United States Department of Labor
Employees' Compensation Appeals Board

R.K., Appellant	)	
and	)	**Docket No. 19-0247**
	)	**Issued: August 1, 2019**
DEPARTMENT OF HOMELAND SECURITY, CUSTOMS & BORDER PATROL, San Diego, CA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On November 1, 2018 appellant filed a timely appeal from a July 30, 2018 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.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 27 percent permanent impairment of his right lower extremity, for which he previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On July 28, 2003 appellant, then a 32-year-old customs and border patrol agent, filed a traumatic injury claim (Form CA-1) alleging that on July 27, 2003 he injured his right ankle when an all-terrain vehicle he was driving struck a rock and overturned while in the performance of duty. OWCP assigned that claim OWCP File No. xxxxxx819 and on August 28, 2003 accepted it for right ankle sprain. Appellant returned to full-duty work on September 30, 2003 and stopped work on January 30, 2004 to undergo right ankle arthroscopy due to instability, synovitis, and peroneal tendon tendinitis. He returned to full-time light-duty work on March 15, 2004 and full-time regular duty on April 26, 2004.

On October 15, 2004 appellant filed claim for a schedule award (Form CA-7). By decision dated December 9, 2004, OWCP granted him a schedule award for 12 percent permanent impairment of his right lower extremity due to right ankle pain and loss of motion impairment in accordance with the fifth edition of the American Medical Associations, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] Appellant had previously received a schedule award for 15 percent permanent impairment of his right lower extremity under a prior claim assigned OWCP File No. xxxxxxx015.[3]

On August 9, 2013 appellant filed a traumatic injury claim (Form CA-1) alleging that on August 9, 2013 he stepped awkwardly and twisted his right knee while in the performance of duty.[4] On August 15, 2013 he underwent a right knee magnetic resonance imaging (MRI) scan which demonstrated diffuse chondral loss, iliotibial band syndrome, and a small popliteal cyst. On September 18, 2013 OWCP accepted appellant's claim for sprain of the lateral collateral ligament of the right knee, chondromalacia patella, and other enthesopathy of the right knee. On October 10, 2013 appellant underwent right knee arthroscopy to repair his right knee chondral flap tear, osteoarthritis, and synovitis. He returned to full-duty work on December 3, 2013.

In a note dated January 13, 2014, appellant's attending physician, Dr. Robert M. Maywood, a Board-certified orthopedic surgeon, found that appellant had reached maximum medical improvement (MMI). In a narrative report of even date, he applied the sixth edition of the A.M.A., *Guides*[5] to his physical findings of continued right knee pain, full thickness chondral loss in the medial femoral condyle, tenderness to palpation along the medial joint line, patellofemoral crepitus, as well as normal strength and range of motion (ROM). Dr. Maywood determined that appellant had eight percent permanent impairment of the right lower extremity.

---

[2] A.M.A., *Guides*, (5th ed. 2000).

[3] In OWCP File No. xxxxxx015, OWCP accepted appellant's July 14, 1999 occupational disease claim for right great toe contusion and right knee lateral meniscus tear with patella chondromalacia. On August 31, 1999 appellant underwent right knee arthroscopy. He received a schedule award for 15 percent permanent impairment of his right lower extremity due to degenerative joint disease of the right knee.

[4] The present claim was assigned OWCP File No. xxxxxx062. OWCP File Nos. xxxxxx015, xxxxxx062, and xxxxxx819 have not been administratively combined.

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

On February 11, 2014 appellant filed a claim for an increased schedule award (Form CA-7). By decision dated February 27, 2014, OWCP denied his claim for an increased schedule award. It found that Dr. Maywood determined that appellant currently exhibited eight percent permanent impairment of his right lower extremity. OWCP determined that as he had previously received schedule awards totaling 27 percent permanent impairment of his right lower extremity, he was not entitled to an increased schedule award.

On May 18 and 26, 2016 Dr. Tal S. David, a Board-certified orthopedic surgeon, and Dr. Maywood examined appellant due to right knee pain. The physicians found focal medial joint line tenderness, crepitus, and joint effusion. Dr. Maywood diagnosed grade 3 to 4 chondromalacia and degenerative arthritis. Both physicians recommended a right total knee arthroplasty as appellant had failed anti-inflammatories, physical therapy, visco-supplementation injection, cortisone injections, brace use, and activity modification. On August 23, 2016 Dr. David performed a right total knee replacement. On January 31, 2017 he performed manipulation of appellant's right knee arthroplasty under anesthesia.

Appellant returned to full-time modified-duty work on April 16, 2017 and full duty on May 31, 2017.

In a May 31, 2017 report, Dr. Maywood found that appellant's right lower extremity was at MMI. He noted that appellant reported continued right knee pain and hamstring iliotibial band tightness. Dr. Maywood performed a physical examination and found mediolateral instability was 7 millimeters and that anteroposterior instability was 10 millimeters. He found that appellant's right knee demonstrated 120 degrees of flexion. Dr. Maywood evaluated appellant's right knee impairment in accordance with Table 16-3, page 511 of the A.M.A., *Guides*. He found that appellant had a fair result from his total knee replacement with mild instability and mild loss of ROM. Dr. Maywood noted that this was a class 3 impairment with grade C or 37 percent permanent impairment of the right lower extremity. He determined that appellant's grade modifier for functional history (GMFH) was mild, that his grade modifier for physical examination (GMPE) was moderate, and that his grade modifier for clinical studies (GMCS) was mild resulting in a net adjustment to grade A or 31 percent permanent impairment of the right lower extremity. On June 23, 2017 and January 3, 2018 appellant filed claims for an increased schedule award (Form CA-7).

In a note dated August 16, 2017, Dr. David reported that appellant had no change in his right knee condition and continued to describe intermittent pain.

On January 28, 2018 Dr. Eric M. Orestein, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), reviewed Dr. Maywood's report and the statement of accepted facts (SOAF). He disagreed with Dr. Maywood's finding that appellant had reached MMI as his examination occurred less than one year after the knee replacement surgery. The DMA recommended a second opinion evaluation.

In a March 21, 2018 note, Dr. David performed an impairment rating based on continued pain, antalgic gait, loss of ROM, and medial instability. He determined that appellant had 31 percent permanent impairment of the right lower extremity in accordance with Table 16-3, page

511 of the A.M.A., *Guides*. Dr. David opined that appellant had a class 3 impairment due to loss of motion and medial instability.

On April 23, 2018 OWCP referred appellant, a SOAF, and list of questions for a second opinion evaluation to Dr. Jon P. Kelly, a Board-certified orthopedic surgeon. In his May 8, 2018 report, Dr. Kelly noted that he was examining appellant's right lower extremity for schedule award purposes. He found that appellant's right total knee replacement was cemented in such a fashion as to create a slight valgus alignment. Dr. Kelly found that appellant's right knee flexion varied between 122 to 124 degrees when measured three times. On x-ray he found that appellant's right knee had five degrees of valgus. Dr. Kelly applied the sixth edition of the A.M.A., *Guides* and determined that, based on x-rays, appellant's arthroplasty was in a fair position with slight valgus. He noted that instability was not evident on clinical examination, but that appellant reported incidents of "giving way" of his right knee. Dr. Kelly also noted appellant's incomplete flexion, a mild motion deficit. He determined that appellant had class 3 impairment. Dr. Kelly found a GMFH of 1 due to episodic "giving way" of the right knee, a GMPE of 1 due to loss of flexion, and a GMCS of 2 due to tibial baseplate valgus position. He applied the net adjustment formula and determined that appellant had 31 percent permanent impairment of the right lower extremity.

On June 15, 2018 a DMA reviewed Dr. Kelly's findings and applied the sixth edition of the A.M.A., *Guides*. He noted that neither appellant's mild valgus alignment of 5 degrees nor his loss of flexion at 122 to 124 degrees were considered to be motion deficits or a fair positioning of the arthroplasty in accordance with Table 16 to 23, page 549 of the A.M.A., *Guides*. The DMA found that appellant had a good result for the right total knee replacement. He determined that appellant had grade 0 GMFH with no antalgic gait and that the GMCS was not applicable. The DMA completed the net adjustment formula and found 21 percent permanent impairment of the right lower extremity. In an addendum dated June 15, 2018, he noted that appellant had previously received schedule awards totaling 27 percent permanent impairment of the right lower extremity and therefore was not eligible for an increased schedule award.

By decision dated July 30, 2018, OWCP denied appellant's claim for an increased schedule award. It found that the DMA's determination of 21 percent permanent impairment of the right lower extremity was entitled to the weight of the medical evidence.

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. 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] For decisions issued after May 1, 2009, the sixth edition is used to calculate schedule awards.[9]

In addressing lower extremity impairments, the sixth edition requires identification of the impairment class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[11] Section 16.2a of the A.M.A., *Guides* provides that, if the class selected is defined by physical examination findings or clinical studies results, these same findings may not be used as grade modifiers to adjust the rating.[12]

The sixth edition of the A.M.A., *Guides* provides for a possibility that two conditions are present within a limb and that there could be multiple lower extremity impairments.[13] These impairments should be combined to reach the total lower extremity impairment. It is well established that benefits payable under 5 U.S.C. § 8107(c) are reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[14]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP DMA for an opinion concerning the nature and percentage of permanent impairment in accordance with the A.M.A., *Guides,* with the DMA providing rationale for the percentage of impairment specified.[15]

Section 8123(a) provides that, 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

[8] *Id.* at § 10.404(a).

[9] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 2017).

[10] A.M.A., *Guides* 521.

[11] *Id.* at 4, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement; *L.G.*, Docket No. 18-0519 (issued March 8, 2019); *W.S.*, Docket No. 16-1111 (issued March 14, 2017).

[12] A.M.A., *Guides* 500.

[13] *Id.* at 529.

[14] *See L.G., supra* note 11; *J.K.*, Docket No. 16-1361 (issued April 18, 2017); *J.S.*, Docket No. 15-1252 (issued January 19, 2016); *T.S.*, Docket No. 09-1308 (issued December 22, 2009); 20 C.F.R. § 10.404(d).

[15] *See supra* note 9 at Chapter 2.808.6(f) (March 2017).

third physician who shall make an examination.[16] The implementing regulations provides that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee or independent medical examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[17] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an independent medical examiner (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.[18]

ANALYSIS

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

In support of his schedule award claim, appellant submitted a May 31, 2017 report from Dr. Maywood finding that appellant had reached MMI and had 31 percent permanent impairment of his right lower extremity due to his total knee arthroplasty. On January 28, 2018 the case file and Dr. Maywood's report was routed to the DMA, who determined that as the impairment rating had been issued less than one year since appellant's August 23, 2016 surgery, it was likely that his right knee condition could continue to improve and that therefore he had not yet reached MMI on May 31, 2017. He recommended a second opinion evaluation.

On March 21, 2018 Dr. David provided an impairment rating based on continued pain, antalgic gait, loss of ROM, and medial instability. He determined that appellant had 31 percent permanent impairment of the right lower extremity. Dr. David attributed appellant's class 3 impairment due to loss of ROM and medial instability. He did not provide correlation of his findings with the A.M.A., *Guides* or indicate that he applied the grade modifiers in the net adjustment formula.

In a May 8, 2018 report, Dr. Kelly, the second opinion evaluator, found that appellant's right total knee replacement was cemented in such a fashion as to create a slight valgus alignment of five degrees. He further found that appellant's right knee flexion varied between 122 to 124 degrees when measured three times. Dr. Kelly applied the sixth edition of the A.M.A., *Guides*, and determined that appellant had class 3 impairment. He found a GMFH of 1 due to episodic "giving way" of the right knee, a GMPE of 1 due to loss of flexion, and a GMCS of 2 due to tibial baseplate valgus position. Dr. Kelly applied the net adjustment formula and determined that appellant had 31 percent permanent impairment of the right lower extremity.

On June 15, 2018 a DMA applied the sixth edition of the A.M.A., *Guides* to Dr. Kelly's findings. He noted that neither appellant's mild valgus alignment of 5 degrees nor his loss of flexion at 122 to 124 degrees were considered to be motion deficits or fair positioning of the

[16] 5 U.S.C. § 8123(a).

[17] 20 C.F.R. § 10.321.

[18] *L.C.*, Docket No. 18-1759 (issued June 26, 2019); *R.C.*, 58 ECAB 238 (2006).

arthroplasty in accordance with Table 16-23, page 549 contrary to Dr. Kelly's application of the A.M.A., *Guides*. The DMA concluded that appellant had a good result for the right total knee replacement, class 2 impairment, rather than the class 3 impairment due to a fair result found by Dr. Kelly. He explained that application of the net adjustment formula for a class 2 total knee replacement resulted in 21 percent impairment of the right lower extremity.

The Board finds that there is a conflict in the medical opinions between appellant's treating and second opinion physicians and the DMA as to the class of injury and the resultant extent of appellant's right lower extremity permanent impairment. As there is a conflict in the medical evidence as to the extent of disability, the case must be remanded to OWCP for referral to an IME for resolution of the conflict in accordance with 5 U.S.C. § 8123(a).[19]

The Board observes that, in an addendum dated June 15, 2018, the DMA noted that appellant had previously received schedule awards totaling 27 percent permanent impairment of the right lower extremity and therefore was not eligible for an increased schedule award. OWCP had previously accepted that appellant sustained right lower extremity permanent impairments of 15 percent permanent impairment of his right lower extremity due to degenerative joint disease of the right knee under OWCP File No. xxxxxx015, and 12 percent permanent impairment of his right lower extremity due to right ankle pain and loss of motion impairment under OWCP File No. xxxxxx819 for a total of 27 percent permanent impairment of his right lower extremity. The record currently before the Board does not contain the impairment rating medical reports contained under OWCP File No. xxxxxx015.[20]

The Board has previously held that simply comparing the prior percentage of permanent impairment awarded to the current impairment for the same member is not always sufficient to deny an increased schedule award claim.[21] The issue is not whether the current permanent impairment rating is greater than the prior impairment ratings, but whether it duplicates in whole or in part the prior impairment rating.[22]

The Board will therefore remand the case to OWCP for further development of the claim, including administratively combining the case files.[23] OWCP shall thereafter refer appellant, an updated SOAF, and all the applicable medical records to an IME to properly determine the extent of permanent impairment of the right lower extremity based on physical examination of her right knee. The IME shall use the proper tables and figures of the A.M.A., *Guides* and shall provide medical rationale as to the assignment of a class of diagnosis and grade modifiers. After such

[19] *See supra* note 15.

[20] Upon return of the case record OWCP shall administratively combine the present claim, which shall serve as the master file, with File Nos. xxxxxx015 and xxxxxx819. Pursuant to OWCP procedures cases should be doubled where correct adjudication depends on cross-referencing between files. *See supra* note 9 at Chapter 2.400.8(c)(2) (February 2000).

[21] *M.K.*, Docket No. 18-1614 (issued March 25, 2019); *T.S.*, Docket No. 16-1406 (issued August 9, 2017).

[22] *Id.*

[23] *See supra* note 20.

further development as OWCP deems necessary it shall fully consider appellant's prior schedule awards and 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 July 30, 2018 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: August 1, 2019
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board