United States Department of Labor
Employees' Compensation Appeals Board

B.G., Appellant	)	
and	)	**Docket No. 24-0027**
	)	**Issued: April 26, 2024**
DEPARTMENT OF THE ARMY, TANK-AUTOMOTIVE AND ARMAMENTS COMMAND, ANNISTON ARMY DEPOT, Anniston, AL, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 15, 2023 appellant filed a timely appeal from an August 1, 2023 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 August 1, 2023 decision, appellant submitted additional evidence to OWCP. 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 the left lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On March 21, 2022 appellant, then a 59-year-old heavy mobile equipment mechanic, filed a traumatic injury claim (Form CA-1) alleging that on March 18, 2022 he sustained a left hip and knee injury when he slipped on water on the floor, causing him to twist his left hip and left knee while in the performance of duty. He did not stop work.

On July 18, 2022 OWCP accepted the claim for unspecified sprain of the left hip; sprain of unspecified site of the left knee; and other left knee meniscus derangements of the posterior horn of the medial meniscus.[3]

On August 17, 2022 Dr. Duane D. Tippets, a Board-certified orthopedic surgeon, performed an OWCP-approved left knee arthroscopy, partial medial meniscectomy, and chondroplasty of medial and patellofemoral compartments. Appellant stopped work on August 17, 2022 and returned to modified-duty work with restrictions, effective September 19, 2022.

In reports dated November 28 and December 15, 2022, Dr. Tippets discussed appellant's physical examination findings for the purposes of an evaluation of lower extremity permanent impairment. He noted appellant's diagnoses of left knee acute medial meniscal tear, other tear of medial meniscus, and left hip strain, and reported that appellant had permanent limitations as a result of his work-related injuries. Dr. Tippets provided a permanent impairment rating of appellant's left lower extremity utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] He utilized the diagnosis-based impairment (DBI) rating method to find that, under Table 16-3 (Knee Regional Grid), page 509, the class of diagnosis (CDX) for appellant's partial meniscectomy, necessitated by the accepted left meniscal injury, resulted in a Class 1 impairment with a default value of two percent. Dr. Tippets assigned a grade modifier for functional history (GMFH) of 1, a grade modifier for physical examination (GMPE) of 0, and a grade modifier for clinical studies (GMCS) of 1. He utilized the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (1 - 1) + (1 - 1) + (0 - 1) = -1, which resulted in a grade B or two percent permanent impairment of the left lower extremity. Dr. Tippets also utilized the DBI rating method to find that, under Table 16-4 (Hip Regional Grid), page 512, the CDX for appellant's left hip strain, with mild motion deficits, resulted in a Class 1 impairment with a default value of two percent. He assigned a GMFH of 1,

[3] On May 9, 2022 appellant underwent a magnetic resonance imaging (MRI) scan of the pelvis which revealed an impression of no acute fracture or dislocation and mild degenerative changes in both hips. On June 10, 2022 he underwent an MRI scan of the left knee which revealed an impression of moderate nonspecific joint effusion, chondral degenerative change of the lateral patella facet, and truncation posterior horn medial meniscus with oblique linear tear extending to the inferior articular surface.

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

a GMPE of 1, and a GMCS of 1. Dr. Tippets utilized the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (1 - 1) + (1 - 1) + (1 - 1) = 0, which resulted in a grade C or two percent permanent impairment of the left hip. He utilized the Combined Values Chart on page 606 to determine that appellant sustained a total of four percent permanent impairment of the left lower extremity.

Dr. Tippets then utilized the range of motion (ROM) methodology and applied Table 16-23, page 549, to find no ratable left knee impairment based on ROM loss of flexion and flexion contracture. He further applied Table 16-24 on page 549, and found that appellant's left hip ROM resulted in 15 percent permanent impairment. Dr. Tippets opined that appellant should receive the higher ROM rating amounting to 15 percent permanent impairment of the left lower extremity. He found that appellant's restrictions were permanent, which included no kneeling, crouching, crawling, stair climbing, and no lifting more than 15 pounds from the floor on an occasional basis.

On December 20, 2022 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a development letter dated December 28, 2022, OWCP requested that Dr. Tippets submit an impairment evaluation report in accordance with the sixth edition of the A.M.A., *Guides* and provide the date that appellant reached maximum medical improvement (MMI). It afforded him 30 days to submit the requested information.

On December 29, 2022 OWCP referred appellant, along with the case file, a statement of accepted facts (SOAF), and a series of questions to Dr. Tai Q. Chung, a Board-certified orthopedic surgeon, for a second opinion medical examination.

In a January 25, 2023 report, Dr. Chung noted his review of the medical evidence of record, discussed the history of injury, and documented the physical examination findings. He noted the work-related diagnoses of unspecified sprain of the left hip; sprain of unspecified site of the left knee; and other left knee meniscus derangements of the posterior horn of the medial meniscus. Dr. Chung opined that the sprain of the left hip and the sprain of unspecified site of the left knee had resolved. However, he opined that the other meniscus derangements of the posterior horn of the left knee medial meniscus had not resolved. Dr. Chung opined that the appearance on the January 14, 2023 MRI scan of the complex tear of appellant's medial meniscus was likely the result of his surgery, explaining that it probably was not a new tear but rather was due to disturbance of the local anatomy from the surgery. He opined that appellant had reached MMI with all diagnoses as he did not expect a change in symptoms in the short or medium term. Dr. Chung advised that appellant could return to work with restrictions and that he would require continued medical treatment. He concluded that the current level of disability was a direct result of the accepted work-related conditions.

In a development letter dated February 2, 2023, OWCP requested that Dr. Tippets review Dr. Chung's January 23, 2023 second opinion examination report and advise whether he agreed with the findings and opinions expressed. It afforded him 30 days to respond.

In a February 16, 2023 note, Dr. Tippets responded and reported that he was in complete agreement with Dr. Chung's assessment and findings.

In a March 1, 2023 report, Dr. Tippets opined that, based on the accepted diagnoses of left knee sprain with meniscal tear and left hip sprain, appellant reached MMI on September 21, 2022, which was six weeks following his left knee arthroscopy. He noted that appellant's left hip demonstrated unremarkable findings as evidenced on the May 9, 2022 MRI scan of the pelvis. Dr. Tippets reported that appellant underwent a functional capacity evaluation (FCE) for the purpose of rating lower extremity permanent impairment. He referred to his impairment rating from late-2022 and opined that appellant sustained 15 percent permanent impairment of the left lower extremity, based on the ROM method.

On March 7, 2023 OWCP requested that Dr. Herbert White, Jr., a physician Board-certified in occupational medicine, serving as an OWCP district medical adviser (DMA), review the case to determine whether appellant sustained permanent impairment of the left lower extremity and to identify a date of MMI.

In a March 10, 2023 report, Dr. White reported that he reviewed the reports of Dr. Tippets but was unable to rate the lower extremity impairment related to the left knee and left hip with the information provided in the record. He explained that appellant's history and physical examination findings, including gait findings, which were required to rate the GMPE and GMFH, had not been provided. Dr. White further requested ROM findings for both knees and hips, which were also needed to provide an impairment rating of the left lower extremity. He noted that, per the standards of section 16.7, page 543, of the A.M.A., *Guides*, the ROM impairment method was not applicable for appellant's lower extremity rating, despite having been applied by Dr. Tippets.

In April 6 and 12, 2023 development letters, OWCP requested that Dr. Tippets review Dr. White's March 10, 2023 report. It requested he provide the missing examination findings outlined in Dr. White's report and further requested that he provide an impairment rating in accordance with the sixth edition of the A.M.A., *Guides* and the date that appellant reached MMI. OWCP afforded him 30 days to submit the requested information.

In an April 14, 2023 addendum report, Dr. Tippets responded to OWCP's development letters and provided clarification of his impairment rating. He explained that to determine the GMFH for the DBI of the left knee, appellant completed a lower extremity function questionnaire and scored 10/80 or 12.5 percent, resulting in an assigned GMFH of 1. Dr. Tippets indicated that the best knee of three ROM measurements taken for each knee showed 0 degrees extension and 120 degrees flexion of the left knee, and 110 degrees flexion and -5 degrees extension of the right knee, amounting to no ratable left knee impairment based on ROM loss. He provided the best of three left hip ROM measurements of 100 degrees flexion, 0 degrees flexion contracture, 20 degrees internal rotation, 30 degrees external rotation, 50 degrees abduction, and 20 degrees adduction. Dr. Tippets reported the best of three right hip ROM measurements of 110 degrees flexion, 10 degrees flexion contracture, 30 degrees internal rotation, 50 degrees external rotation, and 20 degrees adduction. He concluded that the total lower extremity impairment using the DBI method was two percent permanent impairment related to the left knee and two percent permanent impairment related to the left hip for a combined four percent permanent impairment of the left lower extremity. Dr. Tippets concluded that ROM should be used as the rating method which amounted to 15 percent permanent impairment of the left lower extremity.

In a June 25, 2023 medical report, Dr. White utilized the DBI rating method to find that, under Table 16-3, the CDX for appellant's left partial meniscectomy, necessitated by the accepted left-sided meniscal injury, fell under a Class 1 impairment with a default value of two percent. He assigned a GMFH of 1 based on the American Academy of Orthopedic Surgeons (AAOS) lower limb questionnaire score and a GMPE of 0 based on normal motion. Dr. White excluded GMCS from the formula as it was used for class placement. He utilized the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) = (1 - 1) + (0 - 1) = -1 which resulted in a grade B or two percent permanent impairment of the left lower extremity. Dr. White noted that the ROM impairment method was not applicable in accordance with section 16.7, page 543 of the A.M.A., *Guides*.

Dr. White then utilized the DBI rating method to find that, under Table 16-4, the CDX for appellant's left hip strain, with moderate motion deficits, resulted in a Class 1 impairment with a default value of grade C or five percent impairment of the left lower extremity. He excluded GMFH as it was already used by the highest DBI in the extremity and GMPE from the net adjustment formula as it was used for class placement. Dr. White assigned a GMCS of 1 for mild degenerative changes amounting to (GMCS – CDX) = (1 – 1) = 0 which resulted in a grade C or five percent permanent impairment of the left lower extremity.

Dr. White agreed with Dr. Tippets' left knee DBI assessment for two percent permanent impairment of the left knee. He further explained that he obtained a higher DBI left hip impairment rating because Dr. Tippets rated the impairment based on a mild motion impairment whereas appellant showed a moderate motion impairment as indicated in his ROM measurements, amounting to the higher five percent rating. Dr. White disagreed with Dr. Tippets' assessment for 15 percent permanent impairment of the left lower extremity using the ROM method. He explained that the A.M.A., *Guides*, on page 543, indicated that the ROM evaluation method should be used as a stand-alone rating for lower extremity impairment evaluations only when there were no diagnosis-based sections that were applicable or in very rare cases where severe injuries resulted in a passive ROM loss. Dr. White contended that, since the DBI evaluation method did allow for use of appellant's knee and hip diagnoses, utilization of the ROM method was prohibited. Utilizing the Combined Values Chart, he combined the two percent impairment related to the left knee and the five percent impairment related to the left hip and determined that appellant sustained seven percent permanent impairment to the left lower extremity. Dr. White concluded that MMI was reached on November 28, 2022, the date of Dr. Tippets' evaluation.

By decision dated August 1, 2023, OWCP granted appellant a schedule award for seven percent permanent impairment of the left lower extremity. The award ran for 20.16 weeks from January 25 through June 15, 2023, and was based on Dr. Tippets' November 28 and December 15, 2022, March 1, 2023, and April 14, 2023 reports, and Dr. White's June 25, 2023 report.

LEGAL PRECEDENT

The schedule award provisions of FECA,[5] and its implementing federal regulations,[6] 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. 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.[7] 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.[8]

Chapter 16 of the sixth edition of the A.M.A., *Guides*, pertaining to the lower extremities, provides that DBI is the primary method of calculation for the lower limb and that most impairments are based on the DBI where impairment class is determined by the diagnosis and specific criteria as adjusted by a GMFH, a GMPE, and/or a GMCS. It further provides that alternative approaches are also provided for calculating impairment for peripheral nerve deficits, complex regional pain syndrome, amputation, and ROM. ROM is primarily used as a physical examination adjustment factor.[9] 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.[10]

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 knees and hips, reference is made to Table 16-3 (Knee Regional Grid) and Table 16-4 (Hip Regional Grid), respectively.[11] Under each table, after the CDX is determined and a default grade value is identified, the net adjustment formula is applied using the

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] 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 2.808.5a (March 2017); *see also id.* at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

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

[9] A.M.A., *Guides* 497, section 16.2.

[10] *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).

[11] *Id.* at 509-15.

GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX).[12] 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.[13]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a 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.[14]

ANALYSIS

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

In a report dated June 25, 2023, Dr. White utilized the DBI rating method to find that, under Table 16-3 (Knee Regional Grid) on page 509, the CDX for the left partial meniscectomy, necessitated by the accepted left knee meniscal injury, fell under a Class 1 impairment with a default value of two percent. He assigned a GMFH of 1 due to the AAOS lower limb questionnaire score and a GMPE of 0 based on normal motion. Dr. White excluded GMCS from the net adjustment formula as it was used for class placement. He utilized the net adjustment formula, (GMFH – CDX) + (GMPE – CDX) = (1 – 1) + (0 – 1) = -1, which resulted in a grade B or two percent permanent impairment of the left lower extremity related to knee deficits.

Second, Dr. White utilized the DBI rating method to find that, under Table 16-4 (Hip Regional Grid) on page 512, the CDX for appellant's accepted left hip strain, with moderate motion deficits, fell under a Class 1 impairment with a default value of grade C or five percent impairment of the left lower extremity. He excluded GMFH and GMPE from the net adjustment formula as GMPE was used for class placement and GMFH was already used by the highest DBI in the extremity. Dr. White assigned a GMCS of 1 for mild degenerative changes and applied the net adjustment formula, (GMCS - CDX) = (1 - 1) = 0, which resulted in a grade C value or five percent permanent impairment of the left lower extremity related to hip deficits. He noted that appellant's lower extremity conditions did not meet the criteria for applying the ROM impairment rating method.[15] Therefore, Dr. White utilized the Combined Values Chart on page 606 to determine that appellant's two percent impairment related to the left knee and five percent

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

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

[14] *See D.J.*, Docket No. 19-0352 (issued July 24, 2020).

[15] Table 16-3 and Table 16-4 do not provide for use of the ROM method to rate a claimant's lower extremity impairment. *See* A.M.A., *Guides* 509-15. *See also supra* notes 9 and 10.

impairment related to the left hip amounted to a total seven percent permanent impairment of the left lower extremity.[16]

The Board finds that the well-rationalized reports of Dr. White provided an opinion on appellant's lower extremity permanent impairment, which were derived in accordance with the standards of the sixth edition of the A.M.A., *Guides* and therefore, entitled to the weight of the evidence.[17] Dr. White's calculations, including the derivation of grade modifiers and the application of the net adjustment formula, properly applied the relevant standards to the physical examination and diagnostic testing results. As his report is detailed, well rationalized, and based on a proper factual background, Dr. White's opinion represents the weight of the medical evidence.[18]

As there is no medical evidence of record, in conformance with the A.M.A., *Guides*, establishing a greater percentage of permanent impairment than the seven percent permanent impairment of the left lower extremity previously awarded, the Board finds that appellant has not met his burden of proof.[19]

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 the left lower extremity, for which he previously received a schedule award.

[16] *L.B.*, Docket No. 22-1031 (issued April 6, 2023).

[17] *See N.B.* Docket No. 22-1295 (issued May 25, 2023); *Y.S.*, Docket No. 19-0218 (issued May 15, 2020); *R.D.*, Docket No. 17-0334 (issued June 19, 2018).

[18] *R.G.*, Docket No. 21-0491 (issued March 23, 2023).

[19] *See A.R.*, Docket No. 21-0346 (issued August 17, 2022).

ORDER

IT IS HEREBY ORDERED THAT the August 1, 2023 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 26, 2024
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