United States Department of Labor
Employees' Compensation Appeals Board

S.M., Appellant	)	
and	)	**Docket No. 18-0837**
	)	**Issued: January 11, 2019**
U.S. POSTAL SERVICE, POST OFFICE, CHICAGO PROCESSING & DISTRIBUTION CENTER, Chicago, IL, Employer	)	

Appearances:
Appellant, pro se
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 March 13, 2018 appellant filed a timely appeal from a November 13, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of this case.

ISSUE

The issue is whether appellant has met her burden of proof to establish permanent impairment of a scheduled member warranting schedule award compensation.

FACTUAL HISTORY

On December 7, 2012 appellant, then a 41-year-old tractor trailer operator, filed a traumatic injury claim (Form CA-1) alleging that she strained her left knee on December 4, 2012 while exiting her assigned vehicle while in the performance of duty. OWCP assigned File No.

[1] 5 U.S.C. § 8101 *et seq.*

xxxxxx911. On January 28, 2013 it accepted her claim for sprain of the medial collateral ligament of the left knee.

On February 14, 2013 appellant filed an occupational disease claim (Form CA-2) alleging that she sustained bilateral knee and foot injuries as well as a right elbow condition due to her employment duties of walking, bending, crouching, standing, and pushing while working as a truck driver for 12 years. OWCP assigned File No. xxxxxx879. On April 24, 2013 it accepted appellant's occupational disease claim for plantar fasciitis.[2] OWCP expanded acceptance of her claims to include right medial meniscus tear, bilateral patellar bursitis, right knee soft tissue edema, left knee grade 3 medial meniscal tear, left knee Baker's cyst, left knee joint effusion, left knee grade 3 sprain of the medial collateral ligament, and right elbow joint effusion. On April 19, 2013 appellant underwent a left knee arthroscopic debridement and partial meniscectomy.

On August 2, 2013 appellant filed an occupational disease claim (Form CA-2) alleging that she developed low back pain due to her previously listed work activities. OWCP assigned File No. xxxxxx634. On November 15, 2013 it accepted this claim for displacement of lumbar intervertebral disc without myelopathy, lumbar spinal stenosis, and lumbosacral radiculitis.

On February 28, 2014 OWCP expanded acceptance of this claim to include osteoarthritis of the left knee and mild lateral epicondylitis of the right elbow. Appellant underwent a left knee total arthroplasty on July 14, 2014.

On March 16, 2015 appellant underwent right tarsal tunnel release and right plantar fasciotomy surgeries. On April 3, 2015 she underwent right elbow arthroscopy with resection of the lateral plica and resection of the olecranon spur with repair of the triceps tendon. On March 2, 2016 OWCP expanded acceptance of appellant's claim to include the additional condition of permanent aggravation of primary osteoarthritis right hip.[3]

In a report dated January 26, 2016, Dr. Malcolm D. Herzog, a podiatrist, opined that appellant continued to experience right plantar fasciitis following surgery and that she remained disabled due to her foot and ankle condition.

In a letter dated October 21, 2016, OWCP notified appellant that her three claims had been combined and listed her accepted conditions as sprain of the left medial collateral ligament, primary osteoarthritis of her left knee, lateral epicondylitis of her right elbow, tear of the medial meniscus of her right knee, patellar bursitis bilaterally, tear of the medial meniscus left knee, Baker's cyst of the left knee, bilateral knee effusions, intervertebral disc disorders with radiculopathy lumbosacral region, spinal stenosis lumbar region, radiculopathy lumbosacral

[2] On June 10, 2013 OWCP File No. xxxxxx879 was combined with OWCP File No. xxxxxx911 which was designated as the master file.

[3] In a September 24, 2015 letter, the employing establishment noted that appellant had been approved by the Office of Personnel Management for retirement benefits effective September 21, 2015. On October 1, 2015 OWCP provided appellant with an election of benefits form. On February 3, 2016 appellant elected to continue receiving FECA benefits from OWCP.

region, permanent aggravation of primary osteoarthritis of the right hip, and bilateral plantar fascial fibromatosis.[4]

Beginning March 14, 2017, Dr. Thomas A. McNally, a Board-certified orthopedic surgeon, recommended L5-S1 laminectomy and posterior spinal fusion. On April 26, 2017 he formally requested that OWCP authorize this surgery.

In a May 5, 2017, note, Dr. Ankur M. Chhadia, a Board-certified orthopedic surgeon,[5] reported that appellant's accepted right elbow condition of lateral epicondylitis and accepted primary osteoarthritis and total arthroplasty of the left knee had reached maximum medical improvement (MMI).[6] He also listed her lumbar radiculopathy and back conditions as well as her alleged right knee and accepted right hip conditions. On June 27, 2017 appellant filed a claim for a schedule award (Form CA-7).

In a development letter dated June 30, 2017, OWCP requested medical evidence supporting appellant's claim for permanent impairment of a scheduled member. It afforded her 30 days to respond. Appellant did not respond.

By decision dated August 3, 2017, OWCP denied appellant's request for a schedule award finding that she had not submitted medical evidence conforming to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[7] establishing permanent impairment of a scheduled member.

On August 21, 2017 appellant requested reconsideration from the August 3, 2017 OWCP decision. She submitted additional medical reports dated July 31 and August 1, 2017 from Dr. Chhadia. Dr. Chhadia repeated his conclusions that appellant had reached MMI regarding her accepted left knee and right upper extremity conditions.

On July 31, 2017 Dr. Chhadia provided impairment ratings according to the sixth edition of the A.M.A., *Guides* for appellant's accepted left knee osteoarthritis resulting in total knee replacement and her accepted right elbow lateral epicondylitis. Using Table 16-3,[8] he placed appellant in class 2 for good result following total knee replacement. Dr. Chhadia then assigned grade modifier 1 for functional history, grade modifier 1 for physical examination, and grade modifier 0 for clinical studies.[9] Using the net adjustment formula, he found that appellant had 21 percent permanent impairment of her left lower extremity due to her accepted left total knee

[4] On October 19, 2016 OWCP combined File No. xxxxxx634 with Master OWCP File No. xxxxxx911.

[5] Beginning on November 1, 2015, Dr. Chhadia recommended right knee surgery. By decision dated February 22, 2017, OWCP denied appellant's request for right knee surgery. On April 12, 2017 appellant requested reconsideration of this decision. OWCP had not issued a final decision on this issue at the time of appellant's March 13, 2018 appeal to the Board, and the Board cannot address this issue. 20 C.F.R. § 501.2(c)(2).

[6] Dr. McNally and Dr. Chhadia are part of the same practice group, Suburban Orthopedics.

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

[8] *Id.* at 511, Table 16-3.

[9] *Id*. at 516, Table 16-6; 517, Table 16-7; 519, Table 16-8

replacement.[10] With regard to appellant's permanent impairment of her right elbow, Dr. Chhadia used Table 15-4,[11] and placed appellant in class 1 for her accepted right lateral epicondylitis.[12] He then assigned grade modifier 1 for functional history, grade modifier 1 for physical examination, and grade modifier 0 for clinical studies.[13] Using the net adjustment formula,[14] Dr. Chhadia found that appellant had one percent permanent impairment of her right upper extremity.

On September 29, 2017 OWCP authorized L5-S1 laminectomy and posterior spinal fusion.

By decision dated November 13, 2017, OWCP denied modification of the August 3, 2017 decision, finding that the medical evidence did not support that appellant had reached MMI as she was scheduled to undergo additional surgery.

LEGAL PRECEDENT

Under section 8107 of FECA[15] and section 10.404 of the implementing federal regulations,[16] schedule awards are payment for permanent impairment of specified body members, functions, or organs. FECA, however, does not specify the manner in which the percentage loss of a member 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.[17] For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*.[18]

The Board has explained that permanent impairment may only be rated according to the A.M.A., *Guides* after MMI has been achieved.[19] An impairment should not be considered permanent until a reasonable time has passed for the healing or recovery to occur. The A.M.A., *Guides* explain that impairment should not be considered permanent until the clinical findings indicate that the medical condition is static and well stabilized. MMI refers to a date from which

[10] *Id*. at 521.

[11] *Id*. at 399, Table 15-4.

[12] *Id.*

[13] *Id*. at 406, Table 15-7; 408, Table 15-8; 410, Table 15-9.

[14] *Id*. at 411.

[15] 5 U.S.C. § 8107.

[16] 20 C.F.R. § 10.404.

[17] *F.S.*, Docket No. 18-0383 (issued August 22, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[18] A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[19] *See M.J.*, Docket No. 18-0425 (issued September 7, 2018); *A.D.*, Docket No. 17-1996 (issued March 5, 2018); *B.C.*, Docket No. 16-2062 (issued November 18, 2016).

further recovery or deterioration is not anticipated, although over time there may be some expected change.[20] Once impairment has reached MMI, a permanent impairment rating may be performed.[21]

The period covered by a schedule award commences on the date that the employee reaches MMI from the residuals of the injury. The question of when MMI has been reached is a factual one that depends upon the medical findings in the record. The determination of such date is to be made in each case upon the basis of the medical evidence in that case.[22] The date of MMI is usually considered to be the date of the medical examination that determined the extent of the impairment.[23]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based impairment (DBI) method of determining the percentage of permanent impairment. In addressing upper extremity impairments, the sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[24] The A.M.A., *Guides* follow a similar formula for the lower extremities.[25] The A.M.A., *Guides* also provide that the range of motion (ROM) impairment method is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[26] If the ROM method is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[27] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[28]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology versus the ROM methodology basis for rating of upper extremity impairments.[29]

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[20] *Id.*

[21] A.M.A., *Guides* 24; *see M.J., supra* note 19; *Orlando Vivens,* 42 ECAB 303 (1991) (a schedule award is not payable until MMI -- meaning that the physical condition of the injured member of the body has stabilized and will not improve further has been reached).

[22] *See, M.J., supra* note 19.

[23] *Id.*

[24] A.M.A., *Guides* 411.

[25] *Id*. at 521.

[26] *Id*. at 461.

[27] *Id*. at 473.

[28] *Id*. at 474.

[29] FECA Bulletin No. 17-06 (May 8, 2017).

In determining impairment for the upper and lower extremities, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated.[30] 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 an OWCP medical adviser providing rationale for the percentage of impairment specified.[31]

ANALYSIS

The Board finds that this case is not in posture for decision.

OWCP accepted appellant's claims for sprain of the left medial collateral ligament, primary osteoarthritis of her left knee, lateral epicondylitis of her right elbow, tear of the medial meniscus of her right knee, patellar bursitis bilaterally, tear of the medial meniscus left knee, Baker's cyst of the left knee, bilateral knee effusions, intervertebral disc disorders with radiculopathy lumbosacral region, spinal stenosis lumbar region, radiculopathy lumbosacral region, permanent aggravation of primary osteoarthritis of the right hip, and bilateral plantar fascial fibromatosis. It authorized total arthroplasty of the left knee, right tarsal tunnel release and right plantar fasciotomy surgeries, right elbow arthroscopy with resection of the lateral plica and resection of the olecranon spur with repair of the triceps tendon, and L5-S1 laminectomy and posterior spinal fusion.

Appellant requested schedule awards and submitted medical evidence from Dr. Chhadia beginning May 5, 2017 in which he opined that two of her accepted conditions, her left knee primary osteoarthritis with resulting total knee arthroplasty and her right elbow lateral epicondylitis, had reached MMI. Dr. Chhadia noted that she underwent total left knee replacement surgery on July 14, 2014 and right elbow surgery on April 3, 2015.

By development letter dated June 30, 2017, OWCP informed appellant of the type of evidence necessary to establish her schedule award claim and specifically requested that she submit an impairment evaluation from her attending physician in accordance with the sixth edition of the A.M.A., *Guides*. Appellant failed to comply with this request and OWCP denied her schedule award claim by decision dated August 3, 2017.

In support of her August 21, 2017 reconsideration request, appellant provided a July 31, 2017 report from Dr. Chhadia which included impairment ratings in keeping with the A.M.A., *Guides* for her accepted left knee total replacement and her accepted right elbow lateral epicondylitis. OWCP however did not refer the July 31, 2017 report to a district medical adviser (DMA), but instead denied appellant's schedule award claims finding that she was scheduled for back surgery and, therefore, she had not reached MMI.[32]

[30] *M.G.*, Docket No. 18-0568 (issued October 22, 2018).

[31] *Id.;* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (March 2017).

[32] Dr. Chhadia indicated that he was aware of appellant's ongoing lumbar radiculopathy and other back conditions. There is no medical evidence of record finding that appellant had not reached MMI regarding her left knee and right elbow.

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[33] While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[34] OWCP's procedures required it to refer Dr. Chhadia's May 5 and July 31, 2017 reports to a DMA as this medical evidence indicated that appellant had reached MMI for two of her accepted conditions, left knee primary osteoarthritis with total knee arthroplasty and right elbow lateral epicondylitis included impairment ratings comporting with the A.M.A., *Guides* regarding these conditions.[35] Dr. Chhadia clearly opined that appellant had reached MMI regarding her accepted left knee primary osteoarthritis and total knee arthroplasty as well as her accepted right elbow lateral epicondylitis conditions. The opinion of a DMA was required to confirm that MMI had been reached for her accepted left knee and right elbow conditions and to address application of the A.M.A., *Guides* as to permanent impairment, if any.[36]

The Board, therefore, finds that the case must be remanded to OWCP. On remand OWCP should forward the medical evidence to a DMA for an opinion addressing whether appellant has reached MMI for her accepted left knee and right elbow conditions, whether she has permanent impairment of these scheduled members in accordance with the sixth edition of the A.M.A., *Guides* and, if so, the extent of her permanent impairment.[37] Following this and such further development deemed necessary, OWCP shall issue a *de novo* decision on appellant's schedule award claim.

CONCLUSION

The Board finds that this case is not in posture for decision.

[33] *K.G.*, Docket No. 17-0821 (issued May 9, 2018); *John J. Carlone*, 41 ECAB 354 (1989).

[34] *Id.*

[35] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluation Medical Evidence*, Chapter 2.810.8(i) (September 2010).

[36] *Id.; see N.I.*, Docket No. 16-1027 (issued January 11, 2017) (finding that the claimant's physician provided an impairment rating under the sixth edition of the A.M.A., *Guides* and that therefore the file should have been routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*).

[37] *T.W.*, Docket No. 16-0176 (issued January 10, 2018).

ORDER

IT IS HEREBY ORDERED THAT the November 13, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further proceedings consistent with this opinion of the Board.

Issued: January 11, 2019
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