United States Department of Labor
Employees' Compensation Appeals Board

A.W., Appellant	)	
and	)	**Docket No. 23-0618**
	)	**Issued: September 27, 2023**
DEPARTMENT OF VETERANS AFFAIRS, WM. JENNINGS BRYAN DORN VA MEDICAL CENTER, Columbia, SC, Employer	)	

Appearances:
Victor A. Walker, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On March 22, 2022 appellant, through her representative, filed a timely appeal from September 26, 2022 merit decisions 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*.

ISSUES

The issues are: (1) whether appellant has met her burden of proof to establish greater than 27 percent permanent impairment of her left lower extremity, for which she previously received schedule award compensation; and (2) whether OWCP properly denied appellant's request for reconsideration of the merits of her claim, pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On August 11, 2015 appellant, then a 41-year-old pharmacy technician, filed a traumatic injury claim (Form CA-1) alleging that on August 5, 2015 she sustained injury when a patient being pushed in a wheelchair ran into her, causing her to twist her left leg/ankle and fall forward while in the performance of duty. She stopped work on August 6, 2015. OWCP accepted appellant's claim for left ankle sprain and left posterior tibial tendinitis and subsequently expanded the acceptance of appellant's condition to include derangement of the posterior horn of the medial meniscus tear of the left knee (due to an old tear or injury). It paid her wage-loss compensation commencing August 6, 2015 on the supplemental rolls and commencing December 9, 2018 on the periodic rolls. On October 25, 2019 appellant underwent OWCP-authorized left knee surgery, including synovectomy, femoral condyle chondroplasty, and anterior cruciate ligament repair.

In a January 26, 2021 report, Dr. Seth Jaffe, an osteopath and Board-certified orthopedic surgeon serving as an OWCP referral physician, referred to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) and determined that appellant had nine percent permanent impairment of the left lower extremity.[3] He found that she had seven percent permanent impairment of the left lower extremity due to left ankle deficits, and two percent permanent impairment of the left lower extremity due to left knee deficits. OWCP referred appellant's case to Dr. Herbert White, Jr., a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA). In a February 9, 2021 report, Dr. White concurred with the permanent impairment rating of Dr. Jaffe.

On March 26, 2020 appellant filed a claim for compensation (Form CA-7) for a schedule award.

By decision dated February 16, 2021, OWCP granted appellant a schedule award for nine percent permanent impairment of the left lower extremity. The award ran for 25 weeks from January 26 through July 26, 2021 and was based on the schedule award ratings of Dr. Jaffe and Dr. White.

In a June 6, 2022 report, Dr. Mark A. Seldes, an attending Board-certified orthopedic surgeon, reported the findings of his physical examination, noting that appellant had moderate swelling, crepitus, limited range of motion (upon three measurements), and tenderness to palpation of the left knee. Examination of appellant's left ankle revealed swelling, limited range of motion (upon three measurements), and tenderness to palpation. Dr. Seldes diagnosed medial meniscal tear of the left knee and posterior tibial tendon tear of the left ankle. He referred to the sixth edition of the A.M.A., *Guides* and utilized the diagnosis-based impairment (DBI) rating method to find

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

that, under Table 16-3 (Knee Regional Grid), page 509, the Class of diagnosis (CDX) for the injury to the left knee (meniscal tear and underlying arthritis) resulted in a Class 2 impairment with a default value of 20. Dr. Seldes assigned a grade modifier for functional history (GMFH) of 3 based on the lower limb questionnaire score, and a grade modifier for physical examination (GMPE) of 3 based on severely limited range of motion. He found that a grade modifier for clinical studies (GMCS) was not applicable as clinical studies were used to establish the diagnosis. Dr. Seldes utilized the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) = (3 - 2) + (3 - 2) = +2, which resulted in a grade E or 24 percent permanent impairment of the left lower extremity.[4] With regard to the left ankle, he utilized the DBI rating method of the A.M.A., *Guides* to find that, under Table 16-2 (Foot and Ankle Regional Grid), page 501, the CDX for appellant's left ankle tear resulted in a Class2 impairment with a default value of 16 percent. There was no movement from the 16 percent default value under the net adjustment formula.[5] Using the Combined Values Chart of the A.M.A., *Guides* to combine the DBI ratings of 24 percent due to left knee deficits and 16 percent due to left ankle deficits yields total permanent impairment of the left lower extremity of 36 percent.

Appellant claimed that she was entitled to an increased schedule award and OWCP referred her case back to Dr. White who again served as a DMA. In an August 24, 2022 report, Dr. White referred to the sixth edition of the A.M.A., *Guides* and utilized the DBI rating method to find that, under Table 16-3, the CDX for appellant's left knee tear and underlying arthritis resulted in a Class 2 impairment with a default value of 20. He assigned a GMFH of 3 based on the lower limb questionnaire score and assigned a GMPE of 2 for moderate palpatory findings. Dr. White found that a GMCS was not applicable as the clinical studies were used to establish the diagnosis. He utilized the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) = (3 - 2) + (2 - 2) = +1, which resulted in a grade D or 22 percent permanent impairment of the left lower extremity.

With regard to the left ankle, Dr. White referred to the sixth edition of the A.M.A., *Guides* and utilized the DBI rating method to find that, under Table 16-2, the CDX for appellant's left ankle tendon rupture resulted in a Class 1 (tier 2) impairment with a default value of five percent. He assigned a GMPE of 3 for severe left ankle tenderness. Dr. White found that a GMCS was not applicable as the clinical studies were used to establish the diagnosis, and a GMFH was not applicable as a GMFH value was already assigned for the left knee as it provided the greater contribution to appellant's left lower extremity permanent impairment. He utilized the net adjustment formula, (GMPE - CDX) = (3 - 1) = +2, which resulted in a grade E or seven percent permanent impairment of the left lower extremity. Using the Combined Values Chart of the A.M.A., *Guides* to combine the DBI ratings of 22 percent due to left knee deficits and 7 percent due to left ankle deficits yields 27 percent permanent impairment of left lower extremity.

[4] Dr. Seldes also provided an impairment rating for limited range of motion (ROM) of the left knee, but the A.M.A., *Guides* does not allow for such a method of rating the knee. *See* A.M.A., *Guides* 497. *See also E.M.*, Docket No. 14-0311 (issued July 8, 2014).

[5] Dr. Seldes also provided an impairment rating for limited ROM of the left ankle, but the A.M.A., *Guides* does not allow for such a method of rating the ankle. *See id*.

By decision dated September 26, 2022, OWCP modified its February 16, 2021 decision to reflect that appellant had a total left lower extremity permanent impairment of 27 percent.

By separate decision dated September 26, 2022, OWCP granted appellant a schedule award for an additional 18 percent permanent impairment of the left lower extremity (27 percent permanent impairment minus previously awarded 9 percent permanent impairment). The award ran for 51.84 weeks from June 6, 2022 through June 3, 2023 and was based on Dr. White's August 24, 2022 evaluation of the June 6, 2022 impairment rating of Dr. Seldes.

On November 23, 2022 appellant, through her representative, requested reconsideration of the September 26, 2022 decision.

By decision dated February 9, 2023, OWCP denied appellant's request for reconsideration of the merits of her claim, pursuant to 5 U.S.C. § 8128(a).

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing federal regulations[7] 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. 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 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.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9]

Chapter 16 of the sixth edition of the A.M.A., *Guides*, pertaining to the lower extremities, provides that diagnosis-based impairment is the primary method of calculation for the lower limb and that most impairments are based on the diagnosis-based impairment where impairment Class is determined by the diagnosis and specific criteria as adjusted by the GMFH, GMPE, and GMCS. It further provides that alternative approaches are also provided for calculating 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.[10] The A.M.A., *Guides*, however, also explain that some of the diagnosis-based grids refer to the range of motion section when that is the most appropriate mechanism for grading the impairment. This section is

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id.*; *see V.J.*, Docket No. 1789 (issued April 8, 2020); *Jacqueline S. Harris*, 54 ECAB 139 (2002).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

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

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.[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 knee, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[12] After the 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 CMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13] A similar evaluation for permanent impairment of the ankle/foot is made under Table 16-2 (Foot and Ankle Regional Grid) beginning on page 501.[14]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[15] For a conflict to arise, the opposing physicians' opinions must be of virtually equal weight and rationale.[16] In situations where the case is properly referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[17]

ANALYSIS

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

In an August 24, 2022 report, Dr. White found that appellant has a total 27 percent permanent impairment of the left lower extremity under the DBI rating method. Under the sixth edition of the A.M.A., *Guides*, he utilized the DBI rating method to find that, under Table 16-3, the CDX for appellant's left knee tear and underlying arthritis resulted in a Class 2 impairment with a default value of 20.[18] Dr. White assigned a GMFH of 3 based on the lower limb questionnaire score and assigned a GMPE of 2 for moderate palpatory findings. He found that a

[11] *Id*. at 543; *see also M.D.*, Docket No. 16-0207 (issued June 3, 2016); *D.F.*, Docket No. 15-0664 (issued January 8, 2016).

[12] *Id*. at 509-11.

[13] *Id* at 515-22.

[14] *Id*. at 501-08.

[15] 5 U.S.C. § 8123(a); *see E.L.*, Docket No. 20-0944 (issued August 30, 2021); *R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009); *M.S.*, 58 ECAB 328 (2007).

[16] *P.R.*, Docket No. 18-0022 (issued April 9, 2018).

[17] *See D.M.*, Docket No. 18-0746 (issued November 26, 2018); *R.H.*, 59 ECAB 382 (2008); *James P. Roberts*, 31 ECAB 1010 (1980).

[18] *See* A.M.A., *Guides* 509-11.

GMCS was not applicable as the clinical studies were used to establish the diagnosis. Dr. White utilized the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) = (3 - 2) + (2 - 2) = +1, which resulted in a grade D or 22 percent permanent impairment of the left lower extremity. With regard to the left ankle, he referred to the sixth edition of the A.M.A., *Guides* and utilized the DBI rating method to find that, under Table 16-2, the CDX for appellant's left ankle tendon rupture resulted in a Class 1 (tier 2) impairment with a default value of five percent.[19] Dr. White assigned a GMPE of 3 for severe left ankle tenderness. He found that a GMCS was not applicable as the clinical studies were used to establish the diagnosis, and a GMFH was not applicable as a GMFH value was already assigned for the left knee as it provided the greater contribution to appellant's left lower extremity permanent impairment. Dr. White utilized the net adjustment formula, (GMPE - CDX) = (3 - 1) = +2, which resulted in a grade E or seven percent permanent impairment of the left lower extremity. Using the Combined Values Chart of the A.M.A., *Guides* to combine the DBI ratings of 22 percent due to left knee deficits and 7 percent due to left ankle deficits yields a total of 27 percent permanent impairment of the left lower extremity.

In contrast, Dr. Seldes, an attending physician, determined in a June 6, 2022 report that appellant has a total 36 percent permanent impairment of the left lower extremity under the DBI rating method. He referred to the sixth edition of the A.M.A., *Guides* and utilized the DBI rating method to find that, under Table 16-3, the CDX for the injury to the left knee (meniscal tear and underlying arthritis) resulted in a Class 2 impairment with a default value of 20. Dr. Seldes assigned a GMFH of 3 based on the lower limb questionnaire score, and a GMPE of 3 based on severely limited range of motion. He found that a GMCS was not applicable as clinical studies were used to establish the diagnosis and proper placement in the regional grid. Dr. Seldes utilized the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) = (3 - 2) + (3 - 2) = +2, which resulted in a grade E or 24 percent permanent impairment of the left lower extremity.[20] With regard to the left ankle, he utilized the DBI rating method of the A.M.A., *Guides* to find that, under Table 16-2, the CDX for appellant's left ankle tear resulted in a Class 2 impairment with a default value of 16 percent. There was no movement from the 16 percent default value under the net adjustment formula.[21] Using the Combined Values Chart of the A.M.A., *Guides* to combine the DBI ratings of 24 percent due to left knee deficits and 16 percent due to left ankle deficits yields a total of 36 percent permanent impairment of the left lower extremity.

The Board finds that there is a conflict in the medical opinion evidence regarding appellant's left lower extremity permanent impairment, which necessitates further development of the medical evidence.[22]

[19] *Id*. at 501-08.

[20] Dr. Seldes also provided an impairment rating for limited range of motion of the left knee, but the A.M.A., *Guides* does not allow for such a method of rating the knee. *See* A.M.A., *Guides* 497. *See also E.M.*, Docket No. 14-0311 (issued July 8, 2014).

[21] Dr. Seldes also provided an impairment rating for limited range of motion of the left ankle, but the A.M.A., *Guides* does not allow for such a method of rating the ankle. *See id*.

[22] *See supra* notes 15 through 17.

Because there remains an unresolved conflict in medical opinion regarding the permanent impairment of appellant's left lower extremity, pursuant to 5 U.S.C. § 8123(a), the case will be remanded to OWCP for referral of appellant, together with the case record and a statement of accepted facts, to an appropriate specialist for an impartial medical examination to resolve the conflict. Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.[23]

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the September 26, 2022 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: September 27, 2023
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

[23] Given the Board's disposition of Issue 1 of this case, Issue 2 is moot.