United States Department of Labor
Employees' Compensation Appeals Board

M.H., Appellant	)	
and	)	**Docket No. 21-1250**
	)	**Issued: February 17, 2023**
DEPARTMENT OF THE INTERIOR, CANAVERAL NATIONAL SEASHORE, APOLLO VISITOR CENTER, New Smyrna Beach, FL, Employer	)	

Appearances:
Capp P. Taylor, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On August 18, 2021 appellant, through his representative,[2] filed a timely appeal from an August 4, 2021 merit decision of the Office of Workers' Compensation Programs (OWCP).[3]

[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] Appellant passed away after the filing of this appeal. As such, a substitute appellant is required to carry the appeal forward as the Board's jurisdiction was invoked during his lifetime. *See J.W.*, Docket No. 20-0952 (issued February 2, 2022); *D.V.*, Docket No. 20-1291 (issued September 14, 2021); *N.D.*, Docket No. 14-1757 (issued June 2, 2015); *Albert F. Kimbrell*, 4 ECAB 662, 666 (1952). Accordingly, appellant's widow, *K.H.*, is recognized by the Board as the substitute appellant for the purposes of carrying the appeal forward.

[3] In its August 4, 2021 decision, OWCP denied modification of its finding that appellant had no more than 31 percent permanent impairment of the left lower extremity and 2 percent permanent impairment of the right lower extremity. On appeal, appellant's representative advised that he was appealing only the extent of the left lower extremity impairment and thus the issue of the extent of appellant's right lower extremity impairment is not before the Board at this time. 20 C.F.R. § 501.3.

Pursuant to the Federal Employees' Compensation Act[4] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[5]

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 31 percent permanent impairment of the left lower extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

On March 19, 2012 appellant, then a 56-year-old maintenance mechanic, filed a traumatic injury claim (Form CA-1) alleging that on March 8, 2012 he twisted his left knee while in the performance of duty. OWCP accepted the claim for left knee sprain. It subsequently expanded its acceptance of the claim to include a tear of the medial meniscus of the left knee and osteoarthrosis of the left knee. Appellant stopped work on March 9, 2012. On May 30, 2012 he underwent an OWCP-authorized partial medial and lateral meniscectomies and debridement and lateral release of the medial femoral condyle of the left knee. On December 18, 2012 appellant underwent an OWCP-authorized left total knee arthroplasty. He returned to his usual employment on July 1, 2013.

On March 2, 2016 OWCP expanded its acceptance of the claim to include lumbar radiculopathy at L5-S1 as a consequence of appellant's altered gait.

Appellant stopped work in March 2016 and did not return.[6]

By decision dated April 12, 2018, OWCP granted appellant a schedule award for 21 percent permanent impairment of the left lower extremity (leg) due to his left total knee arthroplasty. The award ran for 60.48 weeks for the period March 22, 2018 to May 19, 2019.

An electromyogram and nerve conduction study performed on May 13, 2019 revealed left lumbar radiculopathy at L4 and multiple diffuse changes consistent with neuropathy.

On December 3, 2019 Dr. John Ortolani, a Board-certified neurologist, advised that appellant had developed reflex sympathetic dystrophy of the left lower limb following his left total knee replacement. He discussed appellant's complaints of back pain aggravated by activity. Dr. Ortolani noted that May 13, 2019 diagnostic testing showed lumbar radiculopathy at L4. He diagnosed chronic pain due to trauma, left knee pain, and lumbosacral radiculopathy. Dr. Ortolani noted that appellant had pain over the left sciatic nerve radiating into the left foot.

[4] 5 U.S.C. § 8101 *et seq.*

[5] The Board notes that, following the August 4, 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.*

[6] By decision dated July 1, 2016, OWCP denied appellant's request for wage-loss compensation due to disability from work beginning May 17, 2016. By decision dated January 18, 2017, a representative of OWCP's Branch of Hearings and Review affirmed the July 1, 2016 decision.

In a report dated December 12, 2019, Dr. Mark A. Seldes, Board-certified in family practice, provided an impairment evaluation and referenced the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[7] and *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (*The Guides Newsletter*) (July/August 2009). He found decreased sensation in the lower extremities, a moderate motor deficit in the left quadriceps, and measured range of motion (ROM) of the left knee as 100 degrees flexion and 10 degrees extension. Dr. Seldes diagnosed lumbar radiculopathy at L4 with nerve root irritation, status post left total knee replacement, and a left knee medial and lateral meniscal tear. He opined that appellant had reached maximum medical improvement (MMI). For the left knee, Dr. Seldes identified the class of diagnosis (CDX) as a Class 4 total knee replacement with a poor result due to a moderate motion deficit using Table 16-3 on page 511 of the A.M.A., *Guides*. He applied a grade modifier for functional history (GMFH) of 3 based on appellant's responses to the American Academy of Orthopedic Surgeons Lower Limb Questionnaire and his use of a rolling walker and a grade modifier for physical examination (GMPE) of 3 due to severe palpatory findings and severe motion deficit. Dr. Seldes found a grade modifier for clinical studies (GMCS) was inapplicable. Applying the net adjustment formula yielded no change from the default value of 67 percent. Dr. Seldes subtracted the prior award of 21 percent permanent impairment due to appellant's total knee replacement to find an additional 46 percent left lower extremity impairment as a result of his left knee condition.

Referencing *The Guides Newsletter*, Dr. Seldes found eight percent permanent impairment at L4 due to a grade E, or very severe sensory deficit. He further found 13 percent impairment at L4 due to a grade E, or moderate motor deficit. Dr. Seldes added these impairment ratings to find 21 percent left lower extremity impairment due to L4 radiculopathy. He combined the impairment rating of 46 percent for the left knee and 21 percent for the left lower extremity due to lumbar radiculopathy and concluded that appellant had 67? percent permanent impairment of the left lower extremity.

In a report dated January 9, 2020, Dr. Ortolani advised that appellant had developed reflex sympathetic dystrophy of the left lower limb after a left knee replacement. He noted that appellant used a walker for stability. Dr. Ortolani diagnosed chronic pain due to trauma, left knee pain, lumbosacral radiculopathy, and unspecified polyneuropathy.

On January 17, 2020 appellant filed a claim for compensation (Form CA-7) for a schedule award.

On February 13, 2020 Dr. Ortolani asserted that he had reviewed Dr. Seldes' December 12, 2019 report regarding the left lower extremity rating and concurred with his rating. He advised that the findings obtained by Dr. Seldes were consistent with his examinations of appellant.

On February 21, 2020 Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), diagnosed status post left knee partial medial and lateral meniscectomy, status post total knee replacement, and lumbar radiculopathy. He opined that the December 12, 2019 findings of Dr. Seldes conflicted with Dr. Ortolanti's findings in reports dated December 3, 2019 and January 9, 2020 of no neurological deficit consisted with radiculopathy at L4. Dr. Harris recommended that OWCP refer appellant for a second opinion examination.

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

On June 29, 2020 OWCP referred appellant to Dr. Brian C. Leung, a Board-certified orthopedic surgeon, for a second opinion examination.[8]

In a report dated August 28, 2020, Dr. Leung discussed appellant's history of injury and noted that he had reviewed the medical records. He diagnosed lumbar radiculopathy at L4-5 and L5-S1 and a left total knee replacement. Dr. Leung noted that appellant had a normal gait and used a cane to walk. He discussed appellant's complaints of pain in the knee and back and numbness and tingling of the feet bilaterally. On examination Dr. Leung found a loss of sensation over the great toe bilaterally and over the left lateral plantar foot. He measured ROM of the left knee three times with findings of 0 degrees extension and a maximum of 117 degrees flexion. Dr. Leung found no erythema or drainage, stability to varus and valgus stress, and diffuse tenderness to palpation of the left knee. He advised that x-rays of the left knee revealed a "well[-]seated total knee arthroplasty without evidence of loosening or hardware failure." Dr. Leung identified the CDX as a Class 3 total knee replacement according to Table 16-3 on page 511 of the A.M.A., *Guides*. He applied a GMFH of 2, a GMPE of 1, and a GMCS of 2, to find a net adjustment of negative 4, or 31 percent permanent impairment of the left lower extremity as a result of appellant's total knee replacement.

Dr. Leung further found a mild Class 1 motor deficit at L5 and a Class 1 sensory deficit at L5 and S1 on the left side according to Proposed Table 2 of *The Guides Newsletter*. He applied a GMFH of 2 and a GMCS of 1, for a net adjustment of one. Dr. Leung opined that appellant had 2 percent impairment of the left L5 nerve root, 1 percent sensory impairment of the left S1 nerve root, and 7 percent motor impairment of the L5 nerve root, for a total left lower extremity impairment of 10 percent.[9] He combined the impairment ratings to find 41 percent left lower extremity impairment. Dr. Leung further found two percent permanent impairment of the right lower extremity.

On October 22, 2020 Dr. Harris reviewed the August 28, 2020 report of Dr. Leung. He noted that electrodiagnostic testing performed on May 13, 2019 had demonstrated radiculopathy at L4 on the left side. Dr. Harris found that, for the right lower extremity, appellant had "no neurologic deficit in the lower extremity consistent with lumbar radiculopathy," and thus no right lower extremity impairment according to *The Guides Newsletter*. He indicated that ROM was not allowed as an alternative method for rating impairment. For the left lower extremity, Dr. Harris found 2 percent permanent impairment for mild pain due to left L5 radiculopathy, 1 percent impairment for mild pain due to left S1 radiculopathy, and 7 percent permanent impairment for mild motor weakness due to L5 left radiculopathy, for a total left lower extremity impairment of 10 percent. For the left knee, he found a good result following a knee replacement, noted that there was good position, no instability, and no significant weakness or motion loss. Dr. Harris opined that appellant had 21 percent permanent impairment due to a Class 2 total knee replacement. He found that ROM was not appropriate to rate the diagnosed knee condition. Dr. Harris combined the left lower extremity impairments to find 29 percent left lower extremity impairment. He indicated that appellant had reached MMI on August 28, 2020.

[8] The statement of accepted facts provided to Dr. Leung lists an incorrect date of injury. However, this harmless error does not affect Dr. Leung's finding regarding the extent of appellant's permanent impairment of the left lower extremity.

[9] Dr. Leung indicated that he had found two percent impairment of the right L5 nerve root and one percent impairment of the right S1 nerve root due to sensory impairment; however, this appears to be a typographical error.

In a supplemental report dated March 4, 2021, Dr. Leung reviewed the DMA's October 22, 2020 report and concurred with his finding that appellant had a Class 2 rather than Class 3 total knee replacement according to Table 16-3 on page 511 as it was "stable, in good position, and functional." He applied a GMFH of 2, a GMPE of 1, and a GMCS of 2, to find a net adjustment of negative 1 and 23 percent permanent impairment of the left lower extremity. Dr. Leung noted that he and the DMA both agreed that appellant had 10 percent permanent impairment of the left lower extremity due to the impairment originating in the lumbar spine. He combined the impairment ratings to find 31 percent left lower extremity impairment and 2 percent right lower extremity impairment.

On March 24, 2021 Dr. Harris concurred with Dr. Leung's finding of 23 percent permanent impairment of the left lower extremity due to appellant's total knee arthroplasty. He again found 10 percent permanent impairment of the left lower extremity due to a spinal nerve impairment according to *The Guides Newsletter*. Dr. Harris further concurred with Dr. Leung's finding of two percent permanent impairment of the right lower extremity due to pain at L5 on the right. He opined that appellant had 2 percent right lower extremity impairment and 31 percent left lower extremity impairment.

By decision dated March 31, 2021, OWCP granted appellant a schedule award for 2 percent right lower extremity impairment (leg) and an additional 10 percent left lower extremity impairment (leg). The period of the award ran for 24.56 weeks, from August 28, 2020 to March 27, 2021.

On May 6, 2021 appellant, through his representative, requested reconsideration. The representative asserted that he sought review of the left leg award. He contended that appellant was entitled to an additional award of 36 percent, for a total left lower extremity impairment of 57 percent. The representative maintained that the DMA had failed to review Dr. Seldes' December 12, 2019 impairment rating, noting that Dr. Seldes had provided a detailed description of grade modifiers. He asserted that Dr. Seldes also advised that appellant used a walker due to his poor result from his total knee replacement. The representative asserted that there was no reliable evidence showing a good result after the knee replacement and no reason for the DMA to accept Dr. Leung's findings over Dr. Seldes'.

By decision dated August 4, 2021, OWCP denied modification of its March 31, 2021 decision.

LEGAL PRECEDENT

The schedule award provision of FECA,[10] and its implementing federal regulations,[11] 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

[10] *Supra* note 4.

[11] 20 C.F.R. § 10.404.

specified edition of the A.M.A., *Guides*, published in 2009.[12] 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.[13]

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*).[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]

Neither FECA nor its regulations provide for a schedule award for impairment to the back or to the body as a whole.[18] Furthermore, the back is specifically excluded from the definition of organ under FECA.[19] The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as impairments of the extremities. Recognizing that FECA allows ratings for extremities and precludes ratings for the spine, *The Guides Newsletter* offers an approach to rating spinal nerve impairments consistent with sixth edition methodology. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP's procedures indicate that *The Guides Newsletter* is to be applied.[20] The Board has recognized the adoption of this methodology for rating extremity impairment, including the use of *The Guides Newsletter*, as proper in order to provide a uniform standard applicable to each claimant for a schedule award for extremity impairment originating in the spine.[21]

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.[22]

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[12] 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 Award and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); *see also id*. at Chapter 3.700, Exhibit 1 (January 2010).

[13] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

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

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

[16] *Id*. 411.

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

[18] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see A.H.*, Docket No. 19-1788 (issued March 17, 2020); *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[19] *See id.* § 8101(19); *see also G.S.*, Docket No. 18-0827 (issued May 1, 2019); *Francesco C. Veneziani*, 48 ECAB 572 (1997).

[20] *Supra* note 12 at Chapter 3.700, Exhibit 4 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[21] *W.G.*, Docket No. 21-0675 (issued December 28, 2021); *A.H.*, *supra* note 18.

[22] *See supra* note 12 at Chapter 2.808.6f (March 2017).

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than 31 percent permanent impairment of the left lower extremity, for which he previously received schedule award compensation.

In a report dated December 12, 2019, Dr. Seldes diagnosed lumbar radiculopathy at L4 with nerve root irritation, status post left total knee replacement with a poor result based on moderate loss of motion, and a left knee medial and lateral meniscal tear. On examination he found a loss of sensation in the lower extremities and a moderate motion deficit of the left quadriceps. Dr. Seldes measured ROM of the left knee as 100 degrees flexion and 10 degrees extension. Citing *The Guides Newsletter*, he found that appellant had 8 percent impairment of the left lower extremity due to a sensory deficit at L4 and 13 percent impairment of the left lower extremity due-to-moderate motor deficit at L4. For the left knee, Dr. Seldes identified the CDX as a Class 4 total knee replacement with a poor result, which yielded a default impairment value of 67 percent. He found no change from the default value after the application of grade modifiers. Dr. Seldes subtracted the 21 percent previously awarded appellant due to his total knee replacement to find an additional 46 percent left lower extremity impairment. In reaching his conclusions, he based his finding that appellant had a poor result from his total knee replacement due-to-moderate motion loss. Dr. Seldes, however, failed to measure ROM three times and thus his measurements are not in accordance with the A.M.A., *Guides*. Consequently, his opinion is of diminished probative value.[23]

OWCP referred appellant to Dr. Leung for a second opinion examination. On August 28, 2020 Dr. Leung found a loss of sensation over the great toes and over the lateral plantar foot on the left. He measured ROM of the left knee three times, finding a maximum of 117 degrees flexion and 0 degrees extension. Dr. Leung found that appellant had a normal gait and noted that he used a cane for ambulation. On examination of the left knee, he found no erythema, stability to varus and valgus stress, and tenderness to palpation. Dr. Leung opined that x-rays showed no evidence of loosening or hardware failure and good placement of the total knee arthroplasty. He identified the CDX as a Class 3 total knee replacement, which yielded a default value of 37 percent. Dr. Leung applied grade modifiers and concluded that appellant had 31 percent permanent impairment of the left lower extremity due to his total knee replacement.

Applying Proposed Table 2 of *The Guides Newsletter*, Dr. Leung found that appellant had a Class 1 motor deficit at L5 and a Class 1 sensory deficit at L5 and S1 on the left side. He applied a GMFH of 2 and a GMCS of 1, for a net adjustment of 1, and concluded that appellant had 2 percent sensory impairment of the left L5 nerve root, 1 percent sensory impairment of the left S1 nerve root, and 7 percent motor impairment of the L5 nerve root, for a total left lower extremity impairment of 10 percent. Dr. Leung further found a right lower extremity impairment of two percent.

On October 22, 2020 Dr. Harris, the DMA, opined that appellant had a Class 2 total knee replacement as it was in good position and he had no instability or significant loss of strength or motion, which yielded a default value of 21 percent. He agreed with Dr. Leung's finding of 10 percent permanent impairment of the left lower extremity due to radiculopathy at L5 and S1. Dr. Harris opined that appellant had a combined left lower extremity impairment of 29 percent.

[23] *See D.U.*, Docket No. 13-2086 (issued February 11, 2014); *Mary L. Henninger*, 52 ECAB 408 (2001).

In a supplemental report dated March 4, 2021, Dr. Leung concurred with Dr. Harris' finding that the CDX was a Class 2 rather than a Class 3 total knee replacement based on its position, stability, and functionality. He applied a GMFH of 2, a GMPE of 1, and a GMCS of 2, to find a net adjustment of negative 1, and 23 percent permanent impairment of the left lower extremity.[24] Dr. Leung combined the 23 percent impairment due to the knee replacement with the 10 percent impairment due to radiculopathy to find 31 percent left lower extremity impairment. He additionally found two percent right lower extremity impairment due to radiculopathy.

On March 24, 2021 Dr. Harris concurred with Dr. Leung's findings. Appellant previously received a schedule award for 21 percent permanent impairment due to his left total knee arthroplasty. When the prior impairment is due to a previous work-related injury and a schedule award has been granted for such prior impairment, the percentage already paid is subtracted from the total percentage of impairment.[25] There is no current medical evidence of record, in conformance with the A.M.A., *Guides*, establishing a greater permanent impairment than the 31 percent permanent left lower extremity impairment previously awarded.[26]

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 permanent impairment.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish greater than 31 percent permanent impairment of the left lower extremity, for which he previously received schedule award compensation.

[24] Utilizing the net adjustment formula discussed above, (GMFH - CDX) + (GMPE - CDX) + (GMPE - CDX), or (2-2) + (1-2) + (2-2) = negative 1. Even if the GMCS is omitted as used to identify the CDX, the net adjustment would remain negative one.

[25] 20 C.F.R. § 10.404(d); *see A.R.*, Docket No. 21-0346 (issued July 1, 2021).

[26] *See D.C.*, Docket No. 20-0916 (issued September 14, 2021); *M.H.*, Docket No. 20-1109 (issued September 27, 2021); *A.T.*, Docket No. 20-0370 (issued September 27, 2021).

ORDER

IT IS HEREBY ORDERED THAT the August 4, 2021 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 17, 2023
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board