United States Department of Labor
Employees' Compensation Appeals Board

M.E., Appellant	)	
	)	**Docket No. 19-0452**
and	)	**Issued: July 22, 2019**
	)	
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, FEDERAL CORRECTIONAL INSTITUTION, Fort Worth, TX, 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
JANICE B. ASKIN, Judge

JURISDICTION

On December 26, 2018 appellant, through counsel, filed a timely appeal from a November 30, 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 permanent impairment of his right lower extremity, warranting a schedule award.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts and circumstances of the case as set forth in the prior Board decision are incorporated herein by reference. The relevant facts are as follows.

On June 2, 1986 appellant, then a 24-year-old correctional officer, filed a traumatic injury claim (Form CA-1) alleging a left knee injury on that date when he lost his footing and landed on his left knee while in the performance of duty.[4] By decision dated July 11, 2013, OWCP accepted appellant's claim for closed fracture of the right upper end tibia and fibula and right injury to the peroneal nerve.

On September 5, 2013 appellant filed a claim for a schedule award (Form CA-7).

By decision dated September 9, 2013, OWCP denied the schedule award claim finding that the medical evidence of record established that appellant's right knee conditions had not reached maximum medical improvement (MMI) and that he sustained a new right knee work injury due to factors of his federal employment. OWCP recommended that he file an occupational disease claim (Form CA-2) with supporting medical evidence for the new injury claim.

Appellant filed a second schedule award claim (Form CA-7) on December 17, 2014.

On February 11, 2015 appellant requested reconsideration of OWCP's September 9, 2013 decision and submitted additional medical evidence. OWCP, by decision dated April 1, 2016, affirmed in part and modified in part its prior decision finding that the medical evidence submitted established that appellant had reached MMI. It found, however, that the weight of the medical evidence rested with the opinion of Dr. Mysore Shivaram, a Board-certified orthopedic surgeon and an OWCP referral physician, and Dr. Eric M. Orenstein, a Board-certified orthopedic surgeon, serving as an OWCP district medical adviser (DMA), who both had opined that he had zero percent permanent impairment of the right lower extremity.

Appellant, through counsel, appealed to the Board on October 17, 2016. By decision dated December 2, 2016, the Board affirmed the April 1, 2016 OWCP decision finding that the weight of the medical evidence rested with the opinions of Dr. Shivaram and Dr. Orenstein and

[3] Docket No. 16-1216 (issued December 2, 2016).

[4] The present claim was assigned OWCP File No. xxxxxx926. Appellant has a prior claim for a February 19, 1993 traumatic injury, assigned OWCP File No. xxxxxx722, accepted for lumbar disc displacement. He also has a claim for a September 6, 2003 traumatic injury, assigned OWCP File No. xxxxxx408. OWCP accepted the claim for left shoulder tear. These claims have not been administratively combined.

established that appellant had no permanent impairment of his right lower extremity due to his accepted employment-related conditions.

OWCP subsequently received a medical report dated May 12, 2017 by Dr. Neil Allen, a Board-certified internist and neurologist, who conducted an impairment examination. Dr. Allen's examination of appellant's right knee and lower leg found a stiff gait. He reported girth measurements that included 52.5 centimeters (cm) for the right thigh, 48 cm for the left thigh, 41 cm for the right calf, and 4l.5cm for the left calf. Dr. Allen also reported knee circumference that was 42.5 cm on the right and 41.5 cm on the left. He found moderate joint line tenderness on palpation and tenderness and hypertonicity through the gastrocnemius/soleus musculature. There was moderate/severe patellofemoral and primary knee joint (both medial and lateral crepitus) with active range of motion (ROM). On neurovascular examination, popliteal pulses were intact bilaterally. Soft touch and sharp/dull discrimination were intact over the lateral aspect of the knee and lower and complete loss over the medial aspect of the knee, lower leg, and foot. Muscle strength on the right (affected side) was +5/5 for quadriceps, gastrocnemius, and anterior tibialis and on the left (unaffected side) was +5/5 for hamstrings, quadriceps, gastrocnemius, and anterior tibialis. Dr. Allen reported ROM as 112 degrees (108 degrees, 111 degrees) of flexion with pain, -8 degrees (-5 degrees, -7 degrees) of extension on the right (affected side), 118 degrees of flexion with pain, and -8 degrees of extension on the left (unaffected side). A posterior drawer and medial collateral ligament and lateral collateral ligament stress tests were negative for joint laxity. A Lachman's test was also negative. Clinical studies included January 12, 2016 right knee x-rays which was normal and revealed no evidence of deformity of the right proximal fibula. Overall, excellent healing of the previously reported fracture of the head of the fibula was found. A March 31, 1993 electromyogram/nerve conduction velocity (EMG/NCV) study of the bilateral lower extremities was normal with the exception of mild slowing conduction velocities of the posterior tibial nerves that were not felt to be clinically significant.

Dr. Allen utilized the diagnosis-based impairment (DBI) rating method of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[5] to calculate appellant's right knee permanent impairment. He found that, under Table 16-2, page 511, Knee Regional Grid, a fracture of the upper end of the tibia and fibula represented a class one impairment with a default value of five percent impairment for proximal tibial shaft fracture, nondisplaced with abnormal physical examination findings. Dr. Allen referenced Table 16-6, page 516, and found a grade modifier 3 for functional history (GMFH). He referenced Table 16-7, page 517, and assigned a grade modifier 2 for physical examination (GMPE) with moderate palpatory findings consistently documented and supported by observed abnormalities, stability, a negative Lachman's test, moderate enlargement/deformity compared to opposite, unaffected side, no motion deficit, and no muscle atrophy. However, Dr. Allen excluded clinical studies as a grade modifier (GMCS) from his net adjustment calculation, citing to page 521 because they had been used in the class placement.

Regarding permanent impairment of the peripheral nerve, Dr. Allen utilized Table 16-12, pages 534 to 536, and found a class 1 impairment due to a superficial peroneal nerve with a very severe sensory deficit that represented a default value of three percent impairment. Dr. Allen did

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

not assign a GMFH pursuant to Table 16.6, page 516. He cited Table 17-9, page 581, and assigned a GMCS of zero because an EMG/NCV of the bilateral lower extremities was normal with the exception of mild slowing conduction velocities of the posterior tibial nerves bilaterally, that were not felt to be clinically significant. Dr. Allen applied the net adjustment formula to find seven percent permanent impairment of the right knee and four percent permanent impairment of the peripheral nerve, for a combined right lower extremity permanent impairment of 11 percent due to appellant's accepted employment-related conditions.

On August 4, 2017 OWCP routed Dr. Allen's report, a statement of accepted facts (SOAF), and the case file to DMA Dr. Orenstein for review and a determination of permanent impairment of appellant's right lower extremity and his date of MMI.

In a report dated September 10, 2017, Dr. Orenstein indicated that he had reviewed the SOAF and medical record. He referenced his prior opinion that appellant had no ratable permanent impairment of the right lower extremity due to the accepted employment-related conditions. Dr. Orenstein reviewed Dr. Allen's May 12, 2017 report. He noted that although appellant's right knee x-rays were reported as negative, the severity of symptoms reported on the lower limb questionnaire and pain disability questionnaire (PDQ) inventory were out of proportion for what one would expect from a nondisplaced proximal fibular fracture that healed in anatomical alignment six months post injury. Dr. Orenstein further noted that symptoms from the saphenous nerve would be unrelated to a peroneal nerve injury and there was no evidence on an EMG/NCV study of peroneal nerve damage. He recommended a right knee MRI scan to detect meniscal or cartilage damage from arthritis that could be causing his current knee symptoms and would be unrelated to the accepted employment-related conditions. Dr. Orenstein concluded that he stood by his original opinion that appellant had no ratable employment-related permanent impairment of the right lower extremity.

On December 1, 2017 OWCP requested that Dr. Orenstein submit an additional report regarding the extent of appellant's permanent impairment based on his review of a November 2, 2017 MRI scan report.

In a February 26, 2018 report, Dr. Orenstein again indicated that he had reviewed the SOAF and medical record, including his prior March 21, 2016 report, the reports of Dr. Shivaram and Dr. Allen, and diagnostic test results. He reiterated his prior finding regarding the discrepancy between appellant's negative right knee x-rays and the severity of symptoms reported on his lower limb questionnaire and PDQ inventory. Dr. Orenstein also reiterated his finding that symptoms from the saphenous nerve would be unrelated to a peroneal nerve injury as there was no evidence of peroneal nerve damage on an EMG/NCV study. He indicated that although an October 13, 2017 right knee MRI scan revealed partial thickness cartilage loss and mild underlying subchondral cystic change of the lateral trochlea, such findings did not result in permanent impairment of appellant's right lower extremity. Dr. Orenstein therefore concluded that his prior opinion, that appellant had no permanent impairment of the right lower extremity, remained unchanged.

By decision dated April 3, 2018, OWCP again denied appellant's claim for a schedule award, finding that Dr. Orenstein's February 26, 2018 opinion constituted the weight of the

medical evidence and established that he had zero percent permanent impairment of the right lower extremity.

On April 12, 2018 appellant, through counsel, requested a telephonic hearing with a representative of OWCP's Branch of Hearings and Review, which was held on September 17, 2018.

In an addendum to his May 12, 2017 report, Dr. Allen indicated that he had reviewed Dr. Orenstein's impairment rating. He disagreed with Dr. Orenstein's impairment rating methodology, indicating that it was inconsistent with the sixth edition of the A.M.A., *Guides*. Dr. Allen cited page 389 of the A.M.A., *Guides*, which provides that when a specific diagnosis was not listed in the DBI grid, an examiner should identify a similar listed condition to be used as a guide to the impairment calculation. He indicated that a proximal fibular fracture was not a listed diagnosis and, therefore, the most similar condition (regionally) was chosen, which was a proximal tibial shaft fracture, nondisplaced, with abnormal examination findings. Dr. Allen maintained that his diagnosis was then adjusted according to the A.M.A., *Guides* protocol described on page 3 of his May 12, 2017 report. Regarding appellant's peripheral nerve impairment, he indicated that this was assessed and graded according to section 16.4a on page 532 of the A.M.A., *Guides*. Dr. Allen indicated that there were four criteria considered when rating sensory deficits, none of which involved EMG testing. EMG findings were instead utilized as a "non-key" or adjustment factor. Dr. Allen indicated that Dr. Orenstein inappropriately utilized appellant's EMG findings to find zero percent lower extremity permanent impairment rating. He related that the "key factor" (basis of the impairment) when rating peripheral nerve impairment was objective findings, specifically sensory and/or motor deficit(s), not clinical study findings. Dr. Allen further related that functional history and clinical studies (EMG findings) were used to modify the impairment within a class rather than define the class itself. He indicated that sensory deficits were demonstrated, as noted within the examination portion of his report. Dr. Allen maintained that corresponding impairment, based upon these findings, was calculated accurately and appropriately based on the A.M.A., *Guides*. He reiterated the calculations he first presented in his May 12, 2017 report.

By decision dated November 30, 2018, an OWCP hearing representative affirmed the April 3, 2018 decision, finding that Dr. Orenstein's opinion was entitled to the weight of the medical evidence.

LEGAL PRECEDENT

The schedule award provisions of FECA,[6] and its implementing federal regulations,[7] 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

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants.[8] For decisions issued after May 1, 2009, the sixth edition will be used.[9]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of permanent impairment in accordance with the A.M.A., *Guides*.[10]

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.[11] For a conflict to arise, the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[12]

ANALYSIS

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

OWCP accepted appellant's claim for closed fracture of the right upper end tibia and fibula and right injury to the peroneal nerve as a result of his June 2, 1986 employment injury. In support of his claim for a schedule award, appellant submitted a May 12, 2017 impairment evaluation from Dr. Allen, a Board-certified internist and neurologist. Dr. Allen utilized the DBI method and found 7 percent permanent impairment of the right knee and 4 percent permanent impairment of the peripheral nerve, for a combined total of 11 percent permanent impairment of the right lower extremity.

In a September 10, 2017 report, Dr. Orenstein, the DMA, reviewed Dr. Allen's May 12, 2017 report and disagreed with Dr. Allen's impairment rating. While he found that appellant had no permanent impairment of the right lower extremity, Dr. Orenstein recommended additional diagnostic testing of the right knee. He recommended a right knee MRI scan to determine whether there was meniscal or cartilage damage from arthritis that could be causing appellant's current knee symptoms, which would be unrelated to the accepted work conditions.

In a February 26, 2018 supplemental report, Dr. Orenstein reviewed diagnostic test results, including an October 13, 2017 right knee MRI scan, which revealed partial thickness cartilage loss and mild underlying subchondral cystic change of the lateral trochlea. He maintained that these findings did not result in any permanent impairment of appellant's right lower extremity.

[8] *Id.* at § 10.404(a).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[10] *Id.* at Chapter 2.808.6(e) (March 2017); *see also Tommy R. Martin*, 56 ECAB 273 (2005).

[11] 5 U.S.C. § 8123(a); *A.R.*, Docket No. 18-0632 (issued October 19, 2018).

[12] *C.H.*, Docket No. 18-1065 (issued November 29, 2018).

Dr. Orenstein concluded that his prior opinion that appellant had no permanent impairment of the right lower extremity remained unchanged.

In an addendum to his May 12, 2017 report, Dr. Allen reviewed Dr. Orenstein's findings. He disagreed with Dr. Orenstein's impairment rating, contending that it was inconsistent with the sixth edition of the A.M.A., *Guides*. In addition, he explained that, in accordance with the A.M.A., *Guides*, he used the diagnosis of proximal tibial shaft fracture, nondisplaced with abnormal examination findings because proximal fibular fracture was not a listed as a diagnosis under the DBI method. Dr. Allen further explained that his peripheral nerve impairment rating was calculated in accordance with the A.M.A., *Guides* as it was based on objective sensory deficit findings. He reiterated the calculations from his May 12, 2017 report and opinion that appellant had 11 percent permanent impairment of the right lower extremity.

The Board finds that there remains an unresolved conflict in the medical evidence between Dr. Allen, appellant's treating physician and DMA Dr. Orenstein regarding the extent, if any, of appellant's right lower extremity permanent impairment. Thus, pursuant to 5 U.S.C. § 8123(a), the case will be remanded to OWCP for referral of appellant, together with the medical record and an updated SOAF, to an appropriate Board-certified specialist for an impartial medical examination to determine the extent and degree of appellant's right lower extremity permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*.[13] After such further development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

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

[13] *G.W.*, Docket No. 17-0957 (issued June 19, 2017).

ORDER

IT IS HEREBY ORDERED THAT the November 30, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: July 22, 2019
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board