United States Department of Labor
Employees' Compensation Appeals Board

K.W., Appellant **and** **U.S. POSTAL SERVICE, TRENTON PROCESSING TRANSPORTATION OFFICE, Trenton, NJ, Employer**	)))))))))	**Docket No. 20-0047** **Issued: November 12, 2020**

Appearances:
Thomas R. Uliase, *Esq.*, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND O RDER

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

JURISDICTION

On September 30, 2019 appellant, through counsel, filed a timely appeal from a May 21, 2019 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.[3]

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[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.*

[3] The Board notes that, following the May 21, 2019 decision, OWCP received additional evidence. 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.*

ISSUE

The issue is whether appellant has met his burden of proof to establish more than one percent permanent impairment of the left lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

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

On April 13, 2007 appellant, then a 59-year-old tractor trailer operator, filed a traumatic injury claim (Form CA-1) alleging that on that same date his left knee popped when he was using the clutch to back up his truck while in the performance of duty. He stopped work on the date of injury. OWCP accepted the claim for left knee lateral collateral ligament sprain, and subsequently expanded acceptance of the claim to include left anterior cruciate ligament tear.

In an August 7, 2008 report, Dr. Nicholas Diamond, an osteopath specializing in pain medicine, provided examination findings and diagnosed post-traumatic anterior cruciate ligament patellar tendon and distal quadriceps tears. Using the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[5] he determined that appellant had 25 percent permanent impairment of the left knee due to range of motion (ROM) deficit using Table 17-10, page 537 and 3 percent permanent impairment due to pain using Table 18-1, page 547, resulting in a combined 38 percent left lower extremity permanent impairment.

On December 23, 2008 appellant filed a claim for a schedule award (Form CA-7).

In a report dated August 7, 2008, and received on September 22, 2009, Dr. Diamond modified his prior rating and applied the sixth edition of the A.M.A., *Guides*[6] to determine that appellant had 35 percent permanent impairment of his left lower extremity. He noted his diagnoses as post-traumatic left knee tears of the anterior cruciate ligament, patellar tendon and distal quadriceps. Dr. Diamond also noted that on physical examination appellant's ROM of the left knee revealed flexion/extension of 50/140 degrees with pain. Pursuant to Table 16-23, page 549 of the A.M.A., *Guides*, he determined appellant's condition was consistent with a Class 3 diagnosis for ROM flexion deficit or 35 percent impairment. Dr. Diamond concluded that there was no grade modifier for functional history (GMFH).

OWCP referred appellant to Dr. Stanley R. Askin, a Board-certified orthopedic surgeon, for a second opinion. In a January 22, 2010 report, Dr. Askin performed a physical examination and reviewed the medical evidence, history of the injury and statement of accepted facts (SOAF). He diagnosed an anterior cruciate ligament tear and lateral collateral ligament sprain. Pursuant to Table 16-3, page 510 of the sixth edition of the A.M.A., *Guides*, for the diagnoses of anterior

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[4] Docket No. 17-1577 (issued February 15, 2018); Docket No. 12-0985 (issued December 19, 2012).

[5] A.M.A., *Guides* (5th ed. 2001).

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

cruciate ligament tear and lateral collateral ligament sprain, Dr. Askin noted that appellant's permanent impairment would be rated as a class 0 based on lack of any instability in the left knee. As to ROM, he concluded that appellant was in between mild and moderate rating pursuant to Table 549, page 16-23, resulting in 20 percent permanent impairment of the left lower extremity. In an addendum report dated March 12, 2010, Dr. Askin opined that appellant had reached maximum medical improvement (MMI) on January 22, 2010.

OWCP subsequently referred Dr. Askin's reports to a district medical adviser (DMA) for review. In an August 5, 2010 report, a DMA reviewed the reports from Drs. Askin and Diamond. He concurred with Dr. Askin's 20 percent left lower extremity impairment rating and date of MMI as that was the most recent report and Dr. Diamond's examination had been performed approximately a year and a half prior.

On September 1, 2010 OWCP granted appellant a schedule award for 20 percent permanent impairment of the left lower extremity. The award ran for 57.6 weeks and covered the period January 22, 2010 to March 1, 2011.

In a letter dated September 10, 2010, appellant, through counsel, requested a hearing before an OWCP hearing representative.

Following a preliminary review, by decision dated December 27, 2010, OWCP's hearing representative set aside the September 1, 2010 OWCP decision, finding that there was an unresolved conflict in the medical opinion evidence between Dr. Askin and Dr. Diamond regarding appellant's ROM findings and permanent impairment rating. Thus, the hearing representative remanded the case for a *de novo* decision.

On February 2, 2011 OWCP referred appellant to Dr. James P. Taitsman, a Board-certified orthopedic surgeon, selected as the impartial medical examiner (IME) to resolve the conflict in the medical opinion evidence.

On March 25, 2011 Dr. Taitsman reported that appellant had no more than 13 percent permanent impairment of the left lower extremity using the sixth edition of the A.M.A., *Guides*. Referring to Table 16-3, page 509, the diagnosis-based impairment (DBI) knee regional grid, Dr. Taitsman assigned a Class 1 for moderate motion muscle/tendon deficits. Next, he assigned a grade modifier for GMFH of two using Table 16-6, page 516 and a GMFH of 0 using Table 16-17, page 545. Using Table 16-23, page 549. Dr. Taitsman found appellant's knee motion impairment to be moderate and he noted that a moderate impairment rating according to Table 16-25, page 550 was 14 to 25 percent. He calculated that appellant had a net adjustment of 2, equaling a grade E impairment. Based on these calculations, Dr. Taitsman concluded that appellant had 13 percent permanent impairment of the left lower extremity utilizing the DBI methodology.

On April 18, 2011 OWCP referred Dr. Taitsman's report to Dr. Andrew A. Merola, a Board-certified orthopedic surgeon serving as a DMA, for review. On April 30, 2011 the DMA reviewed Dr. Taitsman's report and concurred with his 13 percent permanent impairment rating.

By decision dated May 16, 2011, OWCP denied appellant's request for an increased schedule award. In a letter dated May 23, 2011,[7] appellant, through counsel, requested a

[7] The date on the letter is mistakenly noted as 2010 instead of 2011.

telephonic hearing before a representative of OWCP's Branch of Hearings and Review. The hearing was held on September 20, 2011.

By decision dated December 19, 2011, OWCP's hearing representative affirmed the denial of an additional schedule award.

On April 4, 2012 appellant appealed to the Board. By decision dated December 19, 2012,[8] the Board set aside OWCP's December 19, 2011 decision. The Board found that OWCP had improperly selected Dr. Taitsman as an IME under the Physicians Directory System (PDS). The Board remanded the case to OWCP for selection of another IME to resolve the conflict in the medical evidence.

On remand OWCP referred appellant to Dr. Dean Carlson, a Board-certified orthopedic surgeon, for an impartial medical examination and impairment evaluation regarding the extent of permanent impairment of appellant's left lower extremity.

In a November 7, 2013 report, Dr. Carlson diagnosed resolved anterior cruciate ligament interstitial tear, resolved suprapatellar and infrapatellar tears, and left knee severe nonorganic loss of flexion. Pursuant to the DBI methodology for rating permanent impairment, using Table 16-3, page 510 he placed appellant in a class 0 using a diagnosis of cruciate and collateral ligament injury and no instability. Dr. Carlson determined that appellant's physical examination findings were inconsistent among the physicians of record and, thus, were invalid. He found that the grade modifier for physical examination (GMPE) and the GMFH were therefore invalid. Dr. Carlson also determined that appellant had no permanent impairment under the ROM methodology as his ROM deficit was nonorganic.

On May 19, 2014 a DMA Dr. Merola, reviewed Dr. Carlson's opinion and concurred with the zero percent lower extremity impairment rating.

By decision August 11, 2014, OWCP denied appellant's request for a schedule award.

On August 14, 2014 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review. By decision dated March 11, 2015, OWCP's hearing represented vacated the August 11, 2014 decision as OWCP had not properly selected Dr. Carlson as an IME using the PDS, and remanded the case for referral to a properly selected IME to resolve the conflict in the medical opinion evidence regarding the extent of appellant's left lower extremity permanent impairment.

On September 11, 2015 OWCP referred appellant to Dr. Jeffrey F. Lakin, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a report dated October 8, 2015, Dr. Lakin, based on a review of the medical evidence, diagnostic tests, list of questions, SOAF, and physical examination findings, noted accepted diagnoses of left knee sprain, left anterior cruciate ligament tear, and left lateral collateral ligament sprain. Pursuant to Table 16-3, page 510, he used the diagnosis of left knee sprain. Dr. Lakin explained that appellant's impairment would be placed in class 0 as there was no instability of the knee and appellant had not undergone any surgical procedure. He determined grade modifiers were not applicable as the given functional history, clinical studies, and examination findings did not correlate and were essentially unremarkable.

[8] *Supra* note 4.

Dr. Lakin determined that appellant had zero percent permanent impairment as there was no correlation between subjective and objective complaints. He concluded that appellant had zero percent left lower extremity permanent impairment.

On November 12, 2015 Dr. Henry J. Magliato, a Board-certified orthopedic surgeon serving as a DMA, reviewed Dr. Lakin's report and the medical evidence of record and noted that it did not correlate with prior impairment ratings. The DMA found that appellant had 13 percent left lower extremity impairment based on the opinion of Dr. Taitsman. He determined that the date of MMI was March 25, 2011, the date of Dr. Taitsman's examination.

By decision dated December 18, 2015, OWCP denied appellant's claim for an increased schedule award.

On August 18, 2016 OWCP issued a preliminary determination that appellant received an overpayment of compensation in the amount of $42,289.98 due to receipt of a schedule award for 20 percent left lower extremity permanent impairment when he had no permanent impairment. By decision dated February 28, 2017, an OWCP hearing representative affirmed as modified the August 18, 2016 preliminary overpayment determination as appellant was entitled to a schedule award for 13 percent permanent impairment of the left lower extremity, but received a schedule award for 20 percent permanent impairment.

On July 13, 2017 appellant appealed to the Board. By decision dated February 15, 2018,[9] the Board set aside OWCP's February 28, 2017 decision. The Board noted that the August 25, 2015 schedule award determination had been vacated by the hearing representative and remanded for referral for another impartial medical examination. OWCP instead referred appellant for a second opinion evaluation with Dr. Lakin, who found zero percent left lower extremity permanent impairment. A DMA reviewed Dr. Lakin's report, which he found failed to correlate with prior reports and determined that appellant had 13 percent left lower extremity permanent impairment based on the opinion of Dr. Taitsman, who the Board previously found had not been properly selected as an IME. Thus, the Board found that there remained an unresolved conflict between appellant's treating physician and an OWCP referral physician regarding the extent of appellant's permanent impairment of the left lower extremity.

On remand OWCP referred appellant to Dr. Howard Pecker, a Board-certified orthopedic surgeon, to resolve the conflict in the medical opinion evidence between Dr. Lakin, an OWCP referral physician, and Dr. Diamond, a treating physician, regarding the extent of appellant's left lower extremity permanent impairment.

In a July 23, 2018 report, Dr. Pecker, based upon review of the medical evidence, the SOAF, and appellant's physical examination, found no traumatic left knee pathology. Using Table 16-3 from the sixth edition of the A.M.A., *Guides*, he assigned a class of diagnosis (CDX) of 1 for mild problem under diagnostic criteria and a Grade C for consistent radiographic findings, corresponding to one percent permanent impairment. Dr. Pecker determined that GMFH could not be used due to inconsistencies in history and variable reporting. He assigned a GMPE of one for patella crepitance using Table 16-7, and a grade modifier for clinical studies (GMCS) of one

[9] *Supra* note 4.

using Table 16-8. Using the net adjustment formula, Dr. Pecker found no modification, resulting in one percent permanent impairment of appellant's left lower extremity.

By decision dated November 29, 2018, OWCP found that appellant had one percent permanent impairment of the left lower extremity, however, as he had previously been determined to have 13 percent permanent impairment of the left lower extremity, it denied further compensation.

On December 6, 2018 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. The hearing was held on April 9, 2019.

By decision dated May 21, 2019, OWCP's hearing representative found that appellant had not established more than one percent permanent impairment of his left lower extremity.

LEGAL PRECEDENT

The schedule award provisions of FECA[10] and its implementing regulations[11] 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 of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[12] For schedule awards issued after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[13]

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).[14] In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the knee, the relevant portion of the leg for the present case, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[15] 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

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[10] *Supra* note 2 at § 8107.

[11] 20 C.F.R. § 10.404.

[12] *Id.*; *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); Chapter 3.700.2 and Exhibit 1 (January 2010).

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

[15] *See id* at 509-11 (6th ed. 2009).

formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[16] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[17]

Section 8123(a) of FECA provides that, if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[18] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an IME for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[19]

ANALYSIS

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

On June 15, 2018 and following the Board's remand instructions, OWCP referred appellant for an impartial medical examination to resolve the conflict between Dr. Diamond, appellant's attending physician, and Dr. Lakin, an OWCP referral physician, regarding the extent of appellant's left lower extremity permanent impairment.

In his report dated July 23, 2018, Dr. Pecker, the selected IME, noted that he had reviewed the medical evidence of record and the SOAF. He noted appellant's physical examination findings and then noted that appellant had a diagnosis of "no traumatic left knee pathology." Despite finding no traumatic left knee pathology, he evaluated appellant's permanent impairment of the left knee under Table 16-3 of the sixth edition of the A.M.A., *Guides*, but he did not identify the diagnosis he used under Table 16-3.

The Board finds that Dr. Pecker's opinion was improper as it was inconsistent with the SOAF. OWCP accepted that appellant's left knee lateral collateral ligament sprain and left anterior cruciate ligament tear were due to the accepted April 13, 2007 employment injury.[20] It is well established that a physician's opinion must be based on a complete and accurate factual and medical background. If OWCP has accepted an employment condition, the physician must base his opinion on these accepted conditions.[21] In evaluating appellant's permanent impairment, Dr. Pecker disregarded that OWCP had accepted left knee lateral collateral ligament sprain and left anterior cruciate ligament tear as work related in rating appellant's permanent impairment under Table 16-3 of the A.M.A., *Guides.*

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

[17] *Id.* at 23-28.

[18] 5 U.S.C. § 8123(a).

[19] *J.T.*, Docket No. 18-0503 (issued October 16, 2018).

[20] *B.S.*, Docket No. 19-1717 (issued August 11, 2020); *D.W.*, Docket No. 18-0123 (issued October 4, 2018); *Willa M. Frazier*, 55 ECAB 379 (2004).

[21] *Id.*; *see also V.C.*, Docket No. 14-1912 (issued September 22, 2015).

For these reasons, Dr. Pecker's opinion is insufficient to resolve the conflict in medical opinion as the special weight of the medical opinion evidence regarding this matter does not presently rest with his opinion and there is an unresolved conflict in the medical opinion evidence. On remand OWCP shall select a new IME for purposes of evaluating the extent of appellant's permanent impairment and whether he is entitled to an increased schedule award.[22] After such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the May 21, 2019 decision is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: November 12, 2020
Washington, DC

Christopher J. Godfrey, Deputy 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

[22] *See K.C.*, Docket No. 18-0234 (issued September 14, 2018).