United States Department of Labor
Employees' Compensation Appeals Board

C.E., Appellant	)	
and	)	**Docket No. 16-1079**
	)	**Issued: November 3, 2016**
DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF PRISONS, LA TUNA, Anthony, NM, Employer	)	

Appearances:
Fernando Dominguez, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 26, 2016 appellant, through her representative, filed a timely appeal of a November 9, 2015 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 to consider the merits of the case.[3]

[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 appellant submitted additional evidence after OWCP rendered its November 9, 2015 decision. The Board's jurisdiction is limited to reviewing the evidence that was before OWCP at the time of its final decision. Therefore the Board lacks jurisdiction to review this additional evidence on appeal. 20 C.F.R. § 501.2(c)(1).

ISSUE

The issue is whether appellant has more than two percent permanent impairment of each of her lower extremities for which she received schedule awards.

On appeal appellant's representative contends that Dr. Joshua Herzog's report contained factual and medical errors and that his examination was cursory such that appellant's attending physician's evaluation was the weight of the medical evidence.

FACTUAL HISTORY

On December 5, 2013 appellant, then a 39-year-old senior officer specialist, filed a traumatic injury claim (Form CA-1) alleging that on that date she tripped on an uneven curb which caused her to fall on her knees, torso, and the palm of her hands. She had difficulty arising and immediate bilateral knee pain. Appellant sought medical treatment from Dr. Charles B. Broome, an orthopedic surgeon, on December 5, 2013 who noted that appellant had experienced prior internal derangement of her left knee including a tear of the medial cartilage and a bucket-handle tear of the lateral meniscus on October 1, 2013. Dr. Broome reviewed bilateral lower leg x-rays and diagnosed bilateral knee contusions on December 5, 2013.

In a note dated December 18, 2013, Dr. Broome reported appellant's improvement in her left knee, but localized pain, swelling, and stiffness in the right knee with locking, buckling, and sharp lateral pain. Appellant underwent a chest x-ray on January 3, 2014 which was normal. She underwent a right knee arthroscopic partial lateral meniscectomy on January 7, 2014 due to an acute tear of the posterior horn of the lateral meniscus. On January 8, 2014 OWCP accepted appellant's claim for bilateral knee contusions.

Appellant submitted an operative report dated January 25, 2014 for left knee arthroscopy and partial resection of the medial meniscus with chondroplasty. OWCP accepted the additional conditions of aggravation of unspecified internal derangement of the right knee, tear of the medial meniscus of the right knee and tear of the medial meniscus of the left knee on March 5, 2014. On March 21, 2014 OWCP corrected the March 5, 2014 decision to include acceptance of bilateral knee contusions, aggravation of unspecified internal derangement of the right knee, and tear of the right lateral meniscus.

Appellant reported that her left knee meniscectomy was necessitated by a nonemployment-related motor vehicle accident occurring in 2012. She returned to part-time, light-duty work on April 4, 2014.

Dr. Alvaro A. Hernandez, a Board-certified orthopedic surgeon, examined appellant on June 2, 2014. He reported appellant's history of injury and right knee surgery. Dr. Hernandez found severe swelling of the right knee, constant pain, and appellant's report of a feeling of weakness in the knee. He noted that appellant was limping and found tenderness over the lateral joint line and patellofemoral joint in the right knee. Dr. Hernandez reported atrophy on the right with mild patellofemoral crepitus. He diagnosed chondromalacia of the right knee. On June 16, 2014 Dr. Hernandez examined appellant and reviewed a June 5, 2014 magnetic resonance

imaging (MRI) scan of the right knee which demonstrated a complex tear of the lateral meniscus, a free margin tear of the medial meniscus and grade three chondromalacia of the medial femoral condyle with subchondral edema. He diagnosed lateral and medial meniscus tears in the right knee. On June 25, 2014 Dr. Hernandez recommended repeat right arthroscopic knee surgery.

Dr. Hernandez performed a comprehensive arthroscopy of the right knee on July 24, 2014 which included a partial lateral meniscectomy and chondroplasty of the medial and lateral compartments of the right knee.

Dr. Hernandez examined appellant on November 10, 2014 and found mild tenderness in her right knee with no anterolateral instability, stable medial collateral ligament, and a negative anterior drawer test. He indicated that appellant could return to regular duty work. Dr. Hernandez referred appellant for a maximum medical improvement (MMI) evaluation. Appellant returned to full duty on November 11, 2014.

On January 7, 2015 appellant filed a claim for compensation (Form CA-7) requesting a schedule award. In a report dated December 29, 2014, Dr. Michael Boone, a Board-certified physiatrist, found that appellant had reached MMI on December 29, 2014. He reported appellant's history of injury and medical treatment. Dr. Boone noted appellant's ongoing constant medial knee pain with difficulties arising from a sitting position. He found no instability in the right knee, with no effusion, no instability to valgus stressing, and a negative Lachman's sign. Dr. Boone reported medial joint line tenderness. He listed appellant's right knee range of motion as 0 degrees of extension and 90 degrees of flexion.[4] Dr. Boone applied the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[5] and found that partial medial and lateral meniscectomies were a class 1 impairment with 10 percent default lower extremity impairment.[6] He opined that appellant had a mild deficit in range of motion yielding a grade 1 physical examination adjustment factor.[7] Dr. Boone noted that the MRI scan study with confirmation of medial and lateral meniscal tears resulted in a grade 1, clinical studies adjustment factor.[8] He further noted that appellant's lower limb questionnaire resulted in a mild or grade 1, functional history adjustment factor. Dr. Boone applied the formula of the A.M.A., *Guides* and determined that appellant's adjustment was 0 resulting in 10 percent impairment of the right lower extremity.

OWCP's medical adviser reviewed Dr. Boone's report on January 28, 2015 and found that the operative reports did not support a right knee partial medial meniscectomy, but rather two partial lateral meniscectomies. He further noted that appellant's claim had been accepted for bilateral knee conditions and that appellant underwent a left knee arthroscopy on January 25,

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[4] *Id*. at 549, Table 16-23.

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

[6] *Id*. at 509, Table 16-3.

[7] *Id*. at 517, Table 16-27.

[8] *Id*. at 519, Table 16-8.

2014 which was not included in Dr. Boone's impairment rating. OWCP requested an additional report from Dr. Boone due to these defects.

OWCP requested a supplemental report from Dr. Boone on March 26, 2015 addressing the absence of a partial medial meniscectomy on the right. It also requested that he address appellant's permanent impairment of her left lower extremity.

In a March 27, 2015 report, Dr. Boone noted that appellant underwent a partial medial meniscectomy of the left knee on January 25, 2014. He found no obvious effusion or angulation of the left knee, but reported some medial joint space tenderness. Dr. Boone including that appellant's range of motion of her left knee was 0 to 109 degrees. He found that appellant's loss of range of motion was grade modifier 1 for physical examination adjustment,[9] that her clinical studies adjustment was grade modifier 1 as her MRI scan confirmed this problem,[10] and that appellant's questionnaire resulted in a grade modifier 1 for functional history adjustment.[11] Dr. Boone concluded that appellant had 10 percent lower extremity impairment due to loss of range of motion.[12]

On April 13, 2015 OWCP's medical adviser reviewed Dr. Boone's supplemental report and found that he continued to apply impairment ratings based on both medial and lateral meniscectomies of both knees. He requested referral to a second opinion evaluator.

OWCP referred appellant for a second opinion evaluation with Dr. Joshua P. Herzog, a Board-certified orthopedic surgeon, on May 27, 2015.

Dr. Hernandez examined appellant on April 27, 2015 due to increased left knee pain. He attributed this condition to appellant compensating for the right knee as it hurt more. Appellant underwent a left knee MRI scan on May 14, 2015 which demonstrated a discoid lateral meniscus, but no other abnormalities. On May 27, 2015 Dr. Hernandez reviewed appellant's left knee MRI scan and noted that she experienced pain with compression of the patella against the front of the femur. He diagnosed chondromalacia of the left knee and recommended a joint injection. On July 15, 2015 Dr. Hernandez found that appellant's left knee pain had improved.

Dr. Herzog examined appellant on July 16, 2015 and reviewed her history of injury and medical treatment. Right knee palpation demonstrated tenderness over the lateral joint line while left knee palpation revealed tenderness over the medial joint line. Dr. Herzog reported mild effusion bilaterally, with negative valgus, varus, Lachman's, McMurray's, and posterior drawer tests bilaterally. He found that appellant's range of motion in her bilateral knees was within normal limits from 0 to 120 degrees. Appellant's sensory testing was also within normal limits as was her strength testing. Dr. Herzog found that appellant had reached MMI. He diagnosed bilateral knee contusion, right knee lateral meniscus tear and left knee medial meniscus tear.

[9] *Id*. at 549, Table 16-23; 517, Table 16-7.

[10] *Id*. at 519, Table 16-8.

[11] *Id*. at 516, Table 16-6.

[12] *Id*. at 549, Table 16-23.

Dr. Herzog applied the A.M.A., *Guides* and noted that appellant's right knee with two partial lateral meniscectomies was class 1 impairment with a default value of 2.[13] He determined that appellant's grade modifiers were grade 1 and that her net adjustment was 0. Dr. Herzog found that appellant had two percent impairment of the right lower extremity. He found that a partial left medial meniscectomy was class 1 impairment.[14] Dr. Herzog found that appellant's grade modifiers for functional history, and physical examination were grade 1. He noted that there were no clinical studies available prior to appellant's left medial meniscectomy, and awarded clinical studies grade modifier of 0. Dr. Herzog applied the net adjustment formula and determined that appellant had an adjustment of negative one or grade B impairment of two percent of the left lower extremity.[15]

OWCP's medical adviser reviewed Dr. Herzog's report on August 21, 2015 and agreed with his findings and conclusions.

By decision dated November 9, 2015, OWCP granted appellant schedule awards for two percent permanent impairment of each of her lower extremities.

LEGAL PRECEDENT

The schedule award provision of FECA[16] and its implementing regulations[17] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of use of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such 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*.[18]

The protocol and formula of the sixth edition of the A.M.A., *Guides* requires that the physician determine the Class of Diagnosis (CDX) for the lower extremity and apply the appropriate grade modifiers for Functional History, (GMFH) Physical Examination (GMPE) and

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

[14] *Id.*

[15] *Id.*

[16] 5 U.S.C. §§ 8101-8193, 8107.

[17] 20 C.F.R. § 10.404.

[18] For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards,* Chapter 3.700, Exhibit 1 (January 2010).

Clinical Studies (GMCS) and apply the following formula (GMFH - CDX) + (GMPE - CDX) + (GMCS – CDX) to reach the appropriate Grade within the class of diagnosis.[19]

ANALYSIS

The Board finds that appellant has no more than two percent permanent impairment of each of her lower extremities for which she received schedule awards.

In support of her claim for schedule awards, appellant submitted reports from Dr. Boone dated December 29, 2014 and March 27, 2015. In his initial report, Dr. Boone did not base his right leg impairment rating on a proper history of injury. Instead, he determined that appellant had both medial and lateral meniscectomies in the right knee and based his impairment rating on this erroneous conclusion. The record establishes that appellant underwent two separate partial lateral meniscectomies on the right, but no medial meniscectomy. Dr. Boone completed a supplemental report on March 27, 2015 addressing appellant's permanent impairment of her left lower extremity. In this report, he based his impairment rating of 10 percent on appellant's loss of range of motion of her left knee. The Board notes that the A.M.A., *Guides* provide that diagnosis-based impairment is the method of choice for calculating impairment.[20] Dr. Boone did not provide an explanation of why he believed that this impairment rating was more appropriate than the diagnosis-based estimates favored by the A.M.A., *Guides*. Without any explanation, the March 27, 2015 report is insufficient to establish appellant's permanent impairment of her left lower extremity for schedule award purposes.

OWCP's medical adviser reviewed Dr. Boone's reports and noted the defects described above. He requested a second opinion evaluation. It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides* his opinion is of diminished probative value in establishing the degree of permanent impairment and OWCP may rely on the opinion of its medical adviser.[21]

Contrary to appellant's arguments on appeal Dr. Herzog's opinion is entitled to the weight of the medical opinion evidence in establishing her permanent impairment for schedule award purposes. He properly applied the diagnosis-based estimates and determined the Class of appellant's impairments, noting that appellant's right lateral partial meniscectomy and left medial partial meniscectomy both had class 1 grade C impairments of two percent.[22] Dr. Herzog then determined the grade modifiers for functional history, physical examination, and clinical studies and applied the formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS – CDX) to reach the appropriate grade within the class of diagnosis finding grade C for appellant's right lower extremity and grade B for appellant's left lower extremity or two percent impairment of each of appellant's lower extremities. OWCP's medical adviser concurred with Dr. Herzog's findings and conclusions.

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[19] A.M.A., *Guides* 521.

[20] *Id*. at 461.

[21] *Linda Beale*, 57 ECAB 429, 434 (2006).

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

The Board finds that the weight of the medical opinion evidence, based on a proper factual background and well-reasoned application of the A.M.A., *Guides*, as represented by the reports of Dr. Herzog and OWCP's medical adviser, established that appellant has no more than two percent permanent impairment of each of her lower extremities for which she has received schedule awards.

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 no more than two percent permanent impairment of each of her lower extremities for which she has received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the November 9, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 3, 2016
Washington, DC

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

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

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