



## **FACTUAL HISTORY**

On March 10, 2006 appellant, then a 47-year-old mail handler, filed a traumatic injury claim (Form CA-1) alleging that on that date, she sustained a soft tissue injury to her right knee ligament as a result of a fall. OWCP accepted her claim for sprain/strain of the right knee and ankle on May 8, 2006. Appellant received intermittent supplemental rolls wage-loss benefits from April 15, 2006 to April 27, 2007. She underwent authorized right knee arthroscopy on February 19, 2007 and returned to work on June 6, 2007. A statement of accepted facts dated July 7, 2015 indicated that appellant's list of accepted conditions had been expanded to include a tear of the medial meniscus of the right knee.

On June 19, 2015 appellant requested a schedule award (Form CA-7). With her request, she submitted a March 5, 2015 impairment report from Dr. Daisy Rodriguez, a Board-certified internist. She listed appellant's accepted conditions as a right knee strain/sprain of the lateral collateral ligament, a right knee meniscal tear, right knee swelling, degenerative joint disease of the right knee, a resolved right ankle sprain, gait abnormality, and chronic pain. Dr. Rodriguez stated that she had evaluated appellant's impairment of the right lower extremity for three separate conditions, based upon the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). She noted that appellant's permanent impairment was rated as 20 percent for her degenerative joint disease; 15 percent for her right knee strain/sprain; and 3 percent for her right meniscal tear. Dr. Rodriguez stated that the combined right lower extremity impairment was 34 percent. She concluded that appellant's date of maximum medical improvement was February 9, 2015, the date of appellant's most recent magnetic resonance imaging (MRI) scan.

OWCP forwarded the case record and a statement of accepted facts to a district medical adviser (DMA) on July 7, 2015. In a report dated July 8, 2015, Dr. Morley Slutsky, Board-certified in occupational medicine and the DMA, arrived at an impairment rating of 12 percent for the right lower extremity based on degenerative joint disease; however, he noted:

“[Appellant] has multiple diagnoses in the right knee including mild ACL laxity at MMI (7-13 percent LEI) and medial meniscal tear (1-3 percent LEI). There was also significant medial compartment arthrosis but no x-rays were performed with joint space measurements and the MRI scan did not discuss if there were full thickness articular cartilage tears. I do not know how Dr. Rodriguez arrive[d] at her impairment assignments as she provided no calculations with rationale. The doctor simpl[y] assigned impairments for degenerative joint disease and plica (20 percent), strain/sprain (15 percent), and meniscal tears (3 percent). The doctor also erred when she rated multiple diagnoses in the knee region as only the most impairing diagnosis is used [under the A.M.A., *Guides* on page 497 and page 526 in example 16-9].

“I would recommend a [second opinion] with an orthopedic surgeon who is trained and experienced in the use of the [A.M.A., *Guides*]....

“I will provide impairment calculations using the medical provided should the [d]epartment still want this information. Although ACL degeneration is not part

of the accepted conditions it is the most impairing diagnosis in the right knee region and will be used for final calculation.”

On August 7, 2015 OWCP informed appellant that Dr. Rodriguez’s calculations were insufficiently explained, and requested that she obtain an addendum report from Dr. Rodriguez. It afforded her 30 days to obtain this report.

In a report dated August 12, 2015, Dr. Rodriguez attached her calculations, noting that she had previously submitted them, but that the DMA had apparently not received them. She stated that according to the diagnosis used by the DMA to determine appellant’s ratable impairment, that of “ACL Laxity,” she would assign appellant a final right lower extremity impairment rating of 13 percent under the A.M.A., *Guides*.

On October 7, 2015 OWCP again forwarded the case record and a statement of accepted facts to the DMA. In a report dated October 17, 2015, the DMA noted that Dr. Rodriguez’ response was confusing as she had not explained how the excerpts she chose to include from the A.M.A., *Guides* applied to her calculations. He stated that her evaluation was not well documented and inconsistent with the rating methods found in the A.M.A., *Guides*. The DMA once again recommended a second opinion evaluation. In the absence of a second opinion evaluation, he reiterated his impairment rating of 12 percent.

On October 26, 2015 OWCP referred appellant to a second opinion physician for evaluation of her percentage of impairment. In a report dated November 6, 2015, Dr. Robert A. Smith, a Board-certified orthopedic surgeon, reviewed the medical record and examined appellant. He found that her right knee sprain had fully resolved without any residual objective abnormal findings, and rated her permanent impairment due to this condition at zero percent. Dr. Smith noted that the accepted ratable condition for this claim was a medial meniscal tear of the right knee status post partial medial meniscectomy. He explained his calculation using the A.M.A., *Guides* of a percentage of impairment based on this condition:

“This is a [c]lass 1 injury according to Table 16-3 Knee Regional Grid, page 509.... The default rating is two percent with a range of one to three percent. From Table 16-6 on page 516 the Functional History Grade Modifier [GMFH] is 1.... The Clinical Stud[ies] Grade Modifier [GMCS] from Table 16-8 on page 519 is also 1. Therefore the [n]et [a]djustment is 0.... The final rating is therefore two percent right lower extremity.”

Dr. Smith also noted that appellant had impairment from right knee arthritis, but that it was not an accepted condition in this claim. He rated her permanent impairment from right knee arthritis at seven percent. Dr. Smith explained that under Table 16-3 primary knee arthritis with a three millimeter (mm) cartilage interval was a class 1 injury with a default rating of seven percent. Functional history adjustment from Table 16-6 was 1, and physical examination adjustment from Table 16-7 was 1. Clinical studies were not applicable because they defined the class. Therefore the net adjustment was zero and that right lower extremity rating for arthritis was seven percent. Dr. Smith noted that the accepted right ankle sprain had also fully recovered and therefore her impairment rating for this condition was zero percent. The total final permanent impairment rating from Dr. Smith, adding her two percent right lower extremity

impairment due to an accepted medial meniscal tear to her seven percent right lower extremity impairment due to unaccepted right knee arthritis, was nine percent.

On December 1, 2015 OWCP forwarded the case record and a statement of accepted facts to Dr. Neil J. Negrin, a Board-certified orthopedic surgeon and a DMA. On December 13, 2015 he found that Dr. Smith's impairment rating of nine percent was the correct impairment rating, explaining;

“In my opinion Dr. Rodriguez did not apply the correct DRE classification to this patient's primary orthopedic problem. The most severe of her conditions is the degenerative arthritis. [Appellant's] most recent imaging study indicates that she has a three mm cartilage interval remaining in her knee. This is a [c]lass 1 impairment with a default grade of seven percent. [Appellant's] grade modifiers include a [g]rade 1 for functional history and [g]rade 1 for physical examination based on the extensive medical records provided for this review. The clinical studies were used to correctly apply the DRE reclassification. Thus, [appellant] has a zero grade modifier, which defaults to seven percent. Her other accepted problems include a partial medial meniscectomy, ankle injury, and knee sprain. The partial medial meniscectomy is a DRE [c]lass 1 abnormality and defaults to a two percent partial permanent impairment, using the same grade modifiers. The ankle injury and the knee sprain have been resolved and are thus [c]lass 0 impairments. In my opinion, the correct calculation is seven percent plus two percent equaling nine percent to the right lower extremity.”

By decision dated December 22, 2015, OWCP granted appellant a schedule award for nine percent permanent right lower extremity impairment. It noted that the weight of medical evidence rested with Dr. Smith and Dr. Negrin.

### **LEGAL PRECEDENT**

The schedule award provision of FECA<sup>3</sup> and its implementing federal regulations<sup>4</sup> 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.<sup>5</sup> The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.<sup>6</sup> For decisions issued after

---

<sup>3</sup> 5 U.S.C. § 8107.

<sup>4</sup> 20 C.F.R. § 10.404.

<sup>5</sup> *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

<sup>6</sup> *Id.*

May 1, 2009, the sixth edition is used to calculate schedule awards.<sup>7</sup> It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.<sup>8</sup>

The sixth edition of 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).<sup>9</sup> Under the sixth edition, the evaluator identifies the impairment for the Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on GMFH, Physical Examination (GMPE), and GMCS.<sup>10</sup> The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).<sup>11</sup>

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.<sup>12</sup>

### ANALYSIS

The Board finds that appellant has not established greater than nine percent permanent right lower extremity impairment. OWCP accepted that appellant sustained sprain/strain of the right knee and ankle and a tear of the medial meniscus as a result of an occupational employment injury. Appellant submitted two reports from Dr. Rodriguez, one assigning 34 percent impairment rating for her right lower extremity, and a later report from Dr. Rodriguez assigning 13 percent impairment rating.

OWCP referred appellant to a second opinion physician, Dr. Smith, for evaluation of her percentage of impairment. He explained with regard to appellant's meniscal injury, "This is a class 1 injury according to Table 16-3 Knee Regional Grid, page 509.... The default rating is two percent with a range of one to three percent. From Table 16-6 on page 516 the [f]unctional [h]istory [g]rade [m]odifier is also 1. The [c]linical [s]tud[ies] [g]rade [m]odifier from Table 16-

---

<sup>7</sup> Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

<sup>8</sup> *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.a.3 (January 2010). This portion of OWCP's procedure provides that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

<sup>9</sup> A.M.A., *Guides* (6<sup>th</sup> ed. 2009), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

<sup>10</sup> *Id.* at 383-419.

<sup>11</sup> *Id.* at 411.

<sup>12</sup> *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

8 on page 519 is also 1. Therefore the net adjustment is 0.... The final rating is therefore two percent right lower extremity.” Dr. Smith also noted that appellant had impairment from the preexisting right knee arthritis. He rated her permanent impairment from her three mm right knee arthritis at seven percent, utilizing Table 16-3, Table 16-6 and Table 16-7. Dr. Smith properly explained that seven percent impairment was the default rating and appellant’s impairment required no adjustment, from her grade modifiers. He noted that the accepted right ankle sprain had also fully recovered and therefore her impairment rating for this condition was zero percent. The total final permanent impairment rating from Dr. Smith, adding appellant’s two percent right lower extremity impairment due to the accepted medial meniscal tear to her seven percent right lower extremity impairment due to the right knee arthritis, was nine percent. The DMA concurred with this rating on December 13, 2015.

The Board finds that Dr. Rodriguez did not sufficiently explain how she arrived at her impairment ratings of 34 and 13 percent. The DMA’s report of October 17, 2015 was correct to note that Dr. Rodriguez’s responses were confusing as she had not explained how excerpts she chose to include from the A.M.A., *Guides* applied to her calculations and also did not explain how specific Tables of the A.M.A., *Guides* applied to her rating. He was correct in concluding that her evaluation was not well documented and inconsistent with the rating methods found in the A.M.A., *Guides*.

Board precedent is well settled that when an attending physician’s report gives an estimate of impairment, but does not address how the estimate was based on the A.M.A., *Guides*, OWCP is correct to follow the advice of its medical adviser where he or she has properly applied the A.M.A., *Guides*.<sup>13</sup>

Furthermore, OWCP procedures provide that impairment ratings for schedule awards include those conditions accepted by OWCP as employment related and any preexisting permanent impairment of the same member or function. If the work-related injury has affected any residual usefulness in whole or in part, a schedule award may be appropriate as there is no apportionment.<sup>14</sup> As noted above, appellant’s attending physician, Dr. Rodriguez, did not sufficiently explain how her impairment rating was based on the A.M.A., *Guides*. The Board finds that OWCP correctly relied on the reports of Dr. Smith and Dr. Negrin.<sup>15</sup>

The rating of two percent right lower extremity impairment for the accepted meniscus injury, added to seven percent for the preexisting degenerative arthritis, was properly calculated

---

<sup>13</sup> *J.Q.*, 59 ECAB 366, 371 (2008); *Laura Heyen*, 57 ECAB 435, 439 (2006).

<sup>14</sup> *B.K.*, 59 ECAB 228 (2007).

<sup>15</sup> The Board notes that the A.M.A., *Guides* explain at page 529, that if there are multiple diagnoses at MMI, the examiner should determine if each should be considered or if the impairments are duplicative. If there are multiple diagnoses within a specific region, then the most impairing diagnosis is rated, because it is probable this will incorporate the functional losses of the less impairing diagnoses. In rare cases of complex injury or occupational exposure, the examiner may combine multiple impairments within a single region, if the most impairing diagnosis does not adequately reflect the losses. In the present case, the DMA explained that the rating for appellant’s accepted medial meniscal tear would not reflect the greater impairment caused by the preexisting arthritis. Both OWCP second opinion physician Dr. Smith, and the DMA therefore rated both conditions of medial meniscal tear and arthritis.

under the A.M.A., *Guides*. The Board finds that the impairment rating was consistent with the examination findings utilizing the A.M.A., *Guides*, and that the medical evidence established that appellant sustained no more than nine percent impairment of the right lower extremity.

Appellant may request a schedule award or an increased schedule award based on evidence of a new exposure or medical evidence showing a progression of an employment-related condition resulting in permanent impairment or increased impairment.

**CONCLUSION**

The Board finds that appellant has not established more than nine percent permanent impairment of her right lower extremity, for which she received a schedule award.

**ORDER**

**IT IS HEREBY ORDERED THAT** the December 22, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 10, 2016  
Washington, DC

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

Colleen Duffy Kiko, Judge  
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge  
Employees' Compensation Appeals Board