United States Department of Labor
Employees' Compensation Appeals Board

M.H., Appellant	)	
and	)	**Docket No. 20-1109**
	)	**Issued: September 27, 2021**
DEPARTMENT OF VETERANS AFFAIRS, EAST ORANGE VA MEDICAL CENTER, East Orange, NJ, 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:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 6, 2020 appellant, through counsel, filed a timely appeal from a March 3, 2020 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.

[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*.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 23 percent permanent impairment of his right lower extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

On November 16, 2010 appellant, then a 47-year-old air conditioning equipment operator, filed a traumatic injury claim (Form CA-1) alleging that on that date he injured his right knee when he fell while stepping down approximately three feet from generator housing, landing on unstable, wet, rocky ground in the performance of duty. He stopped work on November 17, 2010 and returned to limited duty on November 19, 2010. OWCP accepted the claim for right knee sprain, and subsequently expanded its acceptance of the claim to include right and left knee sprain and right knee lateral and meniscal tear. It authorized right knee medial meniscal arthroscopic surgery, which occurred on May 17, 2012. Appellant returned to full-time limited-duty work on July 16, 2012.

By decision dated November 26, 2013, OWCP granted appellant a schedule award for nine percent permanent impairment of the right lower extremity, based upon his right medial meniscectomy. The award ran for 25.92 weeks from November 19, 2012 through May 19, 2013.

On September 28, 2016 appellant underwent OWCP-approved right knee arthroplasty/total right knee replacement performed by Dr. Thomas Helbig, a Board-certified orthopedic surgeon.

On January 18, 2017 appellant filed a claim for compensation (Form CA-7) for an additional schedule award.

In a February 1, 2017 letter, OWCP acknowledged receipt of appellant's claim for an additional schedule award, noting that additional medical evidence was required to determine permanent impairment. It informed him of the evidence required and afforded him 30 days to provide the requested information. No response was received.

By decision dated March 3, 2017, OWCP denied appellant's request for an additional schedule award.

On March 30, 2017 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review, which was subsequently changed to a review of the written record.

In a March 6, 2017 report, Dr. Karen M. Garvey, a Board-certified internist and occupational medicine physician, examined appellant and reviewed medical evidence. She related that physical examination of appellant's right knee demonstrated edema, mild warmth, a well-healed 1.6 centimeter midline scar over the anterior knee, and audible clicking with ambulation. Dr. Garvey reported an antalgic gait, normal knee strength, and 80 degrees right knee flexion, 0 degrees extension, no loss of medial or lateral laxity, and no loss of flexion or extension strength of the right knee. Referring to the sixth edition of the American Medical Association, *Guides to*

the Evaluation of Permanent Impairment (A.M.A., *Guides*),[3] she assigned class of diagnosis (CDX) of 2 for osteotomy/total knee replacement using Table 16, page 511. Dr. Garvey assigned a grade modifier for functional history (GMFH) of 1 for antalgic gait, a grade modifier for physical examination (GMPE) of 2 for moderate palpatory findings for knee edema, and a grade modifier for clinical studies (GMCS) of 2 based on x-ray findings of moderate degenerative changes used to confirm the diagnosis.[4] Application of the net adjustment formula resulted in a finding of -1 or grade B, 23 percent permanent impairment of the right lower extremity.[5] Using Table 16-3, page 509, Dr. Garvey assigned a CDX of 1 for the diagnosis of right knee sprain. Next, she assigned GMFH of 1 for antalgic gait, GMPE was not used as the physical examination defined the class, and GMCS of 2 based on magnetic resonance imaging (MRI) scan used to confirm the diagnosis of moderate pathology.[6] Application of the net adjustment formula resulted in a finding of +1 or grade D, two percent permanent impairment of the right lower extremity.[7] Dr. Garvey combined the impairment ratings for the right knee sprain and osteotomy/total knee replacement, resulting in a total of 25 percent right lower extremity permanent impairment, which represented a 16 percent increase over the previous 9 percent permanent impairment determination.

By decision dated May 1, 2017, OWCP's hearing representative set aside the March 3, 2017 decision and remanded the case for further development of the medical evidence.

On May5, 2017 OWCP referred the record, including a SOAF, to Dr. Todd Fellars, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA). In a report dated May 24, 2017, Dr. Fellars disagreed with Dr. Garvey's 23 percent right lower extremity impairment rating for appellant's knee arthroplasty as knee arthritis was not an accepted condition and clearly preexisting. He also strongly disagreed that appellant had even nine percent lower extremity impairment. Using the sixth edition of the A.M.A., *Guides*, Dr. Fellars used a diagnosis of partial medial meniscectomy with a baseline two percent lower extremity permanent impairment. He assigned a GMFH of 2, due to continued pain, and a GMPE of 1 for minimal palpatory findings. A GMCS was not used as the clinical studies showed pathology for a condition not accepted by OWCP.[8] Dr. Fellars explained that application of the net adjustment formula resulted in two percent right lower extremity permanent impairment.

On June 1, 2017 OWCP referred appellant for a second opinion evaluation with Dr. Timothy Henderson, a Board-certified orthopedic surgeon, for an assessment of appellant's work-related conditions and any resulting permanent impairment. In a report dated June 22, 2017, Dr. Henderson, based upon his examination of appellant, a review of the medical records, SOAF, and list of questions, diagnosed a permanent aggravation of right knee osteoarthritis, which led to total right knee replacement. Physical findings demonstrated right knee range of motion of 0 to

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

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

[5] *Id.* at 521.

[6] *Supra* note 4.

[7] *Supra* note 5.

[8] *Supra* note 4.

95 degrees (normal 0 to 150 degrees), no instability, grossly intact neurologic findings, negative Lachman's test, negative posterior drawer, and negative Homan's sign. Using the sixth edition of the A.M.A., *Guides*, Dr. Henderson determined that appellant had 31 percent permanent impairment of the right lower extremity. He assigned a CDX of 3 for the diagnosis of status post total knee replacement and fair result with a default value of 37 percent.[9] Dr. Henderson assigned a GMFH of 2, due to difficulty walking on stairs, a GMPE of 1, and a GMCS of 2, based on implant in good position.[10] He explained that application of the net adjustment formula resulted in a finding of -4 or grade A, which was the equivalent of 31 percent permanent impairment of the right lower extremity.[11]

In a July 19, 2017 report, Dr. Fellars reviewed Dr. Henderson's impairment rating and agreed that appellant had between 23 percent and 31 percent lower extremity impairment. However, the DMA noted that the only accepted conditions were knee sprain and meniscal tear, which warranted only two percent lower extremity permanent impairment. He advised that clarification was required as to whether the acceptance of appellant's claim should be expanded to include aggravation of his osteoarthritis and a finding that the knee arthroplasty was work related.

On July 20, 2017 OWCP expanded its acceptance of appellant's claim to include permanent aggravation of right knee osteoarthritis.

OWCP routed Dr. Henderson's report, an updated SOAF, and the case record to Dr. Fellars on July 20, 2017 for review and an updated evaluation of appellant's permanent impairment pursuant to the A.M.A., *Guides*. Dr. Fellars was also asked to provide a date of MMI. In an August 7, 2017 report, he again noted his disagreement with Dr. Garvey's impairment rating of 25 percent right lower extremity permanent impairment. Based on his review of Dr. Henderson's report, the revised SOAF, and expansion of the claim to include permanent aggravation of right knee osteoarthritis, Dr. Fellars calculated 23 percent right lower extremity permanent impairment. In reaching this determination, he assigned a CDX of 2 for the diagnosis of post-traumatic knee arthritis and knee arthroplasty.[12] Dr. Fellars assigned a GMFH of 1 as appellant did not use an assistive device, a GMPE of 2 due to motion loss, and no GMCS as it was used to define the class of impairment.[13] He explained that application of the net adjustment formula resulted in a finding of -1 or grade B, which was the equivalent of 23 percent permanent impairment of the right lower extremity.[14]

By decision dated August 11, 2017, OWCP granted appellant a schedule award for an additional 14 percent right lower extremity permanent impairment, resulting in a total of 23 percent

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

[10] *Supra* note 4.

[11] *Supra* note 5.

[12] *Supra* note 9

[13] *Supra* note 4

[14] *Supra* note 5

permanent impairment of the right lower extremity. The award was for 40.32 weeks and ran for the period March 6 through December 13, 2017.

In a letter dated August 23, 2017, appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review, which was held on February 13, 2018.

By decision dated May 1, 2018, OWCP's hearing representative vacated the August 11, 2017 schedule award decision and remanded the case to OWCP to obtain clarification from the DMA regarding the rating differences in his impairment opinion.

In reports dated May 23 and June 18, 2018, Dr. Fellars found 23 percent right lower extremity permanent impairment. He explained that appellant's right knee sprain would not be rated as a separate diagnosis, as only the most serious diagnosis should be rated. Dr. Fellars disagreed with Dr. Henderson's finding of 31 percent right lower agreement impairment as application of grade modifiers did not support a +2 adjustment from a CDX of 2, grade C to a CDX of 2, grade E impairment, but support a -2 grade adjustment, which was the basis of the difference between the impairment ratings.

By decision dated June 22, 2018, OWCP granted appellant a schedule award for an additional 14 percent right lower extremity permanent impairment, resulting in a total 23 percent permanent impairment of the right lower extremity. The award was for 40.32 weeks and ran from March 6 through December 13, 2017.

On July 2, 2018 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

By decision dated September 12, 2018, a representative of OWCP's Branch of Hearings and Review completed a preliminary review and determined the case was not in posture for decision. The hearing representative vacated the June 22, 2018 schedule award decision and remanded the case for further clarification from the DMA regarding appellant's impairment rating.

Dr. Fellars, in a September 28, 2018 report, explained that he determined that appellant had a CDX 2 impairment which ranged from 21 percent to 25 percent and grades A, B, C, D, and E. Using the net adjustment formula resulted in a CDX 2, grade B and 23 percent permanent impairment. Dr. Fellars explained that he found appellant was CDX 2 rather than CDX 3 due to the good result from his surgery rather than the fair result found by Dr. Henderson. He explained a good result was found when the knee with the components was in a good position and was stable while a fair result was demonstrated when components had a slight malalignment, mild instability and/or mild motion deficit. Mild motion deficit was defined as flexion at least 80 degrees and loss of up to 9 degrees extension.

By decision dated October 31, 2018, OWCP denied appellant's claim for an additional schedule award, finding that he was not entitled to greater than 23 percent right lower extremity permanent impairment, for which he previously received schedule award compensation.

On November 7, 2018 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review, which was held on March 18, 2019.

By decision dated June 3, 2019, OWCP's hearing representative affirmed the October 31, 2018 decision.

On December 5, 2019 appellant, through counsel, requested reconsideration of the June 3, 2019 decision. In support of his request, appellant submitted reports dated August 7 and November 6, 2019 from Dr. Helbig.

Dr. Helbig, in his August 7, 2019 report, noted that appellant was seen for a follow-up examination for total right knee replacement surgery performed on September 28, 2016. Appellant indicated that he had a fair result with some persistent symptoms including medial pain, lateral aspect numbness of the knee, and some episodes of the right knee giving way. Appellant's physical examination revealed 0 to 115 degrees flexion with no instability and minimal pain. An x-ray interpretation showed excellent component position without evidence of loosening. In the November 6, 2019 follow-up examination, Dr. Helbig noted that appellant completed physical therapy with some flexibility improvement, but no improvement in his discomfort. Physical examination indicated tenderness over the pes bursa and 0 to 100 degrees of flexion with mild pain.

By decision dated March 3, 2020, OWCP denied modification.

LEGAL PRECEDENT

The schedule award provisions of FECA[15] and its implementing regulations[16] 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 under the law, good administrative practice necessitates 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.[17] 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.[18]

[15] *Supra* note 2.

[16] 20 C.F.R. § 10.404.

[17] 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* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[18] *J.B.*, Docket No. 20-1380 (issued May 12, 2021); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's *The International Classification of Functioning, Disability, and Health (ICF): A Contemporary Model of Disablement*.[19] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by grade modifiers based on a GMFH, GMPE, and/or GMCS.[20] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[21] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[22]

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.[23]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than 23 percent permanent impairment of his right lower extremity for which he previously received schedule award compensation.

In a March 6, 2017 report, Dr. Garvey, appellant's treating physician, found that appellant had 2 percent impairment for a knee sprain and 23 percent impairment for total knee replacement, totaling 25 percent permanent impairment of the right lower extremity under the sixth edition of the A.M.A., *Guides*.

Dr. Fellars, serving as OWCP's DMA, reviewed Dr. Garvey's findings on May 24, 2017, disagreed with her impairment rating for knee arthroplasty as knee arthritis was not an accepted condition and was preexisting. He determined that appellant only had two percent right lower extremity permanent impairment due to the accepted right knee sprain.

In a June 22, 2017 report, Dr. Henderson, based upon a review of the medical records, a SOAF, and list of questions, diagnosed a permanent aggravation of right knee osteoarthritis, which led to total right knee replacement. He provided a permanent impairment rating based upon the sixth edition of the A.M.A., *Guides*. Dr. Henderson assigned a CDX of 3 for the diagnosis of status post total knee replacement and fair result. He applied the net adjustment formula and calculated 31 percent permanent impairment of the right lower extremity based upon the DBI methodology.

[19] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3a.

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

[21] *Id*. at 411.

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

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

OWCP referred Dr. Henderson's report back to Dr. Fellars. In reports dated May 23 and June 18, 2018, Dr. Fellars found 23 percent right lower extremity permanent impairment. He disagreed with Dr. Henderson's finding of 31 percent right lower agreement impairment as application of grade modifiers did not support a +2 adjustment from a CDX of 2, grade C to a CDX of 2, grade E impairment which he explained was the basis of the difference between the impairment ratings. Dr. Fellars in a September 28, 2018 report, further clarified his opinion and explained that he determined appellant had a CDX 2 impairment which ranged from 21 percent to 25 percent and grades A, B, C, D, and E. In support of his determination of CDX 2 rather than CDX 3, as found by Dr. Henderson, he explained was due to the good result from appellant's surgery rather than the fair result used by Dr. Henderson. Dr. Fellars explained that a good result was found when the knee with the components was in a good position and was stable while a fair result would have components in a slight malalignment, mild instability and/or mild motion deficit. In addition, mild motion deficit was defined as flexion at least 80 degrees and loss of up to 9 degrees extension. The Board has reviewed Dr. Fellars' opinion and finds that it conforms to the provisions of the A.M.A., *Guides*. Dr. Fellars properly reviewed the medical evidence and evaluated appellant's impairment of the lower extremities in accordance with the A.M.A., *Guides,* as a CDX of 2, rather than a CDX of 3, based upon his good rather than fair result following total knee replacement. Dr. Fellars' finding of a good result was supported by Dr. Helbig's August 7, 2019 report, which related that current x-rays of appellant's right knee showed excellent component position without evidence of loosening.

There is no medical evidence in conformance with the A.M.A., *Guides* showing greater impairment.[24] As there is no medical evidence of record in conformance with the sixth edition of the A.M.A., *Guides*, establishing that appellant has greater impairment than previously awarded, the Board finds that appellant has not met his burden of proof to establish that he is entitled to additional schedule award compensation.[25]

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 23 percent permanent impairment of his right extremity, for which he previously received schedule award compensation.

[24] *See R.H.*, Docket No. 20-1472 (issued March 15, 2021); *L.D.*, Docket No. 19-0495 (issued February 5, 2020).

[25] *Id*.

ORDER

IT IS HEREBY ORDERED THAT the March 3, 2020 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 27, 2021
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

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