United States Department of Labor
Employees' Compensation Appeals Board

S.W., Appellant	)	
and	)	**Docket No. 23-0804**
	)	**Issued: January 2, 2024**
U.S. POSTAL SERVICE, POST OFFICE, Denver, CO, Employer	)	

Appearances:
Appellant, pro se
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 May 12, 2023 appellant filed a timely appeal from a December 13, 2022 merit decision 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]

ISSUE

The issue is whether appellant has met her burden of proof to establish more than 11 percent permanent impairment of the right upper extremity (arm), 6 percent permanent impairment of the

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the December 13, 2022 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*.

left lower extremity (leg), and/or 7 percent permanent impairment of the right lower extremity (leg), for which she received schedule award compensation.

FACTUAL HISTORY

This case has previously been before the Board on a different issue.[3] The facts and circumstances of the case as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On March 4, 2003 appellant, then a 47-year-old casual laborer/custodian, filed a claim for a traumatic injury (Form CA-1) occurring on February 24, 2003 while in the performance of duty. She stopped work on February 28, 2003 and returned to limited-duty work on March 3, 2003. OWCP accepted the claim for right trapezius strain, right knee sprain, bilateral foot/ankle sprains, and bilateral forearm strain. It subsequently expanded its acceptance of the claim to include depressive disorder and right patella chondromalacia.

A March 22, 2003 magnetic resonance imaging (MRI) scan of the right knee revealed osteoarthritis in the medial and lateral joint space with no evidence of a ligamentous, meniscal, or bone injury.

On November 28, 2003 Dr. Frederick F. Teal, III, a Board-certified orthopedic surgeon, performed arthroscopic surgery on appellant's right knee for stage 4 chondromalacia of the right patella with fibrous medial plica. He noted that she had "stage 3 and stage 4 chondromalacia changes of the patella."

In an April 21, 2004 impairment evaluation, Dr. Gareth E. Shemesh, a Board-certified physiatrist, opined that appellant had obtained maximum medical improvement (MMI). He diagnosed right knee pain secondary to stage III-IV chondromalacia, patellofemoral disease, loss of right knee motion, and proximal right lower extremity weakness. Dr. Shemesh found 41 percent permanent impairment of the lower extremity under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

An October 2, 2006 MRI scan of the right shoulder revealed tendinosis/tendinopathy of the rotator cuff, subacromial bursitis with degenerative changes of the acromioclavicular (AC) joint with a possible acute AC joint injury superimposed on chronic degenerative changes.

Results from an MRI scan of the left ankle, obtained on May 24, 2014, included pes planus with mild distal tendinitis and flexor tenosynovitis without partial or full-thickness posterior tibialis tendon tear, a mild sprain of the spring ligament, a mild lateral sinus tarsitis, and small ankle joint effusion.

OWCP paid appellant wage-loss compensation for total disability on the supplemental rolls effective November 23, 2003, and on the periodic rolls effective October 31, 2004. By decision

[3] Docket No. 07-1286 (issued April 14, 2008).

[4] A.M.A., *Guides* (5th ed. 2001).

dated April 14, 2006, it reduced her wage-loss compensation effective April 16, 2006 based on its finding that she had the capacity to earn wages in the constructed position of a part-time accounting clerk.[5] OWCP continued to pay appellant wage-loss compensation on the periodic rolls based on her loss of wage-earning capacity.

On August 23, 2022 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a development letter dated August 24, 2022, OWCP requested that appellant provide an impairment evaluation from her treating physician addressing whether she had reached MMI and utilizing the sixth edition of the A.M.A., *Guides*.[6] It afforded her 30 days to submit the requested information.

On October 14, 2022 OWCP referred appellant to Dr. John J. Aschberger, a Board-certified physiatrist, for a second opinion examination.

In a report dated November 7, 2022, Dr. Aschberger provided his review of the evidence of record, including the results of diagnostic studies. He diagnosed right knee pain with degenerative change and patellofemoral chondromalacia, right shoulder pain, bilateral forearm pain, bilateral foot/ankle sprains, and right patella chondromalacia. On examination, Dr. Aschberger indicated that he had measured range of motion (ROM) three times and found maximum motion for the left ankle of 40 degrees plantarflexion, 0 degrees dorsiflexion, 10 degrees inversion, and 30 degrees eversion. For the right ankle, he measured 40 degrees plantarflexion, 5 degrees dorsiflexion, 20 degrees inversion, and 10 degrees eversion. Dr. Aschberger found 130 degrees flexion of the right knee in full extension with joint line tenderness, but no swelling or erythema. He further found normal ROM of the left shoulder and, for the right shoulder, 140 degrees abduction, which yielded three percent impairment, 25 degrees adduction which yielded one percent impairment, 140 degrees flexion, which yielded three percent impairment, 70 degrees internal rotation, which yielded two percent impairment, and 40 degrees extension and 90 degrees external rotation, which he found yielded no impairment. Dr. Aschberger added the loss of ROM of the right shoulder to find nine percent permanent impairment of the right upper extremity.

Referencing the A.M.A., *Guides*, Dr. Aschberger found that appellant had no impairment due to her trapezius strain. He identified the class of diagnosis (CDX) for the right shoulder as acromioclavicular (AC) joint injury or disease with a Class1 impairment, which yielded a default value of three percent under Table 15-5 on page 403. Dr. Aschberger applied a grade modifier for functional history (GMFH) of one, a grade modifier for physical examination (GMPE) of two, and a grade modifier for clinical studies of two, to find an adjustment of two and five percent right upper extremity impairment.

Dr. Aschberger found no ankle impairment by imaging studies, but 11 percent right lower extremity impairment and 9 percent left lower extremity impairment due to loss of ROM. For the CDX for right knee chondromalacia, he identified a Class 1 impairment, which yielded a default

[5] By decision dated January 10, 2007, an OWCP hearing representative affirmed the April 14, 2006 decision.

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

value of 10 percent based on imaging studies and operative findings. Dr. Aschberger applied a GMFH, GMPE, and GMCS of 2, to find 13 percent permanent impairment of the right lower extremity. He found no impairment due to loss of ROM of the right knee.

On November 24, 2022 Dr. Herbert White, Jr., a Board-certified occupational medicine specialist serving as a district medical adviser (DMA), applied the provisions of the A.M.A., *Guides* to Dr. Aschberger's findings. Using the diagnosis-based impairment (DBI) method, for the right shoulder, he identified the CDX as Class 1 tendinitis with residual functional loss according to Table 15-5 on page 402. Dr. White applied a GMFH of two for pain with normal activity, a GMPE of one for a mild motion deficit, and a GMCS of one for bursitis, noting that he did not rate the tendinitis as it was used for placement. Utilizing the net adjustment formula, he found an adjustment of one and four percent right upper extremity impairment. Dr. White next rated appellant's shoulder impairment using the ROM method. Using Table 15-34 on page 475, he found 140 degrees flexion yielded 3 percent impairment, 40 degrees extension yielded 1 percent impairment, 140 degrees abduction yielded 3 percent impairment, 30 degrees adduction yielded 1 percent impairment, 70 degrees internal rotational yielded 2 percent impairment, and 90 degrees external rotation yielded no impairment, which he added to find 10 percent right upper extremity impairment. Dr. White applied grade modifiers and found 11 percent right upper extremity impairment due to loss of ROM. As this yielded a greater impairment than the DBI method, he found that appellant's right upper extremity impairment should be based on loss of ROM.

For the right knee, Dr. White identified the CDX as a Class 1 impairment for patellofemoral arthritis using Table 16-3 on page 511 of the A.M.A., *Guides*, which yielded a default value of three percent. He applied a GMFH of two for an antalgic gait/assistive device, a GMPE of two for moderate tenderness, and found that a GMCS was not applicable as there were no studies to review at MMI. Dr. White applied the net adjustment formula and found that the grade increased by two, for a five percent right lower extremity impairment. He noted that an impairment using the ROM method was not provided as an alternative method for the diagnosis under the A.M.A., *Guides*.

Dr. White identified the CDX for the right ankle strain -- all other tendons according to Table 16-2 on page 501 of the A.M.A., *Guides*, as a Class 1 impairment, which yielded a default value of two percent. He found that a GMFH was excluded pursuant to page 516 of the A.M.A., *Guides* as it was used to rate the impairment of the knee, the highest DBI impairment of the extremity. Dr. White further determined that a GMPE was excluded as motion was used for tier placement, and a GMCS was not applicable as there were no studies at MMI to review, which yielded no change from the default value of two percent after application of the net adjustment formula. He combined the five percent lower extremity impairment for the right knee with the two percent lower extremity impairment for the right ankle to find seven percent permanent impairment of the right lower extremity.

Using Table 16-2 on page 501, Dr. White identified the CDX for the left ankle strain of the posterior tibial tendon with a mild motion deficit, as a Class 1 impairment, which yielded a default value of five percent. He applied a GMFH of two and found a GMPE not appliable as it was used for tier placement and GMCS not appliable it was used for diagnostic placement and there were no studies at MMI to review. Dr. White utilized the net adjustment formula to find an adjustment of one place and six percent permanent impairment of the left lower extremity. He noted that the

A.M.A., *Guides* did not provide ROM as an alternate rating method for the ankle, hindfoot, or knee.

Dr. White advised that Dr. Aschberger found a right upper extremity impairment due to loss of ROM of 9 percent instead of 11 percent as he erroneously found that 40 degrees extension constituted no impairment instead of 1 percent impairment, and further failed to apply a GMFH. He related that he was unable to determine how Dr. Aschberger found a right lower extremity impairment of 13 percent. Dr. White noted that Dr. Aschberger inappropriately rated appellant's ankle impairment using the ROM method. He found that she had reached MMI on November 7, 2022.

By decision dated December 13, 2022, OWCP granted appellant a schedule award for 11 percent permanent impairment of the right upper extremity (right arm), 6 percent permanent impairment of the left lower extremity (left leg), and 7 percent permanent impairment of the right lower extremity (right leg). The period of the award ran for 71.76 weeks. OWCP noted that it had adjusted the starting date of the schedule award to December 4, 2022 as appellant had received disability compensation through December 3, 2022.

LEGAL PRECEDENT

The schedule award provision of FECA,[7] and its implementing federal regulation,[8] 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.[9] 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.[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)*.[11] Under the sixth edition, the evaluator identifies the impairment CDX, which

[7] *Supra* note 1.

[8] 20 C.F.R. § 10.404.

[9] 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 2.808.6 (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

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

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

is then adjusted by GMFH, GMPE) and 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 her burden of proof to establish more than 11 percent permanent impairment of the right upper extremity (arm), 6 percent permanent impairment of the left lower extremity (leg), and/or 7 percent permanent impairment of the right lower extremity (leg), for which she previously received schedule award compensation.

Regarding appellant's right upper extremity impairment, Dr. Aschberger found that appellant had 3 percent impairment for 140 degrees abduction, 1 percent impairment for 25 degrees adduction, 3 percent impairment for 140 degrees flexion, 2 percent impairment for 2 degrees internal rotation, and no impairment for 40 degrees extension and 90 degrees external rotation, which yielded a total right upper extremity impairment of 9 percent. However, as noted by the DMA, 40 degrees extension constituted one percent permanent impairment under Table 15-34 of the A.M.A., *Guides*. Dr. Ashberger also rated appellant's shoulder impairment using the DBI method and found that appellant had five percent permanent impairment of the right shoulder for Class 1 AC joint arthritis using Table 55 on page 403 of the A.M.A., *Guides* after the application of grade modifiers.

For the right knee, Dr. Aschberger identified the CDX as a Class 1 impairment for arthritis with a two-millimeter cartilage interval, which he found yielded a default value of 10 percent using Table 16-3 on page 511. He applied a GMFH, GMPE, and GMCS of 2, which yielded 13 percent permanent impairment of the right lower extremity. Dr. Aschberger found no impairment of the right knee due to loss of ROM. He did not, however, explain, with reference to specific x-rays or diagnostic studies, how he determined that appellant had two-millimeter of cartilage interval.

Dr. Aschberger further found that appellant had no ankle impairment using the DBI method but had 11 percent right lower extremity impairment and 9 percent left lower extremity impairment due to loss of ROM. However, Table 16-2 does not provide the ROM impairment rating method as an alternative to the DBI rating method for appellant's condition.[15]

Dr. White, on November 24, 2022, reviewed Dr. Aschberger's findings. Using the DBI method, he identified the CDX for the right shoulder as Class 1 tendinitis using Table 15-5 on page 502 of the A.M.A., *Guides*, which yielded a default value of three percent. Dr. White found a GMFH of 2 for pain with normal activity, a GMPE of 1 for a mild motion deficit, and a GMCS of 1

[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).

[15] *See* A.M.A., *Guides* 501-08, Table 16-2; *see also A.K.*, Docket No. 19-1927 (issued March 31, 2021); *A.M.*, Docket No. 18-1061 (issued November 9, 2018).

for bursitis, which yielded four percent permanent impairment of the right upper extremity after application of the net adjustment formula.[16] He concurred with Dr. Aschberger's impairment findings due to loss of ROM of the right shoulder except for extension, noting that 40 degrees extension constituted a one percent impairment rather than no impairment. Dr. White further found that Dr. Aschberger had not applied a GMFH to the ROM measurements. He concluded that appellant had 11 percent permanent impairment of the right upper extremity due to reduced ROM of the shoulder. Dr. White opined that ROM should be used to rate appellant's right upper extremity impairment as it provided the greater rating.

Dr. White reviewed Dr. Aschberger's findings regarding the right knee and identified the CDX as Class 1 patellofemoral arthritis with a full-thickness articular cartilage defect or ununited osteochondral fracture, which yielded a default value of three percent. He applied a GMFH and a GMPE of two and found that a GMCS was not applicable as there were no clinical studies to review at MMI. Dr. White applied the net adjustment formula and found that the grade increased by two, for a five percent right lower extremity impairment.[17] He noted that an impairment using the ROM method was not set forth as an alternative method under the A.M.A., *Guides*. Dr. White advised that it was unclear how Dr. Aschberger had rated appellant's right knee impairment.

Dr. White further opined that the A.M.A. *Guides* did not provide ROM as an alternative method to rate an impairment of the ankle. He identified the CDX of the right ankle as a Class 1 strain of all other tendons using Table 16-2 on page 501, which yielded a default value of two percent. Dr. White asserted that a GMFH was excluded as it was used to rate the knee impairment, which yielded the highest DBI impairment for the extremity. He further found that a GMPE was excluded as it was used for tier placement and that a GMCS was not applicable as there were no studies at MMI to review. Dr. White thus found no change from the default value of two percent. He combined the five percent lower extremity impairment for the right knee with the two percent lower extremity impairment for the right ankle to find seven percent permanent impairment of the right lower extremity.

For the left ankle, Dr. White identified the CDX as a Class 1 strain of the posterior tibial tendon with a mild motion deficit, for a default value of five percent. He applied a GMFH of two. Dr. White further determined that a GMPE not applicable as it was used for tier placement and GMCS not appliable it was used for diagnostic placement and as there were no studies at MMI to review. He utilized the net adjustment formula to find an adjustment of one, or six percent permanent impairment of the left lower extremity.[18]

The Board finds that OWCP properly determined that appellant had not established greater than 11 percent permanent impairment of the right upper extremity (arm), 6 percent permanent impairment of the left lower extremity (leg), and/or 7 percent permanent impairment of the right

[16] Utilizing the net adjustment formula discussed above, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (2-1) + (1-1) + (1-1) = 1, yielded an adjustment of one.

[17] (GMFH-CDX) + (GMPE-CDX), or (2-1) + (2-1) = 2, yielded an adjustment of 2.

[18] (GMFH-CDX), or (2-1) = 1, yielded an adjustment of 1.

lower extremity (leg), based on the findings of the DMA.[19] There is no probative medical evidence of record demonstrating greater impairment than that previously awarded.[20]

Appellant may request a schedule award or increased schedule award based at any time 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 her burden of proof to establish more than 11 percent permanent impairment of the right upper extremity (arm), 6 percent permanent impaiment of the left lower extremity (leg), and/or 7 percent permanent impairment of the right lower extremity (leg), for which she received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the December 13, 2022 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 2, 2024
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

[19] *See B.L.*, Docket No. 22-0068 (issued October 12, 2022); *J.S.*, Docket No. 19-1567 (issued April 1, 2020); *J.M.*, Docket No. 18-1334 (issued March 7, 2019).

[20] *See D.S.*, Docket No. 20-0670 (issued November 2, 2021); *D.F.*, Docket No. 17-1474 (issued January 26, 2018); *A.T.*, Docket No. 16-0738 (issued May 19, 2016).