United States Department of Labor
Employees' Compensation Appeals Board

W.V., Appellant	)	
and	)	**Docket No. 19-1276**
	)	**Issued: March 15, 2021**
DEPARTMENT OF HOMELAND SECURITY, CUSTOMS & BORDER PATROL, J.F.K. AIRPORT, Jamaica, NY, Employer	)	

Appearances:
*Appella*nt, *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 May 21, 2019 appellant filed a timely appeal from a March 20, 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 March 20, 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 permanent impairment of his bilateral lower extremities, warranting a schedule award.

FACTUAL HISTORY

On June 13, 2007 appellant, then a 45-year-old import specialist, filed a traumatic injury claim (Form CA-1) alleging that on that date he sustained injuries to his knees, elbows, face, neck, hands, fingers, shoulders, and lower back when he tripped on loose carpet tile and fell while in the performance of duty. On August 9, 2007 OWCP accepted the claim for neck and lumbar sprains, right shoulder contusion, and bilateral knee contusions. It paid appellant wage-loss compensation on the supplemental rolls for the period July 29 to September 1, 2007, and on the periodic rolls as of September 2, 2007.

Appellant returned to limited-duty work on June 1, 2009, working four hours per day. He continued to receive wage-loss compensation based upon his wage-earning capacity.

On July 29, 2016 OWCP expanded the acceptance of the claim to include right shoulder adhesive capsulitis.

On December 14, 2016 OWCP received a claim for compensation (Form CA-7) dated December 1, 2016 requesting a schedule award.

In a report dated December 26, 2017, Dr. Craig Levitz, a Board-certified orthopedic surgeon, opined that appellant had 20 percent permanent impairment of the right upper extremity and 15 percent bilateral knee permanent impairment.

On January 5, 2018 OWCP referred the case record, along with a statement of accepted facts (SOAF), to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon, serving as a district medical adviser (DMA).

In a report dated January 19, 2018, Dr. Harris applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] to the findings of Dr. Levitz and found five percent right upper extremity permanent impairment, zero percent upper left extremity permanent impairment, two percent right lower extremity permanent impairment, and zero percent left lower extremity permanent impairment.

In a letter dated April 4, 2018, OWCP referred appellant, along with a SOAF and the medical record, to Dr. Leon Sultan, a Board-certified orthopedic surgeon, for a second opinion regarding appellant's employment-related conditions and any resulting permanent impairment. The letter noted that the acceptance of the claim was expanded to include left finger contusion, bilateral medial meniscus tears, bilateral traumatic lower leg arthropathy, bilateral post-traumatic

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

knee arthritis, thoracic or lumbosacral neuritis or radiculitis, left finger contusion, bilateral knee medial meniscus tear, and acquired left trigger finger.

In a May 8, 2018 report, Dr. Sultan recounted appellant's history of injury, reviewed his medical history, and conducted a physical examination. Physical examination findings for appellant's knees were related as: no bilateral knee joint effusion; normal knee extension and flexion; plus one bilateral patellofemoral joint crepitus; negative patellofemoral compression test; negative bilateral Spring test; and negative bilateral McMurray's test. Using the A.M.A., *Guides*, Dr. Sultan found that appellant had six percent permanent impairment of the right upper extremity, but opined that appellant's subjective complaints in regard to his knees did not correspond with his current objective findings. He did not provide an impairment rating for appellant's bilateral lower extremities.

In a June 8, 2018 report, Dr. Arthur S. Harris, a Board-certified orthopedic surgeon and district medical adviser (DMA), related that he had reviewed the case record on January 10, 2018 at which time the established diagnoses included lumbar disc herniation L3-4, with protrusion L4-5, status post left knee arthroscopic chondroplasty and synovectomy, June 9, 2008, status post right knee arthroscopic partial medial and lateral meniscectomy, chondroplasty, and synovectomy May 20, 2010. He then noted that he had reviewed additional medical reports of record, including Dr. Sultan's May 8, 2018 report and he opined that appellant had 10 percent right lower extremity permanent impairment, and 2 percent left lower extremity permanent impairment.[4] In reaching this impairment determination, the DMA found no impairment for the bilateral lower extremities using a diagnosis of lumbar radiculopathy using Table 16-11, page 533 and Table 16-12, page 534. He also related that appellant's lumbar spine diagnoses did not allow permanent impairment to be evaluated pursuant to the range of motion (ROM) method. Using Table 16-3, page 509 and a diagnosis of partial lateral and medial right knee meniscectomy, the DMA determined that appellant had 10 percent right lower extremity permanent impairment. He again noted that this diagnosis did not allow an alternate rating based on loss of ROM. Next, the DMA determined that appellant had two percent left lower extremity permanent impairment using Table 16-3, page 509 for residual problems postarthroscopic synovectomy. He again noted that this diagnosis did not allow for an alternate ROM rating. The DMA also noted that Dr. Sultan had not provided permanent impairment calculations for the lower extremities.

In a July 26, 2018 supplemental report, Dr. Sultan determined that appellant had zero percent permanent impairment of the bilateral lower extremities. He again noted that appellant had full extension and flexion of both knees, with patellofemoral joint crepitus on both sides, but a negative patellofemoral compression test bilaterally. Using Table 16-3, Dr. Sultan assigned a class zero for appellant's bilateral knee condition, resulting in zero percent bilateral lower extremity permanent impairment.

In an October 3, 2018 report, the DMA reviewed Dr. Sultan's July 26, 2018 addendum and concurred with his rating of zero percent permanent impairment of the bilateral lower extremities. He found no bilateral lower extremity neurologic deficits consistent with lumbar radiculopathy. Using Table 16-11, page 533 and Table 16-12, page 534, the DMA found zero percent bilateral

[4] The DMA also determined that appellant had nine percent right upper extremity permanent impairment and one percent left upper extremity permanent impairment.

lower extremity permanent impairment for the diagnosis of lumbar radiculopathy. He also determined that appellant had zero percent bilateral lower extremity permanent impairment using the diagnosis based impairment (DBI) method for appellant's bilateral knee condition.

By decision dated November 1, 2018, OWCP granted appellant a schedule award for nine percent permanent impairment of the right upper extremity, zero percent permanent impairment for the left upper extremity, and zero percent permanent impairment for both lower extremities.

On January 14, 2019 appellant requested reconsideration of the November 1, 2018 decision only with regard to the denial of a schedule award for permanent impairment of his bilateral lower extremities.

In support of his request for reconsideration, appellant submitted a November 27, 2018 report from Dr. Levitz. Using a permanent impairment worksheet, Dr. Levitz determined that appellant had seven percent right lower extremity permanent impairment and seven percent left lower extremity permanent impairment based on a diagnosis of bilateral knee osteoarthritis. He diagnosed bilateral post-traumatic knee osteoarthritis and provided examination findings. Physical findings for appellant's bilateral knees included no effusion, medial joint line patella tenderness and crepitus, and negative McMurray's, Apley's test, and Lachman test. Dr. Levitz noted that appellant had bilateral knee diagnoses of osteoarthritis, ratable under Table 16-3, page 511 of the A.M.A., *Guides*. He explained that the mild impairment of each knee impairment fell into Class 1, and that each knee had a grade modifier for functional history (GMFH) of 1, a grade modifier for physical examination (GMPE) of 1, a grade modifier for clinical studies (GMCS) of 2, and a *Quick*DASH score of 25, which resulted in a grade C rating of, 7 percent permanent impairment of each lower extremity, for a total bilateral lower extremity permanent impairment rating of 14 percent.

In a March 12, 2019 report, the DMA reviewed Dr. Levitz' report and impairment rating and found that no significant additional information had been provided which would change the impairment rating provided in his October 3, 2018 report.

By decision dated March 20, 2019, OWCP denied modification of its prior decision, finding that the evidence of record was insufficient to establish permanent impairment of appellant's bilateral lower extremities.

LEGAL PRECEDENT

The schedule award provisions of FECA[5] and its implementing regulations[6] 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. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A.,

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

Guides as the uniform standard applicable to all claimants.[7] For decisions issued after May 1, 2009, the sixth edition is used to calculate schedule awards.[8]

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).[9] 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.[10] 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).[11] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[12]

OWCP's 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 DMA providing rationale for the percentage of impairment specified.[13]

ANALYSIS

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

In a June 8, 2018 report, the DMA related that he had reviewed the case record on January 10, 2018 at which time the established diagnoses included lumbar disc herniation L3-4, with protrusion L4-5; status post left knee arthroscopic chondroplasty and synovectomy, June 9, 2008; status post right knee arthroscopic partial medial and lateral meniscectomy, chondroplasty and synovectomy May 20, 2010. He then noted that he had reviewed additional medical reports of record, including Dr. Sultan's May 8, 2018 report and he opined that appellant had 10 percent right lower extremity permanent impairment, and 2 percent left lower extremity permanent impairment. In reaching this impairment determination, the DMA found no impairment for the bilateral lower extremities using a diagnosis of lumbar radiculopathy using Table 16-11, page 533

[7] *Id.* at 10.404(a).

[8] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010); *id*. at Chapter 2.808.6 (March 2017).

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

[10] *See Guides* at 509-11 *id*.

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

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

[13] *See supra* note 8 at Chapter 2.808.6(f) (March 2017).

and Table 16-12, page 534. He also related that appellant's lumbar spine diagnoses did not allow permanent impairment to be evaluated pursuant to the ROM method. Using Table 16-3, page 509 and a diagnosis of partial lateral and medial right knee meniscectomy, the DMA determined that appellant had 10 percent right lower extremity permanent impairment. He again noted that this diagnosis did not allow an alternate rating based on loss of ROM. Next, the DMA determined that appellant had two percent left lower extremity permanent impairment using Table 16-3, page 509 for residual problems postarthroscopic synovectomy. He again noted that this diagnosis did not allow for an alternate ROM rating.

In his July 26, 2018 supplemental report, Dr. Sultan utilized Table 16-3 and assigned a class zero for appellant's bilateral knee condition resulting in zero percent bilateral lower extremity permanent impairment. He, however, never identified which diagnoses he applied to the DBI methodology to determine his zero percent impairment rating.

In an October 3, 2018 report, the DMA then reviewed Dr. Sultan's July 26, 2018 supplemental opinion. While the DMA had previously found 10 percent right lower extremity permanent impairment, and 2 percent left lower extremity permanent impairment, he now concurred with Dr. Sultan that appellant had zero percent bilateral lower extremity permanent impairment. The DMA did not provide rationale explaining why Dr. Sultan's July 26, 2018 supplemental report changed his opinion. In a March 12, 2019 report, October 3, 2018 reviewed Dr. Levitz' November 27, 2018 report and impairment rating, but found no significant additional information which would change the impairment rating provided in his October 3, 2018 report.

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[14] It has the obligation to see that justice is done. Accordingly, once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[15]

Because the reports of the DMA lack rationale explaining his lowered impairment rating, the Board finds that the opinion of the DMA requires clarification. The case is therefore remanded to OWCP to obtain a supplemental report from the DMA regarding whether appellant has permanent impairment of his bilateral lower extremities due to his accepted employment injury. If Dr. Harris is unable to clarify or elaborate on his prior reports or if his supplemental report is also vague, speculative, or lacking in rationale, OWCP must send the case record to a second DMA for the purpose of obtaining a rationalized medical opinion on the issue.[16] Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

[14] *C.W.*, Docket No. 17-0791 (issued December 14, 2018); *R.B.*, Docket No. 08-1662 (issued December 18, 2008).

[15] *C.W.*, *id.*, *see P.D.*, Docket No. 15-1111 (issued December 7, 2015).

[16] *See D.O.*, Docket No. 19-1729 (Issued November 3, 2020); *S.R.*, Docket No. 17-1118 (issued April 5, 2018); *Harold Travis*, 30 ECAB 1071, 1078 (1979).

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 20, 2019 is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: March 15, 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