United States Department of Labor
Employees' Compensation Appeals Board

D.J., Appellant	)	
and	)	**Docket No. 19-0352**
	)	**Issued: July 24, 2020**
DEPARTMENT OF VETERANS AFFAIRS, VA LOMA LINDA HEALTH CARE SYSTEM, Loma Linda, CA, Employer	)	

Appearances:
Daniel M. Goodkin, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On December 3, 2018 appellant, through counsel, filed a timely appeal from a November 6, 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 seven percent permanent impairment of his right lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On April 24, 2013 appellant, then a 62-year-old police officer, filed a traumatic injury claim (Form CA-1) alleging that he sustained a right knee injury on April 10, 2013 when exercising while in the performance of duty. On December 4, 2013 OWCP accepted his claim for right knee and leg sprain. It later expanded the accepted conditions to include internal derangement of the meniscus of the right knee. On March 19, 2014 appellant underwent OWCP-approved arthroscopy with partial medial meniscectomy.

On June 15, 2016 appellant filed a claim for a schedule award (Form CA-7).

In a development letter dated June 16, 2016, OWCP requested that appellant submit a permanent impairment evaluation from his attending physician in accordance with the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] It afforded him 30 days to submit the requested evidence.

In a May 10, 2016 medical report, Dr. Rick Pospisil, a Board-certified orthopedic surgeon, provided a history of appellant's clinical presentation. He described the April 10, 2013 incident at work and appellant's medical treatment, including the March 19, 2014 partial medial meniscectomy. Dr. Pospisil reported physical examination findings for the right knee, including a 2-degree varus deformity, mild medial joint line swelling and tenderness, marked patellofemoral crepitus, and full extension and flexion to approximately 100 degrees. He noted slight weakness to resisted flexion, no instability with varus/valgus stress, full extension with mild patellofemoral crepitus, negative Lachman's test, and negative McMurray's test. Dr. Pospisil advised that x-rays revealed considerable narrowing of the medial joint line, with only two millimeters of articular surface wear medially and a large bone spur along the medial border of the patella which touched the trochlea. He diagnosed status post right knee partial medial meniscectomy with traumatic arthritis and noted that appellant had reached maximum medical improvement (MMI).

Dr. Pospisil then performed a diagnosis-based impairment (DBI) rating by utilizing Table 16-3 (Knee Regional Grid) beginning on page 509 of the sixth edition of the A.M.A., *Guides*. He noted that appellant's meniscal injury of the right knee warranted a class of diagnosis (CDX) at the class 1 level with a default value of two percent of the right lower extremity. Dr. Pospisil found that appellant had a grade modifier for functional history (GMFH) of 1, grade modifier for physical examination (GMPE) of 1, and grade modifier for clinical studies (GMCS) of 1 (based on changes seen on a magnetic resonance imaging (MRI) scan due to the partial medial meniscectomy). Application of the net adjustment formula did not result in movement from the

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

two percent default value and therefore appellant had two percent permanent impairment of the right lower extremity due to the meniscal injury.

Dr. Pospisil determined that, under Table 16-3 page 511, appellant's right knee joint arthritis warranted a CDX of class 2 with a default value of 20 percent. He found that, for this condition, appellant had a GMFH of 2 (due to his gait), GMPE of 2 (due to moderate medial patellofemoral tenderness and moderate restriction of flexion), and GMCS of 3 (due to x-ray findings). Application of the net adjustment formula resulted in movement one space to the right of the 20 percent default value and therefore appellant had 22 percent permanent impairment of the right lower extremity due to primary right knee joint arthritis. Dr. Pospisil then determined that, under Table 16-3, appellant's right patellofemoral arthritis warranted a CDX of class 2 with a default value of 15 percent. With respect to this condition, he indicated that appellant had "a net of a 1+ radiograph change for assigned diagnostic grade of D." Application of the net adjustment formula resulted in movement one space to the right of the 15 percent default value and therefore appellant had 16 percent permanent impairment of the right lower extremity due to right patellofemoral arthritis. Dr. Pospisil totaled the above-described percentages to conclude that appellant had 40 percent permanent impairment of his right lower extremity. He apportioned 10 percent of the permanent impairment to the aging process and 90 percent to appellant's injury.

On October 21, 2016 OWCP routed Dr. Pospisil's report, a statement of accepted facts (SOAF), and the case file to Dr. Jovito Estaris, a Board-certified occupational medicine physician serving as an OWCP district medical adviser (DMA). It requested that the DMA provide an evaluation of appellant's permanent impairment under the sixth edition of the A.M.A., *Guides.*

In a November 7, 2016 report, the DMA indicated that he had reviewed the SOAF and the medical record, including Dr. Pospisil's May 10, 2016 report. He noted that appellant had undergone a medial meniscectomy on March 19, 2014 and returned to work at full duty on April 26, 2014. The DMA noted that appellant's date of MMI was May 10, 2016. He determined that application of the DBI rating method under Table 16-3 on page 511 meant that appellant's primary joint arthritis (with a two-millimeter cartilage interval) fell under class 2 with a default value of 20 percent. The DMA assigned a GMFH of 1 based on antalgic gait without use of ambulatory aids. He assigned a GMPE of 1 based on tenderness over the medial knee with near-full range of motion. The DMA noted that the GMCS was not applicable because clinical studies were used in proper classification in the DBI grid. He calculated a net adjustment of -2, which meant that appellant's primary right knee joint arthritis fell under a CDX of class 2. The DMA found a right lower extremity permanent impairment rating of 16 percent. He explained that his impairment rating differed from Dr. Pospisil's because Dr. Pospisil calculated impairment ratings on three diagnoses for the same knee, which was not in accordance with the A.M.A., *Guides.* The DMA explained that the A.M.A., *Guides* noted on page 497 that in most cases, only one diagnosis in a region would be appropriate and that, if two significant diagnoses were present, the examiner should use the diagnoses with the highest impairment rating in that region that was causally related. He further noted that Dr. Pospisil had given different functional history modifiers for the same knee.

On December 28, 2016 Dr. Pospisil responded to the DMA's November 7, 2016 report. He referenced page 529 of the A.M.A., *Guides*, noting that, if more than one diagnosis is to be used for the same body part, it should have some functional basis for using those diagnoses.

Dr. Pospisil argued that it was well established that the conditions involved should be divided into thirds: those that involve the inside, medial, and lateral portions of the knee. He noted that he had used different functional history modifiers for each of these portions of the knee. Dr. Pospisil continued to maintain that appellant had 22 percent permanent impairment due to primary right knee arthritis, as well as 16 percent permanent impairment for right patellofemoral arthritis, for a total of 34 percent permanent impairment of the right lower extremity. He indicated that he would exclude the two percent he assigned for meniscal tear.

On January 30, 2017 OWCP routed Dr. Pospisil's response to the DMA for review. In a report dated February 9, 2017, the DMA noted that page 529 of the A.M.A., *Guides* indicated that if there were multiple diagnoses within a specific region, then the most impairing diagnosis would be rated, because it was probable that this would incorporate the functional losses of the less impairing diagnosis. He indicated that in rare cases of complex injury, the examiner may combine multiple impairments within a single region. The DMA explained that knee joint arthritis was not considered a complex injury, as it was a degenerative condition that gradually occurred over time and he indicated that, with respect to dividing the knee joint into thirds, there was no evidence that this was accepted by the A.M.A., *Guides.* He further explained that, while Dr. Pospisil had given different functional history modifiers for all three conditions, functional history was only to be used for the single highest diagnosis-based impairment in one limb. The DMA maintained that Dr. Pospisil had improperly used clinical studies for the GMCS when they were used for proper classification in the DBI grid. He concluded that appellant had 16 percent permanent impairment of the right lower extremity.

On March 30, 2017 OWCP referred appellant and the case file (including a SOAF) to Dr. Steven Ma, a Board-certified orthopedic surgeon, for a second opinion regarding whether appellant's conditions had resolved.[4]

In a report dated May 3, 2017, Dr. Ma indicated that he had reviewed the SOAF and the medical record. On physical examination of the right knee, he noted a normal heel-to-toe gait, ability to adopt a semi-squatting position, extensive psoriatic lesions, arthroscopic scars present, no effusion, no swelling, no crepitus, and no ecchymosis. Dr. Ma observed no tenderness on compression of the patellofemoral joint, a negative apprehension sign about both patellae, no point tenderness, and no medial or lateral joint line tenderness. Both knees went from full extension to 140 degrees of flexion and there was no ligamentous laxity about either knee. Sensory examination was intact to light touch and pinprick in both extremities, with motor strength at 5/5 in the right lower extremity. Dr. Ma diagnosed right knee strain and right knee internal derangement of the meniscus, noting that appellant's current diagnosis connected to the work injury was a medial meniscus tear only, with incidental co-existing nonwork-related knee arthritis. He indicated that the work-related conditions had essentially resolved.

In a June 6, 2017 telephone conversation, OWCP informed counsel that there had been a miscommunication with regard to Dr. Ma's second opinion report, as he had not been asked to provide an impairment rating.

[4] In an April 4, 2017 telephone conversation, OWCP informed counsel that, because there was such a large difference between the evaluations of Dr. Pospisil and the DMA, the case had been referred for a second opinion.

On June 6, 2017 OWCP referred appellant and the case file, including a SOAF, to Dr. Michael Einbund, a Board-certified orthopedic surgeon, for a second opinion regarding appellant's permanent impairment under the A.M.A., *Guides*.

In a report dated July 6, 2017, Dr. Einbund provided a history of clinical presentation and described the accepted employment conditions, as well as appellant's medical treatment. On examination of the right knee, Dr. Einbund observed full range of motion, no swelling or instability, diffuse tenderness over the medial and lateral joint, a negative McMurray's test medially and laterally, and some crepitus with range of motion. He noted normal knee extension of 0 degrees and flexion of 135 degrees. Dr. Einbund indicated that x-ray findings revealed no evidence of fracture or dislocation with slight narrowing of the medial joint to about three millimeters, as well as mild degeneration of the patellofemoral joint. He diagnosed right knee strain, internal derangement, and osteoarthritis. Dr. Einbund utilized the DBI rating method of the A.M.A., *Guides* to calculate appellant's right lower extremity impairment. He noted that appellant's accepted diagnoses were right knee strain and right knee internal derangement, and that the diagnosis of primary arthritis had been appropriately used in the past when calculating appellant's right lower extremity impairment. Dr. Einbund found that, under Table 16-3, page 511, a three-millimeter joint space narrowing warranted a CDX of class 1 with a default value of seven percent permanent impairment of the right lower extremity. He determined that appellant had a GMFH of 1 (due to limping gait without use of an ambulatory device), and GMPE of 1 (due to tenderness and crepitus findings on examination). Dr. Einbund advised that the GMCS was not applicable as clinical studies had already been used as a factor in selecting the diagnosis. He concluded that appellant had a net adjustment of zero, maintaining the default value of seven percent permanent impairment of the right lower extremity.

On November 14, 2017 OWCP routed Dr. Einbund's report, a SOAF, and the case file to the DMA for review and a determination of appellant's permanent impairment. In a November 20, 2017 report, the DMA indicated that he had reviewed the SOAF and medical record. Reviewing Dr. Einbund's July 6, 2017 report, he determined that application of the DBI rating method under Table 16-3 on page 511 of the sixth edition of the A.M.A., *Guides* meant that appellant's right knee joint arthritis (three-millimeter cartilage interval) fell under a CDX of class 1 with a default value of seven percent. The DMA assigned a GMFH of 1 (due to antalgic gait, and pain and stiffness of the right knee), and a GMPE of 1 (due to tenderness in the right knee with crepitus). He noted that the GMCS was not applicable because clinical studies were used in proper classification in the DBI grid. The DMA calculated a net adjustment of zero, concurring with Dr. Einbund's rating of seven percent permanent impairment of the right lower extremity. He indicated that there was a marked discrepancy between the ratings of Dr. Pospisil and Dr. Einbund as the physicians observed different right knee cartilage intervals and Dr. Pospisil impermissibly included multiple diagnoses for rating the same joint. The DMA indicated that appellant's date of MMI was July 6, 2017.

By decision dated July 31, 2018, OWCP granted appellant a schedule award for seven percent permanent impairment of the right lower extremity (knee). The award ran for 20.16 weeks from July 6 through November 24, 2017 and was based on the opinions of Drs. Einbund and the DMA.

On August 15, 2018 appellant, through counsel, requested reconsideration of OWCP's July 31, 2018 decision. Counsel argued that a conflict in medical opinion evidence between Dr. Pospisil and Dr. Einbund existed, because there was a discrepancy within the examination itself, and not with the application of the A.M.A., *Guides*.

By decision dated November 9, 2018, OWCP denied modification of the July 31, 2018 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA,[5] and its implementing federal regulations,[6] 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.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

With respect to the right knee, the relevant portion of the right 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]

OWCP's 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 extent of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.[11]

ANALYSIS

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

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id*. at § 10.404(a).

[8] 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).

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

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

[11] *See supra* note 8 at Chapter 2.808.6(f) (March 2017).

OWCP accepted right knee and leg sprain, and internal derangement of the meniscus of the right knee. By decision dated July 31, 2018, it granted appellant a schedule award for seven percent permanent impairment of the right lower extremity (knee). The award was based on the opinions of referral physician Dr. Einbund and the DMA. By decision dated November 9, 2018, OWCP denied modification of the July 31, 2018 decision.

The Board finds that Dr. Einbund properly determined that appellant had seven percent permanent impairment of his right lower extremity.[12] On July 6, 2017 Dr. Einbund conducted an evaluation of the extent of permanent impairment of appellant's right lower extremity using the DBI rating method described in Table 16-3 of the sixth edition of the A.M.A., *Guides*. He correctly determined that, utilizing Table 16-3, the primary arthritis of appellant's right knee had a CDX of class 1, which yielded a default value of seven percent for permanent impairment of the right lower extremity.[13] Dr. Einbund determined that appellant had a GMFH of 1 (due to limping gait without use of an ambulatory device), and GMPE of 1 (due to tenderness and crepitus findings on examination). He correctly advised that the GMCS was not applicable as clinical studies had already been used as a factor in selecting the diagnosis. Dr. Einbund properly found that application of the net adjustment formula did not require movement from the seven percent default value and concluded that appellant had seven percent permanent impairment of his right lower extremity.[14]

The Board further finds that the DMA also properly determined that appellant had seven percent permanent impairment of his right lower extremity. In his November 20, 2017 report, the DMA indicated that he had reviewed Dr. Einbund's July 6, 2017 report and concurred with his determination that appellant had seven percent permanent impairment of his right lower extremity due to right knee deficits under the DBI rating method. He expressed agreement with Dr. Einbund's choice of the greatest impairment right knee diagnosis and grade modifiers, as well as the application of the net adjustment formula, and explained his reasons for agreement with Dr. Einbund's rating.

On appeal counsel argues that Dr. Pospisil's report created a conflict in the medical opinion evidence regarding the extent of permanent impairment of appellant's right lower extremity, requiring referral to an impartial medical specialist. The Board notes, however, that no such conflict exists because Dr. Pospisil's May 10, 2016 report is of limited probative value due to improper application of the A.M.A., *Guides*, as explained by the DMA in his February 9 and November 20, 2017 reports.[15] The DMA noted, *inter alia*, that Dr. Pospisil impermissibly

[12] The Board notes that it was appropriate for OWCP to refer appellant to Dr. Einbund for further evaluation of the permanent impairment of his right lower extremity. There were significant discrepancies between the right lower extremity evaluations of Dr. Pospisil and the DMA, which required further development of the medical evidence. *See supra* note 8 at Chapter 2.810.8(b), (c) (September 2010) (regarding OWCP's procedures describing the role of the DMA in aiding OWCP in the development of evidence); *R.A.*, Docket No. 18-0868 (issued October 25, 2018).

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

[14] *See supra* notes 9 and 10.

[15] *See A.R.*, Docket No. 17-1504 (issued May 25, 2018); *Carl J. Cleary*, 57 ECAB 563, 568 at note 14 (2006) (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 impairment).

provided impairment ratings for all three right knee diagnoses (rather than for the most impairing diagnosis), and improperly divided the knee joint into thirds in order to give different functional history modifiers for all three areas.

The Board finds that appellant has not submitted probative medical evidence to establish more than seven percent permanent impairment of his right lower extremity. As such, an additional schedule award is not warranted.

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 seven percent permanent impairment of his right lower extremity, for which he previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the November 9, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 24, 2020
Washington, DC

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

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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