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

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| **P.S, Appellant** | ) | |
| **and** | ) | **Docket No. 19-0486** |
| | ) | **Issued: September 3, 2019** |
| **U.S. POSTAL SERVICE, POST OFFICE, Cleveland, OH, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

### ***JURISDICTION***

On January 3, 2019 appellant, through counsel, filed a timely appeal from a December 3, 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 greater than 17 percent permanent impairment of the right lower extremity, for which he previously received a schedule award.

## ***FACTUAL HISTORY***

On June 14, 1996 appellant, then a 34-year-old carrier technician, filed a traumatic injury claim (Form CA-1) alleging that on that date he sprained his right knee while in the performance of duty. OWCP accepted the claim for a right knee sprain/strain and assigned the claim OWCP File No. xxxxxx696. It subsequently expanded acceptance of the claim to include a right knee lateral collateral ligament sprain and a tear of the right medial meniscus.

On August 7, 1997 appellant underwent a partial medial and lateral meniscectomy. On February 19, 1998 he underwent a reconstruction of the anterior cruciate ligament (ACL). Appellant returned to his usual employment on June 20, 1998.

OWCP further accepted that appellant sustained a closed fracture of the calcaneus of the right foot on June 8, 2010 while in the performance of duty. It assigned OWCP File No. xxxxxx576.[3]

In a February 9, 2011 impairment evaluation, Dr. William N. Grant, a Board-certified internist, determined that appellant had 33 percent permanent impairment of the right lower extremity using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

On March 7, 2011 appellant filed a claim for a schedule award (Form CA-7).

On April 11, 2013 OWCP referred appellant to Dr. William R. Bohl, a Board-certified orthopedic surgeon, for a second opinion examination regarding the extent of permanent impairment considering both his right knee and right ankle injuries.[5]

In a report dated May 22, 2013, Dr. Bohl found that appellant had 20 percent permanent impairment for his cruciate and collateral ligament condition and 7 percent impairment for his

[3] OWCP administratively combined OWCP File Nos. xxxxxx696 and xxxxxx576, with the former designated as the master file.

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

[5] On June 7, 2012 OWCP initially referred appellant to Dr. Manhal Ghanma, an orthopedic surgeon, for a second opinion examination to determine the extent of permanent impairment, if any, based on appellant's accepted right knee sprain and tear of the medial meniscus with repair. In a report dated July 9, 2012, Dr. Ghanma opined that appellant had eight percent permanent impairment of the right lower extremity due to his right knee condition. An OWCP district medical adviser (DMA) reviewed Dr. Ghanma's report and concurred with his finding of an eight percent right lower extremity impairment due to appellant's right knee condition.

calcaneal fracture, which yielded a combined 27 percent permanent impairment of the right lower extremity.

On July 23, 2015 Dr. Morley Slutsky, a Board-certified occupational medicine specialist serving as a DMA reviewed the medical record. He determined that appellant had 4 percent permanent impairment of the right ankle and 14 percent permanent impairment of the right knee, which he combined to find a total right lower extremity permanent impairment of 17 percent.

By decision dated September 3, 2013, OWCP granted appellant a schedule award for 17 percent permanent impairment of the right lower extremity.

On September 12, 2013 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

By decision dated May 30, 2014, OWCP's hearing representative set aside the September 3, 2013 decision. She found that a conflict existed between Dr. Bohl and the DMA regarding the extent of permanent impairment, and instructed OWCP, on remand, to refer appellant for an impartial medical examination.

On July 9, 2014 OWCP referred appellant to Dr. Kenneth Chapman, a Board-certified orthopedic surgeon, for an impartial medical examination.

In an August 27, 2014 impairment evaluation, Dr. Chapman opined that appellant had 20 percent permanent impairment of the right knee due to his meniscal injury and 4 percent permanent impairment due to his calcaneal fracture, for a total right lower extremity impairment of 23 percent.

On September 22, 2014 Dr. Daniel Zimmerman, a Board-certified internist serving as a DMA, reviewed Dr. Chapman's report and advised that appellant had 15 percent permanent impairment of the right lower extremity.

By decision dated January 28, 2015, OWCP denied appellant's request for an increased schedule award.

On February 2, 2015 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative.

By decision dated June 16, 2015, OWCP's hearing representative set aside the January 28, 2015 decision. She found that OWCP had improperly determined that a conflict arose between its referral physician and the DMA, and that consequently Dr. Chapman's report was that of a second opinion physician, not an impartial medical examiner. The hearing representative discussed Dr. Zimmerman's disagreement with Dr. Chapman's impairment rating and instructed OWCP, on remand, to obtain clarification from Dr. Chapman regarding his impairment rating.

In a July 31, 2015 response to OWCP's request for clarification, Dr. Chapman again opined that appellant had 23 percent right lower extremity permanent impairment.

On August 17, 2015 Dr. Zimmerman reviewed Dr. Chapman's July 31, 2015 addendum and advised that he found no reason to modify his prior impairment determination.

By decision dated August 31, 2015, OWCP denied appellant's claim for an increased schedule award.

On September 10, 2015 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative.

By decision dated August 11, 2016, OWCP's hearing representative set aside the August 31, 2015 decision. She found that neither Dr. Chapman nor Dr. Zimmerman had provided a report demonstrating an understanding of the sixth edition of the A.M.A., *Guides*. The hearing representative instructed OWCP, on remand, to refer appellant for another second opinion examination.

On August 22, 2016 OWCP referred appellant to Dr. Richard Deerhake, a Board-certified orthopedic surgeon, for a second opinion examination.

In an impairment evaluation report dated September 28, 2016, Dr. Deerhake reviewed appellant's history of injury and subsequent medical treatment. On examination, he found range of motion (ROM) of the right knee from 25 to 95 degrees, a 1-2+ Lachman test, and "significant medial and lateral femoral condylar spurring." Dr. Deerhake noted that appellant walked with a slight limp and complained of mild tenderness at the anterior calcaneus process. He advised that appellant had reached maximum medical improvement. Dr. Deerhake identified the relevant diagnoses as class 1 calcaneus fracture, class 1 medial and partial meniscectomy, and class 1 anterior cruciate reconstruction. After applying grade modifiers, he found a right lower extremity permanent impairment of 5 percent due to the calcaneus fracture, 10 percent due to the medial and lateral meniscectomy, and 10 percent permanent impairment due to the anterior cruciate reconstruction, which he determined yielded a whole person impairment of 23 percent.

On November 1, 2016 Dr. Jovito Estaris, Board-certified in occupational medicine and serving as DMA, diagnosed a right ACL tear, a right medial and lateral meniscus tear, and calcaneus fracture of the right foot. In providing an impairment rating, he identified the right knee diagnosis as a class 1 right ACL tear under Table 16-3 on page 510 of the A.M.A., *Guides*, which yielded a default value of 10 percent. The DMA applied a grade modifier for functional history (GMFH) of one due to pain and a grade modifier for physical examination (GMPE) of one for mildly reduced motion. He found that a grade modifier for clinical studies (GMCS) was not applicable as it was used to classify the diagnosis. The DMA applied the net adjustment formula and found no change for default impairment rating of 10 percent. He advised that he was not going to rate appellant's meniscal tear as the A.M.A., *Guides* provided that the examiner should select the diagnosis with the greater impairment rating if there were two significant diagnoses for the same region of the body.

For the right foot, the DMA identified the diagnosis as a class 1 right calcaneus fracture, which yielded a default value of five percent under Table 16-2 on page 503 of the A.M.A., *Guides*. He applied a GMFH of one for appellant's mildly antalgic gait, a GMPE of one for mild tenderness, and found that a GMCS was inapplicable as the record contained no clinical studies. The DMA found no change from the default value of five percent after utilizing the net adjustment formula. He combined the 10 percent knee impairment with the 5 percent impairment of the foot to find 15 percent permanent impairment of the right lower extremity.

By decision dated December 7, 2016, OWCP denied appellant's claim for an increased schedule award.

On December 12, 2016 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative.

A telephonic hearing was held on June 14, 2017. Counsel asserted that the DMA should have included the medial tear as part of the impairment rating as it was an accepted condition.

By decision dated August 29, 2016, OWCP's hearing representative vacated the August 29, 2017 decision. She found that Dr. Deerhake had failed to adequately reference the A.M.A., *Guides* in finding that appellant had 23 percent whole person permanent impairment. The hearing representative further determined that the DMA had failed to provide further explanation of why he disagreed with Dr. Deerhake's rating.

On September 2, 2017 the DMA advised that he had not rated the meniscal impairment as the A.M.A., *Guides* on page 497 provided that the examiner should use the diagnosis with the higher rating for two diagnoses for the same body part. He again found 15 percent permanent impairment of the right lower extremity.

By decision dated April 5, 2018, OWCP denied appellant's claim for an increased schedule award.

On April 10, 2018 counsel requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

A hearing was held on September 17, 2018. Counsel argued that OWCP should have obtained clarification from Dr. Deerhake regarding his findings or further developed the medical evidence.

By decision dated December 3, 2018, OWCP's hearing representative affirmed the April 5, 2018 decision finding that Dr. Estaris had properly applied the provisions of the A.M.A., *Guides* to Dr. Deerhake's findings in reaching his impairment rating.

## ***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. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such a determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the

[6] *Supra* note 2.

[7] 20 C.F.R. § 10.404.

specified edition of the A.M.A., *Guides*, published in 2009.[8] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[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 of diagnosis (CDX), which is then adjusted by GMFH, GMPE, and GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[13]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the percentage of permanent impairment using the A.M.A., *Guides*.[14]

## ***ANALYSIS***

The Board finds that appellant has not met his burden of proof to establish greater than 17 percent permanent impairment of the right lower extremity, for which he previously received a schedule award.

OWCP accepted that appellant sustained a right knee sprain, a right knee lateral collateral ligament sprain, and a tear of the right medial meniscus under OWCP File No. xxxxxx696. It further accepted that he sustained a closed fracture of the right foot calcaneus under OWCP File No. xxxxxx576. OWCP administratively combined the two case files and, by decision dated September 3, 2013, granted appellant a schedule award for 17 percent permanent impairment of the right lower extremity.

Following further development of the medical evidence, an OWCP hearing representative determined that the record failed to contain a medical opinion regarding the extent of appellant's

[8] For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides*, (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[9] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[10] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3, International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[11] *Id*. at 494-531.

[12] *Id*. 411.

[13] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[14] *Supra* note 8 at Chapter 2.808.6(f) (March 2017); *B.B.*, Docket No. 18-0782 (issued January 11, 2019).

permanent impairment of the right lower extremity in accordance with the A.M.A., *Guides*. Consequently, OWCP referred appellant to Dr. Deerhake for a second opinion examination.

On September 28, 2016 Dr. Deerhake found that appellant had 5 percent permanent impairment due to his calcaneus fracture, 10 percent permanent impairment due to his lateral and medial meniscectomy, and 10 percent permanent impairment due to his anterior cruciate reconstruction. He concluded that he had 23 percent whole person impairment.[15]

Dr. Estaris, a DMA, utilized the physical examination findings from Dr. Deerhake's September 28, 2016 report to determine the extent of appellant's permanent impairment of the right lower extremity. Using Table 16-3 on page 510 of the A.M.A., *Guides*, he identified the diagnosis as a class 1 right ACL tear, for a default value of 10 percent. The DMA applied a GMFH of one due to pain, a GMPE of one for mild motion loss, and determined that a GMCS was not applicable. Applying the net adjustment formula yielded no change from the 10 percent default impairment rating.[16] The DMA indicated that he had rated appellant's knee condition based on his ACL tear rather than his meniscal tear as it yielded the higher impairment rating. The A.M.A., *Guides* at page 497 provides, "If a patient has two significant diagnoses, for instance, ankle instability and posterior tibial tendinitis, the examiner should use the diagnosis with the highest causally related impairment rating for the impairment calculation." Appellant's anterior cruciate injury yielded a higher impairment rating, and thus the DMA properly utilized that diagnosis in rating the extent of permanent impairment of the right knee.[17]

The DMA identified the right foot diagnosis as a class 1 right calcaneus fracture, which yielded a default value of five percent. He applied a GMFH of one for appellant's mildly antalgic gait, a GMPE of one for mild tenderness, and found that a GMCS was inapplicable as the record contained no clinical studies. The DMA used the net adjustment formula and found no change from the default value of five percent.[18] He combined the 10 percent knee impairment with the 5 percent impairment of the foot to find a permanent impairment of the right lower extremity of 15 percent. As the record contains no other probative, rationalized medical opinion which indicates that appellant has greater impairment of the right lower extremity based upon the A.M.A., *Guides*, he has not met his burden of proof to establish greater than 17 percent permanent impairment, for which he received a schedule award.[19]

On appeal counsel contends that OWCP failed to give deference to the findings of the attending physician, use the appropriate causation standard, or follow its procedures. As discussed,

[15] A schedule award is not payable for a whole person impairment under FECA. *See K.B.*, Docket No. 19-0431 (issued July 1, 2019).

[16] The net adjustment formula, (GMFH - CDX) + (GMPE - CDX), or (1-1) + (1-1) = 0, yielded a zero adjustment.

[17] A.M.A., *Guides* 497; *see also M.P.*, Docket No. 18-1298 (issued April 12, 2019).

[18] The net adjustment formula, (GMFH - CDX) + (GMPE - CDX), or (1-1) + (1-1) = 0, yielded a zero adjustment

[19] *See J.H.*, Docket No. 18-1207 (issued June 20, 2019).

however, the DMA's opinion is consistent with the provisions of the A.M.A., *Guides* and thus constitutes the weight of the evidence.[20]

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 greater than 17 percent permanent impairment of the right lower extremity, for which he previously received a schedule award.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the December 3, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 3, 2019
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

[20] *See A.T.*, Docket No. 17-1940 (issued December 20, 2018).