# United States Department of Labor
# Employees' Compensation Appeals Board

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| L.D., Appellant<br><br>and<br><br>DEPARTMENT OF THE ARMY, MEDICAL COMMAND, Fort Jackson, SC, Employer | ) | **Docket No. 19-0797**<br>**Issued: October 2, 2019** |

*Appearances:*
*Appellant, pro se*
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

### *JURISDICTION*

On March 1, 2019 appellant filed a timely appeal from a January 17, 2019 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 13 percent permanent impairment of the left lower extremity, for which he previously received a schedule award.

### *FACTUAL HISTORY*

On November 10, 2015 appellant, then a 56-year-old psychiatric nurse, filed a traumatic injury claim (Form CA-1) alleging that on November 7, 2015 he intervened in an altercation

[1] 5 U.S.C. § 8101 *et seq.*

between psychiatric patients and injured his left leg and face while in the performance of duty. He stopped work on November 8, 2015.

On November 18, 2015 appellant underwent an open reduction, internal fixation of bicondylar left tibial plateau fracture *via* medial and lateral approaches, open repair of left lateral meniscus bucket handle tear and removal of preexisting external fixation device from lower left extremity, performed by Dr. Michael C. Tucker, a Board-certified orthopedic surgeon. By decision dated December 17, 2015, OWCP accepted appellant's claim for displaced bicondylar fracture of the left tibia, closed fracture. It paid him compensation on the supplemental rolls for total disability commencing December 23, 2015. Appellant returned to work on April 19, 2016.

In an April 19, 2018 South Carolina physician's statement form report, Dr. Tucker diagnosed left tibial plateau fracture. He indicated in the appropriate space that appellant reached maximum medical improvement (MMI) on December 5, 2017. Dr. Tucker, indicated in the appropriate space that he utilized the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impair*ment (A.M.A., *Guides*),[2] and indicated in the appropriate space that appellant sustained 25 percent permanent impairment of the left lower extremity.

On July 17, 2018 appellant filed a claim for a schedule award (Form CA-7).

OWCP referred Dr. Tucker's report, the medical record, and a statement of accepted facts (SOAF) to Dr. Jovito Estaris, Board-certified in occupational medicine and OWCP district medical adviser (DMA), for evaluation of appellant's permanent impairment rating.

In a report dated August 4, 2018, the DMA, noted that Dr. Tucker's report was deficient because he did not provide a detailed medical history and chief complaint. He also noted that Dr. Tucker had not documented appellant's physical examination of the left knee and no range of motion (ROM) measurements were recorded. The DMA found that Dr. Tucker used a cursory one-page form and did not explain key modifiers, analysis, or calculations. He indicated that OWCP should request that Dr. Tucker provide this additional information. The DMA further noted that, if Dr. Tucker was unable to provide the requested information, a second opinion examination should be obtained, which included three independent ROM measurements of the left knee consistent with the sixth edition of the A.M.A., *Guides*.

By letter dated August 15, 2018, OWCP requested that appellant provide his physician with a copy of the DMA's report and obtain his comments.

In an August 27, 2018 South Carolina physician's statement form report, Dr. Tucker indicated that appellant reached MMI on March 27, 2018. He indicated in the blank space provided that appellant had 20 percent permanent impairment of the left lower extremity.

In a September 28, 2018 report, the DMA explained that "[u]nfortunately, this is also a one[-]page report." He noted that the permanent impairment rating of appellant's left lower

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

extremity was now 20 percent, but no additional medical data had been provided. The DMA recommended a second opinion examination with a Board-certified orthopedic surgeon.

On October 29, 2018 OWCP referred appellant to Dr. Seth Jaffe, an osteopathic physician Board-certified in orthopedic surgery, for a second opinion examination.

In a November 20, 2018 report, Dr. Jaffe noted appellant's history of injury and medical treatment. He related that appellant was currently working modified duty and that he was not under active medical care for his left knee, but that he had some intermittent pain and swelling for which he used over-the-counter medication, but no knee brace or assistive device. Dr. Jaffe noted appellant's diagnosis of displaced left tibial plateau fracture, and that he had undergone open reduction internal fixation of this fracture on November 16, 2015. He related physical examination findings and concluded that appellant had 19 percent permanent impairment of the left lower extremity using the DBI method, Table 16-3, page 510 of the A.M.A., *Guides*, and 10 percent permanent impairment of the left lower extremity using the ROM method.

In a December 29, 2018 report, the DMA noted that under the DBI method, the diagnosis was bicondylar comminuted fracture of the left tibia and fibula. He referred to Table 16-3[3] for a tibial plateau fracture, explained that appellant was a class 1, with a default value of 10, for less than 9 degrees of angulation. The DMA referred to Table 16-6[4] for grade modifier functional history (GMFH) and found that intermittent pain, modified activity, and no use of gait aid warranted a grade modifier of one. He then referred to Table 16-7[5] for grade modifier physical examination (GMPE) and determined that appellant was tender over the medial knee with mild limitation of flexion, stable. The DMA referred to Table 16-8[6] and noted that the grade modifier for clinical studies (GMCS) was three, due to a severe pathology from a comminuted, depressed fracture. He utilized the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) and calculated that appellant had a net adjustment of (1-1) + (2-1) + (3-1) = 3, equaling a grade E impairment. Based on these calculations, he concluded that appellant had 13 percent permanent impairment of the left lower extremity. The DMA determined that using the ROM method resulted in a lesser impairment rating of 10 percent. He referred to Table 16-23[7] and found that for 105 degrees of flexion, appellant would have received a 10 percent lower extremity impairment. The DMA noted that extension of 0 degrees did not support any impairment. He also referred to Table 16-25[8] and Table 16-17.[9]

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[3] *Id*. at 510.

[4] *Id*. at 516.

[5] *Id*. at 517.

[6] *Id*. at 519.

[7] *Id*. at 549.

[8] *Id*. at 550.

[9] *Id*. at 545.

Regarding Dr. Jaffe's report, the DMA explained that the discrepancy in impairment ratings was due to the different classes used. He noted that Dr. Jaffe utilized a class 2A, which required 10 to 19 degrees of angulation or 2 millimeters of articular surface step off. The DMA explained that this was not found on x-rays of the left knee after surgery, which showed a stable position and alignment with healing fractures.[10] He also noted that the DBI class was 1. The DMA explained that, while Dr. Jaffe found three degrees of varus, the proper level was 2, for a class 1, with default value of 10 percent (less than nine degrees of angulation). The DMA found that MMI was reached on March 27, 2018.

By decision dated January 17, 2019, OWCP granted appellant a schedule award for 13 percent permanent impairment of his left lower extremity. The award ran for 37.44 weeks, for the period March 27 to December 14, 2018 (and a fraction of a day).

## ***LEGAL PRECEDENT***

The schedule award provisions of FECA[11] and its implementing 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants.

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]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[15] Under the sixth edition, for lower extremity impairments, the evaluator identifies the impairment of the class of diagnosis (CDX) condition, which is then adjusted by grade modifiers

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[10] A January 19, 2016 x-ray of the left knee read by Dr. William John Savoca, a Board-certified diagnostic radiologist, revealed stable alignment and a stable fixation of the left knee.

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404.

[13] *Id.* at § 10.404(a); *see also R.E.,* Docket No. 18-1661 (issued May 28, 2019); *see also Bernard A. Babcock, Jr.,* 52 ECAB 143 (2000).

[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).

[15] *Supra* note 3 at page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

of GMFH, GMPE, and GMCS.[16] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[17]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[18]

## ***ANALYSIS***

The Board finds that appellant has not met his burden of proof to establish more than 13 percent permanent impairment of the left lower extremity, for which he previously received a schedule award.

In support of his claim for a schedule award, appellant submitted reports dated April 19 and August 27, 2018 from Dr. Tucker. However, his reports did not provide objective physical findings, statement of grade modifiers used, or references to the appropriate Tables in the A.M.A., *Guides*, in sufficient detail so that the claims examiner and others reviewing the file would be able to clearly visualize the impairment with its resulting restrictions and limitations.[19] These reports were therefore insufficient to establish appellant's schedule award claim.

In light of the deficiencies in Dr. Tucker's reports, OWCP properly referred appellant for a second opinion examination with Dr. Jaffe.

The Board notes that in his November 20, 2018 report, Dr. Jaffe, the second opinion physician, provided an impairment rating of 19 percent to the left lower extremity using the DB1 method and 10 percent to the left lower extremity using the ROM method.

The DMA reviewed Dr. Jaffe's report along with the case record, and determined that appellant had 13 percent impairment of the left lower extremity.[20] He determined that appellant had attained MMI as of March 27, 2018, the date of Dr. Tucker's report. The DMA explained that appellant had a class 1, impairment for bicondylar comminuted fracture of the left tibia and fibula, a grade 1 impairment based on a functional history adjustment of 1 for intermittent pain, modified activity, no use of gait aid, and a physical examination adjustment of 2 for tenderness over the

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[16] *Id.* at 493-556.

[17] *Id.* at 521.

[18] *M.J.,* Docket No. 17-1776 (issued December 19, 2018); *P.R.*, Docket No. 18-0022 (issued April 9, 2018). *See* Federal (FECA) Procedure Manual, *supra* note 14 at Chapter 2.808.5 (March 2017).

[19] *See B.V.,* Docket No. 17-0656 (issued March 13, 2018).

[20] 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 impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified. *See* Federal (FECA) Procedure Manual, *supra* note 14 at Chapter 2.808.6(f) (March 2017). *See J.J.,* Docket 18-1615 (issued March 5, 2019).

medial knee with mild limitation of flexion, stable, and a grade modifier of one for clinical studies of severe pathology, comminuted, depressed fracture. These deficits equaled 13 percent permanent impairment of the left lower extremity. The DMA also properly explained that Dr. Jaffe improperly utilized a class 2A, which required 10 to 19 degrees of angulation, or two millimeters of articular surface step off. He explained that this did not appear on x-rays of the left knee post surgery, and that the appropriate class in the DBI was class 1.

The Board finds that the weight of the medical evidence rests with the opinion of the DMA, as he provided the only impairment rating that properly applied the sixth edition of the A.M.A., *Guides*. The DMA appropriately applied the A.M.A., *Guides* in determining that appellant had 13 percent permanent impairment of the left lower extremity.[21] The record does not contain any other medical evidence establishing greater than the 13 percent permanent impairment of the left lower extremity previously awarded. Thus, the Board finds that appellant has not met his burden of proof.

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 13 percent permanent impairment of the left lower extremity, for which he previously received schedule award compensation.

[21] *M.J., supra* note 18; *M.C.*, Docket No. 15-1757 (issued March 17, 2016). (The only medical evidence that demonstrated a proper application of the A.M.A., *Guides* was the report of the medical adviser).

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the January 17, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 2, 2019
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board