United States Department of Labor
Employees' Compensation Appeals Board

J.S., Appellant	)	
and	)	**Docket No. 20-0739**
	)	**Issued: November 13, 2020**
DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF PRISONS, FEDERAL CORRECTIONAL INSTITUTION, Texarkana, TX, Employer	)	

Appearances:
Appellant, pro se
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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On February 18, 2020 appellant filed a timely appeal from an August 29, 2019 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]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the August 29, 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 new evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than 30 percent permanent impairment of her left lower extremity, for which she previously received a schedule award compensation.

FACTUAL HISTORY

On January 28, 2002 appellant, then a 44-year-old legal instrument examiner, filed a traumatic injury claim (Form CA-1) alleging that on January 25, 2002 she sustained a left knee injury during a training exercise when a coworker fell on her left leg while in the performance of duty. OWCP accepted the claim for left knee meniscal tear and later expanded the acceptance of appellant's claim to include the additional condition of localized secondary osteoarthritis of the left lower extremity. Appellant stopped work on January 28, 2002.

On February 28, 2002 Dr. John Young, a Board-certified orthopedic surgeon, performed an arthroscopic anterior cruciate ligament (ACL) reconstruction and debridement of the lateral meniscal tear. He diagnosed left medial collateral ligament (MCL) rupture, ACL rupture, and lateral meniscal tear.[3] OWCP paid appellant wage-loss compensation on the supplemental rolls from June 16 to July 13, 2002.

Appellant filed a claim for a schedule award (Form CA-7). By decision dated April 16, 2003, OWCP granted her a schedule award for eight percent permanent impairment of the left lower extremity.[4] The period of the award, equivalent to 25.92 weeks, ran from February 11 to August 11, 2003.

A March 9, 2012 magnetic resonance imaging (MRI) scan of the left knee revealed an extensive tear of the anterior horn and body of the medial meniscus, small tear of the meniscal root, nondisplaced tear of the posterior horn of the lateral meniscus, grade IV chondromalacia patella, intact ACL graft, osteoarthritis in the medial compartment of the knee, and chondrocalcinosis.

In a January 29, 2013 report, Dr. Richard B. Sharp, a Board-certified physiatrist, diagnosed degenerative changes of the left knee, related to the work injury of 2002; ACL reconstruction, tear of anterior horn and body of the medial meniscus, nondisplaced tear of the posterior horn of the lateral meniscus, and intact ACL graft. He opined that appellant reached maximum medical improvement (MMI) on January 18, 2013. Dr. Sharp advised that, without a definitive episode of trauma or recent injury, it would be difficult to attribute this to another work injury. He also noted that appellant had worsening of degenerative changes of the knee, which could not be solely attributed to her work injury in 2002. Dr. Sharp opined that based on the American Medical

[3] This procedure was authorized by OWCP.

[4] The Board notes that on March 27, 2003 Dr. H. Mobley, Board-certified in orthopedic medicine and a district medical adviser (DMA), calculated impairment under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001). Dr. Mobley opined that appellant had nine percent permanent impairment of the left lower extremity. It is unclear why OWCP granted appellant eight percent permanent impairment.

Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A., *Guides*),[5] appellant would receive zero percent permanent impairment rating for nonwork-related knee findings.

On July 29, 2013 appellant filed a Form CA-7 claim for an increased schedule award.

In an August 5, 2013 report, Dr. Michael M. Katz, Board-certified in orthopedic medicine serving as a DMA, reviewed Dr. Sharp's January 29, 2013 report. He opined that there was a significant probability that the osteoarthritis in appellant's left knee was caused, at least in part, by her work-related injury given the association of the ACL injury with the subsequent osteoarthritis.[6] The DMA recommended appellant be referred for a second opinion impairment evaluation.

On November 8, 2013 OWCP referred appellant's case, along with a statement of accepted facts (SOAF), for a second opinion examination with Dr. Robert E. Holladay, IV, a Board-certified orthopedic surgeon. In a November 21, 2013 report, Dr. Holladay diagnosed left ACL tear, postoperative left knee ACL reconstruction, and osteoarthritis of the left knee with flexion contracture. He referred to the A.M.A., *Guides*, Knee Regional Grid at Table 16-3, page 511 and noted that, for the left knee, the cruciate ligament reconstruction description of diagnostic criteria did not apply so he used the range of motion (ROM) methodology. Pursuant to Table 16-23, page 549, Dr. Holladay found ROM for the left knee for flexion of 102 degrees was 10 percent left lower extremity impairment and 10 degrees of flexion contracture was 20 percent left lower extremity impairment. He applied the higher impairment rating of 20 percent left lower extremity impairment.

In a February 11, 2014 report, Dr. Ronald Blum, Board-certified in orthopedics and serving as a DMA, reviewed Dr. Holladay's November 21, 2013 report, and used his examination findings to calculate appellant's left lower extremity impairment pursuant to the A.M.A., *Guides*. He noted that appellant's diagnosis was tear of the left medial meniscus and osteoarthritis of the left lower leg and he concluded that appellant had 10 percent permanent impairment of the left lower extremity based upon 102 degrees of flexion and 20 percent permanent impairment of the left lower extremity based upon 10 degrees of extension for a combined rating of permanent impairment of 30 percent. The DMA referenced Section 16.7b, page 548 of the A.M.A., *Guides*, which instructs the examiner to add all impairments for a joint. He advised that appellant was previously awarded eight percent impairment[7] of the left lower extremity and would be entitled to an additional award of 22 percent impairment of the left lower extremity. The DMA assigned MMI as of November 21, 2013.

By decision dated February 18, 2014, OWCP granted appellant an increased schedule award for an additional 22 percent left lower extremity impairment for a total award of 30 percent left lower extremity impairment. The period of the award, equivalent to 63.36 weeks of compensation, ran from November 21, 2013 to February 7, 2015.

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

[6] As noted above, OWCP expanded acceptance of appellant's claim to include localized secondary osteoarthritis of the left lower extremity.

[7] *Supra* note 3.

In a September12, 2016 report, Dr. Sharp noted physical examination findings of the left knee. He found that appellant had normal motor strength with flexion and extension of the knee. Appellant had no crepitus, effusion, medial or lateral joint instability and her Lachman's test was negative. She lacked 15 degrees of full extension, but had 120 degrees of flexion. Dr. Sharp noted that appellant reached MMI on January 18, 2013.

On December 15, 2016 appellant filed a claim for an increased schedule award (Form CA-7).

In a May 17, 2017 report, Dr. Sharp indicated that appellant was seen for evaluation on September 12, 2016, and noted that she had a left ACL reconstruction with partial lateral meniscectomy and subsequently developed unicompartmental knee arthritis. He used the diagnosis-based impairment method (DBI). Dr. Sharp referred to the A.M.A., *Guides*, Knee Regional Grid at Table 16-3, page 509 and noted that, for the left knee, the diagnostic key factor was a meniscal injury with partial meniscectomy, which would result in a class of diagnosis (CDX) of class 1, with a default value of two percent. He noted a grade modifier for functional history (GMFH) of 2, a grade modifier for physical examination (GMPE) of 1, and a grade modifier for clinical studies (GMCS) of 2. Dr. Sharp utilized the net adjustment formula and determined that the net adjustment was +2, which corresponded with three percent left lower extremity impairment rating. He further noted that according to Table 16-3, page 511, primary knee joint arthritis, she would be a CDX of class 1, with a default value of seven percent. Dr. Sharp noted a GMFH of 2 and GMPE of 1 for a net adjustment of +1 or 8 percent left lower extremity impairment rating for a combined left lower extremity impairment rating of 11 percent.

On August 30, 2018 OWCP forwarded Dr. Sharp's September 12, 2016 and May 17, 2017 reports to Dr. Arthur S. Harris, an orthopedic surgeon serving as a DMA, for review and determination of appellant's entitlement to an increased schedule award. In a September 5, 2018 report, the DMA noted that Dr. Sharp found that appellant had 11 percent left lower extremity permanent impairment based upon the DBI method by combining impairment for arthroscopic partial medial meniscectomy and a diagnosis of osteoarthritis. He explained that the Knee Regional Grid, Table 16-3, page 509, required documented joint space narrowing for impairment calculation for arthritis; however, Dr. Sharp's September 12, 2016 and May 17, 2017 reports, did not document radiographic findings. The DMA advised that he was unable to verify his impairment calculation based on a diagnosis of arthritis. He further explained that Dr. Sharp provided an impairment rating for both an arthroscopic partial menisectomy and degenerative arthritis. The A.M.A., *Guides* instruct the evaluator to choose the most significant diagnosis and to rate on that diagnosis using the DBI method and if more than one diagnosis can be used, the examiner is to use the most clinically accurate impairment. The DMA further noted that the A.M.A., *Guides* does not allow an impairment rating due to loss of ROM because the applicable diagnosis did not contain an asterisk (*) in the DBI grid; therefore, the ROM method was not applicable. Dr. Harris used the DBI method and referred to Table 16-3 of the A.M.A., *Guides* because appellant underwent a partial medial meniscectomy.[8] He determined that appellant had three percent permanent impairment of the left lower extremity, the maximum allowable rating for a partial medial or lateral meniscectomy. The date of MMI was January 18, 2013. The DMA

[8] A.M.A., *Guides* 494-531.

noted that since appellant was previously awarded 30 percent permanent impairment of the left lower extremity she was not entitled to an increased award.

In a development letter dated January 14, 2019, OWCP advised appellant that the DMA had found Dr. Sharp's reports to be deficient. It provided her a copy of the DMA's report and afforded her 30 days to submit additional evidence in response to the DMA's report. No further evidence was submitted.

By decision dated August 29, 2019, OWCP denied appellant's claim for an increased schedule award finding that the evidence of record was insufficient to establish that she sustained an increase of her permanent impairment due to her accepted employment injury.

LEGAL PRECEDENT

The schedule award provisions of FECA[9] and its implementing federal regulations[10] 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 loss of a member shall be determined. The method used in making such a determination is a matter, which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 2009.[11] 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.[12]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning Disability and Health (ICF).[13] Under the sixth edition, the evaluator identifies the CDX, which is then adjusted by the GMFH, GMPE, and GMCS.[14] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) +

[9] 5 U.S.C. § 8101 *et seq.*

[10] 20 C.F.R. § 10.404.

[11] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides* (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[12] *See G.W.*, Docket No. 19-0430 (issued February 7, 2020); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[13] A.M.A., *Guides* 494-531.

[14] *Id*.

(GMCS-CDX).[15] Evaluators are directed to provide reasons for their impairment rating, including the choice of diagnoses from regional grids and the calculation of the modifier score.[16]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[17]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish greater than 30 percent permanent impairment of her left lower extremity, for which she previously received schedule award compensation.

In support of her request for an increased schedule award, appellant submitted reports from Dr. Sharp dated September 12, 2016 and May 17, 2017, who opined that appellant had 11 percent permanent impairment of the left lower extremity based upon the DBI methodology. OWCP submitted the reports from Dr. Sharp to a DMA who opined that the ratings of Dr. Sharp were deficient as he had failed to properly apply the A.M.A., *Guides*. The DMA's calculations also established less permanent impairment than the 30 percent previously awarded. The Board notes that there is no other medical evidence of record establishing greater than 30 percent permanent impairment.

The Board finds that the record does not contain any medical evidence establishing greater than the 30 percent permanent impairment of the left lower extremity previously awarded. Accordingly, appellant has not met her burden of proof to establish entitlement to a schedule award for a percentage of impairment greater than that previously awarded.[18]

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 permanent impairment.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish greater than 30 percent permanent impairment of her left lower extremity, for which she previously received schedule award compensation.

[15] *Id*. at 521.

[16] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[17] *See supra* note 11 at Chapter 2.808.6(f) (March 2017).

[18] *See T.W.*, Docket No. 18-0765 (issued September 20, 2019).

ORDER

IT IS HEREBY ORDERED THAT the August 29, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 13, 2020
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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