United States Department of Labor
Employees' Compensation Appeals Board

J.L., Appellant	)	
and	)	**Docket No. 13-66**
	)	**Issued: March 19, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
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

JURISDICTION

On September 24, 2012 appellant, through his authorized representative, filed a timely appeal from the July 5, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP), which affirmed his schedule award. 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 this case.

ISSUE

The issue is whether appellant has more than an 18 percent impairment of his right leg or more than a 16 percent impairment of his left leg.

FACTUAL HISTORY

On June 10, 2008 appellant, a 61-year-old motor vehicle service operator, sustained a traumatic injury in the performance of duty when he slipped on a dock plate. OWCP accepted his claim for a left knee sprain. It later accepted a left medial meniscus tear. Appellant

[1] 5 U.S.C. § 8101 *et seq.*

underwent a left partial medial meniscectomy and a right partial medial meniscectomy. OWCP accepted appellant's right knee condition and surgery as a consequential injury.

On April 6, 2011 OWCP issued a schedule award for a two percent impairment of each lower extremity. It based its award on the diagnosis-based impairment for partial medial meniscectomy.

Dr. Nicholas P. Diamond, an osteopath, reevaluated appellant's impairment. He noted that knee x-rays from August 2011 showed a two millimeter cartilage interval medially on the right with three millimeters laterally. X-rays also showed a two millimeter cartilage interval medially on the left with three millimeters laterally. Applying Table 16-3, page 511 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009), Dr. Diamond found that appellant had a 20 percent default impairment rating of each lower extremity due to primary knee joint arthritis, which was a class 2 or moderate problem. He also rated appellant's functional history and physical examination as moderate; no adjustment to the default rating was warranted for either extremity.

On the right, however, Dr. Diamond found a class 1 or mild-to-moderate sensory deficit of the sciatic nerve, for which Table 16-12, page 535 gave a default impairment rating of four percent. He rated appellant's functional history as moderate and clinical studies as negative, so no net adjustment was warranted. Combining appellant's 20 percent impairment of the right lower extremity due to primary knee joint arthritis with the 4 percent impairment for peripheral nerve impairment, Dr. Diamond determined that appellant had a 23 percent impairment of his right lower extremity.

On December 6, 2011 Dr. Christopher R. Brigham, Board-certified in occupational medicine and an OWCP medical consultant, reviewed Dr. Diamond's evaluation and stated that he did not properly apply the A.M.A., *Guides*. He agreed with the 20 percent default impairment rating for primary knee joint arthritis in both lower extremities, but he explained that a moderate rating for functional history was not appropriate on the right: appellant had a limp but did not require an assistive device, such as a cane or crutch. A mild rating for functional history therefore applied. As a result, the default rating for arthritis was adjusted one grade lower to 18 percent on the right.

Dr. Brigham found that Dr. Diamond's moderate rating for left leg functional history was likewise inappropriate. Not only did appellant not use an assistive device, he did not limp on the left. As the left lower extremity was functionally unaffected, the lowest rating for functional history applied. The default rating was adjusted two grades lower to 16 percent on the left. Dr. Brigham added that Dr. Diamond did not discuss how he determined sensory deficits over the L5 and S1 dermatomes or whether this was a subjective complaint without objective evidence of radiculopathy. As there was insufficient information to support an impairment rating for the right lower extremity as a result of nerve impairment, Dr. Brigham made no further rating.

On December 9, 2011 OWCP issued a schedule award for an additional 16 percent impairment of the right lower extremity and an additional 14 percent impairment on the left. As appellant had already received schedule awards for 2 percent impairment bilaterally, the total impairments were 18 on the right and 16 on the left, as the medical consultant recommended.

Dr. Thomas N. Duffy, an osteopath, saw appellant on June 1, 2012 for bilateral knee pain, which resulted from a fall at work on June 10, 2008. He also saw appellant for lumbar spine pain. Dr. Duffy explained that appellant had experienced low back pain since his fall in June 2008. Appellant was initially evaluated for his knees, but when he had to work with the knee pain, his back pain worsened. "I believe that the fall and the injuries to his knees have aggravated the degenerative changes in his back and have led to his chronic low back pain."

On July 5, 2012 an OWCP hearing representative affirmed the December 9, 2011 schedule award. She found that Dr. Brigham had explained why Dr. Diamond's findings did not support a moderate rating for functional history. The hearing representative noted that OWCP had not accepted appellant's claim for a consequential lumbar injury.

Appellant's representative contends on appeal that a conflict in medical opinion exists between Dr. Diamond and Dr. Brigham and that Dr. Diamond's report was in conformity with the A.M.A., *Guides*. Counsel also argues that appellant's low back condition was a consequential injury. "Unfortunately, the [d]istrict [OWCP] has not presented an opinion relative to that condition despite [a]ppellant's request."

LEGAL PRECEDENT

FECA sets forth the number of weeks of compensation payable for permanent impairment from loss, or loss of use, of scheduled members or functions of the body. It does not, however, specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.[2]

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. OWCP has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[3] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[4]

ANALYSIS

Diagnosis-based impairment is the primary method of evaluating the lower extremity. Impairment is determined first by identifying the relevant diagnosis, then by selecting the class of the impairment: no objective problem, mild problem, moderate problem, severe problem, very severe problem approaching total function loss. This will provide a default impairment rating, which may be adjusted slightly based on grade modifiers or nonkey factors, such as functional history, physical examination and clinical studies.[5]

[2] *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

[3] 20 C.F.R. § 10.404.

[4] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.a (January 2010).

[5] A.M.A., *Guides* 497.

Table 16-3 of the A.M.A., *Guides* provides the default impairment ratings for diagnoses of the knee. For a diagnosis of primary knee joint arthritis, the default impairment rating is 20 percent of the lower extremity. This is classified as a moderate problem.

Dr. Diamond, the osteopath, and Dr. Brigham, OWCP's medical consultant, agreed that appellant's physical examination was moderate and therefore did not warrant an adjustment of the default rating. Dr. Brigham disagreed with Dr. Diamond's moderate rating for functional history. Appellant limped on the right but did not require an assistive device. Table 16-6, page 516 of the A.M.A., *Guides* confirms that this describes a mild problem warranting one lower grade than the default rating or a final rating of 18 percent on the right.

Further, as appellant did not limp or require an assistive device on the left, he had no functional problem on that side, according to Table 16-6. This warrants two lower grades than the default rating or a final rating of 16 percent on the left.

Dr. Duffy, another osteopath, opined that appellant's fall at work on June 10, 2008, and the injury to his knees, aggravated the degenerative changes in his back, causing low back pain since right after the fall. As OWCP has not accepted appellant's claim for a consequential low back injury, no lower extremity rating may be given.[6]

The Board finds that appellant has no more than an 18 percent impairment of his right leg and no more than a 16 percent impairment of his left leg. The Board will therefore affirm OWCP's July 5, 2012 decision.

Appellant's representative argues a conflict exists between Dr. Diamond and OWCP's medical consultant. The Board finds, however, that Dr. Diamond did not properly apply the A.M.A., *Guides*. Specifically, he did not properly categorize appellant's functional history as described in Table 16-6, page 516. Dr. Brigham correctly observed that a grade 2 or moderate problem with functional history requires more than a grade 1 antalgic limp, which Dr. Diamond did not support. Accordingly, Dr. Diamond's impairment ratings for primary knee joint arthritis are of diminished probative value and insufficient to create a conflict requiring an impartial medical specialist under 5 U.S.C. § 8123(a).

Dr. Brigham reviewed Dr. Diamond's report to verify the correct application of the A.M.A., *Guides* and to confirm the percentage of permanent impairment.[7] It is well established that when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his opinion is of diminished probative value in establishing the degree of permanent impairment. OWCP may rely on the opinion of its medical consultant to apply the A.M.A., *Guides* to the findings reported by the attending physician.[8]

[6] The Board notes that OWCP has not accepted appellant's claim for primary knee joint arthritis. But as this is considered a preexisting impairment to the member under consideration, it is included in calculating the percentage of loss. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.7.a(2) (January 2010).

[7] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Functions of the Medical Unit*, Chapter 3.200.4 (October 1990).

[8] *Linda Beale*, 57 ECAB 429, 434 (2006).

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 an 18 percent impairment of his right lower extremity and no more than a 16 percent impairment of his left.

ORDER

IT IS HEREBY ORDERED THAT the July 5, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 19, 2013
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