# United States Department of Labor
# Employees' Compensation Appeals Board.

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| **J.H., Appellant** | ) | |
| **and** | ) | **Docket No. 21-1215** |
| | ) | **Issued: May 5, 2022** |
| **DEPARTMENT OF HOMELAND SECURITY, U.S. CUSTOMS & BORDER PROTECTION -- SOUTHWEST LAREDO SECTOR, Laredo, TX, Employer** | ) | |

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

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

### ***JURISDICTION***

On August 9, 2021 appellant filed a timely appeal from March 25 and April 6, 2021 merit decisions 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 April 6, 2021 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 greater than five percent permanent impairment of his right lower extremity for which he previously received a schedule award.

## ***FACTUAL HISTORY***

On March 10, 2019 appellant, then a 38-year-old border patrol agent, filed a traumatic injury claim (Form CA-1) alleging that on March 9, 2019 he sustained injuries when he fell off a 12-foot high fence he was climbing while in the performance of duty. OWCP accepted the claim for right knee medial meniscus bucket-handle tear, right knee contusion, right knee medial meniscus tear, left ankle other ligament sprain, right thigh muscle, fascia, and tendon of the posterior muscle group strain, and right leg tibial collateral bursitis (Pellegrini-Stieda). It authorized appellant's June 20, 2019 right knee diagnostic arthroscopy with anterior horn medial meniscus debridement and medial femoral condyle chondroplasty surgery. Appellant stopped work on June 20, 2019 and returned to work on July 12, 2020.[3]

On February 27, 2020 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a February 13, 2020 report, Dr. Stephen J. Bell, a Board-certified orthopedic surgeon, described appellant's history of injury on March 9, 2019. He also reported appellant's physical examination findings. Dr. Bell indicated that appellant had right knee motion to 115 degrees. Under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[4] he opined that appellant had 10 percent right lower extremity permanent impairment based on the range of motion (ROM) impairment methodology. Under the diagnosis-based impairment (DBI) methodology for the right knee, Dr. Bell opined that appellant had a class of diagnosis (CDX) for medial meniscal tear, status post arthroscopy with partial medial meniscectomy a Class 1, Grade C or two percent impairment. He assigned a grade modifier for functional history (GMFH) of 1 for slight antalgic gait without use of an assistive device, a grade modifier for physical examination (GMPE) of 1 for mild problem with ROM and muscle atrophy, and a grade modifier for clinical studies (GMCS) of 2 for moderate problem as appellant's May 3, 2019 magnetic resonance imaging (MRI) scan revealed peripheral medial meniscal tear. Dr. Bell applied the net adjustment formula (GMFH - CDX) (1-1) + (GMPE - CDX) (1-1) + (GMCS - CDX) (2-1) = +1 net adjustment, which resulted in a final Class 1, Grade D or two percent permanent impairment of right knee. He also used the ROM impairment methodology to rate the right knee. Under Table 16-23, Dr. Bell found an average of 115 degrees of flexion and average of -8 degrees of flexion contracture, which indicated 10 percent mild impairment. Under Table 16-25, he opined that appellant had Class 1 or mild impairment of 10 percent. Dr. Bell opined that, as the ROM impairment methodology yielded the highest impairment rating, appellant

[3] Under OWCP File Nos. xxxxxx992 and xxxxxx722, appellant received schedule award compensation for 7 percent permanent impairment and 10 percent permanent impairment of his left lower extremity, respectively.

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

had 10 percent permanent right lower extremity impairment. He advised that appellant had reached maximum medical improvement (MMI) effective January 15, 2020.

On May 14, 2020 OWCP routed Dr. Bell's February 13, 2020 report, a statement of accepted facts (SOAF), and the case record to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon, serving as an OWCP district medical adviser (DMA), for review and a determination of permanent impairment of appellant's left and right lower extremities under the sixth edition of the A.M.A., *Guides*, and his date of MMI.

On June 26, 2020 Dr. Harris reviewed the findings in Dr. Bell's February 13, 2020 report. He opined that appellant reached MMI on February 13, 2020 the date appellant was evaluated by Dr. Bell. For the right lower extremity/knee, under the DBI impairment method, the DMA opined that under Table 16-3 that appellant had three percent impairment for partial medial meniscectomy. He indicated that appellant's diagnosed condition did not meet any of the criteria in section 16.7, page 543 to allow for an impairment to be calculated under the ROM methodology. The DMA explained that a ROM impairment rating was not available as an alternative to the DBI method because appellant's accepted diagnoses were not eligible for the ROM method under the A.M.A., *Guides*. He further noted that appellant had previously been awarded 17 percent left lower extremity impairment and that appellant was entitled to an additional 2 percent impairment, for a total left lower extremity impairment of 19 percent.

By decision dated August 18, 2020, OWCP granted appellant a schedule award for 3 percent right lower extremity permanent impairment and an additional 2 percent left lower extremity impairment, for a total 19 percent left lower extremity impairment. The award ran for 14.4 weeks from February 13 to May 23, 2020 and was based on the impairment rating of the DMA.

On August 29, 2020 appellant requested reconsideration on an appeal request form. In an August 29, 2020 letter, he contested his right lower extremity permanent impairment award alleging that Dr. Bell's 10 percent impairment rating of his knee under the ROM impairment methodology was proper.

By decision dated September 24, 2020, OWCP denied appellant's request for reconsideration. It found that his August 29, 2020 letter neither raised substantive legal questions, nor included new and relevant evidence.

On October 7, 2020 appellant again requested reconsideration. He again expressed his belief that a 10 percent permanent impairment rating for his right knee was warranted under the ROM impairment methodology. Appellant noted that Dr. Bell performed three measurements for ROM as required by the A.M.A., *Guides* and that, since the ROM methodology yielded the highest impairment over the DBI methodology, it should be used. He further discussed right knee findings, noting that his right knee MRI scan showed displaced meniscal fragments, and arthrofibrosis and other damage.

In the September 30, 2020 right knee MRI scan report, Dr. Richard Anguiano, a Board-certified radiologist, provided an impression of defect along the anterior horn of the medial meniscus, possible displaced meniscal fragment, arthrofibrosis, and mild joint effusion.

Appellant also submitted progress notes concerning his right knee dated September 22, October 6 and 20, 2020 from Dr. John V. Puig, II, a Board-certified family practitioner, and Dr. Anish Potty, an orthopedic surgery specialist, respectively, which provided diagnoses of right knee medial meniscus tear, right knee medial femoral condyle contusion, right knee pain, right knee pes anserine bursitis, right knee semimembranosus muscle and tendon strain with tendinitis, and right knee effusion.[5] Dr. Puig noted that there was atrophy of the vastus medialis oblique muscle and distal quadriceps and ROM was restricted with flexion limited to 3 degrees and movements were painful with flexion beyond 120 degrees. Dr. Potty recommended additional right knee surgery.

On January 5 and February 9, 2021 OWCP requested that the DMA, Dr. Harris, review the additional evidence and provide a supplemental report. An updated SOAF dated January 5, 2021 was also provided.[6]

In a February 19, 2021 supplemental report, Dr. Harris indicated that his review of the medical evidence reflected that appellant had a right knee medial meniscus tear. He opined that appellant reached MMI on September 30, 2020 the date of Dr. Anguiano's examination. For the right lower extremity/knee, under the DBI methodology, Dr. Harris opined that appellant had five percent permanent impairment for partial medial meniscectomy with recurrent documented medial meniscal tear. He opined that appellant's diagnosed condition of status post right knee arthroscopic partial medial meniscectomy and chondroplasty did not meet the criteria in section 16.7, page 543 to allow for an impairment calculation under the ROM impairment methodology. Dr. Harris further opined that there had been no increase in appellant's left lower extremity impairment.

By decision dated March 25, 2021, OWCP modified the August 18, 2020 schedule award decision in part to reflect an additional two percent right lower extremity impairment, for a total of five percent permanent right lower extremity impairment.[7] For the right lower extremity impairment, it noted "though Dr. Harris did not explain why the DBI rating was higher at [five] percent than the [three] percent [impairment] rating found on July 13, 2020 Dr. Harris did explain why he used the DBI methodology instead of ROM [impairment methodology] as the diagnosed condition did not allow use of that method. The weight of the medical [evidence] is with Dr. Harris as he explained why DBI was used instead of ROM."

By decision dated April 6, 2021, OWCP formally granted appellant a schedule award for an additional two percent permanent right lower extremity impairment, for a total impairment of five percent. The award ran for 5.76 weeks from September 30 to November 9, 2020.

[5] In a separate letter, appellant requested that OWCP expand the acceptance of his claim to include the additional conditions identified on the September 30, 2020 right knee MRI scan.

[6] In a January 26, 2020 addendum report, Dr. Harris provided a duplicate opinion of his earlier June 26, 2020 report.

[7] OWCP specifically noted that appellant had not contested the 19 percent left lower extremity permanent impairment rating.

## ***LEGAL PRECEDENT***

The schedule award provision of FECA and its implementing regulations 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.[8] However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[9] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (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 purpose.[11]

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 right knee, the relevant position of the right leg for the present case, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[12] 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).[13] Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnosis from regional grids and calculations of modifier scores.[14]

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.[15]

[8] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[9] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[10] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id*. at Chapter 2.808.5a (March 2017).

[11] *Isidoro Rivera*, 12 ECAB 348 (1961).

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

[13] *Id*. at 515-22.

[14] *Id*. at 23-28; *see D.W*., Docket No. 21-0840 (issued November 30, 2021); *R.V*., Docket No. 10-1827 (issued April 1, 2011).

[15] *See supra* note 10 at Chapter 2.808.6(f) (March 2017).

## ***ANALYSIS***

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

On February 27, 2020 appellant filed a schedule award claim. With respect to the right lower extremity, OWCP initially awarded three percent permanent impairment and then amended the award for an additional two percent permanent impairment, for a total of five percent permanent impairment. It accorded the weight of the medical evidence to the opinion of the DMA, Dr. Harris, who utilized the DBI methodology in determining appellant's impairment.

Appellant contended that he was entitled to the 10 percent permanent impairment which Dr. Bell initially calculated based on the ROM impairment methodology. The DMA addressed this argument and found that appellant's diagnosed condition of status post right knee arthroscopic partial medial meniscectomy and chondroplasty did not meet the criteria in section 16.7, page 543 to allow for an impairment calculation under the ROM impairment methodology. Section 16.7 specifically notes that, under the DBI methodology, ROM is used as a factor in physical examination grade modifier. It further advises that a ROM impairment is to be used as a stand-alone rating only when other grids refer to this section or no other diagnosis-based sections are applicable for rating of a condition.[16] The Board notes that, Table 16-3, Knee Regional Grid -- Lower Extremity Impairment, only allows for one rating methodology, the DBI method rating, for meniscal injury. Thus, the DMA properly found that appellant's diagnosed right lower extremity conditions could not be based on the ROM impairment methodology.[17]

The DMA, Dr. Harris, using the DBI methodology under the sixth edition of the A.M.A., *Guides*, found that appellant's diagnoses of partial medial meniscectomy with recurrent documented medial meniscal tear resulted in an additional two percent permanent impairment from the previously awarded three percent permanent impairment, for a total five percent permanent impairment of the right lower extremity. While this impairment would be pursuant to Table 16-3, the DMA neither referenced nor explained how the grade modifiers were applied to determine the default impairment rating for appellant's diagnoses to reach the five percent permanent impairment. Thus, the Board finds that Dr. Harris' report requires clarification.[18]

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. 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.[19] The case shall, therefore, be remanded for OWCP to have its DMA apply the A.M.A., *Guides* and provide a rationalized opinion to determine if appellant has greater than five percent permanent impairment of his right

[16] *See* A.M.A., *Guides* 543.

[17] *M.W.*, Docket No. 20-1303 (issued June 28, 2021).

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

[19] *See M.W.*, *supra* note 17; s*ee also 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).

lower extremity. After this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for an additional schedule award to the right lower extremity.

## ***CONCLUSION***

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

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the March 25 and April 6, 2021 decisions of the Office of Workers' Compensation Programs are set aside and this case is remanded for further proceedings consistent with this decision of the Board.

Issued: May 5, 2022
Washington, DC

Patricia H. Fitzgerald, 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