United States Department of Labor
Employees' Compensation Appeals Board

R.R., Appellant	)	
and	)	**Docket No. 22-0525**
	)	**Issued: May 18, 2023**
U.S. POSTAL SERVICE, JACKSONVILLE MAIN OFFICE WALK UP POST OFFICE, Jacksonville, FL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On February 24, 2022 appellant filed a timely appeal from a September 17, 2021 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 September 17, 2021 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 his burden of proof to establish greater than seven percent permanent impairment of his left lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On November 11, 2019 appellant, then a 50-year-old tractor trailer operator, filed a traumatic injury claim (Form CA-1) alleging that on that date he injured his left knee when he stepped from the bottom step of his vehicle to the ground while in the performance of duty.

OWCP accepted the claim for left knee sprain, left knee meniscus tear, left knee effusion, and aggravation of left knee preexisting osteoarthritis. It paid appellant wage-loss compensation on the supplemental rolls as of December 27, 2019, and on the periodic rolls effective March 29, 2020.

A December 11, 2019 magnetic resonance imaging (MRI) scan of appellant's left knee read by Dr. Paul P. Byra, a Board-certified diagnostic radiologist, revealed a complex tear of the left knee body and posterior horn of the medial meniscus, large volume joint effusion, and tricompartmental articular cartilage abnormalities. Regarding the articular cartilage, Dr. Byra found a full-thickness cartilage defect along the central weight bearing surface of the medial femoral condyle measuring 13-11 millimeters; grade 1 chondromalacia along the lateral femoral condyle with superficial fissuring along the posterior weightbearing surface with a grade 1 chondromalacia along the lateral tibial plateau with focal deep fissuring posteriorly; a grade 4 chondromalacia lateral trochlear facet and central trochlea with grade 2 to 3 chondromalacia medial trochlear facet; and deep fissuring and small delaminating component at the patellar apex extending toward the lateral facet, grade 1 chondromalacia patella.

On February 18, 2020 appellant underwent OWCP-authorized left knee arthroscopy with partial medial meniscectomy, removal of loose body, limited synovectomy, and abrasion chondroplasty.

In a May 10, 2021 report, Dr. Aaron Bates, Board-certified in orthopedic sports medicine and orthopedic surgery, noted appellant's history of left knee pain, worsening secondary to osteoarthritis, and that appellant had been involved in a motor vehicle accident in February 2021. He noted that appellant had increased pain in the knee after the accident, but the pain was now back to baseline. Dr. Bates also noted that appellant denied using medication or a brace for the knee and "denied keeping up with strengthening exercises." On examination he found that appellant was tender over the anterolateral and lateral knee and had no instability and no crepitation, with a negative McMurray test. Dr. Bates provided one set of measurements for range of motion (ROM). He advised that appellant was status post left knee arthroscopy on February 18, 2020, with partial medial meniscectomy and removal of loose body, and now had worsening pain secondary to osteoarthritis. Dr. Bates diagnosed pain in the left knee and osteoarthritis in the left knee joint. He opined that appellant had reached maximum medical improvement (MMI) and noted appellant's permanent work restrictions.

On June 16, 2021 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a development letter dated June 24, 2021, OWCP advised appellant that additional medical evidence was necessary to support his schedule award claim. It requested that he submit a detailed narrative medical report from his treating physician based on a recent examination, setting forth an opinion on the date of MMI and a rating of permanent impairment in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3]

On June 24, 2021 OWCP routed the May 10, 2021 report from Dr. Bates, a statement of accepted facts (SOAF), and the case record to Dr. Jovito B. Estaris, a Board-certified internist serving as an OWCP district medical adviser (DMA), for review and rating of appellant's left lower extremity permanent impairment under the sixth edition of the A.M.A., *Guides*. OWCP asked Dr. Estaris to provide the date of appellant's MMI.

In a June 29, 2021 report, the DMA noted that appellant reached MMI on May 10, 2021, the date of the evaluation by Dr. Bates. He noted that appellant had findings of tenderness over the anterolateral and lateral knee, ROM from 5 to 120 degrees, no instability, no crepitation, and a negative McMurray test. Dr. Estaris also noted that the MRI scan of appellant's left knee showed a medial meniscus tear and full-thickness cartilage defect at the medial femoral condyle. The DMA referred to the A.M.A., *Guides*, Table 16-3, Knee Regional Grid -- Lower Extremity Impairments, at page 511, for the class of diagnosis (CDX) of left knee medial meniscus tear with primary osteoarthritis, and found a Class 1 impairment, with a default value of 7 for a full-thickness articular cartilage defect. Dr. Estaris referred to Table 16-6, Functional History Adjustment – Lower Extremities, at page 516, and selected a grade modifier for functional history (GMFH) of 1, for left knee pain with difficulty with kneeling and squatting. He referred to Table 16-7, Physical Examination Adjustment -- Lower Extremities, at page 517, and selected a grade modifier for physical examination (GMPE) of 1 for mild limitation of ROM of the left knee. The DMA noted the grade modifier for clinical studies (GMCS) was not used because the MRI scan showing a full-thickness cartilage defect was used in selecting the CDX. Dr. Estaris applied the Net Adjustment Formula and found (GMFH - CDX) + (GMPE - CDX) = (1 - 1) + (1 - 1) = 0, which resulted in no net adjustment. The DMA determined that appellant had a Class 1, grade C, impairment of his left knee which resulted in seven percent permanent impairment of the left lower extremity, according to the diagnosis-based impairment (DBI) method. Dr. Estaris also explained that he could not provide an impairment rating under the ROM method because Dr. Bates did not provide three independent sets of ROM measurements.

In an August 3, 2021 memorandum, OWCP related that a second opinion examination was needed and noted that, "if the *Guides* allow for the use of both the diagnosis-based impairment (DBI) and range of motion (ROM) methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating shall be used." It also noted that, "if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three (3)

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

independent measurements should be documented/recorded and the greatest ROM should be used for determination of the impairment."

On August 19, 2021 OWCP requested that Dr. Bates provide three sets of ROM measurements for the left knee.

In an August 27, 2021 memorandum of telephone call (Form CA-110), appellant advised OWCP that ROM measurements were "already done" and that he would resubmit the paperwork. OWCP received a copy of the measurements contained in the May 10, 2021 report from Dr. Bates.

On August 31, 2021 OWCP requested clarification from Dr. Estaris, the DMA.

OWCP received a September 3, 2021 report from Dr. Michael M. Katz, a Board-certified orthopedic surgeon and DMA, who practiced in the same medical office as Dr. Estaris. Dr. Katz explained that the case was forwarded to him as Dr. Estaris was no longer available for reviews. He explained that the DBI method was the preferred method for evaluating lower extremity impairments and that the ROM method was to be used as a stand-alone method for upper extremity impairments if grids referred to this section of the A.M.A., *Guides*, or for lower extremity impairments if no diagnosis was applicable for rating the condition. Dr. Katz further explained that appellant's loss of ROM of the left knee might justify a GMPE of 1 as a mild motion impairment under Table 16-7, however the point was moot as the objective findings on appellant's physical examination findings of tenderness over the anterolateral and lateral knee would also qualify under Table 16-7 as a GMPE of 1. He thereafter opined that another probative ROM measurement was not required to complete the impairment evaluation. Dr. Katz concurred with Dr. Estaris prior rating of seven percent permanent impairment of the left lower extremity.

By decision dated September 17, 2021, OWCP granted appellant a schedule award for seven percent permanent left lower extremity impairment (left leg), based on the impairment rating from Dr. Estaris, the DMA. The award ran for 20.16 weeks, from May 10 to September 28, 2021.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations 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.[4] 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[5] As of May 1, 2009, schedule awards are determined in

[4] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[5] 20 C.F.R. § 10.404; *see J.H.*, Docket No. 21-1215 (issued May 5, 2022); *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

accordance with the sixth edition of the A.M.A., *Guides* (2009).[6] 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 purpose.[7]

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 DBI methodology where impairment class is determined by the diagnosis and specific criteria as adjusted by the grade modifiers for functional history, physical examination, and clinical studies. It further provides that alternative approaches are also provided for calculating impairment for peripheral nerve deficits, complex regional pain syndrome, amputation, and range of motion. ROM is primarily used as a physical examination adjustment factor.[8] The A.M.A., *Guides*, however, also explain 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.[9]

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, the relevant portion of the leg for the present case, reference is made to Table 16-3, the Knee Regional Grid, beginning on page 509.[10] 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).[11] 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.[12]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed through an OWCP medical adviser for an opinion concerning the nature and

[6] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id*. at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

[7] *Isidoro Rivera*, 12 ECAB 348 (1961).

[8] A.M.A., *Guides* 497, Section 16.2.

[9] *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).

[10] *Id*. at 509-11.

[11] *Id*. at 515-22.

[12] *Id*. at 23-28.

extent of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.[13]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than seven percent permanent impairment of his left lower extremity, for which he previously received a schedule award.

In support of his claim for a schedule award, appellant submitted a May 10, 2021 report from Dr. Bates who noted appellant's history of left knee arthroscopy, and his physical examination findings. Dr. Bates diagnosed left knee pain and osteoarthritis of the left knee joint. He opined that appellant had reached MMI and provided permanent work restrictions. However, Dr. Bates did not provide a permanent impairment rating and, therefore, OWCP properly referred his report to the DMA for an impairment rating.

In a June 29, 2021 report, Dr. Estaris provided an impairment rating using the DBI method under the A.M.A., *Guides*. He noted appellant's diagnosis of left knee medial meniscus tear with primary osteoarthritis, referred to Table 16-3, the Knee Regional Grid, at page 511, and placed appellant in Class 1, with a default value of 7, for a full-thickness articular cartilage defect. Dr. Estaris also applied the grade modifiers, and found a GMFH of 1, under Table 16-6, Functional History Adjustment -- Lower Extremities, at page 516, for left knee pain with difficulty kneeling and squatting, and a GMPE of 1, under Table 16-7, Physical Examination Adjustment -- Lower Extremities, at page 517, for mild limitation of ROM of the left knee. He explained that the GMCS was not used because the MRI scan showing a full-thickness cartilage defect was used to determine the CDX. Dr. Estaris applied the Net Adjustment Formula and calculated, (GMFH - CDX) + (GMPE - CDX) = (1 - 1) + (1 - 1) = 0, which resulted in no net adjustment. As a result, appellant remained in Class 1, grade C, for seven percent permanent impairment of the left lower extremity. Dr. Estaris explained that he could not provide an impairment rating under the ROM method because the report from Dr. Bates did not contain three independent sets of ROM measurements.

On August 31, 2021 OWCP requested clarification from DMA Dr. Estaris with regard to the absence of a rating under the ROM method.

OWCP received a September 3, 2021 report from DMA Dr. Katz, as Dr. Estaris was no longer available. Dr. Katz properly explained that pursuant to the A.M.A., *Guides*, at page 497, a rating based on the ROM method was not required because ROM was not a stand-alone rating method for the lower extremities, unless no diagnosis was available for the rating. He also noted that appellant's loss of ROM would result in the same grade modifier as his other physical examination findings under Table 16-7 for the physical examination adjustment. Dr. Katz noted that Dr. Estaris assigned a GMPE of 1 under Table 16-7, based on minimal palpatory findings, consistently documented, without observable abnormalities, and therefore a ROM measurement

[13] *Supra* note 6 at Chapter 2.808.6f (March 2017).

was not required to complete the impairment recommendation.[14] He concurred with Dr. Estaris that appellant had seven percent permanent impairment of the left lower extremity.

The Board finds that Dr. Estaris and Dr. Katz, both serving as a DMA, explained with rationale how the A.M.A., *Guides* were applied to Dr. Bates' evaluation findings to determine that appellant sustained seven percent permanent impairment of the left lower extremity.

As the record contains no other probative, rationalized medical opinion that supports greater impairment of the left lower extremity based upon the A.M.A., *Guides*, the Board finds that appellant has not met his burden of proof.

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

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish greater than seven percent permanent impairment of his left lower extremity, for which he previously received a schedule award.

[14] A.M.A., *Guides* 497. The Board notes that section 16-2 of Chapter 16 of the A.M.A., *Guides*, pertaining to the lower extremities, provides that, "Range of motion is primarily used as a physical examination adjustment factor and is only used to determine actual impairment values when it is not possible to otherwise define impairment."

ORDER

IT IS HEREBY ORDERED THAT the September 17, 2021 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 18, 2023
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board