

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

_____)	
J.B., claiming as representative of the estate of)	
J.B., Appellant)	
)	
and)	Docket No. 18-0116
)	Issued: October 2, 2020
)	
U.S. POSTAL SERVICE, POST OFFICE,)	
Stratford, NJ, Employer)	
_____)	

Appearances:
Thomas R. Uliase, Esq., for the appellant¹
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On October 20, 2017 appellant, through counsel, filed a timely appeal from a September 11, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act² (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider 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 her burden of proof to establish more than three percent permanent impairment of the employee's left lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

OWCP accepted that on March 16, 2007 the employee, then a 60-year-old mail carrier, sustained an aggravation of degeneration of the left medial meniscus as a result of being attacked by a dog while in the performance of duty.³ It authorized left knee arthroscopy with partial medial meniscectomy and debridement of the medial femoral condyle and patellofemoral joint, which was performed by Dr. Larry Rosenberg, an attending Board-certified orthopedic surgeon, on February 25, 2010. Dr. Rosenberg released the employee to return to full-time light-duty work as of May 17, 2010.

Thereafter, OWCP received a May 24, 2010 medical report by Dr. Rosenberg which noted that the employee was three months status post left knee arthroscopy. He also noted that, objectively, the employee's left knee was cool, nonsynovised, noneffused, and quiet. The employee walked with a normal gait and cadence. On physical examination of the left knee, Dr. Rosenberg observed full range of motion (ROM). He noted that there were no meniscal, ligamentous, or peripatellar findings. Dr. Rosenberg determined that the employee had reached maximum medical improvement (MMI) from his injury and surgery. He released the employee to return to work without restrictions as of the date of his examination and discharged him from his care.

OWCP also received a November 30, 2010 letter by Dr. David O. Weiss, an attending osteopath Board-certified in orthopedic surgery. Dr. Weiss discussed the employee's factual and medical history and reported findings on physical examination. He noted that the employee ambulated with a noticeable left lower extremity limp. A calcaneal and equinus gait was carried through with a modicum of difficulty. Regarding the left knee, Dr. Weiss found well-healed portal arthroscopy scars. He reported ROM measurements of 120/140 degrees of flexion/extension measured three times. A patellofemoral compression test produced pain and crepitus. Patellar apprehension and inhibition signs were positive. There was tenderness along the undersurface of both the medial and lateral patellar facets and medial joint line pain. There was also good stability to both valgus and varus stress testing. Lachman and drawer signs were negative. An Apley's grind was positive producing medial joint line pain. There was crepitus involving the medial joint compartment. Manual muscle strength testing of the lower extremities three times revealed quadriceps graded at 3/5 on the left versus 5/5 on the right and gastrocnemius graded at 4/5 on the left versus 5/5 on the right. Gastrocnemius circumference measurements were 41.5 centimeters (cm) on the right versus 40 cm on the left. Quadriceps circumference measurements at 10 cm above the patella were 51 cm on the right and 51 cm on the left. Dr. Weiss diagnosed, among

³ The employee has a prior claim under OWCP File No. xxxxxx424, for which he filed an occupational disease claim (Form CA-2) on October 5, 2005. On January 13, 2006 OWCP accepted the claim for aggravation of degeneration of the left medial meniscus. This case, has been administratively combined with the current claim, OWCP File No. xxxxxx764, with the latter serving as the master file.

other things, post-traumatic internal derangement to the left knee with a medial meniscus tear; post-traumatic chondromalacia patella to the left knee; post-traumatic osteoarthritis to the left knee; status post February 25, 2010 arthroscopic surgery with partial medial meniscectomy and debridement of medial femoral condyle and patellofemoral joint; and status post viscosupplementation therapy with Synvisc and Supartz injections. He utilized the diagnosis-based impairment (DBI) rating method found at Table 16-3 (Knee Regional Grid) on page 511 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),⁴ to determine that, the employee's left primary joint arthritis fell under a class of diagnosis (CDX) of 1 with a default value of five percent. Dr. Weiss assigned a grade modifier for functional history (GMFH) of one under Table 16-6, page 512 and a grade modifier for physical examination (GMPE) of 2 under Table 16-7, page 517. He noted that a grade modifier for clinical studies (GMCS) was not applicable. Dr. Weiss utilized the net adjustment formula $(GMFH - CDX) + (GMPE - CDX) = (1 - 1) + (2 - 1) = +1$, which resulted in eight percent permanent impairment of the left lower extremity. Dr. Weiss concluded that the employee reached MMI on the date of his impairment evaluation.

In a supplemental letter dated February 25, 2011, Dr. Weiss indicated that he had reviewed January 18, 2011 x-ray films of the employee's left knee, which revealed that the medial joint space measured two cm and the lateral joint space measured three cm. Utilizing Table 16-3, page 511, he found that the employee's left primary joint arthritis fell under a CDX of 2 with a default value of 20 percent. Dr. Weiss again assigned a grade modifier 1 for GMFH under Table 16-6, page 512 and a grade modifier 2 for GMPE under Table 16-7, page 517. In addition, he continued to find that a grade modifier for GMCS was not applicable. Dr. Weiss utilized the net adjustment formula $(GMFH - CDX) + (GMPE - CDX) = (1 - 2) + (2 - 2) = -1$, which resulted in 18 percent permanent impairment of the left lower extremity.

On April 26, 2011 the employee filed a claim for a schedule award (Form CA-7).

In a May 16, 2011 report, Dr. Henry J. Magliato, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), reviewed a statement of accepted facts (SOAF) and the medical record, including Dr. Weiss' findings. He requested to review the January 18, 2011 left knee x-ray films, which were not contained in the case file, before computing a schedule award. The DMA noted that Dr. Rosenberg, in a February 1, 2010 office note, did not mention osteoarthritis. He related that the treating physician only noted a meniscal tear. On August 5, 2013 the DMA reviewed the January 18, 2011 left knee x-ray films and advised that he believed that an 18 percent impairment rating for the left lower extremity was quite high. He related that he would have evaluated impairment of the left knee based on the employee's February 25, 2010 partial medial meniscectomy and accepted diagnosis of aggravation of degeneration of the medial meniscus. The DMA recommended that the employee undergo a second opinion impairment evaluation.

On November 7, 2013 appellant, through counsel, advised OWCP that the employee had passed away on October 30, 2013.

⁴ A.M.A., *Guides* (6th ed. 2009).

In a March 6, 2014 report, DMA Dr. Magliato rereviewed the medical record since the employee had died and no further evaluation could be performed. He found that the employee had three percent impairment of the left lower extremity due to a partial medial meniscectomy under the sixth edition of the A.M.A., *Guides*. The DMA determined that the employee reached MMI on February 25, 2011, the date of Dr. Weiss' updated report.

OWCP, by decision dated March 13, 2014, granted the employee a schedule award for three percent permanent impairment of the left lower extremity based on the opinion of its DMA, Dr. Magliato.⁵ The period of the award ran for 8.64 weeks, from February 25 to April 26, 2011.

On March 25, 2014 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. By decision dated August 18, 2014, an OWCP hearing representative determined that there was a conflict of medical opinion between Dr. Weiss, the employee's treating physician, who opined that the employee had 18 percent permanent impairment, and Dr. Magliato, the DMA, who opined that the employee had three percent permanent impairment of the left lower extremity. She set aside the March 13, 2014 decision and remanded the case for OWCP to refer the employee for an impartial medical examiner (IME) to resolve the existing conflict of medical opinion evidence regarding the extent of his left lower extremity permanent impairment.

On October 2, 2014 OWCP referred a SOAF, the employee's case record, and a series of questions to Dr. Ian B. Fries, a Board-certified orthopedic surgeon serving as the IME. In an October 25, 2014 report, Dr. Fries noted his review of the SOAF and medical records. He indicated that, since he did not have an opportunity to examine the employee, he would provide impairment calculations using the most recent functional history and physical examination findings set forth in Dr. Rosenberg's May 24, 2010 report and alternative impairment calculations provided by Dr. Weiss in his November 30, 2010 report. Dr. Fries utilized Table 16-3, page 509 of the sixth edition of the A.M.A., *Guides* and found a CDX of 1 for a partial (medial or lateral) meniscectomy, meniscal tear, or meniscal repair of the left knee, which yielded a default value of two percent. He referred to Table 16-16, page 516 and assigned a grade modifier 0 based on Dr. Rosenberg's findings and a grade modifier 1 based on Dr. Weiss' findings for GMFH. Dr. Fries assigned a grade modifier 0 based on Dr. Rosenberg's findings and grade modifier 2 based on Dr. Weiss' findings for GMPE under Table 16-7, page 517.⁶ He assigned a grade modifier 1 for GMCS under Table 16-8, page 519 as x-rays mentioned in the case record showed some medial compartment narrowing. Dr. Fries applied Dr. Rosenberg's and his own finding to the net adjustment formula on page 521, $(GMFH - CDX) + (GMPE - CDX) = (0 - 2) + (0 - 2) + (1 - 2) = -5$, which resulted in a grade A, one percent permanent impairment of the left lower extremity. He applied the same formula to Dr. Weiss' and his own finding and calculated $(1 - 2) + (2 - 2) + (1 - 2) = -2$, which also resulted in a grade A, one percent permanent impairment of the left lower extremity. Dr. Fries noted that OWCP had only accepted an aggravation of degeneration of the left medial meniscus according to the SOAF and thus, the employee's condition of

⁵ The record indicates that OWCP paid appellant the schedule award for three percent permanent impairment of the left lower extremity.

⁶ The Board notes that Dr. Fries noted that Table 16-7 was located on page 516 of the A.M.A., *Guides*. However, this appears to be a typographical error and should be page 517.

degenerative knee arthritis was not relevant to choosing the diagnostic criteria. He explained that the major difference between the calculations of Dr. Weiss and DMA Dr. Magliato was Dr. Weiss' assumption that the accepted condition was primary knee joint osteoarthritis, which was contrary to the SOAF. Dr. Fries indicated that he was unable to follow DMA Dr. Magliato's March 6, 2014 impairment calculations. He explained that while DMA Dr. Magliato agreed with him, that the impairment rating should have been based on a CDX of partial medial meniscectomy with a default value of two percent and not on a default value of one percent as used by DMA Dr. Magliato. Dr. Fries notified OWCP that he had not been provided the radiographs he was asked to review as part of his evaluation. As the imaging studies were not forthcoming, he considered it appropriate to issue his report in a timely manner. Dr. Fries related that when he was presented with the images he would issue an addendum report although it was unlikely that his above-noted reasoned opinions and impairment rating would change. He noted that, assuming the radiographs showed more significant findings, he related that this may move the grade modifier for GMCS to 2 based on Table 16-8, page 519. Dr. Fries then applied the net adjustment formula to Dr. Rosenberg's and his own finding (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (0 - 2) + (0 - 2) + (2 - 2) = -4, which still resulted in a grade A, one percent permanent impairment of the left lower extremity.⁷

In a December 15, 2014 report, Dr. Andrew A. Merola, a Board-certified orthopedic surgeon serving as a DMA, reviewed Dr. Fries' October 25, 2014 report. The DMA agreed with Dr. Fries' one percent left lower extremity permanent impairment rating. He advised that appellant reached MMI on October 25, 2014 the date of Dr. Fries' impairment evaluation.

By decision dated January 6, 2015, OWCP denied an additional schedule award for the left lower extremity, finding that the weight of the medical evidence rested with the opinions of Dr. Fries, the IME, and its DMA, Dr. Merola. It noted that he had already been compensated for three percent permanent impairment of the left lower extremity.

On January 12, 2015 appellant, through counsel, again requested an oral hearing before an OWCP hearing representative. By decision dated May 11, 2015, OWCP's hearing representative found that the case was not in posture for a hearing and set aside the January 6, 2015 decision because Dr. Fries noted that he had not received the left knee x-ray films that he was requested to review. She remanded the case to OWCP to forward the subject x-ray films to Dr. Fries and obtain a supplemental report from him rating the employee's left lower extremity impairment under the sixth edition of the A.M.A., *Guides*.

Dr. Fries, in a June 29, 2015 letter, noted that he had reviewed the January 18, 2011 left knee x-ray films. He reported that the x-rays revealed a normal femur, tibia, and fibula. There were no fracture nor dislocations. Minor medial compartment osteophytes off the femur and tibia were only seen with magnification. There was no other evidence of arthritis. These would be common at the employee's age and there was no evidence of symptoms or significant pathology. Medial and lateral joint line measurements were five and six millimeters (mm) on one series of the x-rays and six and seven mm on another series of the x-rays. Dr. Fries related that the differences were well within expected inherent measurement errors. More importantly measurements were

⁷ Dr. Fries also applied the same formula to Dr. Weiss' and his own finding and calculated (1 - 2) + (2 - 2) + (2 - 2) = -1, a grade B, two percent permanent impairment of the left lower extremity.

insufficient to qualify the employee for the primary joint arthritis criteria (Table 16-3, page 511, Diagnostic Criteria (Key Factor) primary knee joint arthritis). Dr. Fries advised that Dr. Weiss' February 25, 2011 findings that the January 18, 2011 x-ray films revealed a medial joint space that measured two cm and a lateral joint space that measured three cm were preposterously large. He maintained that typical knee joint spaces measure less than one cm. Dr. Fries related that he could not give any credence to the use of these "bogus measurements." He also referenced Dr. Weiss' October 11, 2013 report which indicated that the medial joint space measured two mm as demonstrated by the January 18, 2011 x-ray films. Dr. Fries noted that this was not verified by the computer-based measurements he had performed. He related that such narrowing would be obvious visually, even without measurement, and typically would be accompanied by other findings such as, subchondral sclerosis, varus malalignment, and endplate erosions. Dr. Fries summarized that the January 18, 2011 left knee radiographs did not evidence pathology other than minor medial compartment osteophytes common at the employee's age. He concluded that Dr. Weiss' assessment was not credible. Dr. Fries indicated that his impairment rating was based on the accepted condition of aggravation of degeneration of the left medial meniscus resulting in the employee's authorized February 25, 2010 arthroscopic partial medial meniscectomy and debridement of the medial femoral condyle and patellofemoral joint. He reiterated his opinion that the employee had one percent permanent impairment of the left lower extremity. Dr. Fries determined that the employee reached MMI on May 24, 2010.

On July 24, 2015 DMA Dr. Merola reviewed a SOAF and Dr. Fries' October 24, 2014 and June 29, 2015 findings. He again agreed with Dr. Fries' impairment rating. The DMA determined that the date of MMI was May 17, 2010, the date the employee returned to full-duty work.

OWCP, by decision dated August 27, 2015, continued to find that the special weight of the medical evidence rested with the opinions of the IME physician Dr. Fries and DMA Dr. Merola, and again concluded that the employee was not entitled to an additional schedule award for the left lower extremity.

On September 2, 2015 counsel, on behalf of appellant, again requested an oral hearing before an OWCP hearing representative.

By decision dated March 22, 2016, the hearing representative set aside the August 27, 2015 decision, finding that DMA Dr. Merola did not adequately show an independent application of Dr. Fries' findings to confirm that his impairment calculations were proper. She further found that the August 27, 2015 decision was not technically correct in denying an increased schedule award as the March 13, 2014 decision, which granted the employee a schedule award for three percent left lower extremity permanent impairment, had been set aside because a conflict in medical opinion remained unresolved. The hearing representative remanded the case for OWCP to refer the case to a DMA to confirm Dr. Fries' impairment calculations under the sixth edition of the A.M.A., *Guides*.

In an August 15, 2016 report, Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a DMA, reviewed a SOAF and the medical record, including Dr. Fries' June 29, 2015 findings. The DMA recommended that the employee undergo another referee examination, including a physical examination by Dr. Fries or a different referee examiner because it appeared that Dr. Fries had not performed an examination on the employee in over five years. He explained

that this was problematic since Dr. Fries' opinion regarding examination findings should be his alone and not obtained from another physician. For this reason, Dr. Katz opined that his referee examination could not be accepted since no examination appeared to have been performed based on the records reviewed.

On October 6, 2016 OWCP routed an updated SOAF, which indicated that the employee had passed away on October 30, 2013, and the employee's case file, including Dr. Fries' June 29, 2015 report, to DMA Dr. Katz, and requested that he clarify his August 15, 2016 report and determine whether Dr. Fries correctly applied the criteria/tables of the A.M.A., *Guides*.

In an October 13, 2016 report, DMA Dr. Katz reviewed the updated SOAF and Dr. Fries' June 29, 2015 findings. He found a CDX of 1 for a partial medial or lateral meniscectomy, with a default grade C impairment value of two percent under Table 16-3, page 509. The DMA further found a grade modifier 0 for GMFH and GMPE and a grade modifier 1 for GMCS. He utilized the net adjustment formula $(GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (0 - 1) + (0 - 1) + (1 - 1) = -2$ which moved the grade C default value of two percent to a class 1, grade A, one percent permanent impairment of the left lower extremity. The DMA noted that Dr. Fries incorrectly performed the net adjustment formula as he used a CDX of 2 rather than 1. Dr. Katz advised that the date of MMI was May 24, 2010, the examination upon which Dr. Fries based his impairment evaluation.

OWCP, by decision dated January 9, 2017, determined that the special weight of the medical evidence rested with the opinions of Dr. Fries and its DMA, Dr. Katz, and again concluded that the employee was not entitled to an additional schedule award. It noted that the employee was previously paid a schedule award for three percent permanent impairment of the left lower extremity and the evidence of record established that he had no additional impairment.

On January 23, 2017 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

By decision dated September 11, 2017, OWCP's hearing representative affirmed the January 9, 2017 decision, finding that the special weight of the medical evidence rested with Dr. Fries' impartial medical opinion.

LEGAL PRECEDENT

The schedule award provisions of FECA⁸ and its implementing regulations⁹ 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. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate

⁸ 5 U.S.C. § 8107.

⁹ 20 C.F.R. § 10.404.

standard for evaluating schedule losses.¹⁰ As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).¹¹ 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.¹²

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).¹³ 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 509.¹⁴ 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).¹⁵ 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.¹⁶

Section 8123(a) provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.¹⁷ In situations where 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.¹⁸

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish more than three percent impairment of the employee's left lower extremity, for which he previously received a schedule award.

¹⁰ *Id.* See also, *Ronald R. Kraynak*, 53 ECAB 130 (2001).

¹¹ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (March 2017).

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

¹³ A.M.A., *Guides* 3, section 1.3, ICF: A Contemporary Model of Disablement.

¹⁴ See A.M.A., *Guides* 509-11 (6th ed. 2009).

¹⁵ *Id.* at 515-22.

¹⁶ *Id.* at 23-8.

¹⁷ 5 U.S.C. § 8123(a); see also 20 C.F.R. § 10.321.

¹⁸ *K.D.*, Docket No. 19-0281 (issued June 30, 2020); *J.W.*, Docket No. 19-1271 (issued February 14, 2020).

OWCP properly found a conflict in the medical opinion evidence regarding permanent impairment between the employee's attending physician, Dr. Weiss, and the government physician, Dr. Magliato, serving as a DMA. It properly referred the employee's case to Dr. Fries pursuant to 5 U.S.C. § 8123(a) for an impartial medical examination in order to resolve the conflict in medical opinion.¹⁹

In his initial report dated October 25, 2014, Dr. Fries, the IME, discussed the employee's history of injury and his medical records. He related that his impairment calculations would be based on the most recent functional history and physical examination findings set forth in Dr. Rosenberg's May 24, 2010 report and Dr. Weiss' November 30, 2010 report since he did not have an opportunity to examine the employee. Utilizing Table 16-3, page 509 of the sixth edition of the A.M.A., *Guides*, Dr. Fries found a CDX of 1 for a partial (medial or lateral) meniscectomy, meniscal tear, or meniscal repair of the left knee, which yielded a default value of two percent. He explained that Dr. Weiss' CDX of degenerative knee arthritis was not relevant to choosing the diagnostic criteria as the SOAF indicated that the only accepted condition was aggravation of degeneration of the left medial meniscus. Based on Dr. Rosenberg's findings, Dr. Fries assigned a grade modifier 0 for GMFH and GMPE under Table 16-6, page 516 and Table 16-7, page 519, respectively. Based on Dr. Weiss' findings, he assigned a grade modifier 1 for GMFH under Table 16-6 and a grade modifier 2 for GMPE under Table 16-7. Dr. Fries assigned a grade modifier 1 for GMCS under Table 16-8, page 519 based on left knee x-rays mentioned in the case record that showed some medial compartment narrowing. He applied Dr. Rosenberg's and his own finding to the net adjustment formula $(GMFH - CDX) + (GMPE - CDX) = (0 - 2) + (0 - 2) + (1 - 2) = -5$, which resulted in a grade A, one percent permanent impairment of the left lower extremity. Dr. Fries applied the same formula to Dr. Weiss' and his own finding and calculated $(1 - 2) + (2 - 2) + (1 - 2) = -2$, which also resulted in a grade A, one percent permanent impairment of the left lower extremity. He indicated that he had not been provided the x-rays he was asked to review as part of his evaluation. Dr. Fries related that he would issue an addendum report after he received and reviewed these x-rays. He advised, however, that it was unlikely that his above-noted reasoned opinions and impairment rating would change. Dr. Fries noted that, assuming the x-rays showed more significant findings, the grade modifier for GMCS could be 2 under Table 16-8, page 519. He then applied Dr. Rosenberg's findings and his own finding to the net adjustment formula $(GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (0 - 2) + (0 - 2) + (2 - 2) = -4$, which still resulted in a grade A, one percent permanent impairment of the left lower extremity. Dr. Fries also applied Dr. Weiss' findings and his own finding to the same formula and calculated $(1 - 2) + (2 - 2) + (2 - 2) = -1$, which resulted in a grade B, two percent permanent impairment of the left lower extremity.

In a supplemental letter dated June 29, 2015, Dr. Fries noted his review of the January 18, 2011 left knee x-ray films and reiterated his opinion that the employee had one percent permanent impairment of the left lower extremity. He advised that the x-rays did not demonstrate pathology such as primary joint arthritis other than minor medial compartment osteophytes common for the employee's age. Dr. Fries further advised that Dr. Weiss' bogus measurements of two cm for medial joint space and three cm for lateral joint space, which were based on Dr. Weiss' review of

¹⁹ *Id.*, see also *E.M.*, Docket No. 19-1535 (issued August 27, 2020); *B.S.*, Docket No. 19-1717 (issued August 11, 2020); *W.C.*, Docket No. 19-1740 (issued June 4, 2020).

the January 18, 2011 x-rays, were not credible. He explained that typical knee joint spaces measure less than one cm. Dr. Fries also explained that he could not verify Dr. Weiss' measurements by the computer-based measurements he had performed. He noted that such narrowing would be obvious visually, even without measurement, and typically would be accompanied by other findings such as, subchondral sclerosis, varus malalignment, and endplate erosions. Dr. Fries concluded that the date of MMI was May 24, 2010.

On October 13, 2016 DMA Katz reviewed Dr. Fries' supplemental opinion and agreed with his one percent left lower extremity permanent impairment rating. He noted, however, that Dr. Fries improperly applied the net adjustment formula as his calculations were based on a CDX of 2 rather than a CDX of 1. The DMA found that a CDX of 1 for a partial medial or lateral meniscectomy, represented a default grade C impairment value of two percent under Table 16-3, page 509. He assigned a grade modifier 0 for GMFH and GMPE, and a grade modifier 1 for GMCS. The DMA utilized the net adjustment formula $(GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (0 - 1) + (0 - 1) + (1 - 1) = -2$ which moved the grade C default value of two percent to a class 1, grade A, one percent permanent impairment of the left lower extremity. The Board notes that, while Dr. Fries applied the net adjustment formula using a CDX of 2 rather than a CDX of 1 which he properly identified under Table 16-3, this is harmless error as Dr. Fries' calculations also resulted in a one percent left lower extremity impairment rating.

The Board finds that Dr. Fries accurately summarized the relevant medical evidence, provided detailed findings on examination, and reached conclusions about appellant's condition which comported with his findings.²⁰ As his report is detailed, well rationalized, and based on a proper factual background, his opinion is entitled to the special weight accorded an IME.²¹

On appeal counsel contends that there remains a conflict in the medical opinion evidence as Dr. Fries' left lower extremity impairment rating does not include the employee's impairment due to his preexisting primary knee osteoarthritis which served as the basis for Dr. Weiss' left lower extremity impairment rating. As previously discussed, Dr. Fries provided adequate medical rationale explaining why the employee did not have permanent impairment due to primary knee osteoarthritis. In addition, he explained his calculations in conformance with the sixth edition of the A.M.A., *Guides*, establishing that the employee had no more than one percent permanent impairment of the left lower extremity.

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.

²⁰ *W.H.*, Docket No. 19-0102 (issued June 21, 2019); *J.M.*, Docket No. 18-1387 (issued February 1, 2019).

²¹ *W.H.*, *id.*

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish more than three percent impairment of the employee's left lower extremity, for which he previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the September 11, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 2, 2020
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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