United States Department of Labor
Employees' Compensation Appeals Board

K.P., Appellant	)	
	)	**Docket No. 18-0777**
and	)	**Issued: November 13, 2018**
	)	
U.S. POSTAL SERVICE, POST OFFICE Plainfield, IL, 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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On February 28, 2018 appellant, through counsel, filed a timely appeal from a February 1, 2018 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 her burden of proof to establish more than five percent permanent impairment of her right lower extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

On December 9, 2009 appellant, then a 46-year-old rural carrier associate, filed an occupational disease claim (Form CA-2) alleging that she sustained a right knee injury due to "repetitive motion" at work. She noted that she first became aware of her claimed condition in September 2009 and realized its relationship to her federal employment on December 8, 2009. Appellant did not stop work.

On January 6, 2010 OWCP accepted the claim for right knee medial meniscus tear. It authorized right knee arthroscopy with debridement of medial and lateral patellofemoral compartment chondromalacia performed on January 21, 2011, and right knee arthroscopy with debridement of distal medial femoral condyle chondromalacia and patellofemoral compartment chondromalacia and partial medial meniscectomy performed on April 21, 2014. Both surgeries were performed by Dr. William J. Farrell, a Board-certified orthopedic surgeon.

In a letter dated July 5, 2016, appellant, through counsel, requested a schedule award. OWCP received a June 8, 2016 medical report from Dr. Neil Allen, a physician Board-certified in internal medicine and neurology, in which he found that appellant had 26 percent permanent impairment of the right lower extremity pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of permanent Impairment* (A.M.A., *Guides*).[3] Dr. Allen diagnosed grade 3 chondromalacia of the weight-bearing surface of the femur. He utilized the diagnosis-based impairment (DBI) method to determine impairment and found 26 percent right lower extremity permanent impairment under the sixth edition of the A.M.A., *Guides*. Under Table 16-3, Knee Regional Grid, page 511 of the A.M.A., *Guides*, Dr. Allen identified the diagnosis of grade 3 chondromalacia of the weight-bearing of the femur as a class 3 impairment with a default value of 30 percent. He assigned a grade modifier 2 for functional history (GMFH) under Table 16-6, page 516 due to appellant's standardized score of 60 on a lower limb questionnaire, antalgic gait, and regular use of knee orthosis. Under Table 16-7, page 517, Dr. Allen assigned a grade modifier 2 for physical examination (GMPE) due to moderate palpatory findings, consistently documented with observed abnormalities, grade 1 Lachman's, stability, no motion deficit per page 549, negative for deformity compared to unaffected side, positive for muscle atrophy, and 1.0 centimeters at the thigh. Under Table 16-8, page 519, he assigned a grade modifier 3 for clinical studies (GMCS) for several reasons. A right knee magnetic resonance imaging (MRI) scan revealed grade 2 to 3 tricompartmental chondrosis, most advanced in the patellofemoral and medial compartments, postoperative changes related to partial medial meniscectomy, and no evidence of recurrent meniscal tear, and moderate-sized joint effusion and Baker's cyst. An operative report revealed grade 3 chondromalacia of the weight-bearing region of the distal femur and within the patellofemoral compartment. Another right knee MRI scan

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

revealed a small joint effusion with tiny Baker's cyst, an abnormal linear signal in the posterior horn of the medial meniscus, which probably represented degenerative grade 2 signal, an intrameniscal tear with limited surface extension could not be totally excluded, findings consistent with popliteus strain, and mild chondromalacia patella. Using the net adjustment formula of (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), Dr. Allen calculated that appellant had a net adjustment of (2-3) + (2-3) + (3-3) = -2, which equated to a grade C impairment (30 percent default value), which was reduced to a grade A impairment, 26 percent permanent impairment of the right lower extremity. He advised that appellant had reached maximum medical improvement (MMI) as of the date of his evaluation.

On August 17, 2016 OWCP received appellant's claim for a schedule award (Form CA-7) dated June 24, 2016.

On August 22, 2016 Dr. Arthur S. Harris, 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. Allen's June 8, 2016 report. He related that appellant had reached MMI on June 8, 2016, the date of Dr. Allen's evaluation, however he disagreed with Dr. Allen's impairment rating. Dr. Harris determined that, under Table 16-3 on page 511 of the sixth edition of A.M.A., *Guides*, appellant's diagnosis of arthroscopic evidence of grade 3 chondromalacia of the patellofemoral joint represented a class 1 diagnosis with a default value of E, resulting in five percent permanent impairment of the right lower extremity. He noted that, Dr. Allen determined that appellant had 26 percent right lower extremity permanent impairment due to residual problems with post-traumatic chondromalacia of the patellofemoral joint. Dr. Harris further noted that, Dr. Allen's finding was based on arthroscopic evidence of grade 3 chondromalacia of the patellofemoral joint. He advised that the DBI impairment method for patellofemoral arthritis required documented joint space narrowing before the impairment could be rated beyond a class 1, five percent permanent impairment. However, Dr. Allen had not provided any findings substantiating joint space narrowing.

By decision dated May 17, 2017, OWCP granted appellant a schedule award for five percent permanent impairment of the right lower extremity. The award ran from June 8 to September 16, 2016, for a total of 14.4 weeks of compensation.

In a letter received on May 30, 2017, appellant, through counsel, requested a telephone hearing before an OWCP hearing representative, which was held on November 17, 2017.

By decision dated February 1, 2018, an OWCP hearing representative affirmed the May 17, 2017 decision. He found that the weight of the medical evidence rested with the opinion of Dr. Harris and supported a finding that appellant had five percent permanent impairment of the right lower extremity.

LEGAL PRECEDENT

The schedule award provisions of FECA[4] and its implementing federal regulations[5] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members, functions, and organs of the body. FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[6] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[7] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[8] 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.[9] 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 are to be included.[10]

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.[11] 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).[12] 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.[13]

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[7] *Id.*

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[9] *Isidoro Rivera*, 12 ECAB 348 (1961).

[10] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); *supra* note 8 at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.a.3 (January 2010). This portion of OWCP procedures provides that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

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

[12] *Id*. at 515-22.

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

In some instances, OWCP's medical adviser's opinion can constitute the weight of the medical evidence.[14] 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*.[15] 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.[16] 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.[17]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish more than five percent permanent impairment of the right lower extremity for which she previously received schedule award compensation.

OWCP accepted appellant's claim for right knee medial meniscus tear. On January 21, 2011 appellant underwent an authorized right knee arthroscopy with debridement of medial and lateral patellofemoral compartment chondromalacia. She underwent an authorized right knee arthroscopy with debridement of distal medial femoral condyle chondromalacia and patellofemoral compartment chondromalacia and partial medial meniscectomy on April 21, 2014. On May 17, 2017 OWCP awarded five percent permanent impairment of the right lower extremity. This decision was affirmed by an OWCP hearing representative on February 1, 2018.

In a June 8, 2016 report, Dr. Allen, appellant's treating physician, found that appellant had 26 percent permanent impairment of her right lower extremity due to grade 3 chondromalacia of the weight-bearing surface of the femur. Dr. Allen utilized the DBI method for rating appellant's permanent impairment. Under Table 16-3 on page 511 of the A.M.A., *Guides*, he identified the diagnosis of grade 3 chondromalacia of the weight-bearing of the femur as a class 3 impairment with a default value of 30 percent. Dr. Allen applied a grade modifier of 2 for GMFH and GMPE and a grade modifier of 3 for GMCS, resulting in a net adjustment of -2, which equaled 26 percent permanent impairment of the right lower extremity.

On August 22, 2016 Dr. Harris, OWCP's DMA, reviewed the SOAF and medical record, including the clinical findings of Dr. Allen. Dr. Harris disagreed with Dr. Allen's 26 percent right lower extremity permanent impairment rating and found that appellant had 5 percent permanent impairment of the right lower extremity. He found that, under Table 16-3, page 511 of the sixth

[14] *M.P.*, Docket No. 14-1602 (issued January 13, 2015); *supra* note 8 at Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.8j (September 2010).

[15] *Id.*

[16] *Id.*

[17] *Id.*

edition of A.M.A., *Guides*, appellant's diagnosis of arthroscopic evidence of grade 3 chondromalacia of the patellofemoral joint was a class 1 diagnosis with a default value of E, resulting in five percent permanent impairment of the right lower extremity. Dr. Harris noted that while Dr. Allen's impairment rating was based on arthroscopic evidence of grade 3 chondromalacia of the patellofemoral joint, the DBI impairment method for patellofemoral arthritis required documented joint space narrowing before providing impairment greater than five percent. The Board notes that Dr. Allen did not provide radiograph findings, which were required under Table 16-3, to support his impairment determination.[18] Thus, Dr. Allen failed to properly utilize the A.M.A., *Guides* in assessing appellant's right lower extremity permanent impairment and is of diminished probative value.

The Board finds that the August 22, 2016 impairment rating from Dr. Harris represents the weight of the medical evidence in this case as he properly applied the appropriate provisions of the A.M.A., *Guides* to the clinical findings of record.[19] Accordingly, as the record contains no other probative, rationalized medical opinion which indicates that appellant has greater impairment based on her accepted right knee condition pursuant to the A.M.A., *Guides*, appellant has not met her burden of proof to establish greater than five percent right knee permanent impairment, for which she received a schedule award.

On appeal counsel contends that appellant "proved she had a 26 percent permanent impairment of the lower extremity." As previously explained, however, Dr. Allen's opinion is of diminished probative value as he failed to properly utilize the sixth edition of the A.M.A., *Guides* to support an award greater than the five percent.[20] There is no current medical evidence, in conformance with the A.M.A., *Guides*, which supports any greater impairment.

Counsel further contends on appeal that "OWCP's DMA did not properly consider all conditions of the lower extremity and improperly reduced the percentage." Such vague contentions without supporting arguments are inadequate and do not mitigate favorably in the quest for an approbative finding. As stated above, Dr. Harris reviewed the SOAF and medical record, and properly applied the A.M.A., *Guides* to determine that appellant has no more than five percent permanent impairment of the right lower extremity.

Appellant may request a schedule award or an 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.

[18] *M.G.*, Docket No. 10-1771 (issued May 4, 2011).

[19] *W.M.*, Docket No. 11-1156 (issued January 27, 2012).

[20] *M.P.*, Docket No. 13-1225 (issued October 23, 2013); *Linda Beale*, 57 ECAB 429, 434 (2006). *See also James Kennedy, Jr.*, 40 ECAB 620, 627 (1989).

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish more than five percent permanent impairment of her right lower extremity, for which she previously received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the February 1, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 13, 2018
Washington, DC

Patricia H. Fitzgerald, Deputy 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