United States Department of Labor
Employees' Compensation Appeals Board

J.H., Appellant	)	
and	)	**Docket No. 18-1207**
	)	**Issued: June 20, 2019**
DEPARTMENT OF VETERANS AFFAIRS, ORLANDO VETERANS ADMINISTRATION MEDICAL CLINIC, Orlando, FL, Employer	)	

Appearances:
Appellant, pro se
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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On May 29, 2018 appellant filed a timely appeal from a May 2, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[2]

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish more than nine percent permanent impairment of his right lower extremity, for which he previously received

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that appellant submitted additional evidence on appeal. 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.*

schedule award compensation; and (2) whether OWCP properly determined appellant's pay rate when calculating his schedule award compensation.

FACTUAL HISTORY

On December 1, 2011 appellant, then a 50-year-old housekeeping aid, filed a traumatic injury claim (Form CA-1) alleging that on November 28, 2011 he fell on a wet floor when stripping wax while in the performance of duty. He claimed an injury to his head, back, left elbow, and right knee. Appellant stopped work on November 28, 2011 and returned to work November 30, 2011. OWCP accepted the claim for sprain of right knee, medial collateral ligament and tear of medial meniscus of right knee. Appellant underwent authorized right knee arthroscopic partial medial meniscectomy and chondroplasty, on March 26, 2012, by Dr. Joseph B. Billings, an osteopath and Board-certified orthopedic surgeon. Appellant stopped work on the date of surgery and returned to full-duty work on April 24, 2012.

By decision dated July 19, 2012, OWCP granted appellant a schedule award for two percent permanent impairment of the right lower extremity. The award ran from April 24 to June 3, 2012, for a total of 5.76 weeks of compensation. Appellant was paid $378.98 weekly, based on his pay rate as of November 28, 2011.

In an August 12, 2016 medical report, Dr. Robert Reppy, an osteopath and family medicine specialist, noted the history of appellant's November 28, 2011 employment injury and that he had increasing issues with his right knee including pain, stiffness, and instability. He ordered a new magnetic resonance imaging (MRI) scan of the right knee to ascertain to the status of the anterior cruciate (AC) ligament. Appellant underwent a right knee MRI scan on August 16, 2016, which indicated scarring from prior meniscal repair and partial meniscectomy with subtle recurrent tear, mild sprain involving the AC ligament, trace amount of joint effusion, and ganglion cyst.

In a February 27, 2017 medical report, Dr. Reppy noted that, in addition to the November 28, 2011 employment injury, appellant had another employment incident on February 4, 2016 when the ladder he stepped on gave out and he fell onto a granite floor.[3] He noted that appellant had L3-4 and L4-5 nerve distribution on the left side, for which his neurosurgeons had recommended an L3-4 and L4-5 laminectomy. With regard to the right knee, Dr. Reppy indicated that since appellant had undergone a subtotal medial meniscectomy and chondroplasty lateral tibial plateau, it was not surprising that the MRI scan showed chondromalacia in the lateral compartment as the meniscectomy had removed the cushioning at the tibia. He opined that the chondromalacia was a consequence of the surgery. Dr. Reppy further opined that appellant's condition was likely aggravated by his February 4, 2016 employment incident which caused him to favor his left side and aggravated his right knee problems. He indicated that appellant was at maximum medical improvement (MMI) for his right knee as of August 16, 2016, but had increased impairment due to the chondromalacia (osteoarthritis) from the meniscectomy and recurrent meniscal tear. Dr. Reppy diagnosed grade IV chondromalacia. He utilized the diagnosis-based impairment (DBI) method to determine impairment and found that

[3] OWCP assigned OWCP File No. xxxxxx193 to the February 4, 2016 claim. The record reflects that OWCP accepted that claim for fractures of first and second lumbar vertebra, intervertebral disc disorders with myelopathy, lumbar region, and radiculopathy, lumbosacral region.

appellant had 22 percent permanent impairment of the right lower extremity pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] Under Table 16-3, Knee Regional Grid, page 511 of the A.M.A., *Guides*, he identified the diagnosis of grade 4 chondromalacia (patellofemoral arthritis) as a class 2 impairment with default rating of 20 percent. Dr. Reppy assigned a grade modifier of 0 for functional history (GMFH) under Table 16-6, page 516, as appellant's antalgic limp was due to his left-sided radiculopathy from the February 4, 2016 work incident. Under Table 16-7, page 517, he assigned a grade modifier of 2 for physical examination (GMPE) due to positive patella apprehension test. Under Table 16-8, page 519, Dr. Reppy assigned a grade modifier 3 for clinical studies (GMCS) for several reasons. First, the MRI scan showed chondromalacia and recurrent meniscus tear. Second, the meniscal repair was used as a modifier since it was not being rated separately. Dr. Reppy noted that the GMFH was unreliable and would not be used as, under page 518, it was two places lower than the GMPE and GMCS. Using the net adjustment formula of (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), he calculated that appellant had a net adjustment of N/A + (2-2) + (3-2) = 1, which equaled a grade D or 22 percent permanent impairment rating.

On July 13, 2017 appellant filed a claim for a schedule award (Form CA-7).

In a July 14, 2017 report, Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), noted appellant's accepted conditions and reviewed the medical record, including Dr. Reppy's February 27, 2017 report. He related that appellant had reached MMI on August 16, 2016, the date of Dr. Reppy's evaluation, however, he disagreed with Dr. Reppy's impairment rating. The DMA determined that Dr. Reppy's use of class 2 impairment for patellofemoral arthritis was not supported by the record or the methodology set forth in the A.M.A., *Guides.* He noted that under Table 16-3 of the A.M.A., *Guides,* there was no radiograph interpretation of record which indicated a complete loss of articular cartilage to produce "no cartilage interval on x-ray." The DMA indicated, however, that as the August 16, 2016 MRI scan report noted a focal region of full-thickness chondral defect measuring 1 centimeter in diameter of the lateral femoral condyle, it was sufficient to establish class 1 impairment for primary knee arthritis. He noted that page 518 of the A.M.A., *Guides* specifically requested standard standing x-rays for the assessment of cartilage interval to establish the class of impairment for both primary knee joint arthritis and patellofemoral arthritis diagnoses, which relied on cartilage interval. The DMA explained that focal areas of full loss were often noted on MRI scan or arthroscopy. For this reason, he rerated appellant's impairment under the diagnostic key factor of "full-thickness articular cartilage defect." The DMA determined that, under Table 16-3 of the A.M.A., *Guides*, appellant's full-thickness articular cartilage defect represented a class 1 diagnosis with a default value of seven percent for primary knee joint arthritis. Using Dr. Reppy's estimates of GMFH (N/A), GMPE 2, and GMCS 3, he calculated that appellant had a maximum net adjustment of 2,[5] which equated to a grade E impairment or nine percent permanent impairment of the right lower extremity. As appellant previously received two percent permanent impairment

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

[5] (GMPE - CDX)(2-1) + (GMCS - CDX)(3-1) = 3.

of the right lower extremity, the DMA found that he was entitled to an additional award of seven percent permanent impairment.

On August 15, 2017 OWCP received an August 12, 2017 standing x-ray report of both knees which were interpreted as normal.

In an August 25, 2017 report, Dr. Reppy reviewed the August 12, 2017 x-ray report, but indicated that the radiologist had not commented on the amount of arthritis in the knee. He indicated that the A.M.A., *Guides*, as noted on page 518, used x-rays as a grade modifier. Dr. Reppy also indicated that the A.M.A., *Guides* did not mandate the use of x-rays in the initial determination as to a DBI rating. He further noted that Table 16-8, page 519 of the A.M.A., *Guides* indicated that x-rays could not be used in the initial determination and then in the modifier determination. Dr. Reppy thus opined that his 22 percent impairment rating was correct under the A.M.A., *Guides.*

By decision dated September 5, 2017, OWCP granted appellant a schedule award for an additional seven percent permanent impairment of the right lower extremity, for a total award of nine percent permanent impairment. The award ran from August 16, 2016 through January 4, 2017, for a total of 20.16 weeks of compensation. Appellant's weekly pay was based on a pay rate date of March 26, 2012 and equaled $378.96 ($505.29 multiplied by75 percent compensation rate). The weight of the medical evidence regarding the percentage of impairment was accorded to the DMA.

On February 2, 2018 appellant, through his then counsel, requested reconsideration. Counsel argued that since appellant had a traumatic injury claim with prior disability, his pay rate for the increased schedule award should be the date of recurrence. He further noted that OWCP failed to address Dr. Reppy's August 25, 2017 report in its September 5, 2017 decision.

On April 25, 2018 OWCP forwarded Dr. Reppy's August 25, 2017 report and a list of questions to its DMA. In an April 28, 2018 report, the DMA rereviewed the medical record, including Dr. Reppy's August 25, 2017 report. He advised that his DBI rating totaling nine percent permanent right lower extremity impairment was based on the key factor of "primary knee arthritis, full-thickness articular cartilage defect" under Table 16-3 and that it complied with the reprinted 2009 A.M.A., *Guides,* 6th edition and had not changed. The DMA noted that Dr. Reppy's 22 percent permanent impairment rating was based on the key factor under Table 16-3 of "patellofemoral arthritis, no cartilage interval." He explained that it remained his opinion that Dr. Reppy's use of the key factor of "no cartilage interval" was not diagnostically established. The DMA reiterated that the A.M.A., *Guides* were specific on page 518 that standard standing x-rays were used in making an assessment of cartilage interval under the key diagnostic indicator of primary knee joint arthritis and patellofemoral arthritis. He disagreed with Dr. Reppy's assertion that x-rays were used only as a grade modifier. The DMA again explained that focal areas of full loss were often noted on MRI scan or arthroscopy. He further explained that intact pillars of chondral tissue may maintain the joint space or radiographs despite the existence of focal defects.

The DMA noted that since his impairment opinion remained unchanged, a referee evaluation may be necessary.

By decision dated May 2, 2018, OWCP denied modification of its prior decision. It found that appellant was paid the correct pay rate based on date of disability of March 26, 2012. OWCP noted that, on the date of disability, appellant's pay was $12.59 an hour. It multiplied the $12.59 hourly rate by 2087 (the number of hours in one year), and then divided that number by 52 (the number of weeks in one year), which equaled $505.29. OWCP then multiplied $505.29 by the 75 percent augmented compensation rate for employees with dependents to find a weekly pay rate of $378.96. It further found that the weight of the medical evidence remained with the DMA.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA[6] and its implementing federal 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, functions, and organs of the body. FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[8] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[9] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[10] 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.[11]

In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, 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.[12] After the class of diagnosis (CDX) is determined from the Knee Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[13] Under Chapter 2.3,

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *See K.P.*, Docket No. 18-0777 (issued November 13, 2018); *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[9] *Id.*

[10] 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, Exhibit 1 (January 2010).

[11] *See K.P., supra* note 8; *Isidoro Rivera*, 12 ECAB 348 (1961).

[12] *See* A.M.A., *Guides* 509-11 (6th ed. 2009).

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

evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[14]

In some instances, a DMA's opinion can constitute the weight of the medical evidence.[15] This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the A.M.A., *Guides*.[16] In this instance, a detailed opinion by a DMA may constitute the weight of the medical evidence as long as he or she explains his or her opinion, shows values and computation of impairment based on the A.M.A., *Guides*, and considers each of the reported findings of impairment, his or her opinion may constitute the weight.[17] If the attending physician misapplied the A.M.A., *Guides*, no conflict would exist because the attending physician's report would have diminished probative value and the opinion of the DMA would constitute the weight of medical opinion.[18]

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met his burden of proof to establish more than nine percent permanent impairment of his right lower extremity, for which he previously received schedule award compensation.

OWCP accepted appellant's claim for right knee sprain of the medial collateral ligament and right knee tear of the medial meniscus. On March 26, 2012 appellant underwent an OWCP-authorized right knee arthroscopic partial medial meniscectomy and chondroplasty. By decision dated July 19, 2012, OWCP granted him a schedule award for two percent permanent impairment of the right lower extremity. Appellant later filed a claim for an increased schedule award. By decision dated September 5, 2017, OWCP found that he was entitled to an increased schedule award for an additional seven percent permanent impairment of his right lower extremity based on the opinion of a DMA. By decision dated May 2, 2018, it denied modification of its September 5, 2017 decision.

In a February 27, 2017 report, Dr. Reppy, appellant's treating physician, found that appellant had 22 percent permanent impairment of his right lower extremity due to grade 4 chondromalacia (patellofemoral arthritis) as seen on MRI scan. He utilized the DBI method for rating appellant's permanent impairment. Under Table 16-3, Knee Regional Grid, page 511 of the A.M.A., *Guides*, Dr. Reppy identified the diagnosis of grade 4 chondromalacia (patellofemoral arthritis) as a class 2 impairment with default rating of 20 percent. He found GMFH was not applicable and applied a GMPE of 2, and GMCS of 3 to the net adjustment formula, which resulted

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

[15] *See K.P., supra* note 8; *M.P.*, Docket No. 14-1602 (issued January 13, 2015); *supra* note 10 at Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.8(j) (September 2010).

[16] *Id.*

[17] *Id.*

[18] *Id.*

in a net adjustment of 1, which equaled 22 percent permanent impairment of the right lower extremity.

On July 14, 2017 a DMA noted appellant's accepted conditions and reviewed the medical record, including the clinical findings of Dr. Reppy. He disagreed with Dr. Reppy's 22 percent right lower extremity permanent impairment rating as there were no radiographic findings, which were required under Table 16-3 for arthritis of the knee, to support his impairment determination.[19] The DMA also specifically noted that the DBI impairment method for primary knee joint arthritis and patellofemoral arthritis required standing x-rays which indicated cartilage interval. While Dr. Reppy subsequently provided an August 12, 2017 x-ray report, which was interpreted as normal, he indicated that the radiologist had not commented on the amount of arthritis in the knee. He maintained that his 22 percent impairment evaluation was correct under the A.M.A., *Guides*, as x-rays were a grade modifier and not mandated in the initial determination as to a diagnosis-based impairment. The DMA again disagreed, on the basis that Dr. Reppy's use of the key factor of "no cartilage interval" was not diagnostically established. He reiterated that the A.M.A., *Guides* were specific on page 518 that standard standing x-rays were used in making an assessment of cartilage interval under the key diagnostic indicator of primary knee joint arthritis and patellofemoral arthritis.[20] The Board finds that there is no radiographic findings to support Dr. Reppy's DBI impairment rating for a class 2 impairment for primary knee joint arthritis and patellofemoral arthritis, which are required under Table 16-3 of the A.M.A., *Guides*.[21] Thus, Dr. Reppy failed to properly utilize the A.M.A., *Guides* in assessing appellant's right lower extremity permanent impairment, his report is of diminished probative value, and is insufficient to create a conflict of medical opinion.[22]

The Board finds that the July 14, 2017 impairment rating from the DMA represents the weight of the medical evidence in this case as he properly applied the appropriate provisions of the A.M.A., *Guides* to the clinical findings of record.[23] The DMA noted that appellant had reached MMI on August 16, 2016, the date of Dr. Reppy's evaluation. He indicated that as the August 16, 2016 MRI scan report noted a focal region of full-thickness chondral defect measuring 1 centimeter in diameter of the lateral femoral condyle, it was sufficient to establish class 1 impairment for primary knee joint arthritis under the diagnostic key factor of "full-thickness articular cartilage defect" under Table 16-3 of the A.M.A., *Guides*. The DMA found that, under Table 16-3 of the A.M.A., *Guides*, appellant's full-thickness articular cartilage defect represented a class 1 diagnosis with a default value of seven percent for primary knee joint arthritis. Using Dr. Reppy's estimates of GMFH (N/A), GMPE 2, and GMCS 3, he calculated that appellant had a maximum net adjustment of 2,[24] which equated to a grade E impairment or nine percent permanent impairment

[19] *See K.P., supra* note 8; *M.G.*, Docket No. 10-1771 (issued May 4, 2011).

[20] *Id.*

[21] *Id.*

[22] *See supra* note 18.

[23] *See K.P., supra* note 8; *W.M.*, Docket No. 11-1156 (issued January 27, 2012).

[24] (GMPE – CDX)(2-1) + (GMCS – CDX)(3-1) = 3.

of the right lower extremity. As appellant was previously awarded a schedule award for two percent permanent impairment of the right lower extremity and was entitled to an award for nine percent permanent impairment, OWCP properly awarded him an additional schedule award for seven percent permanent impairment of the right lower extremity.

The record contains no other probative, rationalized medical opinion which indicates that appellant has greater impairment based on his accepted right knee condition pursuant to the A.M.A., *Guides.* Thus, appellant has not met his burden of proof to establish greater than nine percent total right knee permanent impairment, for which he received a schedule award.

Appellant may request a schedule award or 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 amount of compensation paid is a function of the injured employee's pay rate.[25] Pay rate for compensation purposes is defined in 5 U.S.C. § 8101(4) as the monthly pay at the time of injury, the time disability begins, or the time disability recurs, if the recurrence is more than six months after returning to full-time work, whichever is greater.[26]

ANALYSIS -- ISSUE 2

The Board finds that OWCP properly determined appellant's pay rate when calculating his schedule award compensation.

Appellant initially filed a schedule award claim in 2012. He received a schedule award on July 19, 2012 for two percent permanent impairment of his right lower extremity. On September 5, 2017 OWCP determined that appellant had an additional seven percent permanent impairment of his right lower extremity. Appellant claimed that his schedule award compensation was paid at an improper pay rate. The record reflects that appellant sustained other unrelated traumatic injuries since the November 28, 2011 employment incident.

In awarding compensation, OWCP properly relied on appellant's date of disability (March 26, 2012) for the weekly pay rate. There is no evidence of record that appellant's schedule award should have been paid at a higher pay rate. Appellant also had not established a recurrent pay rate as he did not sustain a recurrence more than six months after returning to full-time work.[27] OWCP's procedures provide that the effective pay rate for schedule awards for traumatic claims is based on the date of injury, date disability began, or date of recurrence, whichever is greatest.[28] As appellant has not sustained a recurrence of disability and the other injuries he sustained were

[25] 20 C.F.R. § 10.404(b).

[26] 5 U.S.C. § 8101(4); *see also N.C.*, Docket No. 18-1070 (issued January 9, 2019).

[27] *Id.*

[28] *See supra* note 26.

unrelated to the current claim, therefore the Board finds that OWCP properly relied on the date of disability in this case.[29]

OWCP also properly calculated appellant's pay rate. Appellant's hourly pay rate on the date of disability was $12.59. Twelve dollars and fifty-nine cents (hourly rate) times 2087 (the number of hours in a year) divided by 52 (number of weeks in a year) equaled $505.29 weekly pay. As appellant had qualifying dependents, his weekly pay of $505.29 multiplied by the augmented 75 percent compensation rate for an employee with dependents, equaled $378.96 which was the amount utilized by OWCP in paying appellant's schedule award compensation.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish more than nine percent permanent impairment of his right lower extremity, for which he previously received schedule award compensation. The Board further finds that OWCP properly determined his pay rate when calculating his schedule award compensation.

[29] *Cf. R.M.*, Docket No. 15-0461 (issued March 22, 2016).

ORDER

IT IS HEREBY ORDERED THAT the May 2, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 20, 2019
Washington, DC

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

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

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