File Number:
KC-CA-181-D-S

RECEIVED MAR 2 3 2020

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 11 KCM
LONDON, KY 40742-8300
Phone: (816) 268-3040

March 19, 2020

Date of Injury:
Employee:

Dear

Under the schedule award provisions of the Federal Employees' Compensation Act (FECA) at 5 U.S.C. 8107, the Office of Workers' Compensation Programs makes the following:

AWARD OF COMPENSATION

1. Degree and Nature of Permanent Impairment: 1% RIGHT LEG
2. Date of Maximum Medical Improvement:
3. Period of Award: to
4. Number of Weeks of Compensation: 2.88
5. Weekly Pay: $1,235.00 X Compensation Rate: 66 2/3 % = $823.33
6. Effective Date of Pay Rate:
7. After Cost-of-Living Adjustments, Your Weekly Compensation is: $823.33
8. Your Payment and the Period Covered: $2,371.2
9. Your Continuing Payment each Four Weeks: $N/A

Payment of your award ends when you have been paid for the last day shown in item 3 above.

Section 8107 of the Federal Employees' Compensation Act (FECA) and its implementing regulations (20 CFR 10.404; see also 20 CFR Part 10) set forth the number of weeks of compensation to be paid for the permanent loss or loss of use of specified members, functions and organs of the body known as permanent impairment. The commencement period of the award is usually the date of maximum medical improvement, the date that the physical condition of the injured member has stabilized and is not expected to improve further.

The FECA, however, does not in most instances specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* as the appropriate standard for evaluating schedule losses. Currently, schedule awards are calculated using the Sixth Edition of the AMA *Guides.*

A schedule award is payable consecutively but not concurrently with an award for wage loss for the same injury. Therefore, the starting date of the schedule award has been adjusted to
because you received compensation for disability through

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodation(s) and/or modification(s), please contact OWCP.

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The percentage of permanent impairment noted above was based on the medical findings and report of Dr. dated and the report of the District Medical Advisor (DMA) dated . Copies of these reports are provided for your reference.

Dr. examined you on and determined that you had reached maximum medical improvement. Later, on Dr. provided an impairment rating based on table 16-3 on page 509, the Knee Regional Grid, you had an impairment class of 1 for a medial meniscus tear. According to table 16-6 on page 516, your functional history grade modifier is 0. According to table 16-7 on page 517, your physical examination grade modifier was 0. Your clinical studies do not qualify for a clinical studies grade modifier. With the net adjustment of -2, the patient moves to "A" from the default of "C" within class 1. Your impairment is 1% to the right lower extremity.

The DMA indicated that based on the Diagnosis Based Impairment (DBI) rating method, as you have undergone a partial medial meniscectomy, results in 1% impairment of the lower extremity {CDX 1A/GM} (Table 16-3/Page 509).

The DMA indicated that the Range of Motion Method is to be used as a Stand Alone rating when there are no Diagnosis Based Sections that are applicable or, in very rare cases where a severe injury results in a passive range of motion loss, qualifying for class 3 or 4 impairment or for amputation ratings (Section 16.7/ Page 543). The AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition does contain appropriate Diagnosis Based Impairments for your diagnosed condition. The DMA further stated that your diagnosed condition does not meet any of the criteria discussed in Section 16.7 / Page 543 to allow for impairment to be calculated by the Range of Motion (ROM) method. The DMA concluded that you have a 1% right lower extremity impairment rating based on the DBI method.

The percentage of permanent impairment shown above was calculated by a District Medical Advisor (DMA), who applied the Guides to the medical findings provided by your treating physician. The calculation is proper and in accordance with the Guides. The date of maximum medical improvement was determined by the DMA based on the medical evidence of record.

If you disagree with this decision, you should carefully review the attached appeal rights, and pursue whichever avenue is appropriate to your situation.

Sincerely,

Division of Federal Employees' Compensation
KC

Enclosures: Appeal Rights
Important Information
Medical Reports from the DMA dated 02/06/2020 and Dr. dated 07/11/2018

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PAUL H FELSER
ESQUIRE
FELSER LAW FIRM
7393 HODGSON MEMORIAL DRIVE
SUITE 102
SAVANNAH, GA 31406

NOTICE TO ATTORNEY:

According to our records you are the authorized representative in the above case. This correspondence is directed to you for you to handle in this capacity. If the correspondence indicates a response is required, it is expected you will arrange for it. If you have any questions, please contact us at the above address.

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IMPORTANT INFORMATION

Please read the following information carefully. Keep this award letter so you can refer to it when necessary. If you have questions concerning this award, write to the address shown in the letterhead.

1. HOW COMPENSATION IS PAID - Direct deposit is the fastest and most secure way to receive your award payments. **We strongly encourage you to submit a Standard Form 1199A, which will enable us to direct deposit your payment(s) into your bank.** Your first payment will be issued within 30 days. If further payments are due, they will be made every four weeks until the expiration of the award.

2. LUMP SUM PAYMENTS - If you are currently working, or if you are receiving retirement benefits from the Office of Personnel Management, you may be entitled to a "lump-sum" payment of your schedule award. Please contact the District Office at the address listed on the first page of this letter and specifically request information concerning this option.

3. CHANGE OF ADDRESS - Notify this office immediately of any change of address either for correspondence or for direct deposit. Notification must be in writing, signed by you, to the address shown on the first page of this letter. Include your file number, your old address, and your new address.

4. CHANGE IN STATUS OF DEPENDENTS - If your award is paid at the augmented rate of 3/4 because you have one or more dependents, you are required to provide written notification immediately of any change in status of your dependents, to the address on the first page of this letter. The notice must be signed by you and include your file number, the name of the dependent whose status changed, the effective date of the change, and the nature of the change in status. If you originally claimed only one dependent, and there is a change in the status of your sole dependent, do not cash any checks you receive after the change in status of that dependent. Return the checks promptly for adjustment by this Office.

5. RETURN TO WORK - You may work or receive retirement benefits from the Office of Personnel Management (OPM) during the period of this award without any effect on your schedule award payments.

6. SOCIAL SECURITY DISABILITY BENEFITS - Please contact your local Social Security Office regarding this award if you are receiving or have filed for Social Security Disability Benefits.

7. VA BENEFITS - You are required to notify this office if you have received, or are receiving any VA benefits for the same part of the body.

8. EXPIRATION OF AWARD – After the ending date of this award noted in item 3, your entitlement to compensation will be based solely on disability for work resulting from the accepted injury. You may claim continuing compensation by submitting evidence showing that the accepted injury prevents you from performing the kind of work you were doing when injured and from earning comparable wages. Please note that compensation for disability cannot be paid for any period during which you receive retirement benefits from OPM.

March 19, 2020

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Case Number:
Employee: .
Date: March 19, 2020

FEDERAL EMPLOYEES' COMPENSATION ACT APPEAL RIGHTS

If you disagree with the attached decision, you have the right to request an appeal. Review these appeal rights carefully and decide which appeal to request. There are 3 different types of appeal as outlined below. YOU MAY ONLY REQUEST ONE TYPE OF APPEAL AT A TIME.

Place an "X" on the attached form indicating which appeal you are requesting. Complete the information requested at the bottom of the form. Place the form on top of any material you are submitting. Follow the filing instructions (including the type of appeal) and be aware of the time constraints for each appeal.

1. HEARING: If your injury occurred on or after July 4, 1966, and you have not requested reconsideration, as described below, you may request a Hearing. To protect your right to a hearing, any request for a hearing must be made before any request for reconsideration by the District Office (5 U.S.C. 8124(b)(1)). **A hearing request must be made in writing, within 30 calendar days of the date of this decision, as determined by the postmark of your letter.** (20 C.F.R. 10.616) or as received in ECOMP. There are two forms of hearings, both conducted by a hearing representative—**choose one**.

a. **Oral Hearing.** An informal oral hearing is conducted by teleconference unless otherwise determined. You may present oral testimony and written evidence in support of your claim. Any person authorized by you in writing may represent you at an oral hearing.

b. **Review of the Written Record.** You may submit additional written evidence/argument which must be sent with your request for review. You will not be asked to attend or give oral testimony.

2. RECONSIDERATION: If you have additional evidence or legal argument that you believe will establish your claim, you may request, in writing, that OWCP reconsider this decision. **The request must be signed, dated and received within one calendar year of the date of the decision.** It must clearly state the grounds upon which reconsideration is being requested, and be accompanied by relevant evidence not previously submitted, such as medical reports or legal arguments which apply directly to the issue addressed by this decision. A person other than those who made this decision will reconsider your case. (20 C.F.R. 10.605-610)

3. REVIEW BY THE EMPLOYEES' COMPENSATION APPEALS BOARD (ECAB): You have the right to request review by ECAB (20 C.F.R. 10.625). ECAB will review only the evidence received prior to the date of this decision (20 C.F.R. Part 501). **Request for review by ECAB must be made directly to the Board within 180 days from the date of this decision.** To file your appeal with ECAB electronically please visit https://www.dol.gov/ecab/welcome.html. There, you can register with ECAB and file your notice of appeal immediately with the Board. Alternatively, you may submit an Application for Review (AB 1 form) by mail or fax to the Clerk of the Appellate Boards. The AB 1 form can be found here: https://www.dol.gov/ecab/ab-1.pdf.

If you have a disability, federal law gives you the right to receive communication assistance, accommodation(s) and/or modification(s) from DOL such as documents in alternate formats; communication services such as sign language interpretation; or other adjustments/changes to accommodate your disability.

Case Number:
Employee:
Date: March 19, 2020

APPEAL REQUEST FORM If you decide to appeal this decision, read these instructions carefully. You must specify which procedure you request and select **ONLY ONE** option listed below. Place this form on top of any materials you submit. **Submit this request, along with any additional materials electronically or to the appropriate address.**

1. **HEARING**

_____ **REVIEW OF THE WRITTEN RECORD or**

_____ **ORAL HEARING** Hearings will be conducted telephonically unless it is determined that it is necessary that a hearing be conducted in person or by videoconference. If you believe that you require a non-telephonic hearing, please explain below.

_____

_____

For each option above, you must submit this form within 30 calendar days of the date of the decision. You may submit additional written evidence/argument with your request. You may also electronically file your hearing request via ECOMP, an OWCP-hosted free web-based application. To upload and designate a hearing request, visit https://www.ecomp.dol.gov/#Upload_Documents If you are mailing a hearing request, do not mail this request to the District Office. **If mailing a hearing request, send to:**

Branch of Hearings and Review
Office of Workers' Compensation Programs
200 Constitution Avenue, NW, Suite C-3523
Washington, D.C. 20210

2. **RECONSIDERATION BY THE DISTRICT OFFICE**

_____ **RECONSIDERATION:** Your request must be **signed, dated and received** by OWCP within **1 calendar year** of the decision date. You must state the grounds for reconsideration and include relevant new evidence and/or legal argument. You may electronically file your reconsideration request via ECOMP, an OWCP-hosted free web-based application. To upload and designate a reconsideration request, visit https://www.ecomp.dol.gov/#Upload_Documents . If mailing a reconsideration request, send to:

DOL DFEC Central Mailroom
P. O. Box 8300
London, KY 40742

3. **REVIEW BY THE EMPLOYEES' COMPENSATION APPEALS BOARD.**

_____ **ECAB APPEAL:** An ECAB appeal must be filed within **180 calendar** days of the date of this decision. New evidence may **not** be submitted on appeal and any additional evidence received after the date of OWCP's decision will not be reviewed. **Your ECAB appeal request must be made directly to ECAB and cannot be not mailed to the District Office or uploaded via ECOMP.** To file your appeal with ECAB electronically please visit https://www.dol.gov/ecab/welcome.html. You can register with ECAB and file your notice of appeal immediately with ECAB. Alternatively, you may submit an Application for Review (AB 1) https://www.dol.gov/ecab/ab-1.pdf by mail or fax. Information about filing an ECAB appeal can be found at https://www.dol.gov/ecab/appeal-info.htm If mailing an ECAB appeal request, send to: **ECAB Office of the Clerk, U.S Department of Labor, 200 Constitution Ave NW S5220, Washington, DC 20210.**

SIGNATURE_____ TODAY'S DATE_____

PRINTED NAME_____ DECISION DATE_____

ADDRESS_____

PHONE_____