United States Department of Labor
Employees' Compensation Appeals Board

G.S., Appellant	)	
and	)	**Docket No. 17-0481**
	)	**Issued: July 25, 2018**
DEPARTMENT OF TRANSPORTATION, FEDERAL AVIATION ADMINISTRATION, Reno, NV, 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 January 3, 2017 appellant, through counsel, filed a timely appeal from a November 14, 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.

[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 his burden of proof to establish a permanent impairment of a scheduled member entitling him to a schedule award.

FACTUAL HISTORY

On June 18, 2012 appellant, then 65-year-old aviation safety inspector filed a traumatic injury claim (Form CA-1) alleging that on that date he twisted his right knee when getting up from his chair while at work. He did not stop work.

On March 22, 2013 OWCP accepted appellant's claim for sprain of the right knee, lateral collateral ligament on the right.[3]

In a March 29, 2013 report, Dr. Renny Uppal, Board-certified in orthopedic sports medicine and surgery, noted that appellant injured his knee at work. He opined that appellant now had an exacerbation of some chondromalacia, possibly a loose body, and a knee sprain. Dr. Uppal also indicated that appellant had preexisting chondromalacia that was exacerbated by the work injury and that he also had a loose body and possibly a meniscal tear. He advised that he believed that appellant "may have a temporary exacerbation, but a permanent problem with chondromalacia."

In an October 28, 2013 report, Dr. Uppal noted that he initially saw appellant on June 26, 2012 and indicated that appellant got up from a chair and had a twisting injury along with pain and problems over his knee that had continued to worsen. He explained that appellant had prior problems with his knee, but they did not "seem to bother [appellant] much before the incident. We have tried to treat him conservatively and actually tried to get a hyaluronic acid series approved, but which has been denied." Dr. Uppal opined that appellant reached maximum medical improvement (MMI) because he was unable to treat appellant further with the denials for treatment of his exacerbation of preexisting arthritis. He explained that at this point it would be reasonable to consider in the future either a hyaluronic acid series, possibly a knee arthroscopy with removal of the loose body, or ultimately, a total knee replacement.

On November 25, 2013 appellant filed a claim for a schedule award (Form CA-7).

By development letter dated December 11, 2013, OWCP advised the medical evidence submitted was insufficient to establish appellant's claim as there was no narrative report outlining the current condition or whether he had any permanent impairment as a result of his work-related condition. Additionally, it explained that he had preexisting chondromalacia and arthritis and that the medical evidence indicated that these conditions were causing his current symptoms. Furthermore, Dr. Uppal did not explain how appellant getting up from a chair and twisting his

[3] The record reflects that appellant had a preexisting right knee condition accepted by the Department of Veterans Affairs. Additionally, appellant had a prior right lower extremity under OWCP File No. xxxxxx825. In that claim, he filed a traumatic injury claim alleging that on June 1, 2011 while climbing and walking down a mountain range of 6,800 feet, while investigating an aircraft accident, he pulled a muscle or strained his right lower calf leg. OWCP administratively handled the claim for medical benefits which included one medical report and one x-ray. The claim has been closed since June 8, 2011.

right knee could result in the need for a "hyaluronic acid series, possibly a knee arthroscopy with removal of the loose body, or ultimately a total knee replacement." OWCP further advised appellant to submit medical evidence in support of his claim based on the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

In a January 8, 2014 report, Dr. Michael E. Hebrard, Board-certified in physical medicine and rehabilitation, noted appellant's history of injury and treatment. He noted that, on June 8, 2012, appellant was rising from a seated position at his desk when his right foot got caught in the carpet, he twisted his right knee and injured it.[5] Dr. Hebrard examined appellant, provided findings, and diagnosed internal derangement of the knee and osteoarthritis of the right knee and probably of the left knee. He explained that, with a reasonable degree of medical certainty, more probable than not, that appellant's ongoing condition was aggravated by the employment incident. Dr. Hebrard explained that appellant had an initial injury to the right knee in 2011 which was aggravated again in the injury of June 6, 2012 in the course of employment when appellant got up from his desk and tripped over a carpet, which caused additional translational stress along the medial and lateral condyles of the right knee. This led to an acute aggravation with inflammation and reinjured the already tattered articular fibrocartilage of the knee. Dr. Hebrard noted that appellant had significantly restricted range of motion of the right knee, swelling and pain, and gait instability. He opined that appellant was at MMI on January 8, 2014. Dr. Hebrard explained that an impairment rating would be forthcoming upon receipt of x-rays.

January 13, 2014 x-rays, read by Dr. Eric Kraemer, a Board-certified neurologist, revealed moderate osteoarthritis in the right knee and a 1.4 centimeter loose body in Hoffa's fat pad.

In a March 1, 2014 supplemental report, Dr. Hebrard reiterated that appellant reached MMI. He explained that appellant's condition of osteoarthritis of the right knee was a consequential condition from the accepted diagnosis of right knee sprain that did not respond to conservative measures. Dr. Hebrard determined that appellant underwent a surgical menisectomy where portions of the menisci were removed leading to joint narrowing which was consistent with radiographic diagnosis of osteoarthritis.

On August 31, 2015 OWCP referred appellant for a second opinion, along with a statement of accepted facts (SOAF), a set of questions and the medical record to Dr. Aubrey A. Swartz, a Board-certified orthopedic surgeon, for an opinion regarding the nature and extent of appellant's entitlement to a schedule award.

In a November 16, 2015 report, Dr. Swartz noted appellant's history of injury and treatment and his history of preexisting degenerative arthritis in both knees related to his military service. He also noted that the prior claim of June 1, 2011. Dr. Swartz explained that appellant used a cane, as he had pain in both knees, with the right more than the left. He noted that 25 years ago appellant had surgery on the left knee as he had a medial meniscus problem. Dr. Swartz

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

[5] Dr. Hebrard also referenced a 2011 plane crash that appellant was investigating, when he stepped on rocks coming down a hill and fell over, experiencing immediate pain.

indicated that appellant suffered with pain in the left knee, ever since. He related that, after his fall in 2011, appellant's right knee began having problems. Dr. Swartz indicated that surgery, to include total knee arthroscopies was recommended, but the appellant was reluctant. He also noted that appellant's activities of daily living were impacted as he could not climb the stairs without assistance and was unable to drive due to right knee pain. Additionally, appellant's pain was described as an 8 out 10 in the right knee. Dr. Swartz examined appellant and his findings included that the knee reflexes were 1 plus bilaterally and ankle reflexes were zero. His findings also included that appellant was very tender to touch medially and laterally in the right knee and right patella. Regarding the left knee, Dr. Swartz found that appellant was tender laterally to light palpation and with pain with mild patellofemoral compression in both knees. He was unable to test for crepitus in the right knee as he was having too much pain with any motion of the right knee. Dr. Swartz found no crepitus with motion in the left knee.

Dr. Swartz opined that a diagnosis had not been completely established. He indicated that there was no indication of a magnetic resonance imaging (MRI) scan in the records and he opined that the prevailing diagnosis was osteoarthritis of the right knee with worsening right knee pain and condition. Dr. Swartz explained that, without an MRI scan, he could not complete the diagnosis. Additionally, he noted that appellant had substantial pain and disability behavior with findings x-ray dated January 13, 2014, of mild medial compartment narrowing of the right knee, patellofemoral spur formation, loose body within the knee, in addition to chondrocalcinosis of the right knee, with inconsistent findings. Dr. Swartz opined that the osteoarthritis in the right knee appeared to be primary osteoarthritis and explained that the June 18, 2012 incident temporarily aggravated appellant's right knee, which would require a right knee MRI scan to further assess his right knee condition. He indicated that he would be ordering the MRI scan to further diagnose the condition. Dr. Swartz opined that the osteoarthritis of the right knee, with pain was nonindustrial or preexisting. Additionally, a right knee replacement was needed. Dr. Swartz also indicated that appellant was not completely cooperative during his examination. He recommended sedentary work and prescribed restrictions.

A December 29, 2015 MRI scan of the right knee interpreted by Dr. Sivan S. Golan, a Board-certified diagnostic radiologist, revealed findings, which included advanced degenerative changes of the lateral knee joint compartment with full-thickness chondral loss, mild underlying marrow edema and geode formation; complex diffuse degenerative tear of the lateral meniscus; and diffuse interstitial tearing of the posterior horn and body of the medial meniscus with mild undersurface fraying; mild chondrosis within the medial and patellofemoral compartments; and small knee joint effusion with synovitis and numerous intra-articular bodies most notably within the anterior knee joint compartment as well as the popliteus tendon sheath and mild to moderate popliteus tendinopathy.

A December 29, 2015 x-ray of the right knee read by Dr. Golan revealed severe osteoarthritic change of the lateral compartment and mild degenerative change at the patellofemoral compartment with a suggestion of medial compartment chondrocalcinosis.

A December 29, 2015 x-ray of the left knee read by Dr. Golan revealed minimal tear and mild lateral and mild-to-moderate patellofemoral compartment joint space loss as described above. Patellofemoral joint space measurement might be underestimated due to radiographic projection and marginal osteophyte versus intrarticular body within the lateral knee joint compartment.

In a January 8, 2016 report, Dr. Swartz noted that he had reviewed the x-rays and MRI scan reports. He opined that appellant had severe osteoarthritic changes in the lateral component of the right knee with bone on bone joint loss and without a residual joint space as the primary findings, and the MRI scan study revealed advanced degenerative changes in the lateral compartment and a complex diffuse degenerative tear of the lateral meniscus with diffuse interstitial tearing of the medial meniscus, and mild arthritis of the medial and patellofemoral compartment. Regarding the right knee, Dr. Swartz explained that appellant had a temporary aggravation of his right knee, which had severe lateral osteoarthritis and a complex tear of the lateral meniscus, with diffuse interstitial tearing of the medial meniscus. He explained that these "findings would not be related to an acute injury and not related to getting up from [appellant's] chair and twisting his right knee." Dr. Swartz related that, on June 18, 2012, appellant had advanced osteoarthritis of his right knee, primarily the lateral compartment, in addition to milder arthritic changes in the patellofemoral and medial compartments. He advised that this was more likely a temporary aggravation. Dr. Swartz explained that, with regard to the complex degenerative tearing of the lateral meniscus, he was referring to the second printing of the A.M.A., *Guides to the Evaluation of Disease and Injury Causation*, pages 364-370, 2014. He explained that the prevalence of degenerative meniscus tears increased with age and was now recognized as part of the knee osteoarthritic process. Furthermore, there was insufficient evidence that climbing, driving, kneeling, lifting, sitting, squatting, standing, and walking caused meniscus disorders. Dr. Swartz opined that the development of degenerative meniscus tears were established as part of the osteoarthritic process of the knee. He explained that the findings on the MRI scan would not be related and the injury of June 18, 2012 would be considered to be a temporary exacerbation or aggravation of the arthritis in appellant's right knee, which would be considered to have long since subsided. Dr. Swartz explained that temporary aggravation would not last more than three months, or until approximately September 18, 2012. Regarding disability, he opined that there were no injury-related factors of disability, either objective or subjective. Additionally, any need for treatment would be considered nonindustrial based upon appellant's preexisting osteoarthritis. Dr. Swartz indicated that appellant reached MMI within three months of the episode or by September 18, 2012. He reiterated that a schedule award would not be applicable based upon the industrial injury. Dr. Swartz explained that appellant did have 50 percent impairment to the right knee, but this would not be related to the work injury.

On February 25, 2016 OWCP denied appellant's claim for a schedule award based on Dr. Swartz' opinion. In particular, it explained that the report from Dr. Hebrard was based on an incomplete history of injury. OWCP indicated that appellant did not mention anything about tripping over a carpet when he filed his Form CA-1. Furthermore, Dr. Hebrard did not give a rationalized opinion regarding the preexisting conditions to include right knee osteoarthritis. OWCP found that the second opinion physician, Dr. Swartz, provided a rationalized opinion and the medical evidence did not support a permanent impairment.

On March 4, 2016 counsel requested a telephonic hearing, which was held before an OWCP hearing representative on September 22, 2016. During the hearing, appellant explained that, as he was getting up, the carpet was loose and he believed that his foot must have gotten caught and that caused him to twist the knee after he got up. Counsel explained that appellant was merely providing a "further description of the incident as opposed to something new or different."

In a letter dated October 19, 2016, J.P., a program consultant with the employing establishment, controverted the claim and disagreed with appellant's new description of the incident. She noted that, on his claim form, he did not mention getting his shoe caught on a carpet. Furthermore, none of the treating physicians mentioned the carpet until the January 8, 2014 report from Dr. Uppal. J.P. also noted that the SOAF made no mention of appellant's shoe getting caught on a loose carpet. She also indicated that there was no conflict as Dr. Hebrard's reports were based upon an inaccurate factual history and could not create a conflict.

By decision dated November 14, 2016, an OWCP hearing representative affirmed the February 25, 2016 decision.

LEGAL PRECEDENT

Under section 8107 of FECA[6] and section 10.404 of the implementing federal regulations,[7] schedule awards are payable for permanent impairment of specified body members, functions, or organs. It, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[8] The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[9] Under the sixth edition, the evaluator identifies the impairment for the Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11] It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[12] However, where

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404

[8] *D.J.*, 59 ECAB 620 (2008); *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

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

[10] *Id.* at 383-419.

[11] *Id.* at 411.

[12] *See B.M.*, Docket No. 09-2231 (issued May 14, 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3(a)(3) (January 2010); *Dale B. Larson*, 41 ECAB 481 (1990); *Beatrice L. High*, 57 ECAB 329 (2006). This portion of OWCP's procedure provides that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

there is no demonstrated permanent impairment due to an accepted workplace injury, the claim is not ripe for consideration of any preexisting impairment.[13]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed through an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[14]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish a permanent impairment of a scheduled member entitling him to a schedule award.

OWCP accepted appellant's claim for sprain of the right knee, lateral collateral ligament on the right.[15] As previously noted, appellant had a preexisting right knee condition accepted by the Department of Veterans Affairs and a prior right lower extremity claim under OWCP File No. xxxxxx825, which resulted in a muscle or strained his right lower calf leg and was administratively handled.

The Board finds that appellant has not established that he has a permanent impairment of a scheduled member entitling him to a schedule award.

OWCP accepted appellant's claim for sprain of the right knee, lateral collateral ligament on the right. Appellant filed a claim for a schedule award on November 5, 2013.

In support of his claim for a schedule award, appellant provided a March 1, 2014 supplemental report from Dr. Hebrard, who determined that appellant was at MMI and had 20 percent impairment of the right lower extremity. Dr. Hebrard utilized the sixth edition of the A.M.A., *Guides*. He referenced section 2.3 of the A.M.A., *Guides* and opined that the primary diagnosis was "osteoarthritis of the knee." The Board notes, however, that the condition of osteoarthritis of the knee is not an accepted condition in this claim. Since the accepted condition was a sprain of the right knee, lateral collateral ligament on the right, the medical evidence must establish that this condition resulted in a permanent impairment of the right knee.[16] However, Dr. Hebrard did not provide an impairment rating under the A.M.A., *Guides* for sprain of the right knee, lateral collateral ligament on the right, nor has he provided a rationalized medical opinion supporting that appellant's right knee osteoarthritis condition was causally related to the accepted

[13] *M.F.*, Docket No. 16-1089 (issued December 14, 2016); *Thomas P. Lavin*, 57 ECAB 353 (2006).

[14] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013). *See C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

[15] As previously noted, the record reflects that appellant had a preexisting right knee condition accepted by the Veteran's Administration and a prior right lower extremity Claim No. xxxxxx825. *See supra* note 3.

[16] *See M.C.*, Docket No. 17-1089 (issued November 13, 2017).

June 18, 2012 employment injury. Therefore, the medical reports of Dr. Hebrard are insufficient to establish a permanent impairment of a scheduled member for schedule award purposes.

Following receipt of Dr. Hebrard's impairment rating report OWCP scheduled a second opinion examination with Dr. Swartz.

In his January 8, 2016 report, Dr. Swartz found that appellant did not have ratable impairment under the A.M.A., *Guides* for his accepted medical conditions of the right knee. He opined that appellant had severe osteoarthritic changes in the lateral component of the right knee with bone on bone joint loss and without a residual joint space as the primary findings. Regarding the right knee, Dr. Swartz explained that appellant had a temporary aggravation of his right knee, which had severe lateral osteoarthritis and a complex tear of the lateral meniscus, with diffuse interstitial tearing of the medial meniscus. He explained that these "findings would not be related to an acute injury and not related to getting up from his chair and twisting his right knee." Dr. Swartz further explained that the findings on the MRI scan would not be related and the injury of June 18, 2012 would be considered to be a temporary exacerbation or aggravation of the arthritis in his right knee, which would be considered to have long since subsided. He explained that a temporary aggravation would not last more than three months or until approximately September 18, 2012. Regarding disability, Dr. Swartz opined that there were no injury-related factors of disability, either objective, or subjective. He indicated that appellant reached MMI within three months of the episode or by September 18, 2012. Dr. Swartz reiterated that a schedule award would not be applicable based upon the industrial injury.

The Board finds that Dr. Swartz' opinion is entitled to the weight of the evidence as his report is sufficiently well rationalized and based upon a proper factual background.[17] OWCP properly relied upon his reports in finding that appellant was not entitled to any schedule award. Dr. Swartz' examined appellant, reviewed his medical records, and reported accurate medical and employment histories. There is no current probative medical evidence of record establishing that appellant has ratable permanent impairment for his accepted medical condition.

Consequently, appellant has not submitted any medical evidence to establish that his accepted conditions of sprain on the right knee and lateral collateral ligament on the right, caused a permanent impairment to a scheduled member of the body. As such evidence has not been submitted, he has not established entitlement to a schedule award.[18]

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.

[17] *D.B.*, Docket No. 17-1444 (issued January 11, 2018).

[18] *See J.A.*, Docket No. 17-1846 (issued March 27, 2018).

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish a permanent impairment of a scheduled member entitling him to a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the November 14, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 25, 2018
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