

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

G.S., Appellant)	
)	
and)	Docket No. 19-0277
)	Issued: August 22, 2019
U.S. POSTAL SERVICE, POST OFFICE,)	
Grand Rapids, MI, Employer)	
)	

Appearances:
Alan J. Shapiro, Esq., for the appellant¹
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
JANICE B. ASKIN, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On November 19, 2018 appellant, through counsel, filed a timely appeal from a September 27, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act² (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 31 percent permanent impairment of the left lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On January 6, 2014 appellant, then a 60-year-old city carrier, filed an occupational disease claim (Form CA-2) alleging that he developed a left knee condition due to factors of his federal employment including repetitive carrying and delivering mail. He first became aware of his condition and of its relationship to his employment on September 30, 2013.³ By decision dated April 1, 2014, OWCP accepted the claim for mechanical loosening of prosthetic knee joint.

On July 18, 2014 appellant underwent an OWCP-approved surgery for revision of left total knee replacement, both tibial and femoral components for aseptic loosening using cemented and porous coated implants through medial parapatellar arthrotomy.⁴ He stopped work on July 18, 2014 and did not return. Appellant received wage-loss compensation on the periodic rolls beginning October 19, 2014. He subsequently retired from the Postal Service on July 31, 2015.

On May 17, 2016 appellant filed a claim for a schedule award (Form CA-7).

In a development letter dated May 31, 2016, OWCP requested that appellant submit a permanent impairment evaluation from his attending physician in accordance with the sixth edition of American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).⁵ It afforded him 30 days to respond and submit the requested report. No evidence was received.

By decision dated August 4, 2016, OWCP denied appellant's claim for a schedule award finding that the evidence was insufficient to establish that he sustained permanent impairment of a scheduled member or function of the body. It noted that he failed to provide a permanent impairment rating from his treating physician.

On August 12, 2016 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. In support of his claim, he submitted a June 21, 2016 permanent impairment evaluation from Dr. Neil Allen, Board-certified in internal medicine and neurology.

In his June 21, 2016 report, Dr. Allen provided findings on physical examination, reviewed diagnostic testing, and determined that appellant had reached maximum medical improvement

³ The record reflects that OWCP File No. xxxxxx411 is the master file and has been combined with OWCP File No. xxxxxx510. In OWCP File No. xxxxxx510 appellant's October 20, 2005 occupational injury claim (Form CA-2) was accepted for temporary aggravation of left knee arthritis.

⁴ Appellant had a history of total left knee replacement in 2004 and revision of total left knee replacement in 2011.

⁵ A.M.A., *Guides* (6th ed. 2009).

(MMI). He discussed appellant's July 18, 2014 left total knee arthroplasty, diagnostic studies, and noted that an October 21, 2013 bone scan revealed findings consistent with prosthetic loosening within the medial and lateral femoral component of the left knee arthroplasty as there was increased uptake on all three phases at its medial aspect. Dr. Allen reported that x-rays of the left femur were performed on July 21, 2014 which revealed left knee prosthesis and a nondisplaced longitudinal fracture extending from the metaphysis of the femur into the diaphysis more than halfway up the left femur. He further discussed appellant's November 5, 2014 x-rays of the left knee which revealed cemented total knee arthroplasty components with long stems and sleeves, good alignment with no signs of loosening, lysis, or wear, and fracture lines remained well healed. Utilizing Table 16-3, Knee Regional Grid, of the sixth edition of the A.M.A., *Guides*, Dr. Allen assigned a class of diagnosis (CDX) of 4 for the diagnosis of total knee replacement based on the medical records and the July 18, 2014 operative report, at a grade C default value of 75 percent.⁶ He discussed findings related to functional history, physical examination, and clinical studies and assigned grade modifiers of 2, 2, and 4 respectively. Application of the net adjustment formula warranted movement two places to the left of the default value at class C to class A, totaling 67 percent permanent impairment of the left lower extremity.⁷

On February 9, 2017 OWCP routed Dr. Allen's report, a statement of accepted facts (SOAF), and the case record to Dr. Jovito Estaris, Board-certified in occupational medicine serving as an OWCP district medical adviser (DMA), for review and evaluation of appellant's permanent impairment pursuant to the A.M.A., *Guides*. Dr. Estaris was also asked to provide a date of MMI.

In a February 23, 2017 report, the DMA reviewed the case file and determined that appellant reached MMI on June 21, 2016. He disagreed with Dr. Allen's left knee permanent impairment rating and determined that the diagnosis of mechanical loosening of left total knee replacement amounted to a CDX assignment of 3 at a default value of 37 percent for a fair result and mild motion deficits.⁸ The DMA noted that a November 5, 2014 postoperative left knee x-ray revealed good alignment and no signs of loosening. He assigned a grade modifier of 2 for functional history (GMFH), a grade modifier of 1 for physical examination (GMPE), and no grade modifier for clinical studies (GMCS) since it was used for placement of the class. Utilizing the net adjustment formula warranted movement two places to the left of default grade C to grade A, totaling 31 percent permanent impairment of the left lower extremity.⁹

The DMA discussed the differences in his impairment rating from that of Dr. Allen, noting that they disagreed on values assigned for both the CDX as well as the grade modifiers. He reported that the criteria for a CDX of 4 for a total knee replacement diagnosis was a poor result or chronic infection. As such, Dr. Allen's class 4 assignment was improper as there was no chronic infection and the diagnosis was aseptic loosening of hardware. The DMA also noted that a class 4 assignment was not appropriate because x-rays of the left knee post second revision showed

⁶ *Id.* at 511, Table 16-3.

⁷ *Id.* at 521.

⁸ *Supra* note 5.

⁹ *Id.*

good alignment and no signs of loosening. He noted that physical examination findings also failed to support this class which revealed Lachman grade 1 for minimal instability and mild motion deficits. The DMA further disagreed with Dr. Allen's grade modifiers, noting that GMCS could not be assigned since it was used for placement of the class and that physical examination findings amounted to a GMPE of 1 rather than 2 as determined by Dr. Allen.

By letter dated March 31, 2017, OWCP provided Dr. Allen with the DMA's February 23, 2017 report for review and comment. It provided him 30 days to respond. No response was received.

By decision dated May 31, 2017, OWCP granted appellant a schedule award for 31 percent permanent impairment of the left lower extremity. The date of MMI was found to be June 21, 2016. The award covered a period of 89.28 weeks from June 21, 2016 through March 7, 2018. OWCP noted that the weight of the medical evidence rested with Dr. Estaris, serving as the DMA, who correctly applied the A.M.A., *Guides* to Dr. Allen's June 21, 2016 examination findings.

On June 7, 2017 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on November 13, 2017 at which appellant testified in support of his claim and described the effects of his employment injury.

By decision dated January 29, 2018, OWCP's hearing representative affirmed the May 31, 2017 decision. She noted that the DMA provided sufficient medical rationale in support of his opinion and properly applied Dr. Allen's examination findings to establish 31 percent permanent impairment of the left lower extremity. The hearing representative further noted that Dr. Allen incorrectly applied the A.M.A., *Guides* and failed to respond to OWCP's request for his review and comment.

On May 21, 2018 appellant, through counsel, requested reconsideration of OWCP's decision. Counsel noted submission of a new medical report from Dr. Allen not previously considered in support of appellant's schedule award claim.

In an April 12, 2018 medical report, Dr. Allen reevaluated appellant, provided physical examination findings, and discussed diagnostic studies. Based on medical records and physical examination findings of mild motion deficits in flexion and extension, he diagnosed a class 4 impairment at a default value of 67 percent for a left total knee arthroplasty, poor result.¹⁰ Dr. Allen noted that appellant underwent a left total knee arthroplasty in 2004 and a second in 2005, followed by two revisions in 2011 and 2014. He explained that when grading outcomes for a total knee arthroplasty, one is to determine class placement in reference to the primary procedure. Unlike arthroscopic procedures, the number of joint replacements one may undergo in a lifetime is limited, especially given the risks. Dr. Allen reported that appellant was unlikely to be eligible for additional joint replacement procedures and would likely out live his current prosthetic, severely limiting his function later in life. He explained that appellant's revision procedure in 2014 was the result of mechanical loosening of his prosthetic. This loosening was the direct result

¹⁰ *Id.*

of trauma, rather than the age-related breakdown of his hardware, and was an undesired (poor) outcome of the primary knee arthroplasty procedure. Dr. Allen noted that GMCS and GMPE were not considered in the net adjustment as they were used for placement of the class, and GMFH was also not considered as it varied by two or more from clinical studies and physical examination.¹¹ Therefore, he determined that the grade C default value remained unchanged and concluded that appellant sustained 67 percent permanent impairment of the left lower extremity.

On August 15, 2018 OWCP routed a SOAF and Dr. Allen's June 21, 2016 report and updated April 12, 2018 report, to Dr. Estaris the DMA, for review and determination regarding whether his previous 31 percent left lower extremity impairment rating remained unchanged. It also provided him additional records to assist in his impairment review, including: results of diagnostic tests performed on October 21 and December 9, 2013, July 18, and 21, and August 1, 2014; a copy of the July 18, 2014 operative report; physical therapy notes dated July 22 to October 30, 2014; and additional progress notes dated November 5, 2014 from Dr. Bryan Pack, a Board-certified orthopedic surgeon; and February 22, 2016, from Dr. Sam Ho, a Board-certified neurologist.

In a supplemental August 20, 2018 medical report, the DMA reported that his prior 31 percent permanent impairment rating for the left lower extremity remained unchanged, referencing his previous February 23, 2017 report. He argued that Dr. Allen provided an inconsistent impairment rating as his June 21, 2016 report used class 4 with a 75 percent default value while his April 12, 2018 report used class 4 with a 67 percent default value. The DMA noted that Dr. Allen incorrectly utilized mild motion deficits in flexion and extension for a class 4 impairment when the criteria was poor result (poor position), moderate to severe instability, and/or moderate to severe motion deficit. He reported that Dr. Allen's findings correlated with a CDX of 3. The DMA noted that the last x-ray report of the left knee showed that alignments were good overall, no loosening, good overall fixation, fracture femur, healed, callus formation, and no radiolucency. He reported that this x-ray showed that the prosthesis was in a good position, not a poor position, which was the criteria for a class 4 diagnosis. The DMA further reported that Dr. Allen noted these findings in his report when stating that x-rays of the left knee performed on November 5, 2014 revealed cemented total knee arthroplasty components with long stems and sleeves, good alignment with no signs of loosening, lysis, or wear, and fracture lines remained well healed. He concluded that physical examination and clinical study findings supported a class 3 placement, amounting to 31 percent permanent impairment of the left lower extremity due to adjustments for nonkey modifiers.

By decision dated September 27, 2018, OWCP denied modification of its January 29, 2018 decision, finding that appellant was entitled to no more than 31 percent permanent impairment of the left lower extremity previously received.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations set forth the number of weeks of compensation payable to employees sustaining permanent impairment from

¹¹ *Id.* at 517.

loss or loss of use of scheduled members or functions of the body.¹² 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 use of a single set of tables so that there may be uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.¹³

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).¹⁴ 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.¹⁵

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 509.¹⁶ After the CDX is determined from the Knee Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).¹⁷ 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.¹⁸

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA 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.¹⁹

¹² 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

¹³ 20 C.F.R. § 10.404. *See also* Ronald R. Kraynak, 53 ECAB 130 (2001).

¹⁴ *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

¹⁵ *Isidoro Rivera*, 12 ECAB 348 (1961).

¹⁶ *See* A.M.A., *Guides* 509-11 (6th ed. 2009).

¹⁷ *Id.* at 515-22.

¹⁸ *Id.* at 23-28.

¹⁹ *See supra* note 9 at Chapter 2.808.6(e) (March 2017).

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than 31 percent permanent impairment of the left lower extremity, for which he previously received a schedule award.

In support of his schedule award claim, appellant submitted medical reports from Dr. Allen, his attending physician, dated June 21, 2016 and April 12, 2018. In his most recent April 12, 2018 report, Dr. Allen calculated 67 percent permanent impairment of the left lower extremity based on a class 4 diagnosis of total knee replacement. In evaluating appellant's permanent impairment of the left knee, he placed appellant in a class 4 based upon the poor outcome of his 2011 revision procedure and because appellant was unlikely to be eligible for additional joint replacement procedures and would likely out live his current prosthetic. The Board finds that Dr. Allen's impairment opinion was not sufficiently rationalized as he did not explain why appellant's good result following his 2014 revision procedure, rather than a poor result from the 2011 procedure, placed appellant in class 4. Furthermore, Dr. Allen's opinion regarding appellant's future condition was speculative in nature, and therefore insufficient to establish appellant's current extent of permanent impairment.²⁰ A schedule award is appropriate where the physical condition of an injured member has stabilized, despite the possibility of an eventual change in the degree of functional impairment in the member.²¹

OWCP properly referred Dr. Allen's report to Dr. Estaris, serving as a DMA for review.²² In his August 20, 2018 report, the DMA related that Dr. Allen had improperly placed appellant's total knee replacement in class 4 when it should have been placed in class 3. He explained that a class 4 placement was improper because appellant's examination findings revealed mild motion deficits and mild laxity. The DMA explained that appellant's last x-ray report of the left knee showed good overall alignment, no loosening, good overall fixation, fracture femur, healed, callus formation, and no radiolucency. He reported that this x-ray showed that the prosthesis was in a good position. The Board finds that pursuant to Table 16-3, a class 4 placement for a total knee replacement requires poor result (poor position), moderate to severe instability, and or moderate to severe motion deficit.²³ As appellant did not meet this criteria, the DMA properly placed appellant in class 3 for a fair result (fair position, mild instability and/or mild motion deficit). While the default rating for total knee replacement class 3 is 37 percent, Dr. Estaris properly explained that GMFH was 2, GMPE was 1, and no GMCS was assigned since it was used for placement of the class. Utilizing the net adjustment formula the default rating of 37 percent was moved two places to the left for a total 31 percent permanent impairment of the left lower extremity. The DMA also explained that Dr. Allen had improperly assigned GMPE as appellant only had minimal instability and mild motion deficits. The Board finds that the impairment rating

²⁰ *J.A.*, Docket No. 16-1621, 16-1622 (issued May 12, 2017).

²¹ *See T.C.*, Docket No. 17-1906 (issued May 25, 2018).

²² *Supra* note 16.

²³ *Supra* note 6.

from the DMA 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.²⁴

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 31 percent permanent impairment of the left lower extremity, for which he has previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the September 27, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 22, 2019
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

²⁴ *J.H.*, Docket No. 18-1207 (issued June 20, 2019).