United States Department of Labor
Employees' Compensation Appeals Board

S.R., Appellant	)	
and	)	**Docket No. 14-46**
	)	**Issued: April 15, 2014**
DEPARTMENT OF LABOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, Boston, MA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

On October 15, 2013 appellant filed a timely appeal of a May 16, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] Pursuant to the Federal Employees' Compensation Act[2] (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 more than three percent impairment of the right lower extremity, for which she received a schedule award.

On appeal, appellant contends that there is a conflict in medical opinion between her attending physician, Dr. Frank Graf, a Board-certified orthopedic surgeon, and OWCP's medical adviser regarding the extent of impairment to her right knee.

[1] Appellant originally requested an oral argument before the Board, but withdrew her request on January 9, 2014.

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on August 12, 2010 appellant, then a 52-year-old claims examiner, sustained a medial meniscus tear, contusion of the right knee and an abrasion of the right leg when she fell forward while going up an escalator to report for duty. On November 5, 2010 she underwent an authorized right knee arthroscopic partial medial meniscectomy and chondroplasty of the medial femoral condyle performed by Dr. Peter D. Buckley, a Board-certified orthopedic surgeon,[3] whose operative report indicated that a magnetic resonance imaging (MRI) scan was positive for a medial meniscal tear. The patella showed some mild fraying, but no loose articular cartilage. There were no loose bodies in the medial or lateral gutter or the suprapatellar pouch. There was a complex posterior medial meniscal tear and a small area of chondromalacia changes about the lateral aspect of the medial femoral condyle. A partial medial meniscectomy was performed followed by chondroplasty of the medial femoral condyle. The anterior cruciate ligament and posterior cruciate ligament were intact. There was no evidence of lateral meniscal or chondral injury.

On October 7, 2011 appellant filed a claim for a schedule award. In a November 1, 2011 medical report, Dr. Graf provided a history of the accepted employment injuries and appellant's medical treatment. The pain was worse in the morning and evening with some slight improvement in the middle of the day. Pain was also noted with change of position from sitting to standing. Appellant rated her current pain as 5 on a scale of 0 to 10. Dr. Graft noted her complaints of pain, weakness and continued catching and locking in her left knee. He noted his review of the medical records and provided examination findings. Dr. Graf diagnosed persistent synovitis at the right knee with residuals of a twisting injury to the knee; horizontal cleavage tear of the medial meniscus; and chondromalacic changes post injury of the medial aspect of the medial femoral condyle. Appellant was status post debridement of the medial compartment and partial meniscectomy.

Dr. Graf advised that appellant's work-related right knee condition was permanent. He advised that in spite of her long-term prognosis, appellant was at a practical medical end point and permanency could be assessed. Dr. Graf stated that, however, there was a likelihood of slow progression over the coming years. He indicated that once the meniscus has been removed and the cartilage surface of the femoral condyle is altered with a separate chondral injury, a slowly progressive degenerative osteoarthritis will occur. Referencing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A. *Guides*), Table 16-3, page 511, Dr. Graf determined that appellant had class 1 primary knee arthritis with a documented full thickness articular cartilage and meniscal defect, resulting in a default rating of seven percent for the lower extremity. Applying the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS) - CDX), he determined that (1-1) + (2-1) + (2-1) = +2. Dr. Graf concluded that appellant had nine percent impairment of the right lower extremity.

On December 15, 2011 Dr. David O. Zimmerman, a Board-certified internist and OWCP medical adviser, reviewed the medical record. He determined that appellant reached maximum medical improvement on the date of Dr. Graf's examination. Dr. Zimmerman disagreed with

[3] Appellant stopped work on November 5, 2010 and returned to full-duty work on November 30, 2010.

Dr. Graf's impairment rating as the report noted that there were no loose bodies in the medial or lateral gutter or the suprapatellar pouch. The report indicated that the patella showed some mild fraying, but no loose articular cartilage. Dr. Zimmerman stated that Dr. Graf's opinion that the degeneration in the right knee would continue to worsen over time was statistically true, but an impairment rating for schedule award purposes could not be made on the likely progression of the underlying pathology. The impairment rating must be based on current signs, symptoms and diagnostic test findings. Since there was no grade 4 chondromalacia (ununited osteochondral fracture) and full thickness cartilage defects, an impairment rating could not be based on primary knee joint arthritis. Utilizing the operative report, Dr. Zimmerman stated that the impairment rating must be based on a partial medial meniscectomy resulting from a meniscal injury. He determined that a partial (medial or lateral) meniscectomy to repair a meniscal tear ranged from one to three percent impairment. Appellant fell under class 1 with a default value of C or two percent impairment. Dr. Zimmerman advised that the grade modifiers used by Dr. Graf would apply in exactly the same way for a partial meniscectomy, resulting in a default value of E or three percent impairment of the right lower extremity under the sixth edition of the A.M.A., *Guides*.

In a January 12, 2012 decision, OWCP granted appellant a schedule award for three percent impairment of the right lower extremity.

By letter dated February 9, 2012, appellant requested an oral hearing before an OWCP hearing representative. In a February 14, 2012 report, Dr. Graf disagreed with Dr. Zimmerman's statement that his impairment rating was based on likely progressive changes over time. His impairment rating was based on the review of arthroscopic photographs and Dr. Buckley's description of a chondroplasty to stable rim and base cartilage surface changes present at the medial femoral condyle. Dr. Graf noted that Dr. Zimmerman did not question the application of the grade modifier adjustment formula and he applied this modifier in the same way that it was utilized in his November 1, 2011 report. The difference in rating resulted from Dr. Zimmerman's placement of appellant's condition in a diagnosis other than class 1 primary knee arthritis. Dr. Graf stated that utilizing the diagnosis-based impairment method was fully justified as his November 1, 2011 report was based on the full criteria of her history and his examination, review of clinical studies and accurate interpretation of the operative report and clinical photographs. The grade modifiers applied were used correctly and the assignment of appellant to the appropriate diagnosis-based impairment class was performed accurately. Dr. Graf opined that there was no objective basis for Dr. Zimmerman's assignment of a lower impairment class.

In a July 23, 2012 decision, OWCP's hearing representative set aside the January 12, 2012 decision and remanded the case for OWCP to obtain a medical report from Dr. Buckley addressing the severity of appellant's chondromalacia (arthritis) of the knee based on his review of Dr. Zimmerman's December 15, 2011 report, Dr. Graf's November 1, 2011 and February 14, 2012 reports, the arthroscopic photographs and his own operative examination. OWCP was then instructed to refer Dr. Buckley's report to its medical adviser to determine a right lower extremity impairment rating. The hearing representative noted that it had not issued a decision regarding appellant's request to expand the acceptance of her claim to include

chondromalacia as work related. OWCP was instructed to conduct any necessary development and issue a decision regarding this matter.[4]

In an August 13, 2012 report, Dr. Buckley advised that appellant had grade 2 chondromalacia that was mild to moderate in severity.

On September 27, 2012 Dr. Zimmerman reviewed Dr. Buckley's August 13, 2012 report. He stated that the report reinforced his December 15, 2011 right leg impairment rating. Dr. Zimmerman cited to Table 16-3 and advised that Dr. Buckley's finding of grade 2 chondromalacia permitted no consideration of primary knee joint arthritis or patellofemoral arthritis under the diagnostic criteria (key factor). He stated that to consider primary knee joint arthritis or patellofemoral arthritis under the diagnostic criteria (key factor), the grade must be 4. Dr. Zimmerman concluded that Dr. Buckley's report had no impact on his December 15, 2011 impairment rating with a date of maximum medical improvement on November 1, 2011.

In an October 24, 2012 decision, OWCP found that appellant had no more than three percent impairment of the right lower extremity.

On October 19, 2012 appellant requested an oral hearing. A telephonic hearing was held on March 13, 2013 at which she testified.

In a March 18, 2013 report, Dr. Buckley noted appellant's complaint of right knee pain. X-rays were repeated which showed continued changes in the knee consistent with post-traumatic arthritis. Dr. Buckley advised that it was more probable than not that appellant's symptoms were directly related to her work-related injury.

In a May 16, 2013 decision, OWCP's hearing representative affirmed the October 24, 2012 schedule award decision. The hearing representative accorded determinative weight to Dr. Zimmerman's opinion that appellant had three percent impairment of the right leg based on the sixth edition of the A.M.A., *Guides*.

LEGAL PRECEDENT

The schedule award provision 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, functions and organs of the body. FECA, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[7] The A.M.A., *Guides* has been adopted by the implementing

[4] No decision on the expansion of the accepted condition is in the record.

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Ausbon N. Johnson*, 50 ECAB 304 (1999).

regulations as the appropriate standard for evaluating schedule losses.[8] Effective May 1, 2009, FECA adopted the sixth edition of the A.M.A., *Guides*[9] as the appropriate edition for all awards issued after that date.[10]

The sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser proving rationale for the percentage of impairment specified.[13]

ANALYSIS

OWCP accepted appellant's claim for medial meniscus tear and contusion of the right knee and abrasion of the right leg and authorized right knee partial medial meniscectomy and chrondoplasty medial femoral condyle. Appellant received a schedule award for three percent impairment of the right lower extremity. The Board finds that she did not meet her burden of proof to establish greater impairment.

In support of her claim for a schedule award, appellant provided a November 1, 2011 report from Dr. Graf who rated impairment for the right lower extremity based on primary knee joint arthritis. However, the Board notes that Dr. Graf referenced right lower extremity impairment under the A.M.A., *Guides*, but he did not provide a reasoned explanation as to how the extent of the arthritic condition had been established sufficient to warrant an increased schedule award. The record does not contain any diagnostic records contemporaneous to the work injury that demonstrate that appellant had joint arthritis prior to or subsequent to the August 12, 2010 work injury. As noted, the right knee MRI scan demonstrated a medial meniscal tear. Dr. Buckley's August 13, 2012 report found that appellant had grade 2 chondromalacia, which did not allow the impairment rating to be evaluated under the diagnostic criteria for arthritis. Dr. Zimmerman, OWCP's medical adviser, additionally reviewed the

[8] *Supra* note 5; *Mark A. Holloway*, 55 ECAB 321, 325 (2004).

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

[10] Federal (FECA) Procedure Manual, Part 3 -- Claims, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[11] A.M.A., *Guides* 494-531.

[12] *Id.* at 521.

[13] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

matter[14] and found no basis on which an impairment rating could be based on primary knee joint arthritis.

Dr. Zimmerman reviewed the reports from Drs. Graf and Buckley and found that appellant had three percent right lower extremity impairment based on her right knee partial medial meniscectomy. Utilizing the sixth edition of the A.M.A., *Guides*, he determined that a partial meniscectomy to repair a meniscal tear fell under the class with a default value of C or two percent.[15] Dr. Zimmerman applied the same grade modifiers set forth by Dr. Graf to the net adjustment formula, resulting in a default value of E or three percent impairment of the right lower extremity under the sixth edition of the A.M.A., *Guides*.[16] This impairment rating is consistent with the examination findings utilizing the A.M.A., *Guides*. The Board finds that the weight of the medical evidence rests with Dr. Zimmerman, who provided sufficient medical rationale for his conclusion that appellant, had no more than three percent impairment of the right lower extremity.

On appeal, appellant contended that a conflict in medical opinion arose between Dr. Graf and Dr. Zimmerman regarding the extent of impairment to her right knee. Although Dr. Graf found a nine percent impairment of the right lower extremity under the sixth edition of the A.M.A., *Guides*, the rating was based on a condition not verified by the surgical reports. Dr. Zimmerman properly applied the A.M.A., *Guides* and provided a detailed and well-rationalized medical opinion for rating three percent impairment of the right lower extremity.

Appellant may request a schedule award or 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 has no more than three percent impairment of the right lower extremity.

[14] *See supra* note 12.

[15] A.M.A., *Guides* Table 16-3, page 509.

[16] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the May 16, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 15, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board