

he slipped on the stairs at work. OWCP accepted his claim for left knee sprain and left knee medial meniscus tear. Appellant received wage-loss compensation benefits.

In a November 24, 2008 surgical report, Dr. W. Francis Kennard, a Board-certified orthopedic surgeon, stated that he performed a partial lateral meniscectomy to repair a tear of the lateral meniscus of appellant's left knee.

In office notes dated December 19, 2008 to May 22, 2009, Dr. Kennard stated that he saw appellant in follow up after surgery. He observed occasional pain and mild tenderness on the medial joint line, minimal swelling and moderate effusion. In the May 22, 2009 examination note, Dr. Kennard stated that appellant continued to have pain following the medial meniscus repair. He observed that the meniscal tear did not appear healed and recommended further surgery.

On February 24, 2009 OWCP referred appellant for a second opinion examination to determine whether he had disabling residuals as a result of his accepted September 19, 2008 work injury. In a March 17, 2009 report, Dr. Joseph Corona, a Board-certified orthopedic surgeon, reviewed appellant's history of injury and medical treatment. The operative report noted that appellant had a bucket-handle tear of the left lateral meniscus and underwent a lateral meniscectomy but pointed out that the magnetic resonance imaging (MRI) scan of the left knee and subsequent office notes by Dr. Kennard demonstrated that appellant suffered from left knee medial meniscus tear.² Dr. Corona opined that the November 24, 2008 operative note was a typographical error and that the bucket-handle tear involved the medial aspect of appellant's knee, not his lateral meniscus. He concluded that appellant underwent a medial meniscectomy of the left knee. Examination of the left knee revealed full range of motion, normal alignment, and stability in the anteroposterior and varus/valgus plane. Steinman's and McMurray's tests were equivocal and no lateral joint line tenderness was noted. Dr. Corona authorized appellant to return to full duty. Appellant returned to work full duty on March 28, 2009.³

On June 22, 2009 Dr. Kennard performed a partial medial meniscectomy to repair a tear of appellant's left knee medial meniscus. He stated that findings at the time of surgery revealed a nonhealed previously repaired medial meniscus of the left knee but the remainder of appellant's knee joint was within normal limits. Appellant stopped work and returned on August 17, 2009.

On April 16, 2010 appellant filed a claim for schedule award.

In a December 2, 2009 report, Dr. Nicholas Diamond, an osteopath, provided an accurate history of injury and reviewed appellant's medical treatment. He noted that appellant underwent

² In an October 1, 2008 MRI scan report, Dr. Celeste Yap, a Board-certified internist, evaluated appellant's knee for complaints of joint pain and a meniscal tear. She observed a complex tear involving the posterior horn and body of medial meniscus and an intact lateral meniscus. Dr. Yap diagnosed complex tear involving the posterior horn and body of medial meniscus, small joint effusion and strain of superficial fibers of medial collateral ligament.

³ On April 20, 2009 appellant filed a recurrence claim alleging that on April 13, 2009 he sustained a recurrence of the September 19, 2008 injury when he was unable to fulfill his work duties. He stopped work. On June 11, 2009 OWCP accepted appellant's recurrence claim.

a partial lateral meniscectomy on November 24, 2008 and a partial medial meniscectomy on June 22, 2009. Dr. Diamond related appellant's complaints of left knee pain and stiffness that were exacerbated by his mail carrier duties and household chores such as vacuuming, cleaning and shopping. Appellant also complained of difficulty going from a seated to standing position, climbing stairs, with repetitive bending, kneeling, squatting and prolonged driving. The Lower Extremity Activity Scale (LEAS) indicated an impairment level of 12/18 which equaled to 34 percent disability for the left lower extremity. On examination, Dr. Diamond observed ambulation with an intermittent right lower extremity limp and calcaneal and equinus gait. Examination of the left knee revealed portal arthroscopy scars, effusion, peripatellar tenderness and medial joint line tenderness. Crepitus was noted in the medial joint compartment but no crepitus was found in the lateral joint compartment. Range of motion of the flexion-extension was 0 to 125/140 degrees with pain. Manual muscle strength testing of the lower extremities revealed the quadriceps and gastrocnemius were graded at 5/5 on the right and 4/5 to 4+/5 on the left. Dr. Diamond diagnosed post-traumatic left knee complex tear of medial meniscus with medial collateral strain, status post left knee arthroscopy with arthroscopic partial medial meniscectomy, left knee retear of medial meniscus and status post left knee arthroscopy with arthroscopic partial medial meniscectomy.

Dr. Diamond attributed appellant's subjective and objective findings to the September 19, 2008 injury. Utilizing the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (6th ed. 2009) (hereinafter, A.M.A., *Guides*), he rated 13 percent impairment to the left leg. Dr. Diamond applied the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).⁴ He determined that appellant had class 1 left knee medial and lateral meniscectomy rated which was rated at 10.⁵ Dr. Diamond utilized grade modifiers based on Functional History (GMFH) of 1 based on the LEAS score.⁶ He utilized a grade modifier of 2 for Physical Examination (GMPE) based on the observed and palpatory findings.⁷ Dr. Diamond utilized a grade modifier of 2 for Clinical Studies (GMCS) based on the MRI scan, which utilized a net adjustment of 2.⁸ He determined that appellant had 13 percent impairment to the left lower extremity after net adjustment. Dr. Diamond concluded that appellant reached maximum medical improvement on December 2, 2009.

In an April 28, 2010 report, Dr. Henry J. Magliato, a Board-certified orthopedic surgeon and OWCP's medical adviser, reviewed Dr. Diamond's December 2, 2009 report and disagreed with his findings. Utilizing the A.M.A., *Guides*, he explained that Dr. Diamond classified class 1 under the Knee Regional Diagnostic Grid, Table 16-3⁹ and used left knee medial and lateral meniscectomy as the diagnosis which resulted in a default value of 10. Dr. Magliato contended

⁴ A.M.A., *Guides* 521.

⁵ *Id.* at 509.

⁶ *Id.* at 516.

⁷ *Id.* at 517.

⁸ *Id.* at 519.

⁹ *Id.* at 509.

that this value was incorrect because appellant underwent a medial meniscectomy, not a lateral meniscectomy, which resulted in a default value of 2.¹⁰ He explained that OWCP accepted appellant's claim for tear of the left knee medial meniscus and that only one medical report stated that appellant underwent a left knee lateral meniscectomy. The second opinion examiner, however, determined that this was a typographical error since the medical evidence did not support a diagnosis of lateral meniscus tear. Dr. Magliato utilized grade modifiers based on a functional history of 1 because of appellant's 34 percent LEAS score.¹¹ He utilized a grade modifier of 2 based on physical examination and clinical studies.¹² Dr. Magliato determined that a diagnosis class 1, default value of 2, with the net adjustment of +2 resulted in a class E or three percent impairment for the left lower extremity.

In a June 7, 2010 statement, appellant's attorney addressed appellant's September 19, 2008 work injury and noted that he underwent a partial lateral meniscectomy on November 24, 2008 and a partial medial meniscectomy of the left knee on June 22, 2009. He noted that Dr. Diamond's December 2, 2009 report supported a 13 percent left lower extremity impairment pursuant to the sixth edition of the A.M.A., *Guides*.

On June 28, 2010 OWCP granted a schedule award for a three percent impairment of the left lower extremity based on Dr. Magliato's district medical adviser report. It determined that the district medical adviser's opinion represented the weight of the medical evidence.

On July 6, 2010 appellant submitted a request for an oral hearing, which was held on November 8, 2010. The hearing representative pointed out that the file was unclear regarding whether appellant underwent a lateral or medial meniscectomy on November 24, 2008 because the district medical adviser believed the evidence only supported a medial meniscectomy. Appellant's counsel stated that the November 24, 2008 surgical report demonstrated that appellant underwent a partial lateral meniscectomy and a June 22, 2009 report supported that he underwent partial medial meniscectomy for the left knee. He resubmitted the November 24, 2008 surgical note, Dr. Corona's second opinion examination report and Dr. Diamond's December 2, 2009 report.

In a November 2, 2010 report, Dr. Diamond stated that he reviewed the medical adviser's report and Dr. Kennard's November 24, 2008 and June 22, 2009 surgical reports. He noted that Dr. Kennard performed a partial lateral meniscectomy on November 24, 2008 and a partial medial meniscectomy on June 22, 2009. Dr. Diamond concluded that appellant had 13 percent impairment of the left leg due to a class 1 left knee medial and lateral meniscectomy.

In November 11, 2010 letter, appellant's counsel reiterated that Dr. Kennard's November 24, 2008 operative report demonstrated that appellant underwent a partial lateral meniscectomy. Therefore, appellant had 13 percent impairment of his left leg according to Dr. Diamond's report. He resubmitted medical evidence previously of record.

¹⁰ *Id.*

¹¹ *Id.* at 516.

¹² *Id.* at 517, 519.

In a decision dated February 10, 2011, OWCP's hearing representative found that a conflict of medical opinion existed between Dr. Diamond and the district medical adviser regarding whether appellant underwent a lateral and/or medial meniscectomy.

In an April 14, 2011 letter, Dr. Kennard stated that there was an error in his prior dictation and indicated that appellant underwent two separate surgical procedures on the affected left knee. On November 24, 2008 he underwent a meniscal repair but because the repair did not work he underwent a second meniscectomy.

On May 5, 2011 OWCP referred appellant to Dr. Ian Fries, a Board-certified orthopedic surgeon, for an impartial medical examination. In a June 3, 2011 report, Dr. Fries accurately described appellant's September 18, 2008 work injury and noted that his claim was accepted for left knee sprain and medial meniscus tear. He reviewed appellant's medical records and noted that an October 1, 2008 MRI scan of the left knee showed small-to-moderate joint effusion, a complex tear involving the posterior horn and an intact lateral meniscus. Dr. Fries also pointed out that the November 24, 2008 surgical report listed a lateral meniscectomy but subsequent examination notes stated that appellant underwent a repair of the left medial meniscus. Appellant underwent another left knee arthroscopic surgery on June 22, 2009, which revealed that the previously repaired left knee medial meniscus had not healed. Dr. Fries noted that the only mention of lateral meniscal pathology was in the November 24, 2008 surgical note, which Dr. Kennard later acknowledged was dictated in error. He also pointed out that the MRI scan findings and multiple postoperative follow-up notes clearly established that the November 24, 2008 surgery was restricted to a medial meniscal repair, which failed and resulted in the June 22, 2009 partial medial meniscectomy. Dr. Fries stated that a normal lateral compartment was specifically documented and that the lateral meniscus never required a resection or repair. He concluded that appellant did not undergo a lateral meniscectomy on November 24, 2008.

Dr. Fries noted appellant's complaints of constant pain pointing to a band paralleling the left knee medial joint line and mild tingling and numbness occasionally while sitting for a long period of time. Upon examination, he observed mild varus of both knees and minor fullness of the left knee medial and lateral to the patellar tendon. Steinmann's, McMurray's, Lachman's and Bounce tests were negative bilaterally. Dr. Fries also noted acute tenderness over the mid portion of the medial joint line reproducibly and some tenderness slightly distal to the medial joint line. Appellant confirmed that his pain always involved the medial knee, but never the lateral knee. X-rays of the left knee demonstrated normal alignment of both knees and no evidence of joint space narrowing. Dr. Fries opined that appellant reached maximum medical improvement on September 11, 2009 when Dr. Kennard allowed him to resume regular activities. Utilizing the sixth edition of the A.M.A., *Guides* he determined that appellant had a class 1 meniscal injury and partial medial meniscectomy, which was equivalent to two percent.¹³ He used grade modifiers based on functional history of 1 for appellant's score of 14 on the Lower Limb Questionnaire and score of 55 on the Pain Disability Questionnaire.¹⁴ Dr. Fries utilized a grade modifier of 0 based on clinical studies finding no relevant findings.¹⁵ He utilized

¹³ A.M.A., *Guides* 509.

¹⁴ *Id.* at 515.

¹⁵ *Id.*

grade modifiers of 1 based on physical examination because of the minimal palpatory findings and mild misalignment.¹⁶ Dr. Weiss determined that appellant had two percent impairment of the left lower extremity after net adjustment.

In a June 21, 2011 report, Dr. Andrew A. Merola, a Board-certified orthopedic surgeon and an OWCP medical adviser, noted appellant's history and agreed with Dr. Fries' June 3, 2011 report. He utilized the A.M.A., *Guides* and determined that appellant was a class 1 based on a meniscal injury and partial medial meniscectomy.¹⁷ Using the grade modifiers of functional history, physical examination and clinical studies, Dr. Merola found a net adjustment of -1, which was a grade B rating of two percent lower extremity impairment. He stated that the date of maximum medical improvement was June 3, 2011, which was the date of Dr. Fries' medical examination.

In a June 27, 2011 letter, appellant's counsel again contended that appellant should be awarded 13 percent left lower extremity impairment and that the record established that he underwent a partial lateral meniscectomy on November 24, 2008.

In a decision dated July 28, 2011 and reissued on August 15, 2011, OWCP denied appellant's claim for additional schedule award. It found that the impartial medical examiner properly applied the A.M.A., *Guides* to find that appellant sustained a two percent left leg impairment. Since appellant was previously awarded three percent permanent impairment, OWCP determined that the medical evidence did not support an increase in the impairment already compensated.¹⁸

LEGAL PRECEDENT

The schedule award provision of FECA¹⁹ and its implementing federal regulations²⁰ 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 the A.M.A., *Guides* as the uniform standard applicable to all claimants.²¹ As of May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used to calculate schedule awards.²²

¹⁶ *Id.* at 517.

¹⁷ *Id.* at 509.

¹⁸ OWCP also determined appellant did not suffer from a lateral meniscus tear nor received treatment for this condition.

¹⁹ 5 U.S.C. § 8107.

²⁰ 20 C.F.R. § 10.404.

²¹ *Id.* at § 10.404.

²² FECA Bulletin No. 09-03 (issued March 15, 2009); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

In addressing lower extremity impairments, the sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on functional history, physical examination and clinical studies.²³ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).²⁴

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 providing rationale for the percentage of impairment specified.²⁵ In determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.²⁶

If there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.²⁷ In cases where OWCP has referred appellant to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.²⁸

ANALYSIS

Appellant's claim was accepted for left knee sprain and medial meniscus tear. On April 16, 2010 he filed a claim for a schedule award. In a December 2, 2009 report, Dr. Diamond determined that appellant had a 13 percent impairment of the left lower extremity, stating that the record established a torn lateral meniscus. In the April 28, 2010 district medical adviser report, Dr. Magliato disagreed with Dr. Diamond's rating and found that appellant only underwent a medial meniscectomy, not a lateral meniscectomy, which resulted in three percent impairment. On June 28, 2010 appellant was granted a schedule award for three percent impairment of the left lower extremity.

In a decision dated February 10, 2011, an OWCP hearing representative found that a conflict of medical opinion arose between Dr. Diamond and the district medical adviser regarding the extent of appellant's left lower extremity impairment and whether he was treated for a medial meniscus tear or a lateral meniscus tear. It remanded the case for a referee medical examiner to resolve. By decision dated August 15, 2011, OWCP determined that appellant was not entitled to greater than three percent left lower extremity impairment based on Dr. Fries'

²³ A.M.A., *Guides* 494-531; see *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

²⁴ A.M.A., *Guides* 521.

²⁵ See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

²⁶ *Peter C. Belkind*, 56 ECAB 580 (2005).

²⁷ 5 U.S.C. § 8123(a); see *R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

²⁸ *B.P.*, Docket No. 08-1457 (issued February 2, 2009); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

June 3, 2011 impartial medical examiner report. The Board finds that appellant did not meet his burden of proof to establish that he sustained greater impairment.

In a June 3, 2011 report, Dr. Fries observed acute tenderness over the mid portion of the medial joint line and some tenderness slightly distal to the medial joint line. Steinmann's, McMurray's, Lachman's and Bounce tests were negative bilaterally. X-rays of the left knee demonstrated normal alignment of both knees and no evidence of joint space narrowing. Utilizing the sixth edition of the A.M.A., *Guides*, Dr. Fries concluded that appellant had two percent impairment of the left lower extremity due to meniscal injury and partial medial meniscectomy. Table 16-3 of the sixth edition of the A.M.A., *Guides*, Knee Regional Grid, provides classes to be used in rating knee impairments.²⁹ The sixth edition also provides grade modifiers based on functional history, physical examination and clinical studies to use as a net adjustment after identifying the impairment class for the diagnosed condition.³⁰ Dr. Fries determined that appellant had a class 1 meniscal injury and partial medial meniscectomy which resulted in a default value of 2 based on Table 16-3, Knee Regional Grid.³¹ He used grade modifiers based on Table 16-6, Functional History Adjustment -- Lower Extremities and assigned grade modifier 1 for appellant's score of 14 on the Lower Limb Questionnaire and score of 55 on the Pain Disability Questionnaire.³² Dr. Fries referred to section 16-8, Clinical Studies Adjustment -- Lower Extremities and assigned a grade modifier of 0 based on relevant findings.³³ He utilized grade modifiers based on section 16-7, Physical Examination Adjustment -- Lower Extremities and assigned an adjustment of 1 because of the minimal palpatory findings and mild misalignment.³⁴ Dr. Fries determined that the net adjustment compared to default value 2 was -1, which warranted a grade B and translated into two percent lower extremity impairment.

The Board finds that Dr. Fries' opinion is sufficiently well rationalized and based upon a proper factual and medical background. He fully discussed the history of injury and related his comprehensive examination findings in support of his opinion that appellant did not have greater than three percent impairment of the left lower extremity. The weight of the medical opinion is determined by the opportunity for and thoroughness of examination, the accuracy and completeness of physician's knowledge of the facts of the case, the medical history provided the care of analysis manifested and the medical rationale expressed in support of stated conclusions.³⁵ Dr. Fries thoroughly reviewed appellant's history and provided findings on examinations. He sufficiently explained how those findings translated to his impairment rating. Thus, Dr. Fries' report represents the special weight of the medical evidence.

²⁹ A.M.A., *Guides* 509.

³⁰ *Id.* at 521.

³¹ A.M.A., *Guides* 509.

³² *Id.* at 516.

³³ *Id.* at 519.

³⁴ *Id.* at 517.

³⁵ See *Ann C. Leanza*, 48 ECAB 115 (1996).

Dr. Merola, an OWCP medical adviser, agreed with Dr. Fries' impairment rating. He opined that the date of maximum medical improvement was June 3, 2011, which was the date of Dr. Fries' medical examinations. Since appellant was previously awarded three percent permanent impairment, the medical evidence did not support a greater impairment. The Board finds that OWCP properly determined that the medical evidence did not support an increase in the impairment already compensated.

On appeal, appellant's counsel contends that appellant should be granted 13 percent lower extremity impairment based on Dr. Diamond's December 2, 2009 report. The Board finds, however, that Dr. Diamond based his impairment rating on an inaccurate medical history. He determined that appellant had a diagnosis of class 1 for left knee medial and lateral meniscectomy, which resulted in a default value of 10.³⁶ The Board finds, however, that the record establishes that appellant underwent two medial meniscectomy repair surgeries and not a lateral meniscectomy. The only medical evidence supporting that appellant underwent a partial lateral meniscectomy is Dr. Kennard's November 24, 2008 operative report. But Dr. Kennard provided numerous examination notes from December 2008 to May 2009 stating that he treated appellant in follow up for repair of a torn left knee medial meniscus. He stated in an April 14, 2011 letter that appellant underwent a meniscal repair on November 24, 2008 and needed a second medial meniscectomy because the previous surgery did not work. Drs. Corona and Fries also determined that the evidence established that appellant only suffered from a medial meniscus tear and underwent a medial meniscectomy, but not a lateral meniscectomy.

The record does not contain any medical evidence that establishes greater impairment in accordance with the sixth edition of the A.M.A., *Guides*. The Board finds that appellant has not established more than three percent impairment of the left 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 failed to establish that he has more than three percent left lower extremity impairment, for which he received a schedule award.³⁷

³⁶ *Id.* at 509.

³⁷ The Board notes that appellant submitted additional evidence following the August 15, 2011 decision. Since the Board's jurisdiction is limited to evidence that was before OWCP at the time it issued its final decision, the Board may not consider this evidence for the first time on appeal. See 20 C.F.R. § 501.2(c); *Sandra D. Pruitt*, 57 ECAB 126 (2005). Appellant may submit that evidence to OWCP along with a request for reconsideration.

ORDER

IT IS HEREBY ORDERED THAT the August 15, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 24, 2012
Washington, DC

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

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

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