refer appellant for a second opinion examination from an orthopedic surgeon familiar with the application of the sixth edition of the A.M.A., *Guides*.

In an October 8, 2013 letter, OWCP notified Dr. Erlanger of the inconsistencies in his July 22, 2013 impairment report. It requested that he provide an updated medical report which was based on the procedures outlined in the sixth edition of the A.M.A., *Guides.* Dr. Erlanger was afforded 30 days to provide an updated report. No additional evidence was received.

By decision dated November 12, 2013, OWCP denied modification of the August 6, 2012 decision as the medical evidence was insufficient to support a schedule award claim.

On August 15, 2014 appellant requested reconsideration.

In a March 3, 2014 report, Dr. Erlanger indicated that appellant had arthritic changes and a medial meniscal tear from the September 29, 2006 work injury. He indicated that appellant underwent arthroscopic debridement of a torn left medial meniscus and chondroplasty. At surgery grade 3 arthritic changes were present in the medial compartment. Dr. Erlanger reported that x-rays of the left knee showed severe medial compartment arthritis with one millimeter of cartilage remaining on the medial side. He opined that appellant had reached MMI. Dr. Erlanger noted that appellant's osteorarthritis of the left knee was a more significant disability than the meniscal tear. Under Table 16-3, he opined that appellant had 30 percent left lower extremity permanent impairment due to one millimeter cartilage interval and flexion contracture.

In an August 26, 2014 report, a DMA reviewed Dr. Erlanger's March 3, 2014 impairment report. He indicated that Dr. Erlanger failed to identify the class and provide the grade modifiers along with the net modifier adjustment calculation in determining that appellant had 30 percent lower extremity permanent impairment. Given the absence of Dr. Erlanger's calculations, the DMA recommended referral to an OWCP second opinion physician familiar with the A.M.A., *Guides.*

In a September 29, 2014 report, Dr. Erlanger indicated that x-rays of appellant's left knee were obtained and revealed decreased joint space. He opined that appellant had 15 percent permanent impairment of the left lower extremity. Under Table 16-3, Dr. Erlanger advised that appellant was class 1 grade E for 13 percent loss of use of the lower extremity for meniscal injury. He further opined that appellant had an additional two percent impairment for primary osteoarthritic change three millimeter cartilage under Table 15-3 class 1.

By decision dated November 13, 2014, OWCP denied modification of its prior decision of November 12, 2013. It noted that the basis for Dr. Erlanger's impairment findings in his September 29, 2014 were unexplained.

In a November 2, 2015 letter, Dr. Erlanger noted that appellant had reached MMI. Using the default grade C under Table 16-3, for a one millimeter cartilage interval and flexion contracture, he opined that appellant had 30 percent left lower extremity impairment. Dr. Erlanger also suggested that appellant be examined by an OWCP physician who was more familiar with the schedule award process.

In a December 16, 2015 report, a DMA reviewed the medical record and indicated that he was unable to provide either a date of MMI or a permanent impairment determination. He advised that there was insufficient information to assign functional history or physical examination modifiers and that the x-ray report did not provide adequate information to place appellant into a DRE class for arthritis. The DMA further indicated that there was no evidence to suggest that the arthritis being evaluated was caused by the accepted condition and injury.

On February 18, 2016 OWCP referred appellant, along with the medical record and a SOAF to Dr. William A. Somers, a Board-certified orthopedic surgeon, for a second opinion impairment evaluation.

In a March 15, 2016 report, Dr. Somers noted the history of the September 28, 2006 work injury, the medical records, and the SOAF. He noted that, while there were no diagnostic studies presented for review, a one millimeter cartilage space in the left knee was documented in a clinic note describing x-rays dated March 3, 2014, an August 24, 2014 DMA note, and a November 2, 2015 letter. Dr. Somers presented examination findings and provided an impression of degenerative arthritis left knee aggravated by the September 28, 2006 injury and degenerative tear left medial meniscus by direct cause or aggravation related to the September 28, 2006 work injury. He indicated that it was evident that degenerative changes were present in the knee at the time of appellant's original injury and surgery in 2006/2007 and that all symptoms were brought on by the September 28, 2006 work injury. Dr. Somers found that, under Table 16-3, appellant fell into class 3, grade C for primary diagnosis of degenerative arthritis which equaled 30 percent left lower extremity impairment. He noted that appellant had functional history grade modifier of 1 and physical examination grade modifier of 2. Using the net adjustment formula, Dr. Somer's found modifiers totaling 1, which equated to a grade D or 32 percent impairment rating of the left lower extremity. He indicated that it was impossible to give a definite date of MMI, but it should have been reached mid-April to mid-May 2007.

In a June 14, 2016 report, a different DMA reviewed the SOAFs, the medical record, and Dr. Somer's March 15, 2016 impairment rating. He noted that the operative report indicated that

appellant had a "large area of complete thickness articular cartilage loss on the medial femoral condyle involving a large portion of the weight bearing area" at the time of surgery on January 11, 2007, which he indicated preexisted the accepted employment injury. The DMA noted that appellant's accepted conditions did not include osteoarthritis of the left knee and did not include the diagnosis of a temporary or permanent aggravation of osteoarthritis of the left knee. He therefore opined that an impairment rating could only be based on a diagnosis of meniscal injury, partial medial meniscectomy, and not primary osteoarthritis of the left knee. Under Table 16-3, the DMA opined that appellant was class 1 with grade C with a default impairment value of two percent for partial medial meniscectomy. The DMA indicated that the functional history had zero modifier as appellant had normal gait with no pain behaviors. He assigned grade 2 modifiers for physical examination clinical studies adjustment. Using the net adjustment formula, the DMA found net adjustment of 1, for a final impairment rating of the left lower extremity of two percent. He found the MMI was attained April 2012.

On July 13, 2016 OWCP found that conflict in medical opinion existed regarding the permanent impairment rating and referred appellant to Dr. Donald Getz, a Board-certified orthopedic surgeon, for an impartial medical impairment evaluation. It noted that Dr. Erlanger, the attending physician, indicated that appellant had 30 percent permanent impairment; Dr. Somers, the second opinion physician, advised appellant had 32 percent permanent impairment; and the DMA disagreed with both physicians and opined appellant had 2 percent permanent impairment.

In a September 15, 2016 report, Dr. Getz noted the history of the September 28, 2006 employment injury. He indicated that the November 2, 2006 magnetic imaging resonance (MRI) scan revealed torn medial meniscus, but did not mention arthritis. Dr. Getz noted that description of pathology at the January 11, 2007 arthroscopy also did not mention arthritis. He indicated that the postoperative diagnoses included a torn left medial meniscus, medial plica, and osteoarthritis. Dr. Getz also noted, that while the x-ray report was not available, the x-rays seen on March 3, 2014 x-rays showed severe medial compartment arthritis with one millimeter cartilage remaining on the medial side of the left knee.

Dr. Getz indicated that, since appellant declined a total knee arthroplasty, MMI was reached on approximately March 3, 2014. He opined that appellant had end-stage osteoarthritis of the left knee. Dr. Getz noted that, although mild osteoarthritis preexisted the employment injury, he opined that it was aggravated and accelerated by the employment incident and eventually resulted in advanced osteoarthritis of the left knee. Using the sixth edition of the A.M.A., *Guides*, he opined that appellant had 28 percent permanent impairment of the left lower extremity. Under Table 16-3, Dr. Getz found that appellant had class 3 for primary knee joint arthritis, with a default value of 30 percent impairment. He assigned a grade modifier of 2 for functional history. Utilizing the net adjustment formula, Dr. Getz found a net adjustment factor of -2, which equated to a final impairment of 28 percent.

Dr. Getz also commented as to why he felt the DMA's two percent impairment rating which excluded the advanced osteoarthritis as preexisting was incorrect. He indicated that he reviewed the operative report four times and did not find a statement in the pathology description of "a large area of complete thickness articular cartilage loss on the medial femoral condyle involving a large portion of the weight-bearing area." Dr. Getz also indicated that there was no mention of this

alleged advanced osteoarthritis (or any arthritis) on preoperative imaging studies. He then opined that the two percent impairment rating was incorrect. Dr. Getz supported his opinion with medical rationale that single joint osteoarthritis was usually associated with a traumatic event.

In a December 24, 2016 report, a DMA reported that he disagreed with Dr. Getz' report which excluded an impairment rating based on an advanced osteoarthritis as a preexisting condition. He indicated that the January 11, 2007 operative report clearly indicated that there was "a large area of complete thickness articular cartilage loss on the medial femoral condyle involving a large portion of the weight-bearing area" and it was unclear how Dr. Getz could have read the operation report four times and not seen it.

The DMA noted that he agreed with Dr. Getz' impairment calculation of 28 percent left lower extremity impairment if acceptance of the claim were expanded to include permanent aggravation of osteoarthritis of the left knee. Otherwise, based on the accepted work conditions, appellant's impairment rating would be two percent based on the partial medial meniscectomy. The DMA further noted that MMI was April 2012.

By decision dated April 14, 2017, OWCP granted appellant a schedule award of two percent permanent impairment to his left leg. The award ran for 5.76 weeks from April 1 to May 11, 2012 (fraction of a day).

LEGAL PRECEDENT

Section 8107 of FECA 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 permanent impairment of the scheduled member or function.[3] Neither FECA nor its implementing regulations 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.[4] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition.[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 as class of diagnosis (CDX), which is then adjusted by grade modifiers based

[3] 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.

[4] 20 C.F.R. § 10.404(a).

[5] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

[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.

on functional history (GMFH), physical examination (GMPE), and clinical tudies (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, 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]

When determining entitlement to a schedule award, preexisting impairment to the scheduled member should be included.[12] Impairment ratings for schedule awards include those conditions accepted by OWCP as job related, and any preexisting permanent impairment of the same member or function.[13]

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.[14]

ANALYSIS

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

OWCP accepted that appellant sustained tear of medial meniscus of left knee and sprain of left knee and leg. Appellant subsequently filed a claim for a schedule award. OWCP issued him a schedule award for two percent permanent impairment of his lower extremity based on a partial medial menisectomy.

[7] *Id.* at 499.

[8] *Id.*

[9] *Id.* at 509-11

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

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

[12] *Carol A. Smart*, 57 ECAB 340, 343 (2006); *Michael C. Milner*, 53 ECAB 446, 450 (2002).

[13] *Supra* note 5 at Chapter 2.808.5d (March 2017).

[14] *See supra* note 5 at Chapter 2.808.6(f) (March 2017). *See C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

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.[15] For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[16] Where OWCP has referred the case to an impartial medical specialist 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.[17]

The Board finds that OWCP improperly found that there was a conflict in the medical opinion evidence regarding appellant's permanent impairment. In July 2016, OWCP had advised that it was declaring a conflict in the medical opinion evidence. It noted that Dr. Erlanger, the attending physician, provided 30 percent permanent impairment rating, Dr. Somers, the second opinion physician, provided 32 percent permanent impairment rating, and the DMA disagreed with both physicians and provided 2 percent permanent impairment rating.

Dr. Erlanger, however, did not provide a report which was of sufficient probative value to have created a conflict in the medical evidence with either Dr. Somers or the DMA. In his reports, he cited to various tables of the A.M.A., *Guides*, but he failed to explain how grade modifiers were applied and thus how the final impairment rating was derived. Additionally, Dr. Erlanger's finding that appellant reached MMI is vague as he did not provide any explanation for his finding. His report is of limited probative value with respect to appellant's permanent impairment because he did not adequately explain how his impairment ratings were derived under the standards of the sixth edition of the A.M.A., *Guides*.[18]

Under FECA, a conflict in the medical opinion evidence may only be declared between an OWCP-designated physician and the employee's physician. There is no provision for finding a conflict in the medical opinion evidence between two OWCP-designated physicians.[19]

Due to the lack of a conflict in the medical opinion evidence between a treating physician and an OWCP physician, Dr. Getz would be considered an OWCP referral physician.[20] As such, his report would not be given special weight with respect to the matter of permanent impairment based on impartial medical specialist status.[21] However, it can be considered for its own intrinsic

[15] 5 U.S.C. § 8123(a); *Shirley L. Steib*, 46 ECAB 309, 317 (1994).

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

[17] *F.C.*, Docket No. 14-0560 (issued November 12, 2015); *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

[18] *See James Kennedy, Jr.*, 40 ECAB 620, 626 (1989) (finding 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).

[19] *See supra* note 15.

[20] *See e.g., L.Y.*, Docket No. 16-0012 (issued May 17, 2016) (where an impartial medical specialist was converted to an OWCP referral physician due to the lack of a conflict in the medical opinion evidence).

[21] *See supra* note 17.

value.[22] In his September 15, 2016 report, Dr. Getz opined that appellant reached MMI March 3, 2014 and that appellant had 28 percent permanent impairment of the left lower extremity based on primary knee joint arthritis. While OWCP did not accept a left knee arthritic condition, preexisting impairment to the scheduled member is included when determining entitlement to a schedule award.[23]

However, Dr. Getz provided inconsistent information regarding appellant's arthritic condition and a contradictory opinion regarding appellant's permanent impairment. In his September 15, 2016 report, he opined that appellant had preexisting mild osteoarthritis which was aggravated and accelerated by the employment injury. Dr. Getz noted that the January 11, 2007 arthroscopy report included a postoperative diagnoses of osteoarthritis, but stated that the description of pathology did not mention arthritis. This in inherently inconsistent. Dr. Getz also indicated that there was no statement in the pathology description of "a large area of complete thickness articular cartilage loss on the medial femoral condyle involving a large portion of the weight-bearing area." However, the Board notes that the January 11, 2007 surgical report does contain the referenced statement in the pathology description. Dr. Getz then offered an impairment rating based on advanced knee joint osteoarthritis. In light of the inconsistent nature of his statements and his opinion, the Board finds that his report requires clarification.

Additionally, the Board notes that the DMA incorrectly advised that Dr. Getz' impairment calculation of 28 percent permanent impairment would be correct only if the claim was amended to include permanent aggravation of osteoarthritis of the left knee. As previously noted, impairment ratings for schedule awards include those conditions accepted by OWCP as job related, and any preexisting permanent impairment of the same member or function.[24]

It is well established that proceedings under FECA are not adversarial in nature, and while the employee has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[25] Once OWCP undertook development of the evidence by referring appellant to a second opinion physician and an OWCP medical adviser, it had an obligation to do a complete job and obtain a proper evaluation and report that would resolve the issue in this case.[26] The Board will therefore set aside OWCP's April 14, 2017 decision and remand the case for Dr. Getz, followed by a review of a medical adviser**,** to conduct a proper analysis under the A.M.A., *Guides* in order to determine if appellant has greater than two percent left lower extremity permanent impairment based upon his preexisting arthritis of the left knee as well as his tear of the medial meniscus of the left knee. After such further development as deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for a lower extremity schedule award.

[22] *See R.H.*, Docket No. 17-1477 (issued March 14, 2018).

[23] *See supra* notes 12 and 13.

[24] *Id.*

[25] *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[26] *Peter C. Belkind*, 56 ECAB 580 (2005); *Ayanle A. Hashi*, 56 ECAB 234 (2004).

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the April 14, 2017 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: October 9, 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