United States Department of Labor
Employees' Compensation Appeals Board

M.W., Appellant	)	
and	)	**Docket No. 20-1303**
	)	**Issued: June 28, 2021**
U.S. POSTAL SERVICE, EASTWOOD POST OFFICE, Houston, TX, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On June 17, 2020 appellant filed a timely appeal from a March 24, 2020 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, OWCP received additional evidence following the March 24, 2020 decision. 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 greater than seven percent permanent impairment of the left lower extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

On April 13, 2016 appellant, then a 45-year-old city carrier assistant, filed a traumatic injury claim (Form CA-1) alleging that on April 12, 2016 he injured his left knee when he jumped over a fence evading a pit bull dog as he was being chased in the performance of duty. OWCP accepted that he sustained a nondisplaced transverse fracture of shaft of left tibia, closed fracture and paid compensation.

In a September 20, 2016 report, Dr. Mufaddal Gombera, a Board-certified orthopedic surgeon, utilized the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[3] to rate appellant's permanent impairment. He indicated that appellant had normal left knee range of motion (ROM). Dr. Gombera referred to Table 16-3, on page 510-11 of the A.M.A., *Guides* and explained that appellant had a default rating of five percent for a class of diagnosis (CDX) of 1 for the diagnosis of fracture, a grade modifier for functional history (GMFH) of 1 based on altered gait, a grade modifier for physical examination (GMPE) of 2 for tenderness to palpation, atrophy, edema and loss of strength, and grade modifier for clinical studies (GMCS) of 1, as they confirmed the diagnosis. He utilized the net adjustment formula and found a left lower extremity permanent impairment of six percent.

On November 30, 2016 appellant filed a claim for a schedule award (Form CA-7).

In a January 8, 2017 report, Dr. Jovito Estaris, Board-certified in occupational medicine and serving as a district medical adviser (DMA), reviewed a statement of accepted facts (SOAF) and the medical record, including Dr. Gombera's report. He diagnosed nondisplaced fracture of shaft of left tibia, initial encounter for closed fracture. The DMA noted that appellant had a normal gait, full ROM, a stable knee, and a healed fracture in good alignment. He referred to Table 16-3, on page 510 of the A.M.A., *Guides*, for a fracture of the Tibial Plateau of the left knee, and found that it warranted a CDX 1, with a default value of 5, nondisplaced with abnormal examination findings. The DMA applied a GMFH of 0 due to no antalgic gait, pursuant to Table 16-6.[4] He found a GMPE of 1.[5] The DMA noted that the GMCS was not used as the computerized tomography scan showed tibial plateau fracture (nondisplaced) and was used for classification of the diagnosis in the diagnosis-based impairment (DBI) grid. He utilized the net adjustment formula and found that appellant had four percent left lower extremity impairment. The DMA explained that his rating differed from that of Dr. Gombera due to non-key modifiers assignment. He noted that Dr. Gombera assigned a grade modifier of 1 for GMFH due to an altered gait,

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

[4] A.M.A., *Guides* 516.

[5] *Id.* at 517.

however, he found that appellant had a normal gait therefore the grade modifier was 0. The DMA explained that Dr. Gombera assigned a GMPE of 2, but the only positive finding was tenderness over the anterior knee and the knee was stable therefore the grade modifier was 1, as objective findings took precedence over subjective findings.

On March 6, 2017 OWCP granted appellant a schedule award for four percent permanent impairment of the left lower extremity. The award covered a period of 11.52 weeks from September 20 to December 9, 2016.

On June 21, 2018 appellant underwent a left knee arthroscopy with partial medial menisectomy.

On October 17, 2018 appellant filed a claim for an additional schedule award (Form CA-7).

By development letter dated November 13, 2018, OWCP requested that appellant submit a report from his attending physician, which addressed whether he had reached maximum medical improvement (MMI) and, if so, to evaluate permanent impairment in accordance with the standards of the A.M.A., *Guides*. It afforded him 30 days to submit the requested information.

In a January 8, 2019 report, Dr. Charles Kennedy, Jr., a Board-certified orthopedic surgeon, utilized the A.M.A., *Guides*, examined appellant, and provided findings. He advised that, using the DBI method, appellant had undergone medial meniscectomy, for which the CDX default rating was two percent impairment, and that a tibial plateau fracture undisplaced with abnormal findings warranted five percent rating for permanent impairment of the lower extremity. Dr. Kennedy also utilized the ROM method for rating the left knee permanent impairment. He found that ROM was between 80 and 109 degrees, and warranted 10 percent impairment according to Table 16-23.[6] Dr. Kennedy explained that, because the ROM method rating was higher, it would be utilized. He opined that appellant reached MMI on January 8, 2019.

On June 20, 2019 Dr. Arthur S. Harris, a Board-certified orthopedic surgeon, serving as a district medical adviser (DMA), reviewed a SOAF and the medical record. He diagnosed status post left knee arthroscopic partial medial menisectomy and a left lateral tibial plateau fracture. The DMA utilized the DBI method and referred to Table 16-3.[7] He opined that appellant had seven percent left lower extremity impairment for lateral tibial plateau fracture and arthroscopic partial medial menisectomy. Regarding the ROM method, the DMA explained that the A.M.A., *Guides* were to be utilized as a stand-alone rating when there were no diagnosis that was applicable or in very rare cases where a severe injury resulted in a passive ROM loss, qualifying for a class 3 or 4 impairment or for amputation ratings according to section 16.7 on page 543. He advised that appellant's diagnosed conditions did not meet any of the criteria discussed in section 16.7, page 543, to allow for impairment to be calculated under the ROM method and that the DBI method provided the appropriate impairment rating. The DMA opined that appellant had no more than seven percent left lower extremity impairment under the DBI method.

[6] *Id.* at 549.

[7] *Id.* at 510.

On March 24, 2020 OWCP granted appellant an additional schedule award for three percent permanent impairment of the left lower extremity. The award covered a period of 8.64 weeks from January 8 to March 9, 2019. It explained that appellant had previously received an award of four percent to the left lower extremity and that Dr. Harris, the DMA, found that appellant's left lower extremity impairment was seven percent, which represented an increase of three percent.

LEGAL PRECEDENT

The schedule award provisions of FECA,[8] and its implementing federal regulations,[9] 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.[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]

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).[12] Chapter 16 of the sixth edition of the A.M.A., *Guides*, pertaining to the lower extremities, provides that diagnosis-based impairment is the primary method of calculation for the lower limb and that most impairments are based on the diagnosis-based impairment where impairment class is determined by the diagnosis and specific criteria as adjusted by the grade modifiers for functional history, physical examination, and clinical studies. It further provides that alternative approaches are also provided for calculating impairment for peripheral nerve deficits, complex regional pain syndrome, amputation, and ROM. ROM is primarily used as a physical examination adjustment factor.[13] The A.M.A., *Guides*, however, also explain that some of the diagnosis-based grids refer to the ROM section when that is the most appropriate mechanism for grading the impairment. This section is to be used as a stand-alone rating when other grids refer

[8] *Supra* note 1.

[9] 20 C.F.R. § 10.404.

[10] 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 Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Chapter 3.700, Exhibit 1 (January 2010).

[11] *See A.C.*, Docket No. 19-1333 (issued January 8, 2020); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[12] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3, International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[13] *Id*. at 497, section 16.2.

to this section or no other diagnosis-based sections of the chapter are applicable for impairment rating of a condition.[14]

Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by GMFH, GMPE, and GMCS.[15] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[16] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[17]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the percentage of permanent impairment using the A.M.A., *Guides*.[18]

ANALYSIS

The Board finds that the case is not in posture for decision.

In support of his claim, appellant submitted a January 8, 2019 report from Dr. Kennedy. Dr. Kennedy first utilized the DBI method and found that appellant had undergone a medial meniscectomy for which the default rating was two percent impairment, and that he had a tibial plateau fracture undisplaced with abnormal findings, which had a default rating of five percent permanent impairment, for a total of seven percent lower extremity impairment under the DBI method. He also utilized the ROM method for the knee, referred to Table 16-23, and opined that appellant had 10 percent permanent impairment. Dr. Kennedy indicated that, because the ROM rating was higher, it should be utilized.

OWCP properly routed the medical evidence to the DMA, Dr. Harris. On June 20, 2019 the DMA explained that the ROM method for rating appellant's left knee permanent impairment was not applicable in this instance, as appellant's accepted condition did not meet the criteria for rating the left knee condition under the ROM method.[19]

Dr. Harris, using the DBI method under the sixth edition of the A.M.A., *Guides*, found that appellant's diagnoses of lateral tibial plateau fracture and left knee arthroscopic partial medial meniscectomy resulted in seven percent permanent impairment of the left lower extremity pursuant

[14] *Id.* at 543; *see also M.D.*, Docket No. 16-0207 (issued June 3, 2016); *D.F.*, Docket No. 15-0664 (issued January 8, 2016).

[15] *Id.* at 494-531.

[16] *Id*. at 521.

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

[18] Federal (FECA) Procedure Manual, *supra* note 10 at Chapter 2.808.6(f) (March 2017); *B.B.*, Docket No. 18-0782 (issued January 11, 2019).

[19] *See* A.M.A., *Guides* 543. This section of the A.M.A., *Guides* relates that the ROM impairment section is to be used as a stand-alone rating when other grids refer to this section or no other diagnosis-based sections of this chapter are applicable for impairment rating of a condition.

to Table 16-3. However, he did not reference nor explain how the grade modifiers were applied to determine the default impairment rating for each of these diagnoses to reach seven percent permanent lower extremity impairment. Thus, the Board finds that Dr. Harris' report requires clarification.[20]

It is well established that, proceedings under FECA are not adversarial in nature, and while the employee has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[21] Once OWCP undertook development of the evidence by referring appellant's file to a DMA, it had an obligation to do a complete job and obtain a fully-rationalized opinion regarding the issue in this case.[22] The Board will therefore set aside OWCP's March 24, 2020 decision and remand the case to its DMA to apply the A.M.A., *Guides* and provide a rationalized opinion to determine if appellant has greater than seven percent permanent impairment of his left lower extremity. After such further development as deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for an additional schedule award.

CONCLUSION

The Board finds that the case is not in posture for decision.

[20] *G.M.*, Docket No. 19-1931 (issued May 28, 2020).

[21] *See W.W.*, Docket No. 18-0093 (issued October 9, 2018); *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[22] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the March 24, 2020 decision of the Office of Workers' Compensation Programs is set aside and this case is remanded for further proceedings consistent with this decision of the Board.

Issued: June 28, 2021
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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