

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

B.B., Appellant

and

**U.S. POSTAL SERVICE, POST OFFICE,
Los Angeles, CA, Employer**

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**Docket No. 18-1053
Issued: March 26, 2020**

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

Case Submitted on the Record

DECISION AND ORDER

Before:

CHRISTOPHER J. GODFREY, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 27, 2018 appellant filed a timely appeal from December 27, 2017 and April 16, 2018 merit decisions of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act (FECA)¹ and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.²

ISSUES

The issues are: (1) whether appellant has met her burden of proof to establish more than three percent permanent impairment of the right lower extremity and five percent permanent impairment of the left lower extremity, for which she previously received schedule award

¹ 5 U.S.C. § 8101 *et seq.*

² The Board notes that appellant submitted additional evidence on appeal. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

compensation; and (2) whether appellant has met her burden of proof to establish entitlement to wage-loss compensation for 3.63 hours on October 31, 2017 for time lost to obtain medical treatment causally related to her accepted employment injury.

FACTUAL HISTORY

This case has previously been before the Board.³ The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference.⁴ The relevant facts are as follows.

On July 24, 2009 appellant, then a 48-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that she sustained knee strain, lumbar strain, and other lower extremity conditions as a result of factors of her federal employment. OWCP accepted her claim for right and left knee chondromalacia of the lateral tibial plateau, right and left knee discoid of the lateral meniscus, a left knee lateral meniscal tear, bilateral plantar fasciitis, bilateral ankle strain, foot strain, and lumbar strain.

Appellant accepted a modified-employment position with the employing establishment on May 11, 2010.⁵ OWCP paid her intermittent wage-loss compensation benefits on the supplemental rolls commencing April 6, 2011. Appellant underwent an OWCP-authorized left plantar fascia release on May 25, 2012 and OWCP paid her wage-loss compensation benefits on the periodic rolls as of July 29, 2012. On June 6, 2013 she underwent an OWCP-authorized left knee arthroscopy with partial lateral meniscectomy and debridement.

On April 7, 2016 appellant filed a schedule award claim (Form CA-7). With her request, she submitted a February 26, 2016 report from Dr. Charles Xeller, a Board-certified orthopedic surgeon. Dr. Xeller reviewed appellant's history of injury and performed a physical examination. He noted normal range of motion (ROM) of the left knee with slight crepitation, pain over the lateral joint line, no instability, distal circulation, and no neurological deficits. Dr. Xeller diagnosed a left medial meniscus tear and chondromalacia of the left patella. Utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),⁶ he identified the class of diagnosis (CDX), in Table 16-3,⁷ as a Class 1 meniscal injury, which yielded a default value of two percent. Dr. Xeller assigned a functional history grade modifier (GMFH) of 1, physical examination (GMPE) of 1; and clinical studies (GMCS) of 1, to

³ Docket No. 16-1814 (issued April 6, 2017).

⁴ By decision dated July 14, 2016, OWCP determined that appellant's actual earnings as a customer care agent commenced on January 11, 2016 and fairly and reasonably represented her wage-earning capacity. Because the wages appellant earned as a customer care agent equaled the adjusted wages of her date-of-injury position, OWCP found that she had no loss of wage-earning capacity. On September 12, 2016 appellant appealed the July 14, 2016 decision to the Board.

⁵ On January 6, 2016 appellant accepted a position as a customer care agent at the employing establishment, effective January 9, 2016. She began work in this position on January 11, 2016.

⁶ A.M.A., *Guides* (6th ed. 2009).

⁷ *Id.* at 509.

find no change from the default value of two percent. He found that appellant had reached maximum medical improvement (MMI) on December 1, 2015 and had two percent permanent impairment of the left lower extremity.

OWCP referred the medical evidence, a statement of accepted facts (SOAF), and the case file to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA). In an April 18, 2016 report, Dr. Harris requested that additional information be obtained from Dr. Xeller documenting appellant's residual issues involving her feet and ankles, as well as results of physical examination and an impairment rating.

On September 12, 2016 Dr. Xeller advised that appellant's bilateral foot condition was not yet "permanent and stationary."

In a September 30, 2016 report, the DMA opined that appellant had reached MMI, regarding her left lower extremity conditions, on February 26, 2016 the date of the examination by Dr. Xeller. He concurred with Dr. Xeller's finding of two percent permanent impairment of the left lower extremity according to Table 16-3⁸ based upon her having undergone a partial lateral meniscectomy. The DMA indicated that appellant had no permanent impairment of the right lower extremity and noted that she had not reached MMI following her bilateral plantar fascia surgery.

By decision dated October 17, 2016, OWCP granted appellant a schedule award for two percent permanent impairment of the left lower extremity. The award covered a period of 5.76 weeks from August 25 through October 4, 2016. OWCP noted that, because appellant had been receiving wage-loss compensation through August 24, 2016, the date of the schedule award was administratively changed to August 25, 2016.

In a report dated July 12, 2017, Dr. Domenic Signorelli, a podiatrist specializing in orthopedic surgery, reviewed appellant's history of injury and performed a physical examination. He noted difficulty with prolonged ambulation, squatting, crouching, toe walking, and toe standing and found normal ROM of the feet and ankles. Dr. Signorelli observed significant pes planus deformity of the feet and issues regarding bilateral tarsal tunnel syndrome, with radiating pain and a positive Tinel's sign. He further noted palpatory tenderness and swelling of the bilateral feet and ankles. Dr. Signorelli diagnosed sprain/strain of the feet, ankles, and lumbar region; bilateral plantar fibromatosis; bilateral chondromalacia; lumbar disc displacement; and tarsal tunnel syndrome.

Utilizing Table 16-2⁹, Dr. Signorelli identified the CDX as Class 1, for the diagnosis of bilateral plantar fibromatosis, based on appellant's palpatory and/or radiographic findings, which yielded a default impairment value of one percent. He applied a GMFH of two due to her pain with ambulation without orthotics and difficulty with weight bearing, a GMPE of two for findings of palpatory tenderness and swelling of the feet, and a GMCS of one for mild changes on diagnostic

⁸ *Id.*

⁹ *Id.* at 501.

studies. Dr. Signorelli utilized the net adjustment formula to find a grade E or two percent permanent impairment of each lower extremity due to appellant's bilateral foot condition.

For the bilateral ankles, Dr. Signorelli identified the applicable diagnosis as sprain/strain for a CDX of 1, according to Table 16-2,¹⁰ which yielded a default value of one percent. He applied a GMFH of one due to appellant's difficulty with ambulation without orthotics and daily activity limitations due to bilateral ankle pain. Dr. Signorelli assigned a GMPE of one due to palpatory tenderness and swelling of the ankles and a GMCS of one due to mild pathologies on diagnostic studies, including mild effusion of the bilateral ankle joints as demonstrated by magnetic resonance imaging scan. He applied the net adjustment formula to find no change from the default value of one percent permanent impairment of each lower extremity due to appellant's ankle condition.

On August 25, 2017 appellant filed a claim for an increased schedule award (Form CA-7).

In a letter dated September 13, 2017, OWCP requested that Dr. Signorelli provide a report that, specified the date of MMI, the diagnosis upon which the impairment was based, a detailed description of permanent impairment of the same member preexisting the accepted injury, and a final rating of permanent impairment.¹¹ It noted that Dr. Signorelli had not provided combined totals taking into account the previous two percent awarded for the left lower extremity due to the knee.

In a responsive letter dated September 26, 2017, Dr. Signorelli noted that appellant had reached MMI on March 9, 2017. He advised that knee complaints were outside of his expertise.

OWCP referred the medical evidence, a SOAF and the case file to the DMA for review.

In an October 20, 2017 report, the DMA concurred with Dr. Signorelli's finding of two percent permanent impairment of each lower extremity due to his bilateral foot condition and one percent permanent impairment of each lower extremity due to his bilateral ankle condition, which he combined to find three percent permanent impairment of each lower extremity.

For the left knee, referencing Table 16-3,¹² the DMA noted a diagnosis of residual problems status post arthroscopic surgery including saucerization of the lateral meniscus, resulting in two percent permanent impairment of the left lower extremity due to these knee conditions.¹³ Combining this value with the three percent left lower extremity impairment due to appellant's feet and ankle conditions, he found five percent left lower extremity impairment.

¹⁰ *Id.*

¹¹ This letter was inadvertently addressed to "Dr. Brown."

¹² *Supra* note 7.

¹³ Dr. Harris noted that he had used the diagnosis-based impairment (DBI) method for calculating appellant's percentage of permanent impairment for the feet, ankles, and left knee, as the applicable diagnoses did not have an asterisk next to them in the DBI grid indicating that they could be calculated by the ROM method.

By decision dated December 27, 2017, OWCP granted appellant a schedule award for three percent impairment of the right lower extremity and an additional three percent impairment of the left lower extremity, for a total five percent permanent impairment of the left lower extremity. The award covered a period of 17.28 weeks from August 18 through December 16, 2017.¹⁴

On March 29, 2018 appellant filed a wage-loss compensation claim (Form CA-7) for intermittent leave without pay (LWOP) for the period October 31, 2017 through March 13, 2018. She noted office visits with her physicians on October 31, 2017; December 26, 2017, January 11 and 23, 2018, and March 7 and 13, 2018. Appellant claimed 3.63 hours of LWOP for October 31, 2017.

By decision dated April 16, 2018, OWCP denied appellant's wage-loss compensation claim for intermittent LWOP due to time lost from work to obtain medical care for 3.63 hours on October 31, 2017 finding that employees could not concurrently receive schedule award compensation and wage-loss compensation for disability for work.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA¹⁵ and its implementing federal regulations¹⁶ set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members, functions and organs of the body. FECA, however, does not specify the manner by which the percentage loss of a member, function or organ 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 specified edition of the A.M.A., *Guides*, published in 2009.¹⁷ 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.¹⁸

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

¹⁴ OWCP noted that schedule award compensation was payable consecutively, but not concurrently with an award of wage-loss compensation for the same injury, and that, as such, the date of the schedule award was administratively changed to August 18, 2017 because appellant had received compensation for disability through August 17, 2017.

¹⁵ *Supra* note 1.

¹⁶ 20 C.F.R. § 10.404.

¹⁷ 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* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

¹⁸ *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

(ICF).¹⁹ Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by the GMFH, GMPE, and GMCS.²⁰ The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).²¹

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed 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.²²

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met her burden of proof to establish more than three percent permanent impairment of the right lower extremity or five percent permanent impairment of the left lower extremity for which she previously received schedule award compensation.

On July 12, 2017 Dr. Signorelli found bilateral swelling of the feet and ankles, tenderness to palpation, a pes planus deformity, and a positive Tinel's sign. For the feet, he identified the diagnosis plantar fibromatosis and assigned a CDX of 1 according to Table 16-2, which yielded a default value of one percent. Dr. Signorelli applied the net adjustment formula which moved the default value to grade E, for a two percent permanent impairment of each lower extremity.²³ For the ankles, he identified the applicable diagnosis as sprain/strain according for a CDX of 1 according to Table 16-2, which yielded a default value of one percent. Dr. Signorelli applied assigned grade modifiers and applied the net adjustment formula to find no change from the default value of one percent permanent impairment of each lower extremity.

On October 20, 2017 the DMA concurred with Dr. Signorelli's finding that appellant had two percent permanent impairment of each lower extremity due to her bilateral foot condition and one percent permanent impairment of each lower extremity due to her bilateral ankle condition, which he combined to find three percent permanent impairment of each lower extremity. He determined that she had two percent permanent impairment of the left knee for residual problems after arthroscopic surgery, which he combined with the three percent left lower extremity impairment due to appellant's foot and ankle condition to find five percent permanent impairment of the left lower extremity.

¹⁹ 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.

²⁰ *Id.* at 494-531.

²¹ *Id.* at 411.

²² *See supra* note 17 at Chapter 2.808.6(f) (February 2013).

²³ Utilizing the net adjustment formula discussed above, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), or (2-1) + (2-1) + (1-1) = 2, yielded an adjustment of two.

The Board finds that there is no evidence of record demonstrating a greater impairment than that assigned by the DMA and previously awarded.²⁴ Appellant, thus has not established more than three percent permanent impairment of the right lower extremity and five percent permanent impairment of the left lower extremity.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

LEGAL PRECEDENT -- ISSUE 2

A schedule award is payable consecutively, but not concurrently, with an award for wage loss for the same injury.²⁵ If a claimant loses wages to obtain medical treatment during the period of a schedule award (*e.g.*, claims hours due to a medical appointment with the treating physician), compensation for the hours lost may be paid concurrently with a schedule award, as time lost for medical appointments is not considered disability.²⁶ However, time lost for disability surrounding the appointment (if any) cannot be paid concurrently with a schedule award.²⁷

With respect to claimed disability for medical treatment, section 8103 of FECA provides for medical expenses, along with transportation and other expenses incidental to securing medical care, for injuries.²⁸ A claimant is entitled to compensation for any time missed from work due to medical examination or treatment for an employment-related condition.²⁹ However, OWCP's obligation to pay for expenses incidental to obtaining medical care, such as loss of wages, extends only to expenses incurred for treatment of the effects of any employment-related condition. Appellant has the burden of proof, which includes the necessity to submit supporting rationalized medical evidence.³⁰

ANALYSIS -- ISSUE 2

The Board finds that the case is not in posture for decision regarding whether appellant has met her burden of proof to establish entitlement to wage-loss compensation for 3.63 hours on

²⁴ The A.M.A., *Guides* directs examiners to rate DBI's for the lower extremities pursuant to Chapter 16, 2 which indicates at page 497, section 16.2a that impairments are defined by class and grade using regional grids for the hip, knee, and foot/ankle. The A.M.A., *Guides* explains that in most cases only one diagnosis in a region will be appropriate. If a patient has two significant diagnoses, the examiner should use the diagnosis with the highest impairment rating in that region that is causally related for the impairment calculation. A.M.A., *Guides* 497.

²⁵ *Supra* note 17 at Chapter 2.808.4(a)(3) (February 2013).

²⁶ *Id.*

²⁷ *Id.* at Chapter 2.808.4(a)(4).

²⁸ 5 U.S.C. § 8103(a).

²⁹ *See supra* note 17 at Chapter 2.901.19a (February 2013); *see S.M.*, Docket No. 17-1557 (issued September 4, 2018).

³⁰ *S.M.*, *id.*

October 31, 2017 for time lost to obtain medical treatment causally related to her accepted employment injury.

On March 29, 2018 appellant filed a wage-loss compensation claim for intermittent LWOP during the period October 31, 2017 through March 13, 2018. She claimed 3.63 hours of LWOP on October 31, 2017 to attend a medical appointment. By decision dated April 16, 2018, OWCP denied appellant's claim for compensation for intermittent LWOP, due to time lost from work to obtain medical care for 3.63 hours on October 31, 2017, as it found that she was not entitled to receive schedule award compensation and wage-loss compensation for disability concurrently. As set forth above, however, if a claimant incurs a loss of wages to obtain medical treatment during the period covered by a schedule award, compensation for the hours lost may be paid concurrently with the schedule award as time lost for medical appointments is not considered a payment of an award of permanent disability.³¹

As OWCP denied appellant's claim for 3.63 hours on October 31, 2017 based on its finding that she was not entitled to time lost for medical treatment during a period of a schedule award, it failed to adjudicate whether she had established that she had obtained medical treatment on that date causally related to her accepted employment injury. On remand, it should determine whether she is entitled to time lost on October 31, 2017 to obtain medical treatment as a result of her accepted employment injury, to be followed by any necessary further development and a *de novo* decision.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish more than three percent permanent impairment of the right lower extremity and five percent permanent impairment of the left lower extremity, for which she previously received schedule award compensation. The Board further finds that the case is not in posture for decision regarding whether she has established entitlement to wage-loss compensation for wage loss for 3.63 hours on October 31, 2017 due to a medical appointment.

³¹ *Supra* note 22.

ORDER

IT IS HEREBY ORDERED THAT the December 27, 2017 decision of the Office of Workers' Compensation Programs is affirmed. It is further ordered that the April 16, 2018 decision is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: March 26, 2020
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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