United States Department of Labor
Employees' Compensation Appeals Board

K.V., Appellant	)	
and	)	**Docket No. 20-0149**
	)	**Issued: February 24, 2021**
DEPARTMENT OF THE NAVY, POLICE PRECINCT, JOINT EXPEDITIONARY BASE LITTLE CREEK-FORT STORY, Virginia Beach, VA, Employer	)	

Appearances:
Appellant, pro se
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 October 25, 2019 appellant filed a timely appeal from an October 17, 2019 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]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the October 17, 2019 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*.

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than 23 percent permanent impairment of the right lower extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

On March 30, 2010 appellant, then a 35-year-old police officer, filed a traumatic injury claim (Form CA-1) alleging that on that date, she sustained right knee ligament damage when she lost her footing during a nonlethal weapons training exercise while in the performance of duty. OWCP initially accepted the claim for right knee sprain of the right lateral collateral ligament and a tear of the medial meniscus, and later expanded acceptance of the claim to include right leg osteoarthrosis and derangement of the right meniscus.

On April 26, 2010 appellant underwent OWCP-approved right knee arthroscopic-assisted anterior cruciate ligament (ACL) reconstruction, chondroplasty of the medial femoral condyle, and arthroscopic debridement. On January 25, 2011 she underwent OWCP-approved right knee arthroscopy, lysis of adhesions, and excision of a cyclops lesion.

In progress notes dated May 4, 2011, Dr. Arthur W. Wardell, a Board-certified orthopedic surgeon, examined appellant for continued pain. On physical examination of the right knee, he observed range of motion (ROM) from 15 to 110 degrees and anterior joint line tenderness. In notes dated June 1, 2011, Dr. Wardell, referring to Table 16-3, page 510, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] calculated that appellant had 15 percent permanent impairment of her right lower extremity.

On June 6, 2011 appellant filed a claim for a schedule award (Form CA-7).

On March 29, 2012 OWCP referred the record, including a statement of accepted facts (SOAF), to Dr. Lawrence A. Manning, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), to determine appellant's percentage of permanent impairment and date of maximum medical improvement (MMI). By letter dated March 31, 2012, Dr. Manning reviewed the medical record, including Dr. Wardell's May 4, 2011 report, and found that, while there was evidence of permanent impairment, her right knee ROM was inconsistent on different dates of examination, and that as such, it was difficult to assign impairment based on ROM. He suggested that appellant may be entitled to greater impairment than the 15 percent assigned by Dr. Wardell given the degree of arthritic changes and depending on an accurate assessment of ROM. Dr. Manning proposed that she be referred for another medical evaluation to resolve the outstanding questions.

On May 3, 2012 OWCP referred appellant to Dr. Edward W. Gold, a Board-certified orthopedic surgeon, for a second opinion evaluation of appellant's permanent impairment. In a report dated June 29, 2012, Dr. Gold reviewed her history of injury and the medical record. On physical examination of appellant's right knee, he observed ROM of 20 to 95 degrees of flexion,

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

tenderness to palpation of the medial and lateral retinaculum and medial and lateral joint lines, and a mildly positive Lachman test. Dr. Gold diagnosed status post arthroscopic ACL reconstruction of the right knee and chronic pain of the right knee. Referring to the sixth edition of the A.M.A., *Guides*, Table 16-3, page 510, he stated that appellant had a class 1, grade C impairment, which resulted in 10 percent permanent impairment of the right lower extremity due to her ACL injury. Dr. Gold found that there was no evidence of significant arthritis attributable to her injury and therefore found no impairment of her knee due to arthritis.

OWCP forwarded Dr. Gold's report to Dr. Manning, serving as DMA, on November 13, 2012. By letter dated November 14, 2012, Dr. Manning concurred with Dr. Gold's finding of 10 percent permanent impairment of the right lower extremity. He noted that ROM was not considered due to inconsistencies in various measurements, in accordance with the sixth edition of the A.M.A., *Guides*, page 517, section 16.3b. Dr. Manning noted that the date of MMI was January 25, 2012.

By letter dated November 16, 2012, OWCP informed appellant that it had been determined that she would be entitled to a schedule award for 10 percent permanent impairment of the right lower extremity. The period of the award would be for 28.80 weeks. OWCP noted that appellant was currently receiving compensation from OWCP for loss of wage-earning capacity (LWEC) and that she needed to approve an interruption of her compensation for LWEC as she could not receive benefits for temporary total or partial disability and a schedule award at the same time.

On November 20, 2012 appellant confirmed that she wished to receive her schedule award and understood that her LWEC compensation would be interrupted during the period of payment of the schedule award. OWCP thereafter paid her schedule award compensation from November 18, 2012 until June 1, 2013.

On January 27, 2016 OWCP referred appellant to Dr. James Schwartz, a Board-certified orthopedic surgeon, for a second opinion evaluation of appellant's accepted conditions and disability status. On March 1, 2016 Dr. Schwartz reviewed a SOAF and the medical record. On examination of the right knee, he noted an antalgic gait, limited ROM on extension, flexion to 90 degrees, and a positive anterior drawer test. Dr. Schwartz diagnosed ACL reconstruction with residual instability and right knee arthrofibrosis. He recommended additional right knee surgery.

On August 23, 2016 appellant underwent OWCP-approved right knee arthroscopy, excision of the medial plica, and chondroplasty of the medial femoral condyle performed by Dr. Wardell.

On December 6, 2016 Dr. Wardell examined appellant's right knee for complaints of continued pain. Physical examination of the right knee demonstrated marked pain over the anterior and medial joint lines and motion to 95 degrees with crepitus and pain. Referring to the sixth edition of the A.M.A., *Guides*, Dr. Wardell stated that appellant had a class 1, grade A impairment for primary knee osteoarthritis, which resulted in 5 percent impairment rating, and a class 2, grade C impairment for cruciate ligament injury, which resulted in a 16 percent impairment rating, under Table 16-3 of the A.M.A., *Guides*. He concluded that her total right lower extremity permanent impairment rating was 21 percent.

On December 15, 2016 appellant filed a Form CA-7 for an increased schedule award.

On March 7, 2017 OWCP referred the record, including an SOAF, to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a DMA, and requested that he evaluate appellant's permanent impairment under the sixth edition of the A.M.A., *Guides*. In a report dated March 9, 2017, Dr. Harris reviewed the medical record, including the February 19, 2016 report of Dr. Schwartz. He found that appellant's established diagnoses were status post right knee arthroscopy with arthroscopically-assisted ACL reconstruction, chondroplasty, and plica debridement; and status post manipulation under anesthesia with arthroscopic lysis of adhesions and excision of a cyclops lesion. Using the diagnosis-based impairment (DBI) method, the DMA found that under the sixth edition of the A.M.A., *Guides*, Table 16-3, page 510, appellant had a sole permanent impairment of 13 percent of the right lower extremity for residual problems status post arthroscopic surgery including ACL reconstruction with documented residual motion deficits. The DMA concluded that appellant had reached MMI as of Dr. Schwartz' examination of February 19, 2016.

By decision dated April 6, 2017, OWCP granted appellant a schedule award for 13 percent permanent impairment of the right lower extremity. The award ran from April 2 through December 20, 2017.[4]

On September 21, 2018 appellant again filed a Form CA-7 for an increased schedule award.

In a development letter dated October 5, 2018, OWCP informed appellant that no medical evidence had been received in support of her schedule award claim. It requested that she submit additional medical evidence from her treating physician including a date of MMI, the diagnosis on which the impairment was based, a detailed description of any permanent impairment preexisting the injury, and a final rating of the permanent impairment pursuant to the sixth edition of the A.M.A., *Guides*. OWCP afforded appellant at least 30 days to submit this additional evidence.

By letter dated October 22, 2018, Dr. Wardell noted that appellant's date of MMI was December 6, 2016. In an enclosed permanent impairment rating dated December 6, 2016, he stated that she had a class 1, grade A impairment for primary knee osteoarthritis, which resulted in 5 percent impairment rating, and a class 2, grade C impairment for cruciate ligament injury, which resulted in 16 percent impairment rating, under Table 16-3, pages 510-11, of the A.M.A., *Guides*. Dr. Wardell concluded that appellant's right lower extremity permanent impairment totaled 21 percent.

On December 18, 2018 OWCP referred the record, including an SOAF, to Dr. Harris, serving as DMA. It noted that appellant had been previously paid a schedule award for 10 percent permanent impairment of the right lower extremity based on Dr. Manning's November 14, 2012 report and an additional 13 percent based on Dr. Harris' March 14, 2017 report. OWCP indicated that the total amount of schedule award compensation appellant had received for permanent impairment of the right lower extremity was 23 percent. It requested that Dr. Harris evaluate appellant's permanent impairment under the sixth edition of the A.M.A., *Guides* and provide a date of MMI.

[4] The April 6, 2017 schedule award decision incorrectly identified the number of weeks of the schedule award as 262.08 weeks. A review of appellant's compensation history reveals that the period of payment of the schedule award was from April 2 through December 20, 2017.

In a report dated December 20, 2018, Dr. Harris reviewed the medical record, including the December 6, 2016 report and October 22, 2018 letter of Dr. Wardell. He found that the following diagnoses were established: status post right knee arthroscopy with arthroscopically-assisted ACL reconstruction, chondroplasty, and plica debridement; and status post manipulation under anesthesia with arthroscopic lysis of adhesions and excision of a cyclops lesion. Dr. Harris stated that there was insufficient information in the case file to make a determination of permanent impairment based on the sixth edition of the A.M.A., *Guides*. He explained that Dr. Wardell's reports of December 6, 2016 and October 22, 2018, did not document appellant's residual subjective complaints or objective findings on examination. Dr. Harris' report of December 6, 2016 discussed impairment for knee osteoarthritis, but there was no documentation of any reviewed diagnostic studies demonstrating retained joint space, which was a requirement for providing impairment for osteoarthritis based on the Knee Regional Grid, Table 16-3, page 509 of the sixth edition of the A.M.A., *Guides.* The DMA requested additional information from Dr. Wardell, or in the alternative, an examination by another physician.

Subsequently, OWCP requested additional information from Dr. Wardell on February 7, 2019. It included the comments of the DMA for his response. Dr. Wardell responded in a report dated March 11, 2019. He explained that appellant had a moderate problem with her right knee, resulting in a grade modifier of 2, regarding her functional history adjustment (GMFH) due to an antalgic limp under Table 16-6, page 516, of the sixth edition of the A.M.A., *Guides*. Dr. Wardell stated that she had a mild deficit in ROM which was a grade modifier of 1 for physical examination (GMPE) under Table 16-7. Appellant had moderate pathology in imaging studies, resulting in a grade modifier of 2 for clinical studies (GMCS). Dr. Wardell noted that her rating was based on her cruciate ligament injury, class of diagnosis (CDX), which was a class 2 moderate problem due to moderate laxity. He calculated that appellant's grade modifier adjustments resulted in a grade B, 15 percent permanent impairment of the right lower extremity.

On May 29, 2019 OWCP requested further review by Dr. Harris, serving as a DMA, with reference to Dr. Wardell's March 11, 2019 response. On July 1, 2019 the DMA stated that Dr. Wardell's March 11, 2019 report could not be used as the basis for an impairment rating, as it still did not contain documentation of appellant's residual subjective complaints, objective findings on examination, or complete explanation as to his impairment rating under the sixth edition of the A.M.A., *Guides.* He recommended that she be evaluated by another physician.

OWCP prepared a SOAF on August 14, 2019 which listed the accepted conditions as right knee sprain, lateral collateral ligament, right knee medial meniscus tear, right knee meniscus derangement, and osteoarthrosis of the right lower extremity.

On August 14, 2019 OWCP referred appellant to Dr. Willie E. Thompson, a Board-certified orthopedic surgeon, along with the medical record and a SOAF, for evaluation of her permanent impairment, date of MMI, and medical status. On September 11, 2019 Dr. Thompson reviewed the medical record and SOAF and conducted a physical examination. On examination of appellant's right lower extremity, he observed mild diffuse swelling beginning at the distal thigh level and extending to the right ankle and foot, limited motion at the knee, mild laxity of the ACL, and knee tenderness. Dr. Thompson noted that Dr. Wardell had reviewed a magnetic resonance imaging (MRI) scan dated April 1, 2010, of her right knee, which he indicated demonstrated a tear of the ACL. He noted that there was no evidence to support that appellant had a tear of medial meniscus, but that she did have a tear of the ACL. Dr. Thompson opined that the SOAF should include an ACL tear and should not include a medial meniscus tear. He further opined that

radiographs dated March 30, 2010 were within normal limits, and as such, the accepted condition of osteoarthritis should be "deleted" from the SOAF, as it related to the right knee. Dr. Thompson stated that appellant continued to suffer residuals of the injury of March 30, 2010 with subjective findings of persistent pain, a persistent limp, and evidence of laxity of the ACL. He noted that she was at maximum medical improvement as of August 26, 2017. Dr. Thompson rendered an impairment rating under the sixth edition of the A.M.A., *Guides*, referencing the Knee Regional Grid of Chapter 16-3, page 510. He opined that it should be rated as a class 1 with a GMPE of 1, resulting in a class C impairment. Dr. Thompson calculated that appellant's percentage of permanent impairment of the right lower extremity was 10 percent for mild laxity of the ACL.

On September 26, 2019 OWCP forwarded Dr. Thompson's report to Dr. Harris, serving as a DMA. In a report dated October 10, 2019, the DMA reviewed the SOAF and medical record, including Dr. Thompson's September 11, 2019 report. He found that the following diagnoses were established: status post right knee arthroscopy with arthroscopically-assisted ACL reconstruction, chondroplasty, and plica debridement; status post manipulation under anesthesia with arthroscopic lysis of adhesions and excision of a cyclops lesion; and status post right knee arthroscopic excision of medial plica and chondroplasty of the medial femoral condyle. Referring to Table 16-3, page 510 of the sixth edition A.M.A., *Guides*, Dr. Harris calculated that, under the DBI method, appellant had 10 percent permanent impairment of the right knee for ACL laxity. He found that her condition did not meet any of the criteria discussed in section 16.7, page 543 of the A.M.A., *Guides* for rating of permanent impairment due to loss of ROM. The DMA concurred with Dr. Thompson's impairment rating of 10 percent permanent impairment of the right lower extremity and found that the date of MMI was September 11, 2019.

By decision dated October 17, 2019, OWCP denied appellant's claim for an increased schedule award for permanent impairment of her right lower extremity. It noted that she had previously been paid a schedule award for 13 percent permanent impairment of the right lower extremity.[5]

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. 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.

[5] As noted above, appellant had previously been paid schedule awards for 10 percent permanent impairment of the right lower extremity from November 18, 2012 through June 1, 2013 and for 13 percent permanent impairment of the from April 2 through December 20, 2017.

[6] *Supra* note 1.

[7] 20 C.F.R. § 10.404.

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 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).[9] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by GMFH, GMPE, and GMCS.[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11] The standards for evaluation of permanent impairment of an extremity under the A.M.A., *Guides* are based on all factors that prevent a limb from functioning normally, such as pain, sensory deficit, and loss of strength.[12]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the percentage of permanent impairment using the A.M.A., *Guides*.[13]

ANALYSIS

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

OWCP had previously granted appellant schedule award compensation for a total 23 percent permanent impairment of the right lower extremity. On September 21, 2018 appellant filed a claim for an increased schedule award.

On July 1, 2019 the DMA stated that the March 11, 2019 report from Dr. Wardell, appellant's treating physician, could not be used as the basis for a permanent impairment rating, as it did not contain documentation of appellant's residual subjective complaints, objective findings on examination, or explanation as to his impairment rating under the sixth edition of the A.M.A., *Guides.*

OWCP prepared a SOAF on August 14, 2019 which listed the accepted conditions as right knee sprain, lateral collateral ligament, right knee medial meniscus tear, right knee meniscus derangement, and osteoarthrosis of the right lower extremity and referred appellant for a second opinion evaluation with Dr. Thompson. In a September 11, 2019 report, Dr. Thompson, conducted

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

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

[11] *Id*. at 521.

[12] *P.W.*, Docket No. 19-1493 (issued August 12, 2020); *C.H.*, Docket No. 17-1065 (issued December 14, 2017); *E.B.*, Docket No. 10-0670 (issued October 5, 2010); *Robert V. Disalvatore*, 54 ECAB 351 (2003); *Tammy L. Meehan*, 53 ECAB 229 (2001).

[13] *A.C.*, Docket No. 19-1333 (issued January 8, 2020); *B.B.*, Docket No. 18-0782 (issued January 11, 2019); *supra* note 8 at Chapter 2.808.6(f) (March 2017).

a physical examination of appellant's right lower extremity, in which he observed mild diffuse swelling beginning at the distal thigh level and extending to the right ankle and foot, limited motion at the knee, mild laxity of the ACL and knee tenderness. Dr. Thompson reviewed a magnetic resonance imaging (MRI) scan dated April 1, 2010, of her right knee, which demonstrated a tear of the ACL. Dr. Thompson noted that there was no evidence to support that appellant had a tear of medial meniscus, but that she did have a tear of the ACL. He opined that the SOAF should include an ACL tear and should not include a medial meniscus tear. Dr. Thompson further opined that radiographs dated March 30, 2010 were within normal limits, and as such, the accepted condition of osteoarthritis should be "deleted" from the SOAF, as it related to the right knee. Dr. Thompson stated that, under the diagnosis of ACL tear, appellant continued to suffer residuals of the injury of March 30, 2010, with subjective findings of persistent pain, a persistent limp, and evidence of laxity of the ACL. He noted that she was at MMI as of August 26, 2017.

Dr. Thompson rendered a permanent impairment rating under the sixth edition A.M.A., *Guides*, referencing the Knee Regional Grid of Chapter 16-3, page 510. He opined that it was a CDX 1 problem with a GMPE of 1, resulting in a class C impairment. Dr. Thompson calculated that appellant's percentage of permanent impairment of the right lower extremity was 10 percent for mild laxity of the ACL.

The Board finds that Dr. Thompson's opinion is of limited probative value as he provided opinions that were not in keeping with the statement of accepted facts.[14] OWCP provided Dr. Thompson with a statement of accepted facts to use as a frame of reference in forming his opinion. The statement of accepted facts made clear that OWCP had accepted appellant's claim for numerous conditions, including medial meniscus tear and osteoarthrosis of the right lower extremity. OWCP's procedures provide that, when the second opinion physician or impartial medical specialist does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is diminished or negated altogether.[15]

The Board notes that Dr. Thompson indicated in his reports that he did not accept all of the conditions listed in the SOAF as valid employment conditions. Dr. Thompson posited that he had reviewed appellant's April 2010 MRI scan and March 2010 x-rays, and that appellant did not have a medial meniscus tear or osteoarthritis of the right lower extremity; however, he offered no explanation as to why these conditions could not have developed subsequent to these 2010 diagnosis studies and be causally related to appellant's accepted employment injury. Given his failure to acknowledge all the accepted employment conditions without adequate explanation, Dr. Thompson's opinion regarding appellant's right lower extremity permanent impairment is of limited probative value.[16]

This case will be remanded to OWCP for referral of appellant and the case record to a new second opinion physician for examination and an opinion regarding appellant's permanent impairment under the relevant standards. After such further development as OWCP deems

[14] *D.B.*, Docket No. 17-1845 (issued February 16, 2018).

[15] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.600.3(10) (October 1990).

[16] *Supra* note 14.

necessary, a *de novo* decision shall be issued regarding the extent of appellant's right lower extremity permanent impairment.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the October 17, 2019 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: February 24, 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