United States Department of Labor
Employees' Compensation Appeals Board

S.P., Appellant	)	
and	)	**Docket No. 20-0418**
U.S. POSTAL SERVICE, BAY VIEW/ST. FRANCIS STATION, Milwaukee, WI, Employer	)	**Issued: February 19, 2021**

Appearances:
David Teergarden, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On December 11, 2019 appellant, through his representative, filed a timely appeal from a June 25, 2019 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.

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[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 established more than 37 percent permanent impairment of the left lower extremity for which he previously received schedule award compensation.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts and circumstances set forth in the Board's prior decisions are incorporated herein by reference. The relevant facts are as follows.

On May 3, 1994 appellant, then a 37-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on May 2, 1994 he twisted his left knee when ascending stairs to a school carrying a heavy parcel while in the performance of duty. He stopped work on May 3, 1994 and returned to full-duty work on July 18, 1994. OWCP accepted the claim for left medial meniscus tear and authorized left knee arthroscopic surgery, which was performed on May 27, 1994. It subsequently expanded acceptance of the claim to include osteoarthritis of the left lower leg, and other mechanical complications of internal orthopedic devices of the left lower extremity.

On June 13, 1995 appellant filed a claim for a schedule award (Form CA-7). By decision dated December 7, 1995, OWCP granted appellant a schedule award for two percent permanent impairment of the left lower extremity. The period of the award ran for 5.76 weeks from December 8, 1994 to January 17, 1995.

In a letter dated February 12, 1996, appellant requested reconsideration of the December 7, 1995 schedule award decision. By decision dated April 30, 1996, OWCP granted appellant a schedule award for an additional six percent permanent impairment of the left lower extremity, resulting in a schedule award for a total eight percent left lower extremity permanent impairment. The period of the award ran for 23.04 weeks from December 8, 1994 to May 18, 1995.

OWCP accepted a claim for a recurrence of medical treatment (Form CA-2a) on March 1, 2002 and authorized left knee arthroscopy with partial medial meniscectomy and tibial osteotomy, which occurred on August 27, 2002. It paid wage-loss compensation for periods of disability.

On June 27, 2003 appellant filed a Form CA-7 for an increased schedule award. By decision dated April 21, 2004, OWCP granted a schedule award for an additional 22 percent permanent impairment of his left lower extremity, resulting in a total 30 percent left lower extremity permanent impairment. The period of the award ran for 63.36 weeks from June 11, 2003 to August 27, 2004.

Appellant, after undergoing two additional left knee surgeries, again requested an increased schedule award, Form CA-7, on August 14, 2009. By decision dated November 18, 2009, OWCP granted a schedule award for an additional 7 percent permanent impairment, resulting in a total 37

[3] Docket No. 17-1628 (issued February 13, 2018), *petition for recon. denied,* Docket No. 17-1628 (issued August 17, 2018).

percent left lower extremity permanent impairment. The period of the award ran for 20.16 weeks from September 10, 2009 to January 29, 2010.

On June 18, 2013 appellant filed a Form CA-7 for an increased schedule award. By decision dated May 27, 2015, OWCP denied appellant's claim. It found that the medical evidence did not establish greater than the 37 percent permanent left lower extremity impairment previously awarded.

On June 24, 2015 appellant requested a telephonic hearing before an OWCP hearing representative. By decision dated January 8, 2016, the hearing representative set aside the May 27, 2015 decision as further development of the evidence was required. She found that OWCP had incorrectly found a conflict in the medical opinion evidence as the 2014 opinion of Dr. Mysore S. Shivaram, a Board-certified orthopedic surgeon and second opinion physician, was based on a current examination, and that the report of Dr. M. Stephen Wilson, the treating family practitioner, was not. The hearing representative further found that the opinion of Dr. Matthew Jimenez, the Board-certified orthopedic surgeon whom she noted was improperly designated as an impartial medical examiner (IME), to be of no probative value as he failed to provide an impairment rating using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] She instructed OWCP to provide the DMA with Dr. Shivaram's report for review and provide an opinion on appellant's permanent impairment.

By decision dated March 18, 2016, OWCP denied appellant's claim for an increased schedule award.

On April 6, 2016 appellant again requested a telephonic hearing before an OWCP hearing representative, which was held on December 5, 2016. By decision dated January 30, 2017, OWCP's hearing representative affirmed the March 18, 2016 decision. He found the weight of the medical opinion evidence established that appellant did not have more than the 37 percent left lower extremity permanent impairment previously award.

On July 24, 2017 appellant, through his representative, appealed to the Board. By decision dated February 13, 2018, the Board set aside the January 30, 2017 decision, finding that there was an unresolved conflict in the medical opinion evidence between Dr. Wilson, appellant's treating physician, and OWCP's DMA regarding whether appellant's total knee replacement had a good or poor result pursuant to Table 16-3, page 511 of the A.M.A., *Guides*.[5] The Board instructed OWCP to refer appellant to an IME for a rationalized medical opinion with respect to appellant's employment-related permanent impairment of the left lower extremity under the sixth edition of the A.M.A., *Guides*. The Board further instructed OWCP to issue a *de novo* decision after such further development of the evidence as necessary.

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

[5] *Supra* note 3.

On August 1, 2018 OWCP referred appellant to Dr. Christ Pavlatos, a physician Board-certified in orthopedic surgery and internal medicine, to resolve the conflict in the medical opinion. It provided Dr. Pavlatos with appellant's case record and a statement of accepted facts (SOAF).

In an August 27, 2018 report, Dr. Pavlatos noted appellant's history of injury and medical treatment. He related that review of appellant's left knee x-rays showed evidence of total knee arthroplasties and prior Austin osteotomy with reasonable alignment and some loosing around the prosthesis. Based on appellant's persistent pain, Dr. Pavlatos recommended bone scans and computerized tomography scans with spot views and fluid checking for sensitivity and culture to rule out a possible low grade infection. He noted that maximum medical improvement (MMI) could not be determined at that time due to appellant's possible infection and recommendation for further workup. Using Table 16-3, Knee Regional Grid, he assigned a class 4 for total knee arthroscopy, which had a default value of 67 percent.[6] Dr. Pavlatos assigned a grade modifier for functional history (GMFH) of two using Table 16-6, page 516, and a grade modifier for clinical studies (GMCS) of two using Table 16-8, page 519. Application of the net adjustment formula resulted in no adjustment and a total rating of 67 percent permanent impairment of the left lower extremity. Dr. Pavlatos noted that MMI could not be determined due to appellant's possible infection and the workup he recommended.

On November 15, 2018 OWCP referred Dr. Pavlatos' report to the DMA. In a November 27, 2018 report, the DMA reviewed Dr. Pavlatos' report and his recommendation for a further workup for possible left knee joint infection. He recommended a second opinion to determine whether further workup was necessary, whether MMI had been reached and, if so, a physical examination which provided three sets of left knee range of motion (ROM) measurement.

On February 5 and April 8, 2019 OWCP referred appellant to Dr. Allan Brecher, a Board-certified orthopedic surgeon, for a second opinion evaluation to address permanent impairment of appellant's left lower extremity as defined by the sixth edition of the A.M.A., *Guides,* and to provide an opinion as to whether appellant had reached MMI.

In a May 1, 2019 report, Dr. Brecher reported that appellant had reached MMI on August 27, 2018, the date of Dr. Pavlatos' examination. In accordance with the sixth edition of the A.M.A., *Guides*, he determined the diagnosis-based impairment (DBI) method provided a greater impairment rating than the ROM method. Utilizing Table 16-3, Knee Regional Grid of the sixth edition of the A.M.A., *Guides*, Dr. Brecher assigned a class of diagnosis (CDX) of 4 for the diagnosis of total knee replacement based on the medical records and moderate motion deficit, which was a poor result.[7] He assigned a GMFH of 1, a grade modifier for physical examination (GMPE) of 2, and a GMCS of 2.[8] Application of the net adjustment formula warranted movement two places to the left of the default value to class A, totaling 59 percent permanent impairment of

[6] *Supra* note 4 at 511.

[7] *Id*.

[8] *Id.* at 516, 517, 519.

the left lower extremity. Dr. Brecher also related that no further workup was necessary as appellant did not want to undergo further procedures.

In a June 9, 2019 report, the DMA reviewed Dr. Brecher's report and disagreed with his impairment rating. Using Table 16-3, p. 511, he assigned a CDX of 3 for mild ROM and mild instability. The DMA used Dr. Brecher's findings in assigning a GMPE of 1 instead of 2. Application of the net adjustment formula warranted movement two places to the left of the default value to class A, totaling 31 percent permanent impairment of the left lower extremity.

By decision dated June 25, 2019, OWCP denied appellant's claim for an increased schedule award, finding that appellant was entitled to no more than 37 percent permanent impairment of the left lower extremity previously received.

LEGAL PRECEDENT

Under section 8107 of FECA[9] and section 10.404 of the implementing federal regulations,[10] schedule awards are payable for permanent impairment of specified body members, functions or organs. FECA, however, does not specify the manner in which the percentage of impairment 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.[11]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[12] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[13] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[14]

In determining impairment for the lower extremities, 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.[15] 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

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

[11] *D.J.*, 59 ECAB 620 (2008); *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[12] A.M.A., *Guides* (6th ed. 2009), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

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

[14] *Id.* at 521.

[15] *Id.* at 509-11.

GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[16] 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.[17]

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 who shall make an examination.[18] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an IME, pursuant to section 8123(a) of FECA (5 U.S.C. § 8123(a)), to resolve the conflict in the medical evidence.[19] Where a case is referred to an IME for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[20]

OWCP procedures provide that, if a case has been referred for a referee evaluation to resolve the issue of permanent impairment, it is appropriate for OWCP's medical adviser to review the calculations to ensure the referee physician appropriately used the A.M.A., *Guides*. The procedures further note that the Board has held that, while an OWCP medical adviser may review the opinion of a referee specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility. OWCP's medical adviser cannot resolve a conflict in medical opinion. If necessary, clarification by the referee examiner may be needed.[21]

ANALYSIS

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

In the prior appeal, the Board remanded the case to OWCP for referral of appellant to an IME for a rationalized medical opinion as to whether appellant's total knee replacement had a good or poor result for rating appellant's permanent impairment under the sixth edition of the A.M.A., *Guides.*

On remand OWCP referred appellant for an impartial medical examination in accordance with the Board's instructions to Dr. Pavlatos. In an August 27, 2018 report, Dr. Pavlatos

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

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

[18] *Supra* note 2 at § 8123(a). *See R.C.,* Docket No. 18-0463 (issued February 7, 2020); *see also G.B.,* Docket No. 16-0996 (issued September 14, 2016).

[19] *M.G.*, Docket No. 19-1627 (issued April 17, 2020); *M.R.*, Docket No. 19-0526 (issued July 24, 2019); *C.R.*, Docket No. 18-1285 (issued February 12, 2019).

[20] *Id.*

[21] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.8(g) (September 2010); *Richard R. LeMay,* 56 ECAB 341 (2005). *See K.D.*, Docket No. 19-0281 (issued June 30, 2020).

determined that appellant had total permanent impairment of his left lower extremity of 67 percent. He indicated that, using Table 16-3 (Knee Regional Grid) on page 511 of the sixth edition of the A.M.A., *Guides,* appellant's left lower extremity condition should be considered under the diagnosis-based category relating to total knee replacement. Dr. Pavlatos noted that appellant's condition would fall under class 4 under Table 16-3, due to poor result. With respect to grade modifiers, he referenced Table 16-6, Table 16-7, and Table 16-8 on pages 516 through 519 and indicated that appellant had a GMFH of 2, a GMPE of 2, and a GMCS of 2. Dr. Pavlatos advised that application of the net adjustment formula yielded the result of 0 and default value of 67 percent permanent impairment on Table 16-3. He reported that MMI could not be determined based on a possible infection and he recommended additional workup related to this issue.

On November 27, 2018 the DMA reviewed Dr. Pavlatos' report and recommended that appellant be referred to a second opinion physician to determine whether further workup was needed, whether appellant had reached MMI and, if so, for three sets of measurements of appellant's left knee ROM. Based on the DMA's recommendation, OWCP referred appellant for a second opinion evaluation with Dr. Brecher who found that appellant had 59 percent left lower extremity permanent impairment. The DMA, in a June 9, 2019 report, reviewed Dr. Brecher's report and concluded that appellant had 31 percent left lower extremity permanent impairment.

Instead of evaluating whether the report of Dr. Pavlatos, the IME, constituted the special weight of the medical evidence with respect to permanent impairment, OWCP decided that the weight of the medical evidence rested with the June 9, 2019 report of the DMA, who provided an opinion that appellant had 31 percent permanent impairment of his left lower extremity based on Dr. Brecher's May 11, 2019 second opinion report. However, OWCP's procedures and Board precedent provide that, while OWCP's DMA may review the opinion of a referee specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility and OWCP's DMA cannot resolve a conflict in medical opinion.[22]

In a situation where OWCP secures an opinion from an IME for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, OWCP has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[23] OWCP found that Dr. Pavlatos' report required further clarification regarding the questions posed and should have referred the case back to Dr. Pavlatos. Instead, OWCP requested another permanent impairment rating from Dr. Brecher. Therefore, the case shall be remanded to OWCP to provide Dr. Pavlatos an opportunity to provide clarification of his opinion that appellant has 67 percent permanent impairment of his lower extremity under the standards of the sixth edition of the A.M.A., *Guides*. After such other development as may be deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's claim for an increased left lower extremity schedule award.[24]

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[22] *Id.*

[23] *K.C.*, Docket No. 19-1251 (issued January 24, 2020); *F.H.*, Docket No. 17-1924 (issued January 25, 2019); *Talmadge Miller,* 47 ECAB 673 (1996); *Harold Travis,* 30 ECAB 1071 (1979); *see also supra* note 21 at Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810(11)(e) (September 2010).

[24] *Id.*

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the June 25, 2019 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: February 19, 2021
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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