

November 8, 2017 when assisting a staff member in restraining a combative inmate while in the performance of duty.

In a November 30, 2017 report, Dr. Curtis Thorpe, a Board-certified orthopedic surgeon, provided a history of injury. He noted that appellant had undergone two previous arthroscopic surgeries on the left knee, but had been asymptomatic prior to the November 8, 2017 employment incident. Dr. Thorpe diagnosed a left knee strain with possible torn medial meniscus. He administered a cortisone injection to the left knee.

By decision dated December 14, 2017, OWCP accepted appellant's claim for left knee sprain.

A January 20, 2018 magnetic resonance imaging (MRI) scan of the left knee demonstrated moderate-to-severe tricompartmental osteoarthritis and a complete medial meniscal tear.

On April 4, 2018 Dr. Thorpe performed an authorized arthroscopic partial medial meniscectomy of the left knee with arthroscopic chondroplasty of the medial femoral condyle and patellofemoral joint of the left knee.² Appellant remained off work. In a report dated July 26, 2018, Dr. Thorpe related appellant's symptoms of stiffness and crepitation of the left knee. He administered a cortisone injection to the left knee. Dr. Thorpe opined that appellant had attained maximum medical improvement (MMI).

On November 21, 2018 appellant filed a schedule award claim (Form CA-7). In support of his claim, he submitted a September 19, 2018 report by Dr. Frank L. Barnes, a Board-certified orthopedic surgeon. Dr. Barnes provided a history of injury and treatment, and noted that appellant had attained MMI effective July 26, 2018. On examination of the left knee, he noted several 1 cm scars, extension at zero degrees, flexion limited to 104 degrees, mild, continuous crepitus, no ligamentous laxity, and a positive McMurray's test. Dr. Barnes diagnosed a torn left posterior meniscus and chondromalacia of the left knee. He indicated that he would provide an impairment rating using the diagnosis-based impairment (DBI) method for his left knee osteoarthritis. Utilizing Table 16-3 (Knee Regional Grid) at page 509 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment (A.M.A., Guides)*,³ Dr. Barnes determined that appellant's class of diagnosis (CDX) was a class 1 impairment, severity of E. He noted a grade modifier for functional history (GMFH) of 2, moderate, a grade modifier for physical examination (GMPE) of 1 due to a mild loss of flexion, and a grade modifier for clinical studies (GMCS) of 2 due to moderately severe findings. After applying the net adjustment formula (GMFH-CDX) + (GMPE - CDX) + (GMCS - CDX), or $(2-1) + (1-1) + (2-1) = +2$, Dr. Barnes determined that appellant had a net adjustment score of +2, which resulted in three percent permanent impairment of the left lower extremity. He then noted that using the range of motion (ROM) method, appellant had 10 percent permanent impairment of the left lower extremity according to Table 16-23 (Knee Motion Impairments). Dr. Barnes opined that the ROM method was preferable to the DBI method in describing appellant's impairment as it afforded the higher percentage of impairment. He,

² Appellant participated in physical therapy treatments from April through June 2018.

³ A.M.A., *Guides* (6th ed. 2009).

therefore, concluded that appellant had 10 percent permanent impairment of the left lower extremity.

On January 10, 2019 OWCP forwarded Dr. Barnes' report, the medical record, and a statement of accepted facts (SOAF) to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon, to serve as a district medical adviser (DMA). In a January 15, 2019 report, Dr. Harris reviewed the SOAF and medical record. He opined that according to the DBI rating method, appellant had two percent impairment of the left lower extremity according to Table 16-3. Dr. Harris opined that the DBI method should be utilized as it appropriately described appellant's diagnosed condition, and the impairment did not meet the criteria under Section 16.7, page 543 to allow application of the ROM method.

In a February 22, 2019 letter, OWCP requested that Dr. Barnes review Dr. Harris' report and provide a narrative response indicating his agreement or disagreement. It afforded 30 days for submission of the requested evidence. In response, Dr. Barnes provided a March 16, 2019 report noting his disagreement with Dr. Harris' opinion. He opined that the ROM method was the most appropriate method as the Meniscal Injury category under Table 16-3 did not include loss of motion. As appellant had definite loss of left knee motion on examination, meniscal injury was not an adequate diagnosis. Dr. Barnes explained that while several other diagnoses in Table 16-3 encompassed motion defects, meniscal injury did not, indicating that this diagnosis did not describe an individual with meniscal injury with loss or range of motion. He therefore concluded that appellant had 10 percent permanent impairment of the left lower extremity using the ROM method.

On April 15, 2019 OWCP forwarded a SOAF, the medical record, and Dr. Barnes' March 16, 2019 report to Dr. Harris as DMA, to obtain clarification regarding the appropriate rating method for appellant's impairment. In an April 20, 2019 report, Dr. Harris noted that Section 15.2 of the A.M.A., *Guides* provided that the DBI rating method was generally considered preferable to the ROM method. Also, the ROM method was to be used as a stand-alone rating method when there were no applicable diagnosis-based sections, or in the rare case of severe injury with passive motion loss or amputation.

In a May 24, 2019 letter, OWCP requested that Dr. Barnes review Dr. Harris' April 20, 2019 report and provide a narrative response indicating his agreement or disagreement. It afforded 30 days for submission of the requested evidence. In response, Dr. Barnes provided a June 12, 2019 report reiterating that the ROM method better described appellant's impairment as the DBI rating predicated on meniscal injury with partial meniscectomy did not include loss of ROM. He also opined that as the A.M.A., *Guides* instructed application of the rating method that gave a higher impairment value, the ROM method was again preferable to the DBI method.

On December 12, 2019 OWCP referred appellant, a SOAF, and the medical record to Dr. Alexander N. Doman, a Board-certified orthopedic surgeon, for a second opinion examination to determine the extent of permanent impairment of appellant's left lower extremity. In a January 7, 2020 report, Dr. Doman reviewed the SOAF and medical record. He noted that appellant underwent prior left arthroscopic partial meniscectomies in approximately 2002 and 2010, with ongoing aching left knee pain. Dr. Doman also underwent two arthroscopic procedures on his right knee. On examination of the left knee, he found full extension, and flexion limited to 120 degrees utilizing three trials, noting an identical range of motion in the right knee. Dr. Doman

obtained left knee x-rays demonstrating one mm of joint space in the medial compartment, with moderate patellofemoral degenerative changes. He diagnosed left knee osteoarthritis and status-post arthroscopic partial meniscectomy. Dr. Doman opined that appellant had attained MMI as of January 7, 2020. Referring to Table 16-3, page 509, of the A.M.A., *Guides*, he noted a DBI method rating based on a diagnosis of meniscal injury with partial meniscectomy, a grade C impairment with a default value of two percent. Dr. Doman found GMFH, GMPE, and GMCS modifiers of one, resulting in a net modifier of zero, and a permanent left lower extremity impairment of two percent. He explained that the ROM method was inappropriate as appellant had the identical impairment of right knee ROM with bilateral knee osteoarthritis. Dr. Doman attributed restricted ROM to preexisting osteoarthritis.

On January 22, 2020 OWCP forwarded Dr. Doman's report to Dr. Harris to clarify the appropriate percentage of permanent impairment to the left lower extremity. In response, Dr. Harris provided a January 25, 2020 report reviewing Dr. Doman's January 7, 2020 opinion. He noted that appellant had attained MMI as of January 7, 2020. Dr. Harris opined that according to Table 16-3, appellant had 26 percent permanent impairment of the left lower extremity for severe degenerative joint disease of the left knee with documented joint space narrowing, a class 3 impairment using the DBI method. He explained that the impairment did not meet any of the criteria for a ROM method rating.

By decision dated February 28, 2020, OWCP granted appellant a schedule award for 26 percent impairment of the left lower extremity (knee). The award ran for 74.88 weeks from January 7, 2020 through June 14, 2021. OWCP noted that the schedule award was based on the September 19, 2018 report of Dr. Barnes, the January 7, 2020 report of Dr. Doman, and the January 15, 2019 and January 25, 2020 DMA reports of Dr. Harris.

LEGAL PRECEDENT

The schedule award provision of FECA⁴ and its implementing regulations⁵ 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., *Guides* as the uniform standard applicable to all claimants and the Board has concurred in such adoption.⁶ As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.⁷

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 left knee, the relevant position of the left leg for the present case,

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404.

⁶ *Id.* at § 10.404 (a); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

⁷ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also* Chapter 3.700.2 and Exhibit 1 (January 2010).

reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.⁸ After 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).⁹ Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnosis from regional grids and calculations of modifier scores.¹⁰

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed through an OWCP medical adviser for an opinion concerning the nature and extent of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.¹¹

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than 26 percent permanent impairment of the left lower extremity, for which he previously received a schedule award.

OWCP accepted left knee sprain. By decision dated February 28, 2020, it granted appellant a schedule award for 26 percent permanent impairment of the left lower extremity (knee). The award was based on the opinion of referral physician Dr. Doman and the DMA, Dr. Harris.

Dr. Doman reviewed the medical record and SOAF and provided detailed findings on examination. He found that appellant had attained MMI. In his January 25, 2020 report, the DMA indicated that he had reviewed Dr. Doman's January 7, 2020 report and concurred with his use of the DBI rating method. The DMA then applied Table 16-3 to determine 26 percent impairment of the left lower extremity due to severe degenerative joint disease with a one mm cartilage interval on x-ray. Additionally, he explained why the ROM rating method was inappropriate. The DMA properly applied the appropriate tables of the A.M.A., *Guides* to Dr. Doman's clinical findings to determine that appellant has 26 percent permanent impairment of the left lower extremity. The Board thus finds that the weight of the medical evidence rests with Dr. Doman and the DMA. There is no evidence of record sufficient to show greater impairment or to create a conflict of medical opinion.

On appeal appellant contends that OWCP did not properly consider Dr. Barnes' opinion prior to his referral to Dr. Doman. As explained above, the evidence of record is insufficient to establish more than 26 percent permanent impairment of his left lower extremity.

⁸ See A.M.A., *Guides* (6th ed. 2009) 509-11.

⁹ *Id.* at 515-22.

¹⁰ *Id.* at 23-28; see *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

¹¹ See *supra* note 7 at Chapter 2.808.6(f) (March 2017).

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 met his burden of proof to establish greater than 26 percent permanent impairment of the left lower extremity, for which he previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the February 28, 2020 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 16, 2021
Washington, DC

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

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

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