United States Department of Labor
Employees' Compensation Appeals Board

S.C., Appellant	)	
and	)	**Docket No. 20-1476**
	)	**Issued: December 12, 2022**
U.S. POSTAL SERVICE, POST OFFICE, Tompkinsville, KY, 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:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On August 3, 2020 appellant, through counsel, filed a timely appeal from a June 2, 2020 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.[3]

[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*.

[3] The Board notes that following the June 2, 2020 decision, appellant submitted additional evidence to OWCP. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than 13 percent permanent impairment of her left lower extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On January 6, 2017 appellant, then a 59-year-old rural carrier, filed a traumatic injury claim (Form CA-1) alleging that on that date she suffered an injury when, due to snow and ice conditions, her vehicle slid off the road and hit a tree while in the performance of duty. She stopped work on January 6, 2017.

On February 14, 2017 OWCP accepted appellant's claim for displaced bicondylar fracture of the left tibia. On March 19, 2018 it expanded the acceptance of the claim to include medial meniscus tear of the left knee. OWCP paid appellant wage-loss compensation on the supplemental rolls commencing February 21, 2017 and on the periodic rolls commencing March 5, 2017.

Appellant underwent OWCP-authorized left knee surgery to apply an external fixator on January 7, 2017. She underwent OWCP-authorized left knee arthroscopic partial medial meniscectomy, left knee arthroscopic partial lateral meniscectomy, and chondroplasty of the medial femoral condyle and tibial plateau on April 12, 2018.

Appellant returned to full-duty work on May 30, 2018.

On February 8, 2019 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In support of her claim, appellant submitted a February 27, 2019 report from Dr. Rohn T. Kennington, a Board-certified family practitioner, who reviewed appellant's medical history and provided physical examination findings. Dr. Kennington performed range of motion (ROM) testing for both knees and found 130 degrees, 128 degrees, and 134 degrees of flexion in the right knee and 122 degrees, 124 degrees, and 124 degrees of flexion in the left knee. He opined that appellant had reached maximum medical improvement (MMI) on June 25, 2018. Utilizing the diagnosis-based impairment (DBI) rating method of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[4] Dr. Kennington identified the class of diagnosis (CDX) as a class 3 impairment for the diagnosis of tibial plateau fracture under Table 16-3 (Knee Regional Grid), page 510. He assigned a grade modifier for functional history (GMFH) of 1, in accordance with Table 16-6, page 516, as appellant had an antalgic limp with corrective footwear modifications and a grade modifier for physical examination (GMPE) of 1, in accordance with Table 16-7, page 517, as appellant had minimal palpatory findings with mild loss of ROM. He noted that a grade modifier for clinical studies (GMCS) was not applicable since imaging studies were used to make the diagnosis. Dr. Kennington calculated that appellant had a net adjustment of -4, resulting in movement from the default class of C to A and corresponding to 31 percent permanent impairment of the left lower extremity.

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

On April 12, 2019 OWCP referred appellant's case, along with a statement of accepted facts (SOAF), for a schedule award impairment rating with Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA). In an April 17, 2019 report, Dr. Harris reviewed the SOAF and medical record. Utilizing the DBI rating method of the A.M.A., *Guides*, he identified the CDX as a class 1 impairment for the diagnosis of tibial plateau fracture under Table 16-2 (Foot and Ankle Regional Grid), page 503. Dr. Harris found that appellant had 13 percent permanent impairment of the left lower extremity. He noted that a ROM rating was not appropriate under the criteria in Section 16.7, page 543. Dr. Harris disagreed with Dr. Kennington's impairment rating and indicated that appellant's condition did not meet the criteria for a class 3 impairment. He opined that appellant had reached MMI on February 27, 2019.

In a May 20, 2019 report, Dr. Kennington reviewed Dr. Harris' April 17, 2019 report. He disagreed with Dr. Harris' impairment rating and noted that he used a diagnosis of tibial plateau fracture under Table 16-3, page 510, and not tibia fracture under Table 16-2, page 503. Dr. Kennington asserted that the diagnosis he used most accurately reflected appellant's actual injury and was consistent with the allowed conditions in the claim. He reiterated that appellant had 31 percent permanent impairment of the left lower extremity.

On June 7, 2019 OWCP requested that Dr. Harris, the DMA, review and comment on Dr. Kennington's May 20, 2019 report. In a June 13, 2019 addendum report, Dr. Harris reviewed the medical record, including Dr. Kennington's report. He asserted that Dr. Kennington's report represented a conflict of opinion, which was best resolved by a second opinion orthopedic evaluation including more current x-rays and diagnostic studies.

On July 12, 2019 OWCP referred the case record and a SOAF to Dr. Michael A. Mackay, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a July 30, 2019 report, Dr. Mackay reviewed the SOAF and medical record. He provided physical examination findings and reviewed x-rays of appellant's left knee. Dr. Mackay diagnosed post-traumatic osteoarthritis of the left knee, medial meniscus tear of the left knee, and closed fracture of the left tibial plateau. Utilizing the sixth edition of the A.M.A., *Guides*, he opined that appellant had three percent impairment of the left lower extremity due to the medial meniscus condition, five percent impairment due to the tibial plateau fracture, and five percent impairment due to degenerative joint disease. Dr. Mackay utilized the Combined Values Chart, page 604, to combine these impairment values and concluded that appellant had 13 percent permanent impairment of the left lower extremity. He opined that appellant had reached MMI on July 30, 2019, the date of his examination.

On August 13, 2019 OWCP referred the case record to Dr. Harris, the DMA, for a schedule award impairment rating. In an August 15, 2019 report, Dr. Harris reviewed the SOAF and medical record, including Dr. Mackay's July 30, 2019 report. He clarified his earlier reports by utilizing the DBI rating method of the sixth edition of the A.M.A., *Guides*, and identifying the CDX as a class 1 impairment for the diagnosis of tibial plateau fracture under Table 16-3, page 510. Dr. Harris found that appellant had 13 percent permanent impairment of the lower extremity. He noted that a ROM rating was not appropriate under the criteria in Section 16.7, page 543. Dr. Harris agreed with Dr. Mackay's rating of 13 percent permanent impairment of the left lower extremity and opined that appellant had reached MMI on July 30, 2019.

By decision dated November 14, 2019, OWCP granted appellant a schedule award for 13 percent permanent impairment of her left lower extremity. The award ran for 37.44 weeks from

July 30, 2019 through April 17, 2020. OWCP noted that the schedule award was based on the impairment ratings of Dr. Mackay and Dr. Harris.

On November 19, 2019 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review, which was held on March 19, 2020.

By decision dated June 2, 2020, OWCP's hearing representative affirmed the November 14, 2019 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA,[5] and its implementing federal regulations,[6] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[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]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's *International Classification of Functioning Disability and Health: A Contemporary Model of Disablement*.[10] Under the sixth edition, the evaluator identifies the CDX, which is then adjusted by the GMFH, GMPE, and GMCS.[11] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[12] Evaluators are directed to provide reasons for their impairment rating, including the choice of diagnoses from regional grids, and the calculation of the modifier score.[13]

Section 8123(a) of FECA provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.* at § 10.404(a).

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Chapter 3.700.2 and Exhibit 1 (January 2010).

[9] *See S.C.*, Docket No. 20-0769 (issued January 12, 2021); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[10] A.M.A., *Guides* (6th ed. 2009) at 3, section 1.3.

[11] *Id.* at 493-556.

[12] *Id.* at 521.

[13] *E.W.*, Docket No. 19-1720 (issued November 25, 2020); *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

shall make an examination.[14] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[15] When there exists opposing reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently rationalized and based upon a proper factual background, must be given special weight.[16]

ANALYSIS

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

In February 27 and May 20, 2019 reports, Dr. Kennington determined that appellant had 31 percent permanent impairment of the left lower extremity under the standards of the sixth edition of the A.M.A., *Guides*. Utilizing the DBI rating method, he identified the CDX as a class 3 impairment for the diagnosis of tibial plateau fracture under Table 16-3, page 510. He assigned a GMFH of 1 and a GMPE of 1, and noted that a GMCS was not applicable. Dr. Kennington calculated that appellant had a net adjustment of -4, resulting in movement from the default class of C to A and corresponding to 31 percent permanent impairment of the left lower extremity.

In contrast, Dr. Mackay, the second opinion physician, determined in a July 30, 2019 report that appellant had 13 percent permanent impairment of the left lower extremity. Utilizing the sixth edition of the A.M.A., *Guides*, he opined that appellant had three percent impairment of the left lower extremity due to the medial meniscus condition, five percent impairment due to the tibial plateau fracture, and five percent impairment due to degenerative joint disease. Dr. Mackay utilized the Combined Values Chart, page 604, to combine these impairment values and concluded that appellant had 13 percent permanent impairment of the left lower extremity.

In April 17 and August 15, 2019 reports, Dr. Harris, OWCP's DMA, opined that appellant had 13 percent permanent impairment of the left lower extremity. Dr. Harris utilized the DBI rating method under the sixth edition of the A.M.A., *Guides* and identified the CDX as a class 1 impairment for the diagnosis of tibial plateau fracture under Table 16-3 (Knee Regional Grid), page 510.

The Board thus finds that there is a conflict in the medical opinion evidence between the opinions of Dr. Kennington, appellant's attending physician, and Drs. Mackay and Harris, OWCP's second opinion physician and DMA, regarding the nature and extent of appellant's left lower extremity permanent impairment.

Because there remains an unresolved conflict in the medical opinion evidence regarding appellant's left lower extremity permanent impairment, pursuant to 5 U.S.C. § 8123(a), the case will be remanded to OWCP for referral of appellant, together with the case record and a SOAF, to

[14] 5 U.S.C. § 8123(a); *L.S.*, Docket No. 19-1730 (issued August 26, 2020); *M.S.*, 58 ECAB 328 (2007).

[15] 20 C.F.R. § 10.321; *see also R.C.*, 58 ECAB 238 (2006).

[16] *P.B.*, Docket No. 20-0984 (issued November 25, 2020); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

an appropriate specialist for an impartial medical examination to resolve the conflict.[17] Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's permanent impairment.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the June 2, 2020 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: December 12, 2022
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

[17] *See id.*