United States Department of Labor
Employees' Compensation Appeals Board

A.W., Appellant	)	
and	)	**Docket No. 13-621**
	)	**Issued: July 22, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Atlanta, GA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On January 24, 2013 appellant filed a timely appeal of a December 11, 2012 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 the case.

ISSUE

The issue is whether appellant sustained an additional permanent impairment of the right lower extremity.

FACTUAL HISTORY

On April 11, 2007 appellant, then a 53-year-old letter carrier, injured his right knee while in the performance of duty. OWCP accepted his traumatic injury claim for joint effusion and subsequently expanded it to include torn medial meniscus and authorized several surgeries.

[1] 5 U.S.C. § 8101 *et seq.*

Appellant underwent right partial medial and lateral meniscectomy and chondroplasty on July 18, 2007. By decision dated November 16, 2007, OWCP granted a schedule award for 10 percent permanent impairment of the right lower extremity for the period September 24, 2007 to April 12, 2008. Following repeat surgery on March 3, 2009, it expanded appellant's claim to include osteoarthritis.

Appellant underwent a right total knee replacement on July 28, 2009.[2] By decision dated June 16, 2010, OWCP granted an additional schedule award for 21 percent permanent impairment of the right lower extremity for the period June 12, 2010 to August 9, 2011.[3] Appellant was discharged to limited duty on September 24, 2010 but did not return to work.[4]

In a February 14, 2011 report, Dr. Howard B. Krone, a Board-certified orthopedic surgeon, examined appellant's right knee and observed mild swelling. X-rays showed excellent implant placement with no signs of loosening or abnormality. Citing the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[5] Dr. Krone stated that appellant sustained 37 percent permanent impairment of the right knee and reached maximum medical improvement. In a September 26, 2012 report, he reexamined appellant's right knee and observed mild swelling and instability during flexion. X-rays exhibited mild varus deformity of the tibial component. Regarding appellant's impairment rating, Dr. Krone commented that the determination was "subjective" to a degree.

Appellant filed a claim for an additional schedule award on October 3, 2012.

In an October 11, 2012 letter, OWCP asked Dr. Krone to render an impairment rating based on the sixth edition of the A.M.A., *Guides*.[6] In an October 24, 2012 report and November 21, 2012 addendum, Dr. Krone remarked that appellant sustained 15 percent permanent impairment of the right knee.[7] He cited "Example 16-11: [Status Post] Total Knee Replacement, With Apportionment" of the sixth edition.[8]

[2] The case record also indicates that appellant underwent closed manipulation of the right knee on December 1, 2009.

[3] OWCP noted that appellant sustained 31 percent permanent impairment of the right leg overall.

[4] Information was incorporated into the January 20, 2010 statement of accepted facts and March 23, 2011 addendum.

[5] *See infra* note 6.

[6] A.M.A., *Guides* (6th ed. 2008).

[7] Dr. Krone restated the objective findings contained in his earlier February 14, 2011 report.

[8] Example16-11 presents an anonymous 60-year-old female subject and, using her medical history, objective findings, and diagnosis, calculates a 15 percent impairment rating by identifying the appropriate impairment class (CDX) and modifying for Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS). The A.M.A., *Guides* does not indicate whether this data is fabricated or based on an actual patient. *See supra* note 6 at 527.

On November 21, 2012 Dr. Howard P. Hogshead, an OWCP medical adviser and Board-certified orthopedic surgeon, reviewed the medical file and disagreed with Dr. Krone's opinion. He specified that Dr. Krone did not provide sufficient rationale to support additional impairment.

By decision dated December 11, 2012, OWCP denied appellant's claim for an additional schedule award, finding the medical evidence insufficient to establish that he sustained more than 31 percent permanent impairment of the right leg.

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 of or loss of use of scheduled members or functions of the body.[9] 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. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[10]

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). For lower extremity impairments, the evaluator identifies the impairment class for the diagnosed condition, which is then adjusted by grade modifiers based on functional history, physical examination and clinical studies. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX). Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[11]

ANALYSIS

OWCP accepted that appellant sustained right knee joint effusion, torn medial meniscus, and osteoarthritis while in the performance of duty and granted schedule awards for 31 percent permanent impairment of the right lower extremity. Appellant filed a claim for an additional schedule award on October 3, 2012 and submitted a February 14, 2011 report from Dr. Krone, whose original impairment rating was erroneously based on the fifth edition of the A.M.A., *Guides*. OWCP subsequently directed Dr. Krone to apply the sixth edition.[12] In an October 24,

[9] 5 U.S.C. § 8107; 20 C.F.R. § 10.404. No schedule award is payable for a member, function or organ of the body not specified under FECA or the implementing regulations. *J.Q.*, 59 ECAB 366 (2008).

[10] *K.H.*, Docket No. 09-341 (issued December 30, 2011). For impairment ratings calculated on and after May 1, 2009, the sixth edition will be applied. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013). *See also B.M.*, Docket No. 09-2231 (issued May 14, 2010).

[11] *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[12] *See supra* note 10. An impairment rating that does not utilize the proper edition of the A.M.A., *Guides* is of diminished probative value. *A.B.*, Docket No. 10-2124 (issued August 10, 2011).

2012 report and a November 21, 2012 addendum, Dr. Krone concluded that appellant sustained 15 percent permanent impairment of the right knee. He referred to "Example 16-11: [Status Post] Total Knee Replacement, With Apportionment" on page 527 of the sixth edition. Dr. Hogshead, the medical adviser, disagreed with the new rating on the grounds that Dr. Krone did not provide sufficient rationale to support additional impairment.

The Board finds that appellant did not sustain an additional permanent impairment of the right lower extremity. According to OWCP procedures, an attending physician's impairment rating report must include a detailed description of the impairment and a rationalized opinion as to the percentage of permanent impairment under the A.M.A., *Guides*.[13] When the attending physician fails to provide a rating that conforms to the A.M.A., *Guides*, his or her opinion is of diminished probative value in establishing the degree of permanent impairment.[14] In this case, Dr. Krone did not utilize tables or grids to identify the impairment class for appellant's diagnosed condition and any relevant grade modifiers. In fact, he did not calculate an impairment rating. Instead, Dr. Krone adopted the rating found in the A.M.A., *Guides*' Example 16-11, the purpose of which is to illustrate the proper use of the diagnosis-based method of evaluation if a patient is status post total knee replacement. At no point did he relate the facts and circumstances of appellant's specific situation with the process described in Example 16-11. Thus, the rating that Dr. Krone derived cannot constitute a rationalized opinion as to the percentage of appellant's right lower extremity permanent impairment under the A.M.A., *Guides*.[15]

In the absence of other impairment rating reports that conform to the A.M.A., *Guides* and demonstrate greater impairment, the Board finds that appellant did not sustain more than 31 percent permanent impairment of the right leg overall. Appellant may request an 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 did not sustain an additional permanent impairment of the right lower extremity.

[13] Federal (FECA) Procedure Manual, *supra* note 10 at Chapter 2.808.5(b).

[14] *Linda Beale*, 57 ECAB 429, 434 (2006). *See also James Kennedy, Jr.*, 40 ECAB 620, 627 (1989).

[15] The Board further adds that Dr. Krone's own findings, namely mild right knee symptoms and normal x-rays, seemingly undermined his opinion in support of additional impairment. *See Robert P. Bourgeois*, 45 ECAB 745 (1994); *Kenneth J. Deerman*, 34 ECAB 641 (1983) (medical evidence must necessarily convince the adjudicator that the conclusion drawn is rational, sound and logical).

ORDER

IT IS HEREBY ORDERED THAT the December 11, 2012 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: July 22, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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