United States Department of Labor
Employees' Compensation Appeals Board

K.W., Appellant **and** **DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF PRISONS, FEDERAL CORRECTIONAL COMPLEX BUTNER, Butner, NC, Employer**	)	**Docket No. 26-0157** **Issued: March 30, 2026**

Appearances:
John L. DeGeneres, Jr., 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 December 5, 2025 appellant, through counsel, filed a timely appeal from a November 18, 2025 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). He contended that OWCP improperly assigned the weight of the medical evidence in rendering its decision. The Board, in exercising its discretion, denies appellant's request for oral argument because this matter requires an evaluation of the medical evidence presented. As such, the arguments on appeal can adequately be addressed in a decision based on a review of the case record. Oral argument in this appeal would not serve a useful purpose. Therefore, 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 over the merits of this case.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 18 percent permanent impairment of his left lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On December 4, 2009 appellant, then a 39-year-old correctional officer, filed a traumatic injury claim (Form CA-1) alleging that on that date he injured his left ankle when he jumped from a sniper platform during training while in the performance of duty.[4] OWCP accepted the claim for left ankle sprain and closed fracture of the medial malleolus of the left ankle.

On September 16, 2024 appellant filed a claim for compensation (Form CA-7) for a schedule award. In support thereof, he submitted an August 6, 2024 permanent impairment rating report by Dr. William A. Somers, a Board-certified orthopedic surgeon, who noted that appellant had a past medical history of left patellar tendon bursitis (jumper's knee), left knee meniscus damage, and left groin pain. Dr. Somers also noted that appellant related complaints of residual pain in the left hip, knee, and ankle and a catching sensation in the left ankle, which he attributed to the December 4, 2009 employment injury. He performed a physical examination of the left hip, where he observed mild left gluteal and abductor discomfort during Trendelenburg testing. Dr. Somers also obtained range of motion (ROM) measurements of 0 degrees internal rotation in extension, 20 degrees internal rotation in flexion, 30 degrees external rotation in extension, 70 degrees external rotation in flexion, 40 degrees abduction, 20 degrees adduction, and 111 degrees flexion.

On examination of the left knee, Dr. Somers observed tenderness about the medial and lateral joint lines with crepitus, marked tenderness at the distal patella/patellar tendon junction with the knee in extension, grade ½ anterior drawer and Lachman tests with soft endpoint, posterolateral knee pain with pivot shift testing, and 3 to 135 degrees extension with anteromedial and lateral joint pain and a rubbery end point with forced extension.

On examination of the left ankle, Dr. Somers observed tenderness about the anterior talofibular, calcaneofibular (CF), and deltoid ligaments of the left ankle, absence of the CF ligament with inversion of the left ankle, soft endpoint to anterior drawer testing with production of lateral ligamentous pain and anterolateral pain, and a thickened band of anterolateral synovium/scar, which was tender and reproduced appellant's sense of catching. He obtained ROM measurements of 10 degrees dorsiflexion, 40 degrees plantar flexion, 35 degrees subtalar inversion, 15 degreed subtalar eversion, 15 degrees midfoot abduction, and 15 degrees midfoot adduction.

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[3] 5 U.S.C. § 8101 *et seq*.

[4] OWCP assigned the present claim OWCP File No. xxxxx6397. Appellant subsequently filed a notice of recurrence (Form CA-2a) alleging that on January 25, 2010 he experienced left ankle soreness while running at work. OWCP converted the Form CA-2a to a Form CA-1 assigned OWCP File No. xxxxx5397. It administratively combined OWCP File Nos. xxxxx5397 and xxxxx6397, with the latter serving as the master file.

Dr. Somers diagnosed mild anterolateral instability and osteoarthritis of the left hip; osteoarthritis, jumper's knee, and early degenerative joint disease in the left knee; and grade 3 medial ankle sprain with instability and chronic lateral instability with anterolateral impingement in the left ankle. He noted that his physical examination did not reveal any mechanical meniscal pathology but that it was indicative of anterior collateral ligament (ACL) insufficiency with left knee pain. Dr. Somers opined that appellant had reached maximum medical improvement (MMI) on August 6, 2024.

Dr. Somers applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[5] to his examination findings. Using the diagnosis-based impairment (DBI) rating methodology, he utilized Table 16-4 (Hip Regional Grid), page 514. For the class of diagnosis (CDX) of hip arthritis, he found a Class 1 impairment with a default rating of 7 percent permanent impairment of the left lower extremity. For the left knee, he utilized Table 16-3 (Knee Regional Grid), page 510, and found a default rating of 10 percent permanent impairment of the left lower extremity for cruciate ligament laxity.[6] Regarding the left ankle, Dr. Somers utilized Table 16-2 (Foot and Ankle Regional Grid) and found a default rating of 10 percent of the left lower extremity for traumatic joint stability with ligamentous laxity in the left ankle. He assigned a grade modifier for clinical studies (GMCS) of 2 for confirmed moderate pathology, which resulted in 12 percent permanent impairment of the left lower extremity for the left ankle. Dr. Somers applied the Combined Values Chart and found a total of 27 percent permanent impairment of the left lower extremity.

OWCP referred Dr. Somers' August 6, 2024 report and a statement of accepted facts (SOAF) to Dr. Nathan Hammel, a Board-certified orthopedic surgeon, serving as a district medical adviser (DMA), for a review and an opinion regarding appellant's permanent impairment.

In a report dated October 2, 2024, Dr. Hammel applied the sixth edition of the A.M.A., *Guides* to Dr. Somers' examination findings. He concurred with Dr. Somers that appellant had 7 percent permanent impairment of the left lower extremity for the left hip and 12 percent permanent impairment of the left lower extremity for the left ankle. Dr. Hammel disagreed with Dr. Somers' opinion regarding the left knee, noting that "the rating a physician rates for cruciate ligament injury without imaging findings to support this diagnosis." Utilizing the Combine Values Chart, he found 18 percent permanent impairment of the left lower extremity for the left hip and ankle. Dr. Hammel opined that appellant reached MMI on August 6, 2024, the date of Dr. Somers' examination.

By decision dated October 30, 2024, OWCP granted appellant a schedule award for 18 percent permanent impairment of the left lower extremity. It accorded the weight of the medical opinion evidence to the October 2, 2024 report of Dr. Hammel, as the DMA. The award ran for 51.84 weeks from August 6, 2024 through August 3, 2025.

On November 4, 2024 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. On November 22, 2024 he converted his request to a request for a review of the written record.

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

[6] Dr. Somers noted that a grade modifier for physical examination (GMPE) and a grade modifier for functional history (GMFH) did not result in any net adjustment of the default ratings for appellant's left hip and knee.

Following a preliminary review, by decision dated December 20, 2024, an OWCP hearing representative vacated the October 30, 2024 decision and remanded the case for further development.

In an April 15, 2022 medical report, Dr. Kendall E. Bradley, a Board-certified orthopedic surgeon, noted that in April 2022 appellant "went to a new gym, and the belt slipped," causing a "hyperextension moment and acute pain and swelling." He documented physical examination findings and diagnosed a complex tear of the medial meniscus of the left knee.

Dr. Bradley, in a June 3, 2022 medical report, noted that appellant had undergone a left knee MRI scan, which revealed a degenerative meniscal tear.

On October 25, 2022 appellant underwent an ultrasound guided injection to the left knee.

On February 12, 2025 OWCP submitted additional medical records to Dr. Hammel for his review and comment.

In an addendum report dated February 26, 2025, Dr. Hammel indicated that his opinions remained unchanged. He noted that "the MRI from 2022 specifically notes the ACL is intact."

By *de novo* decision dated March 10, 2025, OWCP denied appellant's claim for a schedule award for increased permanent impairment of the left lower extremity.

On March 19, 2025 appellant, through counsel, requested a review of the written record by a representative of OWCP's Branch of Hearings and Review.

By decision dated June 16, 2025, an OWCP hearing representative affirmed the March 10, 2025 decision.

On August 20, 2025, appellant, through counsel, requested reconsideration.

On September 12, 2025, OWCP requested clarification from Dr. Hammel, including whether Dr. Somers' diagnosis of ACL insufficiency altered his opinion regarding appellant's left lower extremity permanent impairment.

In a report dated September 17, 2025, Dr. Hammel noted that Dr. Somers found mild laxity in the plane of the ACL on examination. He reiterated that "the MRI shows an intact [ACL]." Dr. Hammel opined that Table 16-3, page 510, provided for rating of ligament injuries but that there was no evidence of a ligament injury on the MRI and, therefore, appellant "does not qualify for the [DBI] for an ACL injury." He further opined that "there is no diagnosis-based category for ACL laxity." Dr. Hammel concluded that appellant had an 18 percent permanent impairment of the left lower extremity for the left hip and left ankle.

By decision dated November 18, 2025, OWCP denied modification of the June 16, 2025 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[7] and its implementing regulations[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. However, FECA does not specify the manner in which the percentage of loss of a member 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.[9] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, is used to calculate schedule awards.[10]

It is the claimant's burden of proof to establish permanent impairment of the scheduled member or function of the body as a result of an employment injury.[11] OWCP procedures provide that, to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred (date of MMI), describes the impairment in sufficient detail so that it can be visualized on review, and computes the percentage of impairment in accordance with the A.M.A., *Guides*.[12]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's *International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement*.[13] Under the sixth edition, for lower extremity impairments, the evaluator identifies the impairment of the CDX,[14] which is then adjusted by a GMFH, a GMPE, and/or a 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]

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[7] *Supra* note 3.

[8] 20 C.F.R. § 10.404.

[9] *Id.*; *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards 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).

[11] *E.D.,* Docket No. 19-1562 (issued March 3, 2020); *Edward Spohr,* 54 ECAB 806, 810 (2003); *Tammy L. Meehan,* 53 ECAB 229 (2001).

[12] *Supra* note 10 at Chapter 2.808.5 (March 2017).

[13] A.M.A., *Guides*, page 3, section 1.3.

[14] The knee is defined as the region from the mid femur to the mid tibia and including all of the bone, joint, ligamentous, and soft tissue structures encompassing the joint. In the event that a specific diagnosis is not listed in the DBI impairment grid, Table 16-3, the examiner should identify a similar listed condition to be used as a guide to the impairment calculation and include rationale for his or her decision. *Id*. at page 500, section 16.2c.

[15] *Id*. at 493-556.

[16] *Id*. at 521.

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

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's 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.[18]

Section 8123(a) of FECA provides, in pertinent part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician (known as a referee physician or an impartial medical examiner (IME)) who shall make an examination."[19] This is called an impartial medical examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case. When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an IME 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.[20]

ANALYSIS

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

In his August 6, 2024 report, Dr. Somers, appellant's attending physician, applied the DBI rating methodology to his examination findings for the left hip and, referencing Table 16-4, found 7 percent permanent impairment of the left lower extremity for osteoarthritis. Regarding the left knee, he referenced Table 16-3 and found 10 percent left lower extremity impairment due to mild ACL insufficiency. Regarding the left ankle, Dr. Somers referenced Table 16-2 to find 12 percent left lower extremity impairment due to traumatic joint instability and ligamentous laxity. He opined that appellant was entitled to a schedule award for 27 percent permanent impairment of the left lower extremity for the left hip, knee, and ankle.

In reports dated October 2, 2024 and February 26 and September 17, 2025, Dr. Hammel, the DMA, applied the sixth edition of the A.M.A., *Guides* to Dr. Somers' examination findings. He concurred with Dr. Somers that appellant had 7 percent permanent impairment of the left lower extremity for the left hip and 12 percent permanent impairment of the left lower extremity for the left ankle. Dr. Hammel disagreed with Dr. Somers' opinion regarding the left knee, noting that Table 16-3, page 510, provided for rating of ligament injuries but that there was no evidence of a ligament injury on the MRI and therefore appellant "does not qualify for the [DBI] for an ACL injury." He also opined that there was no diagnosis-based category for ACL laxity. Dr. Hammel combined the ratings for the left hip and left ankle and found a combined value of 18 percent permanent impairment of the left lower extremity.

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[18] *See supra* note 10 at Chapter 2.808.6(f) (March 2017); *see also J.T.*, Docket No. 17-1465 (issued September 25, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

[19] 5 U.S.C. § 8123(a). *See R.C.*, Docket No. 18-0463 (issued February 7, 2020); *see also G.B.*, Docket No. 16-0996 (issued September 14, 2016).

[20] 20 C.F.R. § 10.321. *See also J.H.*, Docket No. 22-0981 (issued October 30, 2023); *N.D.*, Docket No. 21-1134 (issued July 13, 2022); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001); *James P. Roberts*, 31 ECAB 1010 (1980).

As noted above, if there is a disagreement between an employee's physician and an OWCP physician, OWCP will appoint an IME who shall make an examination.[21] The Board finds that a conflict in medical opinion exists between Dr. Somers and the DMA, Dr. Hammel, regarding the extent of the permanent impairment of appellant's left lower extremity and application of the sixth edition of the A.M.A., *Guides* to appellant's diagnosed left knee conditions.

The Board, therefore, will remand the case for OWCP to refer appellant to an IME for resolution of the conflict in medical opinion evidence. On remand OWCP shall refer the case record, a SOAF, and appellant to a specialist in the appropriate field of medicine, to serve as an IME, for a reasoned medical opinion regarding the extent of permanent impairment of appellant's left lower extremity.[22] Following this and other such further development as deemed necessary, OWCP 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 November 18, 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: March 30, 2026
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

[21] *See E.B.*, Docket No. 23-0169 (issued August 24, 2023); *S.S.*, Docket No. 19-1658 (issued November 12, 2020); *C.S.*, Docket No. 19-0731 (issued August 22, 2019); *see also supra* note 19.

[22] *See S.W.,* Docket No. 22-0917 (issued October 26, 2022); *K.D.,* Docket No. 19-0281 (issued June 30, 2020).