United States Department of Labor
Employees' Compensation Appeals Board

A.W., Appellant	)	
and	)	**Docket No. 25-0542**
	)	**Issued: June 24, 2025**
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
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On May 13, 2025, appellant, through her representative, filed a timely appeal from an April 1, 2025 merit decision 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*.

ISSUE

The issue is 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.

FACTUAL HISTORY

This case has previously been before the Board.[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 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 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 her conditions 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 for disability from work on the supplemental rolls, effective August 6, 2015, and on the periodic rolls, effective December 9, 2018. On October 25, 2019, appellant underwent OWCP-authorized left knee surgery, including synovectomy, femoral condyle chondroplasty, and anterior cruciate ligament repair.

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

On January 5, 2021, OWCP referred appellant, along with the case record, a statement of accepted facts (SOAF), and a series of questions to Dr. Seth Jaffe, an osteopath and Board-certified orthopedic surgeon, for a second opinion examination. It requested that Dr. Jaffe provide an opinion regarding permanent impairment of appellant's left lower extremity under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

In a January 26, 2021 report, Dr. Jaffe referred to the sixth edition of the A.M.A., *Guides* and determined that appellant had nine percent permanent impairment of the left lower extremity. He further 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 medical record 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.

[3] Docket No. 23-0618 (issued September 27, 2023).

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

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 that, under Table 16-3 (Knee Regional Grid), beginning on page 509, the class of diagnosis (CDX) for 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, which resulted in a grade E or 24 percent permanent impairment of the left lower extremity. 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 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. 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 yielded total permanent impairment of the left lower extremity of 36 percent.

Appellant claimed that she was entitled to an additional 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, 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, 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 yielded 27 percent permanent impairment of left lower extremity.

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 rating 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 (for a total of 27 percent permanent impairment). The award ran for 51.84 weeks from June 6, 2022 through June 3, 2023.

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).

Appellant appealed the two September 26, 2022 merit decisions to the Board and, by decision dated September 27, 2023,[5] the Board set aside the September 26, 2022 decisions, finding that there was a conflict in the medical opinion evidence between Dr. White and Dr. Seldes regarding appellant's left lower extremity permanent impairment. It directed OWCP to refer appellant to an appropriate specialist for an impartial medical examination to resolve the conflict and to issue a *de novo* decision.

On remand, OWCP referred appellant, along with the case record, a SOAF, and a series of questions, to Dr. Robert S. Schaefer, a Board-certified orthopedic surgeon, for an impartial medical examination and permanent impairment evaluation.

In a January 17, 2024 report, Dr. Schaefer discussed appellant's factual and medical history, including her accepted employment conditions and receipt of medical treatment. He reported the findings of his physical examination, noting appellant had no inversion or eversion at the left subtalar joint due to her previous subtalar fusion, and that her bilateral feet demonstrated pes planus valgus deformity with collapse of the midfoot. Dr. Schaefer advised that appellant had crepitation of the left knee, but had resisted his attempts to obtain ROM findings for the knee. He discussed the prior impairment ratings that were performed with respect to appellant's left lower extremity. Dr. Schaefer noted that on June 6, 2022 Dr. Seldes provided an impairment rating seven years after the original injury and three years after the last surgical procedure was completed. He advised that he had reviewed Dr. Seldes' impairment rating and found it to be erroneous. Dr. Schaefer indicated that Dr. Seldes used tricompartmental cartilage degeneration, a nonaccepted condition, as the basis for his impairment rating. He noted that Dr. Seldes obtained radiographs that were taken seven years after the original injury. Dr. Schaefer related that Dr. Seldes performed an impairment rating, which utilized both a DBI rating method and a ROM rating method, and maintained that Dr. Seldes' impairment rating did not have "any relationship to reality for the injury that occurred in August of 2015 or even the condition of the claimant following the surgical treatment that she receive[d] in 2018 and 2019."

[5] Docket No. 23-0618 (issued September 27, 2023).

He asserted that Dr. Seldes' ROM measurements were not consistent with the medical records, noting that he found that "the motion that he recorded of the left ankle and left knee to be totally unreliable and not consistent with the reviewed medical records at the time of injury, treatment, and Dr. Jaffe's original impairment rating." Dr. Schaefer further noted "I do not support any additional permanent impairment rating of the left lower extremity beyond a 27% [sic] that has previously been awarded by Dr. White."

By *de novo* decision dated March 29, 2024, OWCP denied appellant's claim for an additional schedule award beyond the 27 percent permanent impairment of her left lower extremity, for which she previously received schedule award compensation. It based its determination on the opinion of Dr. Schaefer, the impartial medical examiner (IME).

On January 29, 2025, appellant, through her representative, requested reconsideration of the March 29, 2024 decision.

On February 7, 2025, OWCP requested that Dr. Schaefer, in his role as IME, provide a supplemental report regarding the permanent impairment of appellant's left lower extremity.

On April 1, 2025, OWCP received a March 24, 2025 supplemental report, wherein Dr. Schaefer discussed appellant's medical history and the accepted employment conditions. He indicated that appellant's current medical state had "nothing to do" with the accepted employment conditions. Dr. Schaefer noted that, with respect to the conflict in the medical opinion evidence between Dr. Seldes and Dr. White, he did not support Dr. Seldes' impairment rating of 36 percent and opined that he would "select the impairment rating of Dr. White of 27 percent for the left lower extremity." He advised that it had been over 10 years since appellant's injury occurred and maintained that her "conditions were treated and an appropriate impairment rating was given years ago." Dr. Schaefer further noted, "I can provide no additional explanation for an impairment rating beyond 27 percent of the left lower extremity."

By decision dated April 1, 2025, OWCP denied modification of its March 29, 2024 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA,[6] and its implementing federal regulation,[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

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants.[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 ROM. ROM is primarily used as a physical examination adjustment factor.[10] The A.M.A., *Guides*, however, also explains 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.[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 GMCS. 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 IME) 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

[8] *Id. See also T.T.,* Docket No. 18-1622 (issued May 14, 2019).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *id.* at 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.

[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); *see also Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001); *James P. Roberts,* 30 ECAB 1010 (1980).

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]

When OWCP obtains an opinion from an IME for the purpose of resolving a conflict in medical opinion evidence and the specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to correct the defect in the original report.[18] However, when the IME is unable to clarify or elaborate on the original report or if a supplemental report is also vague, speculative or lacking in rationale, OWCP must submit the case record and a detailed SOAF to a second IME for the purpose of obtaining a rationalized medical opinion on the issue.[19]

ANALYSIS

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

In a report dated January 17, 2024, Dr. Schaefer advised that he had reviewed Dr. Seldes' June 6, 2022 impairment rating and found it to be erroneous. He asserted that Dr. Seldes used tricompartmental cartilage degeneration, a nonaccepted condition, as the basis for his impairment rating, and maintained that his ROM measurements for the left lower extremity were not consistent with those detailed in the prior medical records. Dr. Schaefer noted, "I do not support any additional permanent impairment rating of the left lower extremity beyond a 27% [sic] that has previously been awarded by Dr. White." OWCP subsequently requested that Dr. Schaefer provide a supplemental report regarding additional permanent impairment of appellant's left lower extremity. In his March 24, 2025 supplemental report, he indicated that he did not support Dr. Seldes' impairment rating of 36 percent and opined that he would "select the impairment rating of Dr. White of 27 percent for the left lower extremity." Dr. Schaefer further noted, "I can provide no additional explanation for an impairment rating beyond 27 percent of the left lower extremity."

The Board finds that Dr. Schaefer, in his role as an IME, did not provide a sufficiently-rationalized medical opinion regarding the permanent impairment of appellant's left lower extremity. Rather, he only generally opined that he disagreed with the June 6, 2022 impairment rating of Dr. Seldes that appellant had greater than 27 percent permanent impairment of the left lower extremity.[20] He did not explain how he applied the standards of the sixth edition of the A.M.A., *Guides* in finding that appellant had no greater than the 27 percent permanent impairment previously awarded. As explained above, when the IME is unable to clarify or elaborate on the original report or if a supplemental report is also vague, speculative, or lacking

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

[18] *G.C.*, Docket No. 24-0718 (issued September 19, 1924); *Raymond A. Fondots*, 53 ECAB 637, 641 (2002); *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232 (1988); *Ramon K. Ferrin, Jr.*, 39 ECAB 736 (1988).

[19] *Nancy Keenan*, 56 ECAB 687 (2005); *Roger W. Griffith*, 51 ECAB 491 (2000); *Talmadge Miller*, 47 ECAB 673 (1996).

[20] As previously noted, Dr. Seldes found 36 percent permanent impairment of the left lower extremity.

in rationale, OWCP must submit the case record and a detailed SOAF to a second IME for the purpose of obtaining a rationalized medical opinion on the issue.[21]

Therefore, the Board finds that there is an unresolved conflict in the medical opinion evidence regarding the permanent impairment of appellant's left lower extremity and OWCP shall refer appellant to a new IME in the appropriate field of medicine for an opinion regarding this matter in order to resolve the conflict.[22] After this and other such further development as deemed necessary, it shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the April 1, 2025 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: June 24, 2025
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

[21] *Id*.. *See also N.A*., Docket No. 19-0248 (issued May 17, 2019); *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989) (finding that an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's permanent impairment).

[22] *See supra* notes 19 and 21.