

FACTUAL HISTORY

On May 27, 2010 appellant, then a 59-year-old enumerator, filed a traumatic injury claim (Form CA-1) alleging that on May 14, 2010 she injured her left wrist, lower back, knees, and left hip when she slipped and fell while in the performance of duty. On the reverse side of the claim form, the employing establishment indicated that she stopped work on May 14, 2010 and received continuation of pay beginning May 15, 2010.³ On August 2, 2010 OWCP accepted appellant's claim for lumbar sprain, bilateral knee/leg sprain, bilateral knee contusion, and left hip/thigh sprain. It paid wage-loss compensation for the period June 28 through September 24, 2010 and subsequently authorized a December 12, 2013 right knee arthroscopic procedure.⁴

By decision dated September 15, 2014, OWCP granted appellant a schedule award for 62 percent permanent impairment of the right lower extremity under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).⁵ It based its schedule award decision on the October 24, 2012 report of Dr. Edward A. Rankin, a Board-certified orthopedic surgeon, and the July 9, 2013 report of Dr. Lawrence A. Manning, an OWCP district medical adviser (DMA) and orthopedic surgeon. The overall rating included a combination of impairments for right hip arthritis (50 percent) and right knee arthritis (24 percent) under the sixth edition of the A.M.A., *Guides*. The award covered a period of 178.56 weeks from May 14, 2011 through October 14, 2014.

Appellant timely requested a review of the written record before a representative of OWCP's Branch of Hearings and Review. By decision dated March 23, 2015, OWCP's hearing representative affirmed the September 15, 2014 decision, finding that the medical evidence of record was insufficient to establish greater than 62 percent permanent impairment of the right lower extremity.

On April 9, 2015 OWCP expanded the acceptance of appellant's claim to include right knee lateral meniscus tear and contusion of the left wrist.

On May 22, 2015 appellant filed a claim for an additional schedule award (Form CA-7).

On May 29, 2015 appellant underwent an OWCP-approved right knee medial and lateral meniscectomy and a right knee abrasion arthroplasty.

By letter dated August 6, 2015, OWCP informed appellant that because the medical evidence of record indicated that her condition had not yet reached maximum medical improvement (MMI), no additional action could be taken on her claim for an additional schedule award at that time.

On May 3, 2016 appellant again filed a claim for an additional schedule award (Form CA-7).

³ Effective July 3, 2010, the employing establishment terminated appellant's services due to lack of work.

⁴ Dr. Angela E. Jones, a Board-certified orthopedic surgeon, performed an arthroscopic medial and lateral meniscectomy and abrasion arthroplasty of the patella and medial femoral condyle.

⁵ A.M.A., *Guides* (6th ed. 2009).

By development letter dated May 18, 2016, OWCP noted that it had not received any medical evidence in support of appellant's claim for an additional schedule award and afforded her 30 days for the submission of additional evidence.

In a report dated June 6, 2016, Dr. Joseph T. Crowe, a Board-certified orthopedic surgeon, found that appellant had 10 percent permanent impairment of the right lower extremity under the fifth edition of the A.M.A., *Guides*.⁶ He rated her based on her right knee partial medial and lateral meniscectomies and post-traumatic degenerative changes (arthritis) in the lateral compartment. Dr. Crowe explained that he did not use the sixth edition of the A.M.A., *Guides* because the results were shown "to be not reproducible by different examiners."

On August 1, 2016 OWCP referred appellant to Dr. Chester DiLallo, a Board-certified orthopedic surgeon, for a second opinion evaluation regarding the extent of her permanent impairment due to the accepted employment injury.

In an August 23, 2016 impairment evaluation, Dr. DiLallo diagnosed osteoarthritis of the right knee, a lateral meniscus tear, and a medial meniscus tear. Using the sixth edition of the A.M.A., *Guides*, he calculated right lower extremity impairment of 15 percent. Dr. DiLallo noted a date of MMI of August 23, 2016.

By letter dated November 2, 2016, OWCP requested that Dr. DiLallo clarify whether his final 15 percent permanent impairment rating for the right lower extremity was a calculation of a total impairment rating or a figure in addition to appellant's prior rating of 62 percent. In a supplemental opinion dated December 22, 2016, Dr. DiLallo explained that his assessment was 15 percent of the right lower extremity, attributable to the knee. He noted that his impairment evaluation did not replace the 62 percent that had previously been awarded.

On February 3, 2017 Dr. Arthur S. Harris, a Board-certified orthopedic surgeon and DMA, applied the sixth edition A.M.A., *Guides* to Dr. DiLallo's findings. He noted that, under the A.M.A., *Guides*, diagnosis-based impairment (DBI) rating methodology for the knee allowed for 16 percent impairment for documented degenerative joint disease, rather than 15 percent, and that for this reason he disagreed with Dr. DiLallo's impairment rating. Dr. Harris stated that there had been no increase in appellant's right lower extremity impairment for the knee and no increase in appellant's overall prior impairment of the right lower extremity. He opined that appellant had reached MMI on August 23, 2016.

By decision dated February 15, 2017, OWCP denied appellant's claim for an increased schedule award, finding that the weight of the medical evidence rested with Dr. Harris.

On March 3, 2017 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

In an impairment evaluation dated March 18, 2017, Dr. Robert W. Macht, a general surgeon, diagnosed sprain injury of the left wrist, contusions of both knees with subsequent arthritis, status post partial right medial and lateral meniscectomies, and a sprain injury of both hips. Using the DBI methodology for rating permanent impairment, he identified a diagnosis of left wrist sprain. Referring to a *QuickDASH* questionnaire and to Table 15-7, page 406 of the

⁶ A.M.A., *Guides* (5th ed. 2001).

A.M.A., *Guides*, Dr. Macht found a grade modifier of 3 for functional history. Using Table 15-8, page 408, he found a grade modifier of 1 for physical examination. Referring to the Wrist Regional Grid, Table 15-3, page 395, with regard to appellant's wrist sprain injury, Dr. Macht stated that she had a class 1 impairment of the left arm. He noted that, as her functional history was 2 higher and clinical studies were not present, they would not be used for calculation of the impairment. Therefore, appellant's final permanent impairment rating for the left upper extremity was one percent.

Identifying a diagnosis of arthritis for the left lower extremity, Dr. Macht referred to Table 16-3, page 511, for a class 1 impairment. He stated that clinical studies confirmed this diagnosis, so that appellant was assigned a default position, because the functional history and physical examinations were also class 1 based on a lower limb questionnaire and a loss of range of motion (ROM), along with Table 16-6 and Table 16-7, pages 516-517. As such, appellant's permanent impairment of the left lower extremity was seven percent due to a left knee condition. Referring to the hip regional grid, Table 16-4, page 512, she had a class 1 strain injury. Dr. Macht noted that appellant had moderate impairment of ROM of the left hip, referring to Table 16-24, page 549. He further noted that she had minimal palpatory findings that had been consistently documented, referring to Table 16-7, page 517. Dr. Macht stated that appellant was therefore assigned a default position for her strain injury and had a five percent impairment of the left lower extremity. Combined with the 7 percent impairment due to the knee condition, this resulted in a final permanent impairment rating of 12 percent for the left lower extremity.

With regard to appellant's right lower extremity, Dr. Macht referred to Table 16-3 for partial medial and lateral meniscectomies, resulting in a class 1 impairment of the right knee. The grade modifier for functional history was 3 according to Table 16-6 based on a lower limb questionnaire, while the grade modifier for physical examination was 1 due to loss of ROM according to Table 16-7. This resulted in a default position for selection of impairment of the right leg, because the functional history score was 2 higher. As such, appellant's permanent partial impairment of the right lower extremity was 10 percent. Referring to the hip regional grid, Table 16-4, Dr. Macht noted a class 1 strain injury with mild impairment of ROM of the right hip due to loss of external rotation. Referring to Table 16-7, he noted a grade modifier of 1 due to minimal palpatory findings that had been consistently documented. Dr. Macht stated that appellant was therefore assigned a default position from her strain injury and had a two percent impairment of the right lower extremity. Combined with the 10 percent impairment due to the knee condition, this resulted in a final permanent impairment of 12 percent of the right lower extremity. Dr. Macht stated that appellant had reached MMI by February 6, 2017.

The hearing was held on September 14, 2017. During the hearing, appellant noted that her previous schedule award for 62 percent permanent impairment of the right lower extremity did not include other parts of her body that were injured, such as her back and wrists. OWCP's hearing representative held the record open for 30 days for the submission of additional evidence.

By decision dated November 14, 2017, OWCP's hearing representative set aside the decision of February 15, 2017 and remanded appellant's claim for additional development. He indicated that a DMA should opine whether new evidence warranted a change in her prior impairment rating to the right leg, and should also opine as to whether any work-related impairment existed in the left arm and left leg. The hearing representative noted that, if there was work-related impairment to the left arm and left leg documented, it would be payable.

In a January 27, 2018 report, Dr. Harris reviewed a statement of accepted facts and appellant's medical records. He noted diagnoses of: status post right knee arthroscopy with arthroscopic partial medial and lateral meniscectomy and abrasion arthroplasty; status post right knee arthroscopy with arthroscopic partial medial and lateral meniscectomy; left knee degenerative joint disease; bilateral hip strains; and a history of left wrist contusion. Dr. Harris concurred with Dr. Macht's 12 percent rating for the right lower extremity based on DBI, combining a 2 percent impairment of the right hip with a 10 percent impairment of the right knee. With regard to appellant's left lower extremity impairment, he also concurred with Dr. Macht's 12 percent rating for the left lower extremity based on DBI, combining a 5 percent impairment of the left hip with a 7 percent impairment of the left knee. Dr. Harris found that she did not have any impairment in the left upper extremity, as there were no significant objective findings to support it. He noted the date of MMI as March 18, 2017, contrary to Dr. Macht's February 6, 2017 date of MMI, explaining that the case file did not contain any medical records documenting that appellant had reached MMI prior to her evaluation by Dr. Macht. Dr. Harris concluded that she had no increase in her right lower extremity impairment.

By decision dated February 28, 2018, OWCP issued a *de novo* decision denying appellant's claim for an additional schedule award. It noted that Dr. Harris opined that she had a total 12 percent right lower extremity permanent impairment and 12 percent left lower extremity permanent impairment. OWCP found that, as the combined left and right lower extremity impairments (24 percent) were less than the previously paid 62 percent permanent impairment of the right lower extremity, appellant was not due any additional compensation for a schedule award. It also noted that the DMA found no permanent impairment of the left upper extremity.

On March 27, 2018 appellant requested reconsideration of OWCP's February 28, 2018 decision. She attached a statement, in which she noted that Dr. Macht had not ordered an MRI scan.

OWCP also received treatment records from Dr. Daniel R. Ignacio, a Board-certified physiatrist, covering the period March 8 to May 31, 2018. Dr. Ignacio noted that he was treating appellant for work-related injuries sustained on May 14, 2010. In his latest report, he diagnosed chronic lumbar sprain with lumbar neuritis, bilateral knee sprain, bilateral knee internal derangement, post-traumatic arthropathy of the knees, right knee lateral meniscus tear, chronic left wrist sprain, and chronic left carpal tunnel syndrome.

By decision dated June 25, 2018, OWCP denied modification of its February 28, 2018 decision.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA,⁷ and its implementing federal regulations,⁸ 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

⁷ 5 U.S.C. § 8107.

⁸ 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants and the Board has concurred in such adoption.⁹ For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.¹⁰

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).¹¹ The sixth edition requires identifying the impairment class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE) and clinical studies (GMCS).¹² The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).¹³

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed through a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.¹⁴

Section 8107(c)(20) of FECA provides that, in the case of loss of use of more than one member or parts of more than one member as enumerated by this schedule, the compensation is for loss of use of each member or part thereof, and the awards run consecutively.¹⁵

It is well established that benefits payable under 5 U.S.C. § 8107(c) are reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.¹⁶

⁹ *Id.* at § 10.404(a); *see also Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

¹⁰ *See D.T.*, Docket No. 12-0503 (issued August 21, 2012); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (March 2017); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

¹¹ *Supra* note 5, page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

¹² *Id.* at 411, 494-531.

¹³ *Id.*

¹⁴ *P.R.*, Docket No. 18-0022 (issued April 9, 2018); *supra* note 10 at Chapter 2.808.6f (March 2017).

¹⁵ 5 U.S.C. § 8107(c)(20); *see R.B.*, Docket No. 13-0904 (issued September 6, 2013) (FECA provides that lower extremity impairments are rated for each member; the two members are not totaled into one sum for lower extremity impairment); *A.V.*, Docket No. 06-0481 (issued October 24, 2006); *Erma L. Moore*, Docket No. 99-1554 (issued September 25, 2000) (the fact that appellant established that she had a 10 percent impairment of the left arm in 1996 and was evaluated as having two percent impairment of that arm in 1998 did not mean that OWCP could deny her claim for a permanent impairment of the right arm on the grounds that she received a greater total award than she would be entitled to for both arms); *Cleo R. Hatch*, 49 ECAB 636 (1998).

¹⁶ 20 C.F.R. § 10.404(d); *see J.K.*, Docket No. 16-1361 (issued April 18, 2017); *T.S.*, Docket No. 09-1308 (issued December 22, 2009).

ANALYSIS -- ISSUE 1

The Board finds that this case is not in posture for decision with regard to the extent of appellant's lower extremity impairment.

Appellant previously received a schedule award for 62 percent permanent impairment of her right lower extremity, which was based on a combination of impairments for hip arthritis (50 percent) and knee arthritis (24 percent) under the sixth edition of the A.M.A., *Guides* (2009). The latest medical evidence, as represented by the opinions of Dr. Macht and the DMA, indicated that she currently had 12 percent permanent impairment of her right lower extremity and 12 percent permanent impairment of her left lower extremity, which included a combination of impairments involving the bilateral hips and knees under the A.M.A., *Guides* (6th ed. 2009).

In its February 28, 2018 decision, OWCP combined appellant's bilateral lower extremity impairments (24 percent), and determined that she was not entitled to an additional schedule award because of her previous 62 percent right lower extremity award. OWCP's hearing representative subsequently denied modification of the February 28, 2018 decision.

The Board finds that OWCP improperly combined appellant's left and right lower extremity impairment. By combining the impairment ratings for the left and right lower extremities, OWCP improperly offset her left lower extremity impairment against her prior right lower extremity schedule award. Absent evidence that the later impairment is duplicative in whole or in part of a previous schedule award, there is no basis for an offset.¹⁷ Because appellant has not previously received a schedule award with respect to her left lower extremity, the current 12 percent left lower extremity impairment is not duplicative of the September 15, 2014 right lower extremity schedule award.¹⁸ Accordingly, the case is remanded to OWCP for further consideration regarding her entitlement to schedule award compensation. After such further development as deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's entitlement to a schedule award for her left and right lower extremities.

LEGAL PRECEDENT -- ISSUE 2

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility to see that justice is done.¹⁹ The nonadversarial nature of proceedings under FECA is reflected in OWCP's regulations at section 10.121.²⁰ Once OWCP undertakes development of the record, it must procure medical evidence that will resolve the relevant issues in the case.²¹

¹⁷ *Id.*

¹⁸ *See B.C.*, Docket No. 13-1855 (issued July 22, 2014).

¹⁹ *K.S.*, Docket No. 18-0845 (issued October 26, 2018); *John J. Carlone*, 41 ECAB 354 (1989).

²⁰ *See C.F.*, Docket No. 18-1607 (issued March 12, 2019); 20 C.F.R. § 10.121.

²¹ *See K.G.*, Docket No. 17-0821 (issued May 9, 2018).

With respect to upper extremity permanent impairment, the A.M.A., *Guides* provide that the ROM impairment method is to be used as a stand-alone rating when other regional grids direct its use or when no other diagnosis-based sections are applicable.²² If ROM 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.²³ Adjustments for GMFH 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.²⁴

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology for rating upper extremity impairments.²⁵ FECA Bulletin No. 17-06 provides in pertinent part:

“As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).

“Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify: (1) the methodology used by the rating physician (*i.e.*, DBI or ROM), and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*” (Emphasis in the original.)²⁶

The Bulletin further advises:

“If the medical evidence of record is [in]sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence.”²⁷

“If the original impairment rating found by the DMA to be insufficient was provided from a second opinion or referee physician (*versus* the claimant’s physician), the CE should request a supplemental/clarification report from the second opinion or referee physician to address the medical evidence necessary to

²² *Supra* note 11 at 461.

²³ *Id.* at 473.

²⁴ *Id.* at 474.

²⁵ FECA Bulletin No. 17-06, which was effective for all decisions issued by OWCP on and after May 8, 2017.

²⁶ *Id.*

²⁷ *Id.*

complete the impairment assessment. Medical evidence received in response to this request should then be routed back to the DMA for a final determination. The CE should not render a decision on the schedule award impairment rating until the necessary medical evidence has been obtained.”²⁸

ANALYSIS -- ISSUE 2

The Board finds that the case is not in posture for decision with regard to the extent of appellant’s left upper extremity permanent impairment.

In its February 28, 2018 decision, OWCP noted that the DMA agreed with appellant’s physician, Dr. Macht, that she did not have a permanent impairment of the left upper extremity. However, Dr. Macht found one percent left upper extremity permanent impairment based on a diagnosis of left wrist sprain.²⁹

The Board finds that the DBI rating provided by Dr. Macht under Table 15-3 (Wrist Regional Grid) allows for an alternative rating based on loss of ROM. Therefore, OWCP’s guidance under FECA Bulletin 17-06 is applicable.

Accordingly, the case shall be remanded to OWCP in order for the DMA to reevaluate Dr. Macht’s upper extremity impairment rating in accordance with FECA Bulletin No. 17-06. Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision on the extent of impairment to appellant’s left upper extremity.³⁰

CONCLUSION

The Board finds that this case is not in posture for decision as to either upper or lower extremity permanent impairment.

²⁸ *Id.*

²⁹ Table 15-3 (Wrist Regional Grid), A.M.A., *Guides* 395 (6th ed. 2009).

³⁰ *Id.*

ORDER

IT IS HEREBY ORDERED THAT the June 25, 2018 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision of the Board.

Issued: August 2, 2019
Washington, DC

Patricia H. Fitzgerald, Deputy 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