United States Department of Labor
Employees' Compensation Appeals Board

M.G., Appellant	)	
and	)	**Docket No. 20-0078**
	)	**Issued: December 22, 2020**
DEPARTMENT OF THE NAVY, NAVAL FACILITIES ENGINEERNG CMD-STATIONS, San Diego, CA, 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, Deputy Chief Judge
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On October 10, 2019 appellant, through counsel, filed a timely appeal from a May 22, 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.[3]

[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.*

[3] The Board notes that, following the May 22, 2019 decision, OWCP received additional evidence. 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.*

ISSUE

The issue is whether appellant has met his burden of proof to establish more than 13 percent permanent impairment of the right lower extremity for which he previously received a schedule award.

FACTUAL HISTORY

This case has previously been before the Board. The facts and circumstances set forth in the Board's prior order are incorporated herein by reference.[4] The relevant facts are as follows.

On November 5, 2012 appellant, then a 54-year-old motor vehicle operator, filed a traumatic injury claim (Form CA-1) alleging that on October 24, 2012 he twisted his right knee while stepping off a sweeper truck in the performance of duty. OWCP initially accepted the claim for right knee sprain and subsequently expanded acceptance of the claim to include the additional conditions of right medial meniscus tear and right lower leg primary osteoarthritis.

In a November 18, 2015 report, Dr. Mesfin Seyoum, a physician specializing in family medicine, noted appellant's history of injury and medical treatment. He noted appellant's findings on physical examination, reviewed diagnostic testing, and determined that appellant had reached maximum medical improvement (MMI). Using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[5] Dr. Seyoum determined that appellant had 50 percent permanent impairment of the right lower extremity and that he had reached MMI. He reported that an April 28, 2015 x-ray interpretation showed bone-on-bone in the medial compartment and joint space patellofemoral compartment narrowing. Utilizing Table 16-3, Knee Regional Grid, of the sixth edition of the A.M.A., *Guides*, Dr. Seyoum assigned a class diagnosis (CDX) of 4 for the diagnoses of right knee medial meniscus tear, right knee strain/sprain, right lower leg osteoarthritis, and status post right knee surgery with residuals.[6] He assigned grade modifier for functional history (GMFH) of 2, a grade modifier for physical examination (GMPE) of 2, and a grade modifier for clinical studies (GMCS) of 4.[7] Dr. Seyoum explained that application of the net adjustment formula warranted movement four places to the left of the default value, resulting in a finding of 50 percent permanent impairment of the right lower extremity.[8]

On January 26, 2016 appellant filed a claim for a schedule award (Form CA-7).

On January 28, 2016 OWCP routed Dr. Seyoum's report, a statement of accepted facts (SOAF), and the case record to Dr. Morley Slutsky, Board-certified in occupational medicine serving as an OWCP district medical adviser (DMA), for review and evaluation of appellant's

[4] *Order Remanding Case*, Docket No. 18-0699 (issued February 15, 2018).

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

[6] *Id.* at 511, Table 16-3.

[7] *Id.* at 516, Table 16-6, 517, Table 16-7, and 519, Table 16-8.

[8] The physician mistakenly referred to "left" instead of "right."

permanent impairment pursuant to the A.M.A., *Guides*. Dr. Slutsky was also asked to provide a date of MMI.

In a February 3, 2016 report, the DMA reviewed the case file and determined that appellant reached MMI on November 18, 2015. He disagreed with Dr. Seyoum's right knee permanent impairment rating and found that appellant was not eligible to be rated for primary knee joint arthritis since this condition was not supported by x-rays or a magnetic resonance imaging (MRI) scan. In support of this conclusion, the DMA explained that the radiologist who reviewed the June 26, 2015 x-ray interpretation found only moderate medial joint space narrowing and not bone-on-bone and the MRI scan had not shown an osteochondral fracture or full-thickness cartilage articular defect. He referenced Table 16-3, page 511 for the criteria to be used for primary knee joint arthritis. The DMA found that the only ratable diagnoses were right knee medial and lateral meniscal injuries, which required a CDX assignment of 1.[9] He assigned a GMFH of 2, a GMPE of 2, and a GMCS of 2.[10] The DMA explained that the net adjustment formula warranted movement two places to the right of default grade C to grade E, resulting in the maximum rating for CDX 1 of 13 percent permanent impairment of the right lower extremity.[11]

In a September 12, 2016 letter, counsel requested a reevaluation by the DMA of appellant's schedule award determination as his claim had been accepted for osteoarthritis of the right knee.

By decision dated October 14, 2016, OWCP granted appellant a schedule award for 13 percent permanent impairment of the right lower extremity. The date of MMI was found to be November 18, 2015. The award covered a period of 37.44 weeks from November 18, 2015 through October 16, 2016. OWCP noted that the weight of the medical evidence rested with the DMA, who correctly applied the A.M.A., *Guides* to Dr. Seyoum's November 18, 2015 examination findings.

On October 25, 2016 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on May 15, 2017 during which counsel argued that the DMA's findings were unreliable and, thus, should not constitute the weight of the medical opinion evidence.

By decision dated July 28, 2017, OWCP's hearing representative affirmed the October 14, 2016 decision. She noted that the DMA provided sufficient medical rationale in support of his opinion. The hearing representative further noted that Dr. Seyoum incorrectly applied the A.M.A., *Guides* as the x-ray evidence established preserved cartilage and that, in order to establish 50 percent impairment, the x-ray evidence required no cartilage interval.

On October 10, 2017 appellant, through counsel, requested reconsideration. In support of his request, appellant submitted x-ray interpretations dated November 10, 2014 and June 26, 2015 and medical reports dated October 17, 2016, October 11, November 15, and December 6, 2017 from Dr. Robert M. Maywood, a Board-certified orthopedic surgeon.

[9] *Supra* note 7 at 509, Table 16-3.

[10] *Supra* note 7.

[11] *Supra* note 10.

In an October 17, 2016 report, Dr. Maywood diagnosed right knee degenerative joint disease, right knee medial meniscus tear, and status post right knee arthroscopy with a partial medial meniscectomy, synovectomy, and patellofemoral joint and medial compartment chondroplasty.

Dr. Maywood, in October 11, 2017 progress notes, provided examination findings and diagnoses of right knee degenerative joint disease, right knee medial meniscus tear, and status post right knee arthroscopy with a partial medial meniscectomy, synovectomy, and patellofemoral joint and medial compartment. Examination findings included 2+ patellar crepitus, 0 to 125 degrees range of motion, stable to valgus/varus test, and trace effusion and medial joint line tenderness. Dr. Maywood noted that his request for authorization for total knee arthroplasty surgery had been denied.

In progress notes dated November 15, 2017, Dr. Maywood provided diagnoses and examination findings, which were unchanged from his prior report. He noted that appellant had no right knee treatment since the authorization for right knee arthroplasty surgery had been denied. Dr. Maywood concluded that appellant's condition remained permanent and stationary.

Dr. Maywood, in progress notes dated December 6, 2017, reported no change in appellant's condition or diagnoses.

In December 13, 2017 progress notes, Dr. Maywood diagnosed right knee osteoarthritis. A physical examination revealed 0 to 130 degrees range of motion, no effusion, and 3+ crepitus.

By decision dated December 20, 2017, OWCP denied modification.

OWCP subsequently received a progress note from Dr. Maywood dated December 20, 2017, which repeated his prior findings.

In a progress note dated February 14, 2018, Dr. Maywood requested authorization for a right knee MRI scan to be performed due to appellant's worsening examination findings. He also noted that appellant's physical examination of the right knee revealed small joint effusion, mild laxity 3+ crepitus, 0 to 126 degrees range of motion, and tenderness on palpation over the patellar tendon and medial joint line.

On February 15, 2018 appellant filed an appeal with the Board.

A February 22, 2018 right knee MRI scan showed complete posterior horn and medial meniscus body tear with horizontal and radial components, cartilage abnormalities, and horizontal tear through the lateral meniscus.

Dr. Maywood, in a progress note dated February 28, 2018, diagnosed right knee degenerative joint disease, right knee complex medial meniscus tear, right knee sprain, and status post right knee arthroscopy with a partial medial meniscectomy, synovectomy, and patellofemoral joint and medical compartment chondroplasty. He noted that appellant's February 22, 2018 MRI scan revealed complex medial meniscus body and posterior horn tearing, medial lateral aspect femoral condyle full-thickness cartilage loss, partial and full lateral patellar facet cartilage loss, and lateral trochlear facet and central sulcus partial cartilage loss. Based on diagnostic testing, examination findings, and appellant's continuing symptoms, Dr. Maywood recommended right

knee arthroscopy with partial medial meniscectomy, possible chondroplasty, and possible synovectomy surgery.

In a progress note dated April 2, 2018, Dr. Maywood noted that appellant noted that his constant right knee pain was unchanged and he had frequent grinding and swelling in his knee. Physical examination findings revealed 3+ patellar crepitus with range of motion testing, 0 to 125 degrees range of motion, negative Lachman's, tenderness on palpation over medial joint line, positive Steinman's, and no varus and valgus stress. An April 2, 2018 x-ray interpretation showed severe right knee degenerative joint disease especially narrow medial joint space, marginal osteophytes, and sclerosis. Due to appellant's severe osteoarthritis, Dr. Maywood determined that right total knee surgery was preferable to arthroscopic surgery. Thus, he recommended that appellant be referred to Dr. Joseph J. Jankiewicz, a Board-certified orthopedic surgeon, who specialized in total joint replacement surgery.

In reports dated April 25 and June 20, 2018, Dr. Tal S. David, a Board-certified orthopedic surgeon, diagnosed right knee degenerative arthritis, acute right knee lateral meniscal injury, and right acute medial meniscal tear. Appellant's physical examination findings were noted.

On May 25, 2018 OWCP authorized total right knee arthroplasty.

By order dated March 22, 2019, the Board set aside the July 28, 2017 decision and remanded for OWCP to make proper findings of fact regarding appellant's request for reconsideration on the denial of his claim for an additional schedule award.[12]

By decision dated May 22, 2019, OWCP denied modification, finding none of the evidence submitted directly addressed appellant's right lower extremity permanent impairment. It further noted that the evidence suggested that he was no longer at MMI as his condition continued to worsen. Thus, OWCP found that the record contained no evidence that the October 14, 2016 schedule award determination or July 28, 2017 hearing representative's decision was incorrect.

LEGAL PRECEDENT

The schedule award provisions of FECA[13] and its implementing regulations[14] 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. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, 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 OWCP as a standard for evaluation of schedule losses and

[12] *Supra* note 4.

[13] *Supra* note 2.

[14] 20 C.F.R. § 10.404.

the Board has concurred in such adoption.[15] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[16]

It is the claimant's burden of proof to establish permanent impairment of the scheduled member or function of the body as a result of an employment injury.[17] OWCP procedures provide that, to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred (date of MMI), describes the impairment in sufficient detail so that it can be visualized on review, and computes the percentage of impairment in accordance with the A.M.A., *Guides*.[18] Its procedures further provide that, if a claimant has not submitted a permanent impairment evaluation, it should request a detailed report that includes a discussion of how the impairment rating was calculated.[19] If the claimant does not provide an impairment evaluation and there is no indication of permanent impairment in the medical evidence of file, the claims examiner may proceed with a formal denial of the award.[20]

In some instances, a DMA's opinion can constitute the weight of the medical evidence.[21] 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*.[22] 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.[23] 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.[24]

[15] *Id.*; *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[16] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[17] *E.D.*, Docket No. 19-1562 (issued March 3, 2020); *Edward Spohr*, 54 ECAB 806, 810 (2003); *Tammy L. Meehan*, 53 ECAB 229 (2001).

[18] *Supra* note 16 at Chapter 2.808.5 (March 2017).

[19] *Id.* at Chapter 2.808.6(a) (March 2017).

[20] *Id.* at Chapter 2.808.6(c).

[21] *R.R.*, Docket No. 19-1314 (issued January3, 2020); *J.H.*, Docket No. 18-1207 (issued June 20, 2019); *M.P.*, Docket No. 14-1602 (issued January 13, 2015); *supra* note 16 at Chapter 2.810.8(j) (September 2010).

[22] *Id.*

[23] *Id.*

[24] *Id.*

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than 13 percent permanent impairment of the right lower extremity for which he previously received a schedule award.

In support of his claim for a schedule award, appellant submitted a November 18, 2016 report from Dr. Seyoum in which he found that appellant had 50 percent right lower extremity permanent impairment. Dr. Seyoum noted diagnoses of right medial meniscus tear, right knee strain/sprain, right lower extremity osteoarthritis, and status post right knee surgery, which he found under Table 16-3, page 511 should be rated as a Class 4 impairment. He assigned a GMFH of 2 using Table 16-6, page 516; a GMPE of 2 using Table 16-7, page 516; and a GMCS of 4 using Table 16-8, page 519. Application of the net adjustment formula warranted movement four places to the left of the default value, which resulted in a rating of 50 percent permanent impairment of the right lower extremity.

On February 8, 2016 the DMA reviewed the medical record, including the clinical findings of Dr. Seyoum. He disagreed with Dr. Seyoum's 50 percent right lower extremity permanent impairment rating as there were no radiographic or MRI scan findings, which were required under Table 16-3 for arthritis of the knee, to support his Class 4 impairment determination.[25] The Board finds that there were no radiographic findings to support Dr. Seyoum's DBI impairment rating as a Class 4 for primary knee joint arthritis, which are required under Table 16-3 of the A.M.A., *Guides*.[26] Thus, Dr. Seyoum failed to properly utilize the A.M.A., *Guides* in assessing appellant's right lower extremity permanent impairment, and OWCP properly found that his report was of diminished probative value.

The DMA properly referenced Table 16-3, page 511 for the criteria to be used for primary knee joint arthritis. He found that appellant's right knee diagnoses required a CDX assignment of 1. The DMA assigned a GMFH of 2, a GMPE of 2, and a GMCS of 2 and thereafter explained that the net adjustment formula warranted movement two places to the right of default grade C to grade E, resulting in the maximum rating for a right knee CDX 1 of 13 percent permanent impairment.

The Board therefore finds that the DMA's impairment rating report is entitled to the weight of the medical evidence as he relied upon the proper citations of the A.M.A., *Guides* and set forth the basis for his assigned diagnoses and grade modifiers and because Dr. Seyoum improperly rated impairment as the x-ray evidence upon which he relied established preserved cartilage, which precludes the assigned 50 percent impairment.

The record also contains medical reports dated October 17, 2016, October 11, November 15, December 6, 13, and 20, 2017, February 14 and 28, and April 2, 2018 from Dr. Maywood, and reports dated April 25 and June 20, 2018 from Dr. David.

[25] *See J.H.*, Docket No. 18-1207 (issued June 20, 2019); *K.P.*, Docket No. 18-0777 (issued November 13, 2018); *M.G.*, Docket No. 10-1771 (issued May 4, 2011).

[26] *Id.*

Both Dr. Maywood and Dr. David, attending physicians, provided findings on examination of appellant's knee; however, none of their reports provided any opinion on the extent of impairment stemming from his accepted right knee conditions. While both Dr. Maywood and Dr. David noted findings on examination and provided updates on appellant's current condition, they did not address permanent impairment with regard to the A.M.A., *Guides*.[27] Appellant has submitted no other medical evidence establishing greater permanent impairment of his right lower extremity.

As noted above, OWCP's procedures provide that, to support a schedule award, the file must contain medical evidence which shows that the impairment has reached a permanent and fixed state, indicates the date on which this occurred, describes the impairment in sufficient detail so that it can be visualized on review, and computes the percentage of permanent impairment in accordance with the A.M.A., *Guides*.[28] Following appellant's February 22, 2018 MRI scan, in his April 2, 2018 report, Dr. Maywood noted that appellant's right knee condition had worsened to the point wherein he no longer recommended an arthroscopic procedure, but rather recommended that appellant be referred for a total right knee replacement. The Board therefore finds that the evidence submitted by appellant is insufficient to overcome the weight of the medical evidence afforded the DMA's report or to create a conflict as to the extent of permanent impairment.

On appeal counsel contends that OWCP failed to give deference to appellant's attending physician. He also asserts that FECA does not allow apportionment in impairment ratings and failed to use the proper standard of causation in adjudicating the claim. For the reasons set forth above, the Board finds that there is no evidence of record establish greater than 13 percent permanent impairment of his right lower extremity.

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.

CONCLUSION

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

[27] The Board notes that a description of appellant's impairment must be obtained from appellant's physician, which 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. *See G.M.*, Docket No. 10-1242 (issued February 24, 2011); *Peter C. Belkind*, 56 ECAB 580 (2005).

[28] *Supra* note 20.

ORDER

IT IS HEREBY ORDERED THAT the May 22, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 22, 2020
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board