United States Department of Labor
Employees' Compensation Appeals Board

M.S., Appellant	)	
and	)	**Docket No. 20-0036**
	)	**Issued: February 5, 2021**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Glynco, GA, Employer	)	

Appearances:
Jeffrey P. Zeelander, 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
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 27, 2019 appellant, through counsel, filed a timely appeal from an August 8, 2019 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 one percent permanent impairment of the left lower extremity for which she previously received a schedule award.

FACTUAL HISTORY

On March 15, 2017 appellant, then a 39-year-old special agent trainee, filed a traumatic injury claim (Form CA-1) alleging that she sustained a left knee injury on March 6, 2017 while in the performance of duty. She explained that, when in a training class, she jumped over a student who was on the ground acting as a "trash can" and when she landed, her left knee buckled. Appellant indicated that she heard a "popping" sound when she landed and was unable to walk. She did not stop work.

OWCP accepted the claim for left knee anterior cruciate ligament (ACL) rupture on May 4, 2017. It authorized left knee arthroscopy with arthroscopic ACL reconstruction surgery with hamstring autograft and a lateral meniscus repair, which Dr. Cody B. Bellard, a Board-certified orthopedic surgeon, performed on June 8, 2017. On August 1, 2017 OWCP expanded acceptance of the claim to include other tear of lateral meniscus, left knee and placed appellant on the periodic compensation rolls effective August 20, 2017.

Appellant returned to full-time, limited-duty work effective September 5, 2017.

In an April 30, 2018 medical report, Dr. Bellard noted that he initially evaluated appellant in April 2017 following a work-related left knee injury she sustained six weeks prior while participating in a training course. He indicated that she underwent a magnetic resonance imaging (MRI) scan and was diagnosed with an ACL rupture. Dr. Bellard noted that an ACL reconstruction surgery was performed at which time a lateral meniscus tear was discovered and also surgically repaired. He described postsurgical progress and examination findings through appellant's 10-month follow up, which revealed no effusion in the knee, range of motion (ROM) of 0 to 130 degrees, no pain on ROM, and negative Lachman's and posterior draw tests. Dr. Bellard indicated that the left knee was stable, but that the quadriceps showed some mild residual atrophy. He found that appellant had reached maximum medical improvement (MMI) as of the date of his evaluation, noting that she had minimal symptoms and was able to perform all duties required with no limitations. Dr. Bellard concluded that she had a class of diagnosis (CDX) of 1, default grade C based on the ACL reconstruction and that the presence of the meniscal tear and subsequent repair resulted in a grade modifier for clinical studies (GMCS) of 2. He opined that, when utilizing the net adjustment formula, the net adjustment was +1 resulting in a CDX of 1 with a grade D or 12 percent permanent impairment of the left lower extremity.

On May 7, 2018 appellant filed a claim for a schedule award (Form CA-7).

Dr. Bellard, in a May 7, 2018 report, reiterated his findings and opinion that appellant had 12 percent permanent impairment of the left lower extremity as a result of her accepted left knee injury.

On July 6, 2018 OWCP referred Dr. Bellard's rating reports, along with a statement of accepted facts, and the medical record to Dr. Nelson S. Haas, a Board-certified occupational

medicine specialist serving as a district medical adviser (DMA). In a July 14, 2018 report, the DMA opined that appellant had reached MMI as of March 26, 2018, after she had completed treatment, had no complaints, a nearly-normal examination, and was released to full duty three months earlier. Utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[3] he indicated that he had used the diagnosis-based impairment (DBI) method for his impairment rating. The DMA found that appellant's most impairing diagnosis was lateral meniscus tear, which resulted in a CDX of 1 with a default grade C, equating to two percent permanent impairment of the left lower extremity. He noted that she had a torn or ruptured left ACL that had been successfully repaired and the A.M.A., *Guides* provided that surgical intervention was only relevant if it altered the functional status of the condition being evaluated at the point of MMI. Thus, the DMA found that the left ACL tear was a CDX of zero or zero percent permanent impairment of the left lower extremity. Referring to Table 16-6 at page 516, Table 16-7[4] at page 517, and Table 16-8 at pages 519 to 520, he assigned a grade modifier for functional history (GMFH) of zero due to no deficits in function, a grade modifier for physical examination (GMPE) of zero, and a GMCS of 1, respectively. The DMA disagreed with Dr. Bellard's impairment rating, finding that Dr. Bellard had used a CDX of 1 for an ACL tear with successful reconstruction and without instability at MMI, where he had assigned a CDX of zero impairment for the ACL tear with successful reconstruction, consistent with the methods specified in the A.M.A., *Guides*. Dr. Bellard had also allowed an increase in the grade of impairment due to the presence of a meniscal tear, and while the DMA noted no strong disagreement with the use of a GMCS, he asserted that it was not part of the adjustments in Table 16-8 and, therefore, he did not allow modification of the grade for the presence of a meniscal tear. Utilizing the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), or (0-1) + (0-1) + (1-1) = -2, yielded an adjustment of -2, or a CDX of 1, grade A, which equated to one percent permanent impairment of the left lower extremity for tear and repair of the left lateral meniscus.

By decision dated January 8, 2019, OWCP granted appellant a schedule award for one percent permanent impairment of the left lower extremity. The award covered a period of 2.88 weeks from March 27 through April 16, 2018.

Thereafter, appellant continued to submit progress reports from Dr. Bellard dated March 19 through April 1, 2019, indicating that she had a sudden increase in pain in the left knee with no previous trauma. She was evaluated and clinically she had no ACL instability and the meniscus tear also appeared to be intact. On April 1, 2019 Dr. Bellard reviewed a March 26, 2019 MRI scan of the left knee and found that the ACL graft and the meniscus repair "appears" to be intact and there was no evidence of a new tear in relation to her previous injury. There was a small cartilage lesion on the medial femoral condyle without bony edema, but overall the MRI scan showed a structurally sound knee joint.

Appellant, through counsel, requested reconsideration of the January 8, 2019 decision on April 29, 2019.

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

[4] The Board notes that it appears that the DMA inadvertently indicated that he utilized Table 15-7 on page 517 rather than Table 16-7 on page 517 as his findings correspond to the values listed in Table 16-7 on page 517 for a GMPE grade modifier.

In support of her request, appellant submitted additional medical evidence. A February 12, 2019 report from Dr. Lisa Marie Sheppard, a Board-certified radiologist, indicated that she had reviewed a weight-bearing examination of the left knee dated January 30, 2019 and found a previous repair of an ACL tear, suprapatellar effusion, narrowing of the lateral joint space with a superior to inferior measurement of 2.4 millimeters (mm), the patellofemoral joint space demonstrated osteophyte formation of the femur, and the joint space at its narrowest portion showed an anterior-to-posterior measurement of 3.8 mm.

OWCP also received an impairment rating report, dated April 8, 2019, by Dr. Neil Allen, a Board-certified internist and neurologist, wherein he referenced the A.M.A, *Guides* and indicated that he used the DBI methodology in calculating appellant's left knee impairment. Dr. Allen found that appellant had a CDX of 2 for primary knee joint osteoarthritis, no cartilage with a default grade C or 20 percent permanent impairment of the left lower extremity. He assigned a GMFH of 2 due to antalgic gait and an American Academy of Orthopedic Surgery Lower Limb Questionnaire score of 60, and a GMPE of 2 based on Table 16-7, on page 517 of the A.M.A, *Guides*. Dr. Allen did not assign a GMCS, noting that it was used in class placement. Utilizing the net adjustment (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), or (2-2) + (2-2) = 0, yielded an adjustment of 0. He concluded that appellant had 20 percent permanent impairment of the left lower extremity based on the diagnosis of primary knee joint osteoarthritis, no cartilage interval.

In an addendum report dated August 5, 2019, Dr. Haas, the DMA, reviewed Dr. Allen's April 8, 2019 impairment rating and explained that there were discrepancies between their approaches because Dr. Allen had not performed a thorough review and summary of all pertinent records and did not explain the inconsistencies between his impairment evaluation findings and objective and physical examination findings in the records from treating clinicians for functional history and examination abnormalities. The DMA reiterated his opinion that appellant had a one percent permanent impairment of the left lower extremity for tear and repair of the left lateral meniscus.

By decision dated August 8, 2019, OWCP denied modification of its prior January 8, 2019 schedule award decision.[5]

LEGAL PRECEDENT

The schedule award provision 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, functions and organs of the body. FECA, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. The method used in making such a determination is a matter which rests in the

[5] The Board notes that appellant, through counsel, specifically appealed OWCP's August 8, 2019 merit decision. Although OWCP's September 16, 2019 nonmerit decision, which denied appellant's request for an oral hearing before a representative of OWCP's Branch of Hearing and Review as she had previously requested reconsideration under 5 U.S.C. § 8128, is within the Board's jurisdiction, she has not appealed that decision. Therefore, the Board will not address the September 16, 2019 nonmerit decision in this appeal. *See* 20 C.F.R. § 501.3.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

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.[8] 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.[9]

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).[10] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by the GMFH, GMPE, and GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed a 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.[13]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish more than one percent permanent impairment of the left lower extremity for which she previously received a schedule award.

Appellant submitted an April 8, 2019 rating report from Dr. Allen who provided an impairment rating of 20 percent permanent impairment of the left lower extremity based on the diagnosis of primary knee joint osteoarthritis, no cartilage interval. The Board finds that appellant's impairment rating should be based on the accepted conditions of left ACL rupture and tear of lateral meniscus, left knee.[14] OWCP has not accepted a work-related condition of left primary knee joint osteoarthritis, no cartilage interval. Furthermore, Dr. Allen failed to provide a well-rationalized opinion causally relating the condition of left primary knee joint osteoarthritis to

[8] 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 Award and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also id*. at Chapter 3.700, Exhibit 1 (January 2010).

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

[10] A.M.A., *Guides* (6th ed. 2009), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): *A Contemporary Model of Disablement*.

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

[12] *Id.* at 411.

[13] *See supra* note 8 at Chapter 2.808.6(f) (February 2013).

[14] *T.T.*, Docket No. 18-1622 (issued May 14, 2019). *G.I.*, Docket No. 11-0030 (issued October 13, 2011).

residuals of the accepted left ACL rupture and tear of lateral meniscus, left knee.[15] It is appellant's burden of proof to establish that she suffers from additional conditions as a result of the accepted employment-related injury.[16] Given the lack of rationalized evidence establishing work-related left primary knee joint osteoarthritis, Dr. Allen's report fails to establish an accurate permanent impairment rating of the left lower extremity causally related to the March 6, 2017 employment injury.

In an April 30, 2018 report, Dr. Bellard found that appellant had reached MMI due to her accepted left knee ACL rupture and tear of the medial meniscus and authorized left knee repair. He utilized the sixth edition of the A.M.A., *Guides* and determined that appellant's accepted diagnosis of ACL rupture and authorized surgery represented a CDX of 1 with a default value of grade C. Dr. Bellard assigned a GMCS of 2. He then applied the net adjustment formula, which resulted in a net adjustment of +1, which increased the default value of C to grade D equaling 12 percent permanent impairment of the left lower extremity.

The Board finds that the weight of the medical evidence rests with the opinion of the DMA, Dr. Haas, as he properly utilized the medical evidence of record, Dr. Bellard's examination findings, and applied the appropriate provisions and grading schemes of the sixth edition of the A.M.A., *Guides* to the clinical findings in determining that appellant had one percent permanent impairment of the left lower extremity based on her accepted left knee conditions.[17] Using the DBI rating method of the A.M.A. *Guides*, the DMA identified a CDX of 1 with a default grade C for a lateral meniscus tear. He explained the assignment of modifiers, reporting a GMFH and GMPE of zero and a GMCS of 1 under Table 16-6 at page 516, Table 16-7 at page 517, and Table 16-8 at pages 519 to 520, respectively, explaining that Table 16-8 did not allow for GMCS for the presence of a meniscal tear. Application of the net adjustment resulted in a score of -2 ((0-1) + (0-1) + (1-1)), warranting movement from the default grade C to a grade A, equating to one percent permanent impairment of the left lower extremity for tear and repair of the left lateral meniscus. For these reasons, the Board finds that OWCP properly relied on the DMA's assessment of one percent permanent impairment of the left lower extremity in granting appellant's schedule award.[18]

On appeal counsel contends that the April 8, 2019 rating provided by Dr. Allen supports entitlement to a greater impairment than previously awarded. As noted above, Dr. Allen's impairment rating was based on left primary knee joint osteoarthritis, no cartilage interval, a condition which had not been accepted as a work-related condition. Thus, his rating does not

[15] OWCP's procedures provide that impairment ratings for schedule awards include those conditions accepted by OWCP as work related, and any preexisting permanent impairment of the same member or function. *Supra* note 8 at Chapter 2.808.5(d). *See also Raymond E. Gwynn*, 35 ECAB 247, 253 (1983).

[16] *See Charlene R. Herrera*, 44 ECAB 361 (1993).

[17] *G.W.*, Docket No. 19-0430 (issued February 7, 2020).

[18] The A.M.A., *Guides* directs examiners to rate DBI's for the lower extremities pursuant to Chapter 16.2 which indicates at page 497, section 16.2a that impairments are defined by class and grade using regional grids for the hip, knee, and foot/ankle. The A.M.A., *Guides* explains that in most cases only one diagnosis in a region will be appropriate. If a patient has two significant diagnoses, the examiner should use the diagnosis with the highest impairment rating in that region that is causally related for the impairment calculation. A.M.A., *Guides* 497.

establish permanent impairment of the left lower extremity greater than the one percent previously awarded.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish more than one percent permanent impairment of the left lower extremity, for which she previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the August 8, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 5, 2021
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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