United States Department of Labor
Employees' Compensation Appeals Board

G.R., Appellant	)	
and	)	**Docket No. 18-0735**
	)	**Issued: November 15, 2018**
DEPARTMENT OF THE ARMY,	)	
U.S. ARMY MEDICAL COMMAND,	)	
Fort Jackson, SC, 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:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On February 22, 2018 appellant, through counsel, filed a timely appeal from a January 9, 2018 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 the 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.*

ISSUES

The issues are: (1) whether appellant has established more than 13 percent permanent impairment of the right lower extremity, for which she previously received a schedule award; and (2) whether appellant has established a left knee condition consequential to her accepted right knee injury.

FACTUAL HISTORY

On October 9, 2009 appellant, then a 51-year-old medical support assistant, filed a traumatic injury claim (Form CA-1) alleging that while in the performance of her federal employment on September 10, 2009 she stumbled on a carpet laid over a concrete floor, fell, and landed on her right knee sustaining a meniscal tear. She did not stop work.

On April 13, 2011 Dr. Jeffrey A. Guy, an attending Board-certified orthopedic surgeon, performed an authorized arthroscopic right partial medial meniscectomy, partial lateral meniscectomy, chondroplasty of the medial femoral condyle, and excision of plica. He returned appellant to light-duty work, effective June 7, 2011.

On August 18, 2011 OWCP accepted that appellant's September 10, 2009 employment incident caused a torn right lateral and medial meniscus.[3]

In a report dated January 19, 2012, Dr. Guy diagnosed iliotibial band tendinitis of the right knee. He diagnosed lateral joint line pain on March 15, 2012, and medial joint overload on April 12, 2012.

An April 10, 2012 magnetic resonance imaging (MRI) scan of appellant's right knee demonstrated moderate-to-severe degenerative change in the medial compartment with joint space loss, marginal osteophytes, subchondral cysts, areas of partial and full-thickness cartilage loss, reactive bone marrow edema, free edge degenerative fraying of the medial meniscus, and a small knee joint effusion.

In a report dated June 29, 2012, Dr. Neville Bennett, an attending Board-certified internist, noted that a June 25, 2012 MRI scan of the left knee showed a suprapatellar bursal effusion, meniscal abnormalities, and small bone contusions.

In a report dated August 9, 2012, Dr. Guy opined that appellant's left knee symptoms were caused by a "contribution that is compensatory from the opposite knee."

In a report dated August 24, 2012, Dr. Bennett related appellant's account that on May 30, 2012, her right knee gave way while she was descending steps, causing her to fall. Appellant experienced pain and swelling in her left knee. She had been ambulating with a cane following her right knee injury, but "now that she has injured both knees, the use of the cane is problematic."

[3] OWCP had initially denied the claim by decision dated June 25, 2010. Following additional development, it accepted the claim on August 18, 2011.

Dr. Bennett opined that appellant's left knee symptoms were a consequence of the accepted right knee injury.

On April 25, 2013 Dr. Guy diagnosed left knee pain due to overcompensation from the accepted right knee injury. Appellant underwent a series of orthovisc injection to the left knee. A May 22, 2013 MRI scan of the left knee demonstrated a medial meniscus tear, small Baker's cyst, chondromalacia, and arthrosis of the medial compartment.

In a report dated October 16, 2014, Dr. Guy opined that appellant had attained maximum medical improvement (MMI) of both knees and was not a candidate for additional surgical intervention. He noted that imaging studies demonstrated "significant medial joint arthritis."

In a report dated September 23, 2014, Dr. Guy noted that x-rays of the right knee showed medial compartment osteoarthritis with displacement.

In a report dated October 28, 2014, Dr. Randal Westerkam, an attending Board-certified physiatrist, opined that appellant was not a candidate for additional surgeries other than total bilateral knee arthroplasties. In a report dated November 19, 2014, he diagnosed bilateral degenerative knee changes, right greater than left. Dr. Westerkam opined that, according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[4] appellant had a class 3 impairment of the right knee with a grade modifier for functional history (GMFH) of 2 and a grade modifier for physical examination (GMPE) of 3, resulting in a net modifier of 2, equaling 26 percent permanent impairment of the right lower extremity.

In a letter dated November 7, 2014, appellant, through counsel, requested that OWCP expand acceptance of the claim to include a left knee condition.

On December 23, 2014 appellant filed a claim for a schedule award (Form CA-7).

On January 15, 2015 Dr. James W. Dyer, an OWCP district medical director, reviewed the medical record. He opined that appellant had attained MMI regarding the right knee on July 21, 2011. Dr. Dyer noted that OWCP had not accepted a left knee injury. He disagreed with Dr. Westerkam's October 28, 2014 impairment rating of 26 percent permanent impairment of the right lower extremity. Dr. Dyer found that, according to Table 16-3 of the A.M.A., *Guides*,[5] appellant had 13 percent permanent impairment of the right lower extremity due to class 1, grade E meniscal injury. He explained that appellant's claim was only accepted for tear of the medial and lateral meniscus, for which a partial medial and lateral meniscus repair was performed.

A January 29, 2015 MRI scan of the right knee showed moderate-to-severe medial joint space loss, marginal osteophytes, multiple tiny subchondral cysts, and reactive/degenerative bone marrow edema along the medial tibial plateau.

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

[5] Table 16-3, page 509 of the A.M.A., *Guides* is titled "Knee Regional Grid (LEI) [lower extremity impairment]."

In a report dated February 2, 2015, Dr. Marsha L. Johnson Williams, an attending Board-certified internist, diagnosed bilateral knee degenerative arthritis.

By decision dated April 2, 2015, OWCP granted appellant a schedule award for 13 percent permanent impairment of the right lower extremity. The period of the award ran for a period of 37.44 weeks from July 21, 2011 to April 8, 2012.

On April 14, 2015 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative. The hearing was held on November 19, 2015. At the hearing, counsel asserted that Dr. Westerkam's rating should be controlling and that OWCP should consider osteoarthritis in calculating the percentage of permanent impairment.

By decision dated December 2, 2015, an OWCP hearing representative affirmed the April 2, 2015 schedule award determination.

A December 14, 2015 MRI scan of the left knee showed a truncated free edge of the posterior horn and body of the medial meniscus with a grade 3 meniscal extrusion, a discoid lateral meniscus with degenerative fraying, and severe medial compartment joint osteoarthritis with complete articular cartilage loss, marrow edema, and cyst formation, and mild lateral compartment arthritis changes and cartilage loss at the medial femoral trochlea.

In a report dated December 15, 2015, Dr. Westerkam noted that appellant's left knee symptoms had worsened significantly on November 8, 2015. Appellant sought treatment at a hospital emergency department and was prescribed a knee immobilizer and narcotic medication.

In a report dated January 12, 2016, Dr. David Koon, an attending Board-certified orthopedic surgeon, noted that appellant had multiple medical problems. On examination of the left knee, he found nearly full range of motion, intact cruciate and collateral ligaments, and 2+ pitting edema from the mid-tibial region distally. X-rays demonstrated "mild varus degenerative joint disease." Dr. Koon recommended that appellant not consider a left knee arthroplasty until some of her other medical issues had resolved.

By decision dated February 4, 2016, an OWCP hearing representative vacated the April 2, 2015 schedule award determination and remanded the case to obtain an updated impairment rating of the right lower extremity by an OWCP district medical adviser.

In a report dated January 29, 2016, Dr. Jeff Holloway, an attending physician Board-certified in pediatrics and pediatric sports medicine, diagnosed osteoarthritis of the left knee.

In a report dated February 28, 2016, Dr. Herbert White Jr., an OWCP district medical adviser, found 13 percent permanent impairment of the right lower extremity due to a class 1 meniscal injury. He found a GMFH of 2 for antalgic gait, a GMPE of 2 for moderate palpatory findings, and a grade modifier clinical studies (GMCS) of 2 for radiographic confirmation of moderate pathology. Applying the net adjustment formula, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (2-1) + (2-1) + (2-1), resulted in a net modifier of 3, raising the class 1 default CDX from 10 percent to 13 percent, for a total 13 percent permanent impairment of the right lower extremity.

By decision dated June 22, 2016, OWCP found that appellant had 13 percent permanent impairment of the right lower extremity. However, as appellant had previously received a schedule award for 13 percent permanent impairment of the right lower extremity, there was no increased percentage of impairment.

On July 1, 2016 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative. The hearing was held on February 14, 2017. Counsel contended that appellant had sustained a consequential left knee condition and that OWCP should consider osteoarthritis of the right knee in evaluating the appropriate percentage of permanent impairment. The hearing representative advised appellant that for OWCP to rate osteoarthritis, she must submit x-rays of her right knee showing the measurements of the articular cartilage defects.

In a report dated June 20, 2016, Dr. Guy opined that appellant's left knee condition was causally related to the accepted right knee injury. Appellant underwent a series of orthovisc injections in both knees in October and November 2016.

By decision dated April 5, 2017, an OWCP hearing representative affirmed the June 22, 2016 schedule award determination. She noted that appellant had not provided right knee x-rays with cartilage interval measurements as requested.

On June 6, 2017 appellant, through counsel, requested reconsideration. She submitted additional medical evidence.

In a January 31, 2017 report, Dr. Matthew Pollack, a Board-certified radiologist, diagnosed primary osteoarthritis of both knees.

In a report dated May 10, 2017, Dr. Holloway diagnosed primary osteoarthritis of both knees.

In a report dated June 12, 2017, Dr. Guy noted that a series of orthovisc injections in both knees significantly reduced appellant's pain symptoms.

By decision dated January 9, 2018, OWCP denied modification of the prior decision, finding that the additional medical evidence submitted did not establish a greater percentage of permanent impairment than that previously granted. It found that appellant's attending physicians had not provided x-rays documenting the measurement of the articular cartilage defects caused by preexisting osteoarthritis of the right knee. OWCP also found that as it had not accepted an employment-related left knee condition, the left lower extremity "was not considered in the schedule award." It noted that appellant had not submitted sufficient medical evidence to establish a consequential left knee condition.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA[6] and its implementing regulations[7] 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 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. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[8] The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.[9]

In addressing lower extremity impairments, the sixth edition requires identifying the impairment class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[10] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[11]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to 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.[12]

ANALYSIS -- ISSUE 1

The Board finds that appellant has not established more than 13 percent permanent impairment of the right lower extremity, for which she previously received a schedule award.

On December 23, 2014 appellant claimed a schedule award. In support of her claim, she provided an October 28, 2014 impairment rating from Dr. Westerkam, an attending Board-certified physiatrist, who found a class 3 impairment of the right knee with a GMFH of 2 and a GMPE of 3, for a total 26 percent impairment of the right lower extremity. Dr. Westerkam's

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id*. *See also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (January 2010).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

[10] A.M.A., *Guides* 521.

[11] *Id*.

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

impairment rating, however, was improper. OWCP has accepted the claim for torn right lateral and medial meniscus. A meniscus injury is rated under Table 16-3 of the A.M.A., *Guides.* Table 16 does not allow a meniscal injury to be rated as a class 3 impairment, rather a partial lateral and medial meniscectomy is rated as a class 1 impairment.[13]

OWCP routed Dr. Westerkam's report to Dr. Dyer, an OWCP district medical director, for review. Dr. Dyer opined that according to Table 16-3 of the A.M.A., *Guides*, appellant had 13 percent impairment of the right lower extremity due to a class 1, grade E meniscal injury. OWCP based its April 2, 2015 schedule award determination on Dr. Dyer's impairment rating.

Following additional development, OWCP vacated the April 2, 2015 schedule award determination by decision dated February 4, 2016. It obtained a new impairment rating from Dr. White, a district medical director, who also found a class 1, grade E meniscal injury according to Table 16-3. Based on Dr. White's opinion, OWCP issued a June 22, 2016 decision granting appellant a schedule award for 13 percent permanent impairment of the right lower extremity, affirmed by decisions dated April 5, 2017 and January 9, 2018.

The Board finds that Dr. White properly applied the A.M.A., *Guides* to rate appellant's right lower extremity permanent impairment at 13 percent, and that his report constitutes the weight of the medical opinion evidence.[14] Under Table 16-3 a meniscal injury resulting in a partial medial and lateral menisectomy can receive a maximum rating of 13 percent permanent impairment.[15] Appellant has therefore received the maximum schedule award allowable under Table 16 of the A.M.A., *Guides* for her right knee meniscus injury.

On appeal counsel contends that OWCP should have considered appellant's preexisting osteoarthritis of the right knee in calculating the schedule award. A preexisting, underlying condition should be considered when determining entitlement to a schedule award, but only to the extent that the work-related injury has affected any residual usefulness in whole or in part of the scheduled member.[16] Board precedent requires that the record contain a medical report with a detailed description of the impairment. This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[17] However, as set forth above, appellant's physicians did not provide x-rays with measurements demonstrating a degree of cartilage loss that would warrant an additional schedule award according to Table 16-3 of the A.M.A., *Guides*.

[13] A.M.A., *Guides* 509.

[14] *Id.*

[15] *Id.*

[16] *See F.T.*, Docket No. 16-1326 (issued March 12, 2018).

[17] *Vanessa Young*, 55 ECAB 575 (2004).

Appellant may, request a schedule award or an 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.

LEGAL PRECEDENT -- ISSUE 2

The claimant bears the burden of proof to establish a claim for a consequential injury. As part of this burden, he or she must present rationalized medical opinion evidence, based on a complete factual and medical background, establishing causal relationship. The opinion must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship of the diagnosed condition and the specific employment factors or employment injury.[18]

Causal relationship is a medical issue, and the medical evidence required to establish causal relationship is rationalized medical evidence.[19] Neither the mere fact that a disease or condition manifests itself during a period of employment, nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[20]

In discussing the range of compensable consequences, once the primary injury is causally connected with the employment, the question is whether compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury. The rules that come into play are essentially based upon the concepts of direct and natural results and of the claimant's own conduct as an independent intervening cause. The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.[21]

ANALYSIS -- ISSUE 2

The Board finds that the case is not in posture for a decision regarding whether appellant sustained a consequential left knee injury.

In a letter dated November 7, 2014, appellant, through counsel, claimed a consequential left knee injury. In its schedule award decision dated January 9, 2018, OWCP noted that it had not accepted an employment-related left knee condition.

The Board finds, however, that OWCP failed to properly explain its findings with respect to the issue presented. OWCP did not discharge its responsibility as to a consequential left knee

[18] *Charles W. Downey*, 54 ECAB 421 (2003); *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

[19] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[20] *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

[21] Arthur Larson & Lex K. Larson, *The Law of Workers' Compensation* § 3.05 (2014); *K.S.*, Docket No. 17-1583 (issued May 10, 2018).

condition because it failed to set forth findings of fact and a clear statement of reasons explaining the disposition so that appellant could understand the basis for the decision, *i.e.*, why the evidence of record was insufficient to establish that she sustained a consequential left knee condition causally related to the accepted right knee injury.[22]

The Board will therefore set aside OWCP's January 9, 2018 decision, in part, and remand the case for a *de novo* decision on appellant's claim for a consequential left knee condition.

CONCLUSION

The Board finds that appellant has not established more than 13 percent permanent impairment of the right lower extremity for which she previously received schedule award compensation. The Board further finds that the case is not in posture for decision as to whether appellant sustained a left knee condition consequential to the accepted right knee injury.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated January 9, 2018 is affirmed in part and set aside in part, and the case is remanded to OWCP for additional development consistent with this decision.

Issued: November 15, 2018
Washington, DC

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

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

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

[22] *See* 20 C.F.R. § 10.126; *see also D.Y.*, Docket No. 17-0476 (issued June 22, 2018); *J.J.*, Docket No. 11-1958 (issued June 27, 2012).