United States Department of Labor
Employees' Compensation Appeals Board

R.F., Appellant	)	
and	)	**Docket No. 22-0052**
	)	**Issued: September 20, 2023**
U.S. POSTAL SERVICE, MIDDLESEX ESSEX PROCESSING & DISTRIBUTION CENTER, North Reading, MA, Employer	)	

Appearances:
Daniel B. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 14, 2021 appellant, through counsel, filed a timely appeal from a September 17, 2021 merit decision of the Office of Workers' Compensation Programs (OWCP).[2]

[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, through counsel, submitted a timely request for oral argument before the Board. 20 C.F.R. § 501.5(b). Pursuant to the Board's *Rules of Procedure*, oral argument may be held in the discretion of the Board. 20 C.F.R. § 501.5(a). In support of his oral argument request, counsel asserted that oral argument should be granted in order to present argument demonstrating that range of motion should have been used to evaluate appellant's right lower extremity impairment. The Board, in exercising its discretion, denies his request for oral argument because this matter requires an evaluation of the medical evidence presented. As such, the arguments on appeal can be adequately addressed in a decision based on a review of the case record. Oral argument in this appeal would further delay issuance of a Board decision and not serve a useful purpose. As such, the oral argument request is denied, and this decision is based on the case record as submitted to the Board.

Pursuant to the Federal Employees' Compensation Act[3] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of this case.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 36 percent permanent impairment of his right lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On October 17, 2019 appellant, then a 56-year-old truck driver, filed an occupational disease claim (Form CA-2) alleging he developed right hip and knee osteoarthritis causally related to factors of his federal employment. He noted that he first became aware of his condition and realized its relation to his federal employment on April 26, 2019. Appellant did not stop work. OWCP accepted the claim for permanent aggravation of bilateral hip osteoarthritis and permanent aggravation of right knee osteoarthritis.

Appellant provided medical records regarding a right knee injury that occurred in October 1997 when a trash cart fell against his knee. He underwent anterior cruciate ligament (ACL) and medial cruciate ligament reconstructions on January 7, 1998 and right knee arthroscopic lysis of adhesions and manipulation under anesthesia on March 25, 1998. On January 12, 2000 appellant underwent a right knee chondroplasty patella and medial femoral condyle and right knee lysis of adhesions.

On August 23, 2018 Dr. Justin W. Kung, a Board-certified radiologist, advised that he had reviewed appellant's bilateral hip and knee radiographs obtained on May 8 and July 27, 2018 and found a right medial compartment joint space interval of 3.0 millimeters and a lateral compartment joint space interval of 4.5 millimeters with a prior ACL repair. His frontal pelvic radiograph demonstrated that the right femoroacetabular joint measured 2.0 millimeters and the left femoroacetabular joint measured 3.0 millimeters.

In a September 17, 2019 report, Dr. John J. Walsh, Jr., a Board-certified orthopedic surgeon, reviewed appellant's August 23, 2018 right knee x-ray showing 3.0 millimeters of right knee medial compartment joint space and 4.5 millimeters of lateral compartment joint space. He found prominent osteophytes arising from the right femoral head. Dr. Walsh noted that appellant walked with a "bent knee" antalgic gait. His findings on physical examination included bilateral knee effusions and palpable osteophytes along the medial joint lines. Dr. Walsh diagnosed osteoarthritis of the right knee and hip. He provided appellant's right knee range of motion (ROM) measurements with a surface goniometer and obtained three separate measurements to reach 10 degrees of flexion contracture, flexion of 113 degrees, and total flexion of 103 degrees. Dr. Walsh measured right hip ROM of 75 degrees of flexion, 0 degrees of extension, 30 degrees of abduction, 27 degrees of adduction, 9 degrees of internal rotation, and 5 degrees of external rotation. He found that appellant had reached maximum medical improvement (MMI). Dr. Walsh applied the ROM method for rating impairment set forth in sixth edition American Medical Associations

[3] 5 U.S.C. § 8101 *et seq*.

Guides to the Evaluation of Permanent Impairment (A.M.A., *Guides*)[4] at Table 16-23 on page 549 to find 30 percent permanent impairment of the right knee for loss of flexion and flexion contracture. He further applied Table 16-24, page 549, and found that appellant right hip ROM resulted in 25 percent permanent impairment. Dr. Walsh utilized the Combined Values Chart on page 606 of the A.M.A., *Guides* to reach 48 percent permanent impairment of the right lower extremity impairment.

On April 14, 2020 appellant filed a claim for compensation (Form CA-7) requesting a scheduled award.

On April 20, 2020 OWCP referred the case record and a statement of accepted facts (SOAF) to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as OWCP's district medical adviser (DMA). In a May 1, 2020 report, Dr. Harris diagnosed status post right knee ACL reconstruction and chondroplasty, status post right knee arthroscopic lysis of adhesions and manipulation, and bilateral knee degenerative joint disease. He found that appellant's diagnoses did not meet any of the criteria discussed in Section 16.7, page 543, of the A.M.A., *Guides* to allow impairment calculation by ROM, as this was a stand-alone rating used when no diagnosis-based sections were applicable or in very rare cases where a severe injury results in a passive ROM loss, qualifying for a Class 3 or 4 impairment or for amputation ratings, in accordance with section 16.7, page 543, A.M.A., *Guides*. Dr. Harris calculated appellant's impairment rating based on the diagnosis-based impairment (DBI) estimates for mild degenerative joint disease of the right knee with documented joint space narrowing of a three-millimeter cartilage interval, resulting in seven percent permanent impairment of the right lower extremity in accordance with Table 16-3, page 511 of the A.M.A., *Guides*. In regard to appellant's right hip, he found residual moderate degenerative joint disease of the hip, hip arthritis, with documented joint space narrowing with a 2-millimeter cartilage interval, resulting in 20 percent permanent impairment in accordance with Table 16-4, page 514 of the A.M.A., *Guides*. Dr. Harris concluded that appellant had 26 percent right lower extremity permanent impairment.

On June 15, 2020 OWCP provided Dr. Walsh with the DMA's impairment ratings and requested that he submit additional comments or evidence in support of his impairment rating. In a June 29, 2020 response, Dr. Walsh asserted that he had appropriately applied the ROM method. He maintained that the A.M.A., *Guides* provided that impairments due to knee flexion contracture should not be estimated using x-rays, because the measurements were unreliable. Dr. Walsh concluded that the ROM method must, therefore, be used to rate appellant's permanent impairment.

On September 21, 2020 OWCP referred Dr. Walsh's June 29, 2020 report to Dr. Harris, the DMA, for review. In an October 31, 2020 report, Dr. Harris found that appellant's right knee impairment should not be calculated based on radiographic findings for degenerative changes, as he had a 10 percent flexion contracture and x-rays were not reliable. The DMA determined that appellant had 20 percent right lower permanent impairment for residual knee flexion contracture in accordance with Table 16-23, page 549 of the A.M.A., *Guides*. Dr. Harris further found that appellant's right hip impairment should be calculated through the DBI resulting in 20 percent

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

permanent impairment. The DMA combined these impairment ratings to reach 36 percent permanent impairment of the right lower extremity.

On February 5, 2021 OWCP requested clarification from the DMA, regarding his impairment rating. In a February 16, 2021 supplemental report, the DMA, Dr. Harris, opined that appellant had reached MMI on April 26, 2019 and that he had 36 percent permanent impairment of his right lower extremity.

By decision dated April 26, 2021, OWCP granted appellant a schedule award for 36 percent permanent impairment of the right lower extremity. The period of the award ran for 103.68 weeks from April 26, 2019 to April 20, 2021.

On June 22, 2021 appellant, through counsel, requested reconsideration and contended that, based on Dr. Walsh's reports, appellant had an additional 10 percent permanent impairment of his right knee due to loss of flexion in accordance with Table 16-23 of the A.M.A., *Guides*. Counsel asserted that the permanent impairment of appellant's right hip should be calculated based on loss of ROM, not the DBI methodology.

By decision dated September 17, 2021, OWCP denied modification of its prior decision.

LEGAL PRECEDENT

The schedule award provisions of FECA,[5] and its implementing federal 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 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 specified edition of the A.M.A., *Guides*, published in 2009.[7] 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.[8]

Chapter 16 of the sixth edition of the A.M.A., *Guides*, pertaining to the lower extremities, provides that DBI is the primary method of calculation for the lower limb and that most impairments are based on the DBI where impairment class is determined by the diagnosis and specific criteria as adjusted by the grade modifiers for functional history, physical examination, and clinical studies. It further provides that alternative approaches are also provided for calculating

[5] *Supra* note 3.

[6] 20 C.F.R. § 10.404.

[7] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also id*. at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

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

impairment for peripheral nerve deficits, complex regional pain syndrome, amputation, and range of motion. Range of motion is primarily used as a physical examination adjustment factor.[9] The A.M.A., *Guides*, however, also explain that some of the diagnosis-based grids refer to the ROM section when that is the most appropriate mechanism for grading the impairment. This section is to be used as a stand-alone rating when other grids refer to this section or no other diagnosis-based sections of the chapter are applicable for impairment rating of a condition.[10]

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): A Contemporary Model of Disablement*.[11] Under the sixth edition, the evaluator identifies the impairment class of diagnosis (CDX), which is then adjusted by the grade modifier functional history (GMFH), grade modifier physical examination (GMPE), and/or grade modifier clinical studies (GMCS).[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[14]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than 36 percent permanent impairment of his right lower extremity, for which he previously received a schedule award.

In support of his schedule award claim, appellant submitted reports from his, Dr. Walsh, dated September 17, 2019, and June 29, 2020 finding his right hip ROM of 75 degrees of flexion, 0 degrees of extension, 30 degrees of abduction, 27 degrees of adduction, 9 degrees of internal rotation, and 5 degrees of external rotation. Dr. Walsh applied Table 16-24, page 549, of the A.M.A., *Guides* and found that appellant right hip ROM resulted in 25 percent permanent impairment of the right lower extremity.

In reports dated May 2 and October 31, 2020, the DMA, Dr. Harris, found residual moderate degenerative joint disease of the hip, hip arthritis, with documented joint space narrowing with a 2-millimeter cartilage interval, resulting in 20 percent permanent impairment in accordance with Table 16-4, page 514 of the A.M.A., *Guides*. He properly found that appellant's right hip diagnoses did not meet any of the criteria discussed in Section 16.7, page 543 of the A.M.A., *Guides* to allow impairment calculation by ROM.

[9] A.M.A., *Guides* (6th ed. 2009) 497, section 16.2.

[10] *Id.* at 543; *see also C.H.*, Docket No. 20-0831 (issued December 27, 2021); *M.D.*, Docket No. 16-0207 (issued June 3, 2016); *D.F.*, Docket No. 15-0664 (issued January 8, 2016).

[11] A.M.A., *Guides*, 3, section 1.3.

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

[13] *Id.* at 411.

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

Page 518 of the A.M.A., *Guides* notes that x-rays of the hip joint are taken in the neutral position and that the joint space of the hip is relatively constant in the various positions, such that hip position is not as critical as for knee x-rays. Therefore, the DMA, properly calculated appellant's right hip impairment based on the DBI rating of 20 percent.

The DMA found 20 percent right lower extremity impairment for residual knee flexion contracture in accordance with Table 16-23, page 549 of the A.M.A., *Guides*. The remaining knee ROM figure provided by Dr. Walsh of knee flexion of 113 degrees, is a 0 percent impairment in accordance with Table 16-23, page 549, A.M.A., *Guides*.[15]

The Board finds that the DMA, Dr. Harris, properly calculated appellant's permanent impairment for the right lower extremity using the DBI methodology. There is no other current medical evidence in conformance with the sixth edition of the A.M.A., *Guides* establishing greater than the 36 percent permanent impairment of the right lower extremity for which appellant previously received a schedule award. Accordingly, appellant has not met his burden of proof.

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 36 percent permanent impairment of his right lower extremity, for which he previously received a schedule award.

[15] The A.M.A., *Guides* do not provide a motion impairment for total knee flexion as measured by Dr. Walsh, only for knee flexion of 109 degrees or less and flexion contracture of 5 degrees or greater. A.M.A., *Guides*, 549, Table 16-23.

ORDER

IT IS HEREBY ORDERED THAT the September 17, 2021 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 20, 2023
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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