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

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| **S.H., Appellant** | ) | |
| **and** | ) | **Docket No. 17-0174** |
| | ) | **Issued: May 8, 2017** |
| **U.S. POSTAL SERVICE, POST OFFICE, Fairborn, OH, Employer** | ) | |

*Appearances:*
*Alan J. Shapiro, Esq.*, 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 November 3, 2016 appellant, through counsel, filed a timely appeal from a September 13, 2016 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.

### ***ISSUE***

The issue is whether appellant has more than 13 percent permanent impairment of the left lower extremity, for which she previously received a schedule award.

[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.*

## ***FACTUAL HISTORY***

On July 29, 2008 appellant, then a 41-year-old mail carrier, filed a traumatic injury claim (Form CA-1) alleging that on July 23, 2008 she injured her left knee when she slipped on a step in the performance of duty. OWCP accepted the claim on December 23, 2008 for buttock contusion, left knee sprain/strain, and left knee medial meniscus tear. Appellant received wage-loss compensation from February 10 to March 14, 2009.

The record indicates that on January 25, 2011 appellant underwent a left knee partial medial meniscectomy, performed by Dr. Kevin Paley, an orthopedic surgeon. She filed a claim for a recurrence of disability (Form CA-2a) and began receiving wage-loss compensation as of January 25, 2011. On July 1, 2013 appellant accepted a job offer from the employing establishment for a modified letter carrier position.

Appellant filed a claim for a schedule award (Form CA-7) on March 11, 2014. By decision dated May 5, 2014, OWCP found appellant was not entitled to a schedule award. It found there was no medical evidence of record supporting a left knee permanent impairment.

Appellant, through counsel, requested a hearing before an OWCP hearing representative on May 8, 2014. The hearing was held on December 2, 2014.

In a report dated December 8, 2014, Dr. Martin Fritzhand, a Board-certified urologist, provided a history and results on examination. Flexion of the left knee was 90 degrees, and flexion contracture 20 degrees. Dr. Fritzhand opined that appellant had reached maximum medical improvement (MMI) in January 2014. As to permanent impairment of the left lower extremity, he applied Table 16-23 for knee range of motion. Dr. Fritzhand opined that there was no category on the diagnosis-based grid to account for appellant's permanent impairment. Based on Table 16-23, he found 10 percent permanent impairment for loss of flexion and 35 percent for loss of flexion contracture, totaling 45 percent left lower extremity permanent impairment.

By decision dated February 18, 2015, the hearing representative set aside OWCP's May 5, 2014 decision and remanded the case to OWCP. She found the evidence was sufficient to warrant referral of the evidence to an OWCP medical adviser.

In a report dated April 8, 2015, Dr. Morley Slutsky, an OWCP medical adviser Board-certified in occupational medicine, opined that appellant had five percent left lower extremity permanent impairment. He found that Table 16-3, the knee regional grid, should be applied, with a diagnosis of left knee patellofemoral arthritis.

OWCP thereafter found that a conflict in the medical evidence was created, and Dr. James Davidson, a Board-certified orthopedic surgeon, was selected as a referee physician. In a report dated June 27, 2015, Dr. Davidson found that appellant had 13 percent permanent impairment under Table 16-3. He indicated that the diagnosis was left knee strain, with moderate loss of range of motion.

Another OWCP medical adviser, Dr. Daniel Zimmerman, an internist, reviewed the evidence and provided a July 26, 2015 report. He opined that appellant had 12 percent left lower

extremity permanent impairment under Table 16-3 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).

On July 28, 2015 OWCP expanded acceptance of the claim to include aggravation of left knee arthritis. It also requested that Dr. Davidson provide clarification of his opinion regarding permanent impairment. In an August 26, 2015 note, OWCP indicated that his office had informed OWCP that he would not provide an additional report.

OWCP then selected Dr. Bernard Bacevich, a Board-certified orthopedic surgeon, as a referee physician. In a report dated October 1, 2015, Dr. Bacevich provided a history and results of a September 30, 2015 examination. He reported 115 degrees of flexion, with 23 degrees flexion contracture in the left knee. Dr. Bacevich indicated that he would use the diagnosis of sprain/strain under Table 16-3. He wrote, "Since [appellant's] primary problem has been loss of motion, this would be a more appropriate category" than using a meniscal injury diagnosis under Table 16-3. Dr. Bacevich opined that appellant had moderate motion deficits and/or significant weakness, with 10 percent (grade C) default impairment. He found that appellant had 13 percent permanent impairment based on +2 adjustment to grade E, based on functional history, physical examination, and clinical studies.

In a report dated December 3, 2015, another OWCP medical adviser, Dr. Michael M. Katz, opined that Dr. Bacevich correctly applied the A.M.A., *Guides*. He reported the date of MMI was September 30, 2015.

By decision dated December 17, 2015, OWCP issued a schedule award for 13 percent left lower extremity permanent impairment. The period of the award was 37.44 weeks from January 8, 2014.

On December 28, 2015 appellant, through counsel, requested a hearing before an OWCP hearing representative. On April 13, 2016 appellant submitted a report dated March 18, 2016 from Dr. Fritzhand. He opined that loss of range of motion was the appropriate methodology to determine permanent impairment in this case. A hearing was held on August 3, 2016.

By decision dated September 13, 2016, the hearing representative found appellant did not establish more than 13 percent left lower extremity permanent impairment for which she previously received a schedule award. The hearing representative found the weight of the evidence was represented by Dr. Bacevich.

## ***LEGAL PRECEDENT***

5 U.S.C. § 8107 provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[3] Neither FECA nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be

[3] 5 U.S.C. § 8107. This section enumerates specific members or functions of the body for which a schedule award is payable and the maximum number of weeks of compensation to be paid; additional members of the body are found at 20 C.F.R. § 10.404(a).

determined. For consistent results and to ensure equal justice for all claimants OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[4] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition.[5]

With respect to a knee impairment, the A.M.A., *Guides* provides a regional grid at Table 16-3.[6] The Class of Diagnosis (CDX) is determined based on specific diagnosis, and then the default value for the identified CDX is determined. The default value (grade C) may be adjusted by using grade modifiers for functional history, physical examination, and clinical studies. Table 16-23 of the A.M.A., *Guides* provides a method of evaluating leg permanent impairment based on knee motion impairments for loss of flexion or loss of flexion contracture.[7]

## ***ANALYSIS***

OWCP had found a conflict in the evidence under 5 U.S.C. § 8123(a) with regard to appellant's left knee permanent impairment and selected a referee physician.[8] Dr. Fritzhand had opined that appellant had 45 percent permanent impairment under Table 16-23, for loss of left knee range of motion. An OWCP medical adviser, Dr. Slutsky, found the impairment was five percent under Table 16-3, the diagnosis-based regional grid for the knee. The initial physician selected as a referee, Dr. Davidson, provided a June 27, 2015 report. When asked to provide clarification, Dr. Davidson declined, and OWCP then selected Dr. Bacevich.[9]

The October 1, 2015 report from Dr. Bacevich opined that appellant had 13 percent permanent impairment under the diagnosis-based regional grid, Table 16-3, but there was an issue that he failed to address prior to the application of Table 16-3. The A.M.A., *Guides* indicate that the diagnosis-based method is the primary method of lower extremity permanent impairment evaluation.[10] This does not mean, however, that the range of motion method under

[4] *A. George Lampo*, 45 ECAB 441 (1994).

[5] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Award*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

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

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

[8] 5 U.S.C. § 8123(a) provides that when there is a disagreement between the physician making the examination for the United States and the physician of the employee, a third physician shall be appointed to make an examination to resolve the conflict.

[9] At the August 3, 2016 hearing, counsel indicated that he had not seen evidence regarding the selection of Dr. Bacevich. The record contains a ME023 appointment notification and a bypass history, in accord with OWCP procedures. Federal (FECA) Procedure Manual, Part 3 -- Medical, *OWCP Directed Medical Examinations*, Chapter 3.500.5 (May 2013).

[10] *Supra* note 6 at 497.

Table 16-23 is precluded,[11] nor has the Board held that using Table 16-23 to evaluate a lower extremity permanent impairment is without probative value.[12]

Dr. Bacevich did not address the issue of whether a range of motion evaluation under Table 16-23 would be appropriate. He applied Table 16-3, and referred only to the use of the knee strain diagnosis under that table. It is particularly important to address the issue of whether Table 16-23 would be applicable in this case, as (1) Dr. Fritzhand used such an approach, and (2) Dr. Bacevich himself indicated that appellant's "primary problem has been loss of motion." Dr. Bacevich's examination results indicated a flexion contracture of 23 degrees, which would be 35 percent permanent impairment of the lower extremity under Table 16-23.[13]

The case will be remanded to OWCP to secure a clarifying report from the referee physician.[14] Dr. Bacevich should be asked to explain whether application of Table 16-23 would be appropriate in this case under the A.M.A., *Guides* to properly determine the left lower extremity permanent impairment.

The Board also notes that the December 17, 2015 schedule award commenced on January 8, 2014. The period covered by a schedule award commences on the date that the claimant reaches MMI from the residuals of the injury. The determination of such date is to be made in each case upon the basis of the medical evidence in that case.[15] Dr. Bacevich examined appellant on September 30, 2015, and OWCP's medical adviser, Dr. Katz, had used this date as the MMI date. On return of the case record OWCP should clarify the date of MMI in this case and explain its findings. After such further development as is deemed necessary, OWCP should issue a *de novo* decision.

## ***CONCLUSION***

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

[11] The A.M.A. *Guides* notes that in some cases range of motion will serve as an alternate approach. *Supra* note 6 at 500. When regional grids refer to the range of motion section, or no diagnosis-based approach is applicable, range of motion may be used as a stand-alone method.

[12] When an attending physician has provided a probative medical opinion using Table 16-23, the Board has indicated the evidence is sufficient to require further development. *See P.W.*, Docket No. 16-0684 (issued October 3, 2016); *J.D.*, Docket No. 16-0207 (issued June 3, 2016); *D.F.*, Docket No. 15-0664 (issued January 8, 2016).

[13] *Supra* note 6 at 549.

[14] A referee physician must resolve the conflict in the medical evidence, not an OWCP medical adviser or other physician. *Richard R. Lemay*, 56 ECAB 341 (2005).

[15] *L.H.*, 58 ECAB 561 (2007).

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated September 13, 2016 is set aside and the case remanded for further action consistent with this decision of the Board.

Issued: May 8, 2017
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