

FACTUAL HISTORY

On June 6, 2011 OWCP accepted that appellant, a 50-year-old letter carrier, sustained an aggravation of articular cartilage wear on the right medial femoral condyle due to her repetitive work duties. It authorized arthroscopic right knee surgery performed on June 10, 2011 by Dr. Nathan K. Endres, a Board-certified orthopedic surgeon, to treat appellant's right knee pain and right knee medial meniscus tear.²

On September 3, 2013 appellant filed a claim for a schedule award.

By letter dated September 16, 2013, OWCP requested that Dr. Jason T. Gramling, an attending Board-certified internist, provide an opinion on whether appellant had any impairment of the right lower extremity in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).³ On September 25, 2013 OWCP was advised by Dr. Gramling's office that he did not perform disability impairment determinations.

By letter dated October 11, 2013, appellant informed OWCP that she had scheduled an impairment evaluation on November 6, 2013. Subsequently, she submitted a November 6, 2013 medical report from Dr. Philip J. Davignon, a family practitioner. Dr. Davignon reviewed appellant's medical records and provided a history of her injury, her medical treatment, and her occupational and family background. Upon examination he found that she had normal pain based on a pain drawing she completed as well as the results of her Beck Depression Inventory. Dr. Davignon noted that she had a disability score of 36 percent based on a pain disability index.

On physical examination, Dr. Davignon reported that appellant sat comfortably in no acute distress without splints or assistive devices. Thigh and calf circumferences were symmetric. Reflexes were symmetric at the knees and ankles. There was no effusion over either knee. There was crepitation over the right knee with range of motion. Motor strength was 5/5 in the lower extremities in all muscle groups. A sensory examination was intact to pinprick in all dermatomes of the lower extremities. A vascular examination revealed skin that was warm and pink with good peripheral pulses and good capillary refill. Range of motion testing of the right knee revealed 0 degrees of extension and 110 degrees of flexion. Range of motion testing of the left knee revealed 0 degrees of extension and 130 degrees of flexion. Anterior drawer testing and Lachman's testing were negative bilaterally. There was no instability to varus or valgus stress. Gait was antalgic with shortened stance on the right side.

In his narrative report, Dr. Davignon provided a history of right knee injury and status post right knee arthroscopy, chondroplasty patella trochlea, and medial femoral condyle performed on June 10, 2011. He opined that appellant's right knee symptoms were causally related to the injury of record. Dr. Davignon advised that she had reached a medical end result and agreed with Dr. Endres' finding that her symptoms were due to chondral damage rather than

² Appellant did not return to work following her right knee surgery. In September 2012 she began work as a substitute teacher.

³ A.M.A., *Guides* (2009).

meniscal pathology. Utilizing Chapter 16, Table 16-23, he utilized the formula (Functional History) GMFH-CDX + (Physical Examination) GMPE-CDX + (Clinical Studies) GMCS-CDX when the Class of Diagnosis (CDX) or condition diagnosed (chondral damage) was 1, GMFH = 1, GMPE = 1 and GMCS = 3. Therefore he found two percent grade modifiers for a nine percent permanent impairment of the right lower extremity.

Alternatively, Dr. Davignon calculated appellant's right lower extremity impairment under the range of motion method. He determined that her knee range of motion was mild or 10 percent impairment under Table 16-23 which was consistent with a class 1 impairment under Table 16-25. Dr. Davignon noted that the A.M.A., *Guides* provided that, if there were two or more methods to calculate impairment, the method providing the higher impairment should be adopted. Dr. Davignon, therefore, concluded that appellant had 10 percent impairment of the right lower extremity.

In a February 24, 2014 report, Dr. Morley Slutsky, Board-certified in occupational medicine and an OWCP medical adviser, reviewed the medical record and Dr. Davignon's November 6, 2013 findings. He determined that appellant had nine percent impairment of the right lower extremity according to the diagnosis-based method and advised that maximum medical improvement was reached on January 5, 2012, the date of an evaluation performed by Dr. Mark Kircher, a Board-certified orthopedic surgeon and an OWCP referral physician.⁴ Dr. Slutsky noted that his nine percent right lower extremity impairment rating was the same impairment rating assigned by Dr. Davignon for cartilage damage in the right knee. He noted that Dr. Davignon improperly calculated the range of motion measurements under Table 16-23. Dr. Slutsky advised that 110 degrees of flexion resulted in 0 percent impairment not 10 percent and 0 degrees of extension resulted in 0 percent impairment under Table 16-23, page 549 of the A.M.A., *Guides*. Utilizing Table 16-25, page 550, for zero percent impairment the class is zero or zero percent impairment.

Dr. Slutsky noted appellant's postoperative diagnoses and advised that his impairment calculations were based on the diagnosis of primary knee joint degenerative disease with full thickness articular cartilage defect. He referred to Table 16-3, pages 509-11 and determined that appellant had class 1 impairment for her diagnosis. Utilizing Table 16-6, page 516, Dr. Slutsky assigned a grade modifier 1 for functional history as she still had symptoms in the knee joint. He noted that Dr. Davignon's report did not document an antalgic gait requiring appellant's use of a single gait aid or external orthotic device for stabilization which would have increased the grade modifier. There was also no documentation of a positive Trendelenburg. Dr. Slutsky referred to Table 16-7, page 517 and assigned a grade modifier of 1 for physical examination findings of crepitation to palpation.

Utilizing Table 16-8, page 519, Dr. Slutsky assigned a grade modifier of 3 for clinical studies. He noted that right knee x-rays performed on February 20, 2012 and compared with an April 23, 2010 test demonstrated moderate joint space narrowing seen on the medial femorotibial

⁴ In his January 5, 2012 report, Dr. Kircher had advised that appellant continued to suffer from residuals of her accepted employment-related degenerative chondral cartilage changes in the right knee and that she was unable to return to her letter carrier position. He recommended that she undergo a functional capacity evaluation to determine her work limitations.

compartment which was evidence of subchondral sclerosis and osteophyte formation. The joint space on the lateral femorotibial compartment appeared preserved. Marginal osteophyte formation seen on the periphery of the lateral tibial plateau. There was spurring of the tibial spines and on ossific density projected in the posteromedial aspect of the joint on these two views concerning an intra-articular body. Soft tissues were otherwise grossly unremarkable. Mineralization was age appropriate. The overall degree of osteoarthritis on the right knee had progressed in the interval, particularly in the medial compartment.

Dr. Slutsky referred to an April 23, 2012 report of Dr. David A. Halsey, a Board-certified orthopedic surgeon, when, after reviewing x-rays of the right knee, it demonstrated Kellgren-Lawrence grade 2 to 3 changes in the medial tibiofemoral compartment and patellofemoral compartment, grade 3 changes in the medial tibiofemoral compartments and patellofemoral compartment, and grade 2 changes in the lateral tibiofemoral compartment which were severe. He applied the net adjustment formula to find a grade modifier of 2, which moved appellant from default grade C to grade E for nine percent right lower extremity impairment.

By letter dated April 28, 2014, OWCP asked Dr. Davignon to review Dr. Slutsky's February 24, 2014 report and provide his comments. He did not respond.

In letters dated May 14 and 22, and June 17, 2014, counsel requested that OWCP grant appellant a schedule award for 10 percent impairment of the right lower extremity impairment consistent with Dr. Davignon's opinion.

In a July 1, 2014 decision, OWCP granted appellant a schedule award for nine percent impairment of the right lower extremity based on Dr. Slutsky's February 24, 2014 opinion.

By letter dated July 10, 2014, appellant, through counsel, requested a telephone hearing which was held before an OWCP hearing representative on January 26, 2015.

In a March 10, 2015 decision, an OWCP hearing representative affirmed the July 1, 2014 decision. He found that the weight of the medical opinion evidence rested with Dr. Slutsky's opinion that appellant had nine percent right lower extremity impairment.

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

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 For decisions issued after May 1, 2009, the sixth edition will be applied.⁹

The A.M.A., *Guides* provide a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health. For lower extremity impairments, the evaluator identifies the impairment class for the diagnosed condition, which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.¹⁰ The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).¹¹ 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 procedures provide that, after obtaining all necessary medical evidence, the file should be routed through the 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.¹³

ANALYSIS

The Board finds that appellant has no more than nine percent impairment of the right lower extremity.

OWCP accepted appellant's claim for aggravation of articular cartilage wear on the right medial femoral condyle and authorized right knee surgery performed on June 10, 2011. It granted her a schedule award for nine percent permanent impairment of her right lower extremity. Appellant's treating physician, Dr. Davignon, rated 10 percent right lower extremity impairment based on loss of range of motion, a class 1 impairment under Table 16-23, page 549 and Table 16-25, page 550, respectively, of the sixth edition of the A.M.A., *Guides*. This contrasted with the opinion of Dr. Slutsky, OWCP's medical adviser, which found that appellant had nine percent impairment of the right lower extremity under Table 16-3, pages 509-11 based on the diagnosis of primary knee joint degenerative joint disease with full thickness articular cartilage defect.

⁸ *K.H.*, Docket No. 09-341 (issued December 30, 2011).

⁹ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); see also Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

¹⁰ *Supra* note 3 at 493-531.

¹¹ *Id.* at 521.

¹² *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

¹³ See Federal (FECA) Procedure Manual, Part 2 -- *supra* note 9 at Chapter 2.808.6(d) (January 2010); *C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

The Board notes that the A.M.A., *Guides* indicate that the diagnosis-based impairment method is the preferred rating method for the lower extremities.¹⁴ Range of motion impairment method is primarily used as a physical adjustment factor and is only used to determine actual impairment values when it is not possible to otherwise define impairment.¹⁵ It is also noted that the range of motion impairment method is to be used when other grids refer to its use or no other diagnosis-based sections of the chapter are applicable for impairment rating of a lower extremity condition.¹⁶ The A.M.A., *Guides* further state that, while range of motion will be used in some cases as an alternative approach to rating impairment, it is not to be combined with the diagnosis-based impairment and stands alone as an impairment rating.¹⁷ The A.M.A., *Guides* directs examiners to rate diagnosis-based impairments for the lower extremities pursuant to Chapter 16, which indicates at page 497, section 16.2a that impairments are defined by class and grade. Where a claim has two significant diagnoses, the examiner is instructed by the A.M.A., *Guides* to use the diagnosis with the highest causally-related impairment rating for the impairment calculation. Pursuant to the above criteria, OWCP's medical adviser properly relied on the diagnosis-based method for rating appellant's right knee impairment based on a class 1 impairment for primary knee joint degenerative disease pursuant to Table 16-3, pages 509-11.

In accordance with Chapter 16, the examiner is instructed to utilize the net adjustment formula outlined at section 16.3, pages 509-11 of the A.M.A., *Guides*,¹⁸ to obtain the proper impairment rating.

Dr. Davignon reported on November 6, 2013 that an examination of appellant's right knee revealed crepitance with range of motion, 5/5 motor strength, intact sensation, diminished range of motion, and no instability. He utilized Table 16-25, page 550 and determined that her knee classification was class 1 and that her range of motion under Table 16-23, page 549 was mild or 10 percent impairment of the right lower extremity. Alternatively, Dr. Davignon assigned a grade modifier of 1 each for functional history, for physical examination findings, and for clinical studies. He found a +2 net adjustment when applying the formula and determined that appellant had nine percent impairment of the right lower extremity under the sixth edition of the A.M.A., *Guides*. Dr. Davignon found, however, that the range of motion method was appropriate for rating her right lower extremity impairment because it yielded a higher rating than the diagnosis-based impairment rating method.

Based upon Dr. Davignon's findings, Dr. Slutsky utilized Table 16-3, pages 509-11 of the A.M.A., *Guides*, the Knee Regional Grid, and found that appellant had a class 1 impairment for primary knee joint degenerative joint disease with full thickness articular cartilage defect. Utilizing Table 16-6, page 516 he assigned a grade modifier of 1 for functional history based on her current knee joint symptoms. Dr. Slutsky assigned a grade modifier of 1 for physical

¹⁴ *Supra* note 3 at 497.

¹⁵ *Id.*

¹⁶ *Id.* at 543.

¹⁷ *Id.* at 500.

¹⁸ *Id.* at 521-22.

examination findings of crepitation to palpation pursuant to Table 16-7, page 517. He assigned a grade modifier of 3 for clinical studies based on appellant's x-ray results. Dr. Slutsky applied the net adjustment formula which produced two and moved the default value grade C to grade E which represented nine percent impairment of the right lower extremity. He noted that his nine percent right lower extremity impairment rating was the same impairment rating determined by Dr. Davignon for cartilage damage in appellant's right knee. Based on the report from Dr. Slutsky, OWCP determined that she had nine percent impairment of the right lower extremity, as he calculated this rating based on the applicable protocols and tables of the sixth edition of the A.M.A., *Guides*. Dr. Slutsky explained that Dr. Davignon improperly calculated the range of motion impairment to assign 10 percent lower extremity impairment. He advised that 110 degrees of flexion represented 0 percent impairment and that 0 degrees of extension represented 0 percent impairment under Table 16-23, page 549, not 10 percent as found by Dr. Davignon. Utilizing Table 16-25, page 550, Dr. Slutsky assigned a grade modifier of 0 for range of motion.

OWCP may rely on the opinion of an OWCP medical adviser to apply the A.M.A., *Guides*.¹⁹ The Board finds that the February 24, 2014 impairment rating from Dr. Slutsky, OWCP's medical adviser, is the only impairment rating rendered in conformance with the applicable protocols and tables of the A.M.A., *Guides*, and therefore represents the weight of the medical evidence in this case. Accordingly, as the record contains no other probative, rationalized medical opinion which indicates that appellant has greater impairment based on her accepted right knee condition, OWCP properly granted her a schedule award for nine percent right lower extremity impairment in its March 10, 2015 decision.

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 nine percent of the right lower extremity, for which she received a schedule award.

¹⁹ See *J.G.*, Docket No. 09-1714 (issued April 7, 2010).

ORDER

IT IS HEREBY ORDERED THAT the March 10, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 27, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board