United States Department of Labor
Employees' Compensation Appeals Board

R.A., Appellant	)	
and	)	**Docket No. 18-0499**
	)	**Issued: July 20, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Corpus Christi, TX, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 10, 2018 appellant, through counsel, filed a timely appeal from an October 30, 2017 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 more than two percent permanent impairment of his left lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On January 14, 2008 appellant, then a 46-year-old mail handler, filed a traumatic injury claim (Form CA-1) alleging that, on January 8, 2008, he injured his left knee at work. He asserted that he felt a sharp pain in his left knee while delivering mail on that date. Appellant stopped work on January 9, 2008 and initially received continuation of pay.

The findings of a January 9, 2008 magnetic resonance imaging (MRI) scan of appellant's left knee contained an impression of radial tear of the lateral meniscus.

OWCP accepted appellant's claim for chondromalacia of the left lateral condyle of his left knee and tear of the lateral meniscus of his left knee.[3]

On January 29, 2009 Dr. Bernard Seger, an attending Board-certified orthopedic surgeon, performed OWCP-approved left knee surgery, including partial lateral meniscectomy, anterior synovectomy, and chondroplasty of the lateral femoral condyle and patella-femoral sulcus.

Dr. Seger determined that appellant could return to limited-duty work on March 24, 2009 and he returned to such work for the employing establishment shortly after that date. On April 9, 2009 appellant returned to full-duty work.

In a May 21, 2010 report, Dr. Wright W. Singleton, an attending physician specializing in general practice, noted that he examined appellant on that date and he provided the diagnosis of internal derangement of the left knee.[4] He determined that appellant reached maximum medical improvement (MMI) on May 21, 2010 and indicated, "For range of motion of left knee 10 [percent] was obtained using goniometer measurement which compared to the contralateral normal right. Intraoperative repair of the left knee was allowed a 3 [percent] impairment for partial medial meniscectomy." Dr. Singleton advised that combining the 10 and 3 percent values meant that the total permanent impairment of appellant's left lower extremity was 13 percent.

On December 8, 2010 OWCP referred appellant's case to Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as an OWCP medical adviser. It asked Dr. Katz to review the case record, including Dr. Singleton's May 21, 2010 report, and provide an opinion on appellant's

[3] Appellant received disability compensation on the daily rolls from April 17, 2008 to April 8, 2009.

[4] Dr. Singleton did not provide any specific examination findings other than noting that appellant had a normal gait and that there was no varus/valgus deformity or strength loss of the left knee.

permanent impairment under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5]

On December 20, 2010 Dr. Katz determined that Dr. Singleton's May 21, 2010 impairment rating was not probative for determination of a schedule award because Dr. Singleton did not reference detailed examination findings or explain how his calculation was derived in accordance with the standards of the sixth edition of the A.M.A., *Guides.* He recommended that appellant be referred for a second opinion examination to an appropriate specialist who was familiar with the sixth edition of the A.M.A., *Guides*.

On April 16, 2014 OWCP referred appellant for a second opinion examination to Dr. Sofia M. Weigel, a Board-certified physical medicine and rehabilitation physician. It requested that she provide an opinion regarding permanent impairment of his left lower extremity under the sixth edition of the A.M.A., *Guides.*

In a May 30, 2014 report, Dr. Weigel discussed appellant's factual and medical history and she noted that he complained of pain and stiffness in his left knee which were aggravated by activity. She detailed the findings of the left knee physical examination she conducted on that date, noting that he exhibited mild crepitus and mild pain of the medial and lateral joint lines upon motion of the knee. Appellant had good active range of motion of the left knee and the knee was stable to anterior, posterior, varus, and valgus stresses. Dr. Weigel indicated that the McMurray and Lachman tests were negative and that there was no effusion or swelling of the left knee. She determined that, under Table 16-3 (Knee Regional Grid) on page 509 of the sixth edition of the A.M.A., *Guides,* appellant's 2009 partial lateral meniscectomy fell under class 1 and justified a two percent default value for permanent impairment of the left lower extremity. Under Table 16-5 through Table16-8, appellant had a functional history grade modifier of 1, a physical examination grade modifier of 1, and a clinical studies grade modifier of 2.[6] Dr. Weigel indicated that application of the net adjustment formula did not require movement from the default value on Table 16-2. Therefore, she concluded that appellant had two percent permanent impairment of his left lower extremity under the standards of the sixth edition of the A.M.A., *Guides.*[7]

OWCP referred appellant's case to Dr. Jovito Estaris, a Board-certified occupational medicine physician serving as an OWCP medical adviser. It asked Dr. Estaris to review the case record, including Dr. Weigel's May 30, 2014 report, and provide an opinion on appellant's permanent impairment under the standards of the sixth edition of the A.M.A., *Guides.*

In an August 11, 2016 report, Dr. Estaris advised that he had reviewed the medical evidence of record, including Dr. Weigel's May 30, 2014 report. He provided a summary of appellant's factual and medical history. Dr. Estaris indicated that, under Table 16-3 on page 509 of the sixth edition of the A.M.A., *Guides,* appellant's partial lateral meniscectomy (a class 1 condition) meant that he had two percent default value for permanent impairment of the left lower

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

[6] *See* A.M.A., *Guides* 515-19, Table 16-5 through Table16-8.

[7] *Id.* at 521. Dr. Weigel determined that appellant reached MMI on May 21, 2010, the date of Dr. Singleton's examination.

extremity. Under Table 16-5 through Table 16-8, appellant had a functional history grade modifier of 1 (constant pain and normal gait per Dr. Singleton's examination) and a physical examination grade modifier of 1 (mild tenderness upon active range of motion). Dr. Estaris found that a clinical studies grade modifier was not applicable because an MRI scan was used to place appellant in the correct diagnostic class.[8] He noted that application of the net adjustment formula did not require movement from the default value on Table 16-2 and he concluded that appellant had two percent permanent impairment of his left lower extremity under the standards of the sixth edition of the A.M.A., *Guides.*[9]

On February 9, 2017 appellant filed a claim for compensation (Form CA-7) seeking a schedule award due to his accepted employment injury.

By decision dated April 18, 2017, OWCP granted appellant a schedule award for two percent permanent impairment of his left lower extremity. The award ran for 5.76 weeks from May 30 to July 9, 2014 and was based on the impairment rating of Dr. Estaris.

On May 1, 2017 counsel, on behalf of appellant, requested a telephone hearing with a representative of OWCP's Branch of Hearings and Review. During the hearing, held on August 16, 2017, he argued that the medical evidence of record showed that appellant was entitled to an increased schedule award for his left knee.

By decision dated October 30, 2017, OWCP's hearing representative affirmed OWCP's April 18, 2017 decision. She determined that the medical evidence of record failed to show that appellant had more than two percent permanent impairment of his left lower extremity. The hearing representative found that the weight of the medical evidence with respect to his permanent impairment rested with the opinion of Dr. Estaris who calculated that appellant had two percent permanent impairment of his left lower extremity under the sixth edition of the A.M.A., *Guides*.

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. 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

[8] *Id.* at 519-20, Table 16-8. Dr. Estaris noted that, therefore, Dr. Weigel improperly assigned a value for the clinical studies grade modifier.

[9] Dr. Estaris noted that appellant reached MMI on May 30, 2014, the date of Dr. Weigel's examination. He indicated that Dr. Singleton's May 21, 2010 report did not show that appellant had more than two percent permanent impairment of his left lower extremity because Dr. Singleton did not provide an impairment rating derived in accordance with the standards of the sixth edition of the A.M.A., *Guides.* Dr. Estaris noted that Dr. Singleton combined a range of motion impairment with a diagnosis-based impairment, but that the text on page 518 of the sixth edition provides that range of motion impairments and diagnosis-based impairments should not be combined.

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404 (1999).

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.[12] The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.[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 Class of Diagnosis (CDX) is determined from the Knee Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the grade modifier for Functional History (GMFH), grade modifier for Physical Examination (GMPE), and grade modifier for Clinical Studies (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]

In some instances, OWCP's medical adviser's opinion can constitute the weight of the medical evidence.[17] This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the A.M.A., *Guides*.[18] In this instance, a detailed opinion by OWCP's medical adviser may constitute the weight of the medical evidence as long as the medical adviser explains his or her opinion, shows values and computation of impairment based on the A.M.A., *Guides*, and considers each of the reported findings of impairment, his or her opinion may constitute the weight.[19] If the attending physician misapplied the A.M.A., *Guides*, no conflict would exist because the attending physician's report would have diminished probative value and the opinion of OWCP's medical adviser would constitute the weight of medical opinion.[20]

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[12] *Id. See also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (January 2010); *id.* at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (January 2010).

[13] *Id.* at Chapter 2.808.5a (February 2013); *see also id.* at Chapter 3.700, Exhibit 1 (January 2010).

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

[15] *Id* at 515-22.

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

[17] *M.P.*, Docket No. 14-1602 (issued January 13, 2015); *supra* note 12 at Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.8j (September 2010).

[18] *Id.*

[19] *Id.*

[20] *Id.*

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than two percent permanent impairment of his left lower extremity, for which he previously received a schedule award.

OWCP accepted appellant's claim for chondromalacia of the left lateral condyle of his left knee and tear of the lateral meniscus of his left knee. It granted him a schedule award for two percent permanent impairment of his left lower extremity. The award was based on the permanent impairment rating of Dr. Estaris, OWCP's medical adviser who had reviewed the examination findings of Dr. Weigel, OWCP's referral physician.

The Board finds that OWCP properly found that the weight of the medical evidence with respect to appellant's permanent impairment rested with the opinion of Dr. Estaris who correctly calculated that appellant had two percent permanent impairment of his left lower extremity under the sixth edition of the A.M.A., *Guides*.[21]

In an August 11, 2016 report, Dr. Estaris correctly indicated that, under Table 16-3 on page 509 of the sixth edition of the A.M.A., *Guides*, appellant's partial lateral meniscectomy (a class 1 condition) meant that appellant had two percent default value for permanent impairment of his left lower extremity.[22] Under Table 16-5 through Table 16-8, he properly determined appellant's grade modifiers.[23] Appellant had a GMFH of 1 (constant pain and normal gait per Dr. Singleton's examination) and a GMPE of 1 (mild tenderness upon active range of motion). Dr. Singleton found that a GMCS was not applicable because an MRI scan was used to place appellant in the correct diagnostic class.[24] Dr. Estaris noted that application of the net adjustment formula did not require movement from the default value on Table 16-2 and he concluded that appellant had two percent permanent impairment of his left lower extremity under the standards of the sixth edition of the A.M.A., *Guides*.[25]

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[21] *See supra* notes 17 through 20 regarding the role of OWCP's medical adviser in schedule award cases.

[22] A.M.A., *Guides* 509, Table 16-2.

[23] *Id.* at 515-19.

[24] *Id.* at 519-20, Table 16-8. Therefore, Dr. Estaris properly noted that Dr. Weigel should not have assigned a value for the clinical studies grade modifier. Dr. Estaris determined that appellant reached MMI on May 30, 2014, the date of Dr. Weigel's examination.

[25] In a May 21, 2010 report, Dr. Singleton determined that appellant had 13 percent permanent impairment of his left lower extremity based on his left knee surgery and range of motion deficits of his left knee. The Board notes that Dr. Estaris properly found that Dr. Singleton's May 21, 2010 report did not show that appellant had more than two percent permanent impairment of his left lower extremity. The report is of limited probative value on the relevant issue of the case because Dr. Singleton did not provide detailed examination findings or explain how his calculation was derived in accordance with the standards of the sixth edition of the A.M.A., *Guides*. The Board has held that an opinion on permanent impairment is of limited probative value if it is not derived in accordance with the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses. *See James Kennedy, Jr.*, 40 ECAB 620, 626 (1989).

Appellant has not presented any rationalized medical evidence establishing greater permanent impairment.

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 not met his burden of proof to establish more than two percent permanent impairment of his left lower extremity, for which he previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the October 30, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 20, 2018
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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