United States Department of Labor
Employees' Compensation Appeals Board

J.K., Appellant	)	
and	)	**Docket No. 12-1807**
	)	**Issued: May 9, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Boston, MA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On August 29, 2012 appellant filed a timely appeal from a June 5, 2012 decision of the Office of Workers' Compensation Programs (OWCP), which denied modification of a decision granting appellant a 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 the case.

ISSUE

The issue is whether appellant has more than 23 percent permanent impairment of the left lower extremity for which he received a schedule award.

FACTUAL HISTORY

On October 12, 2005 appellant, then a 56-year-old mail handler, was injured when he slipped and fell at work. OWCP accepted the claim for bilateral contusion of the knees, bilateral

[1] 5 U.S.C. §§ 8101-8193.

knee strains, abrasion of the hip and leg and expanded his claim to include tear of the medial meniscus of the right knee, secondary osteoarthritis of the right leg and permanent aggravation of left knee osteoarthritis. It authorized right knee arthroscopic surgery which was performed on February 10, 2006, a total right knee replacement was performed on July 23, 2007 and a total left knee replacement was performed on December 2, 2008. Appellant worked intermittently thereafter.[2]

Appellant was treated by Dr. Robert McGuirk, a Board-certified orthopedic surgeon, who in August 21 and October 7, 2008 reports diagnosed traumatic arthritis of the left knee, torn left medial meniscus and torn left lateral meniscus and recommended surgery. On December 2, 2008 Dr. McGuirk performed a left total knee arthroplasty and diagnosed traumatic arthritis of the left knee. In reports dated March 23 to September 22, 2009, he noted that appellant experienced persistent soreness of the medial hamstring and diagnosed probable pes anserine bursitis status post December 2, 2008 left total knee replacement. On June 25, 2009 Dr. McGuirk administered a lidocaine injection into the medial hamstring.

On September 3, 2009 appellant filed a claim for a schedule award. In a January 25, 2012 letter, OWCP requested that Dr. McGuirk evaluate the extent of permanent impairment of the left leg under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*).[3]

On February 9, 2010 Dr. McGuirk noted that appellant was status post left knee arthroplasty on December 2, 2008. Appellant reported stiffness and weakness, inability to kneel, difficulty in bending, squatting and climbing and walking was limited to 30 minutes. Dr. McGuirk noted varus deformity, range of motion was 125 degrees with one centimeter (cm) of quadriceps atrophy. In a March 9, 2010 impairment worksheet, he advised that in accordance with Chapter 16 of the sixth edition of the A.M.A., *Guides* appellant had 15 percent impairment of the left leg. Dr. McGuirk explained that, under Table 16-3, Knee Regional Grid, Total Knee Replacement, appellant was a class 3.[4] Applying the net adjustment formula at pages 521-22 of the A.M.A., *Guides*,[5] he found that for functional history appellant was a grade 2 modifier; for physical examination he was a grade modifier 1 pursuant to Table 16-7; and for clinical studies, he was a grade modifier 2 pursuant to Table 16-8. Dr. McGuirk utilized the net adjustment formula to find a net adjustment of +2. He adjusted the impairment rating, noting that appellant

[2] Appellant had a right foot injury on April 22, 1984, File No. xxxxxxx237. On September 25, 1992 OWCP granted him a schedule award for 15 percent permanent impairment of the right foot. On January 9, 2008 appellant filed a claim for a schedule award in the present claim, File No. xxxxxx892. On August 6, 2008 OWCP granted him a schedule award for 50 percent impairment to the right leg. On August 13, 2008 it asked its medical adviser to clarify whether the 50 percent impairment rating granted on August 6, 2008 was in addition to or including the 15 percent impairment for the right foot schedule award from September 25, 1992 in File No. xxxxxx237. In a September 9, 2008 note, the medical adviser indicated that the 50 percent impairment rating was separate from the accepted impairment for the right foot granted in 1992. In an October 8, 2008 decision, OWCP found that appellant had 58 percent total combined impairment of the right leg.

[3] A.M.A., *Guides* (6th ed. 2008).

[4] *Id.* at 511.

[5] *Id.* at 521-22.

was a grade D concluding that he had 15 percent left lower extremity impairment under the A.M.A., *Guides* for left total knee replacement. In the summary section of the impairment worksheet, Dr. McGuirk noted diagnosis-based impairment of 16 percent for the left lower extremity and range of motion impairment of 10 percent. He stated that the final combined impairment was 26 percent impairment of the left lower extremity and regional impairment was 64 percent.

In an April 30, 2010 report, Dr. Barry W. Levine, an OWCP medical adviser, reviewed the medical record including Dr. McGuirk's March 9, 2010 report. He noted that appellant underwent a total left knee replacement on December 2, 2008 and addressed Dr. McGuirk's grade modifiers for functional history 2, physical examination 1, clinical studies 2 and an AAOS score 3. The medical adviser indicated that based, on the knee grid Table 16-3, page 511, appellant had a default impairment of 37 percent impairment of the lower extremity. He indicated that, using the net adjustment formula on page 521, appellant was a grade D with 43 percent lower extremity impairment. The date of maximum medical improvement was March 9, 2010.

In a December 21, 2010 report, Dr. Christopher R. Brigham, an OWCP medical consultant, reviewed the medical record including Dr. McGuirk's March 9, 2010 report. He stated that there were two methodologies to be considered under the A.M.A., *Guides,* diagnosis-based impairment and the range of motion method and that the greater of the two methods should be chosen. Dr. McGuirk's examination noted that, range of motion was 125 degrees for the left knee, there was no instability of the knee and no documentation that the prosthesis was mal-aligned. Dr. Brigham noted that pursuant to Table 16-3, Knee Regional Grid, appellant had a default impairment class 2 left knee, total knee replacement, which yielded a grade C impairment of 25 percent at Table 16-3, page 511 of the A.M.A., *Guides*.[6] Applying the net adjustment formula at pages 521-22 of the A.M.A., *Guides*,[7] he found that the grade pursuant to Table 16-6 for functional history was not assigned contrary to Dr. McGuirk's conclusion. Dr. Brigham stated that pursuant to page 516 of the A.M.A., *Guides,* if the grade for functional history differs by two or more grades from that defined by physical examination or clinical studies, the functional history should be assumed unreliable. In this case, Dr. McGuirk assigned a grade modifier 3 based on the AAOS score. The medical adviser noted that Dr. McGuirk's rating for physical examination was a grade modifier one which would make functional history grade modifier unreliable and unusable. He noted that the grade for physical examination at Table 16 -7 was one, for a mild problem (one cm of quadriceps atrophy); and the grade for clinical studies pursuant to Table 16-8 was not assigned as the clinical studies were used to confirm the diagnoses. The medical adviser utilized the net adjustment formula to find a net adjustment of -1. He adjusted the impairment rating, findings that appellant had 23 percent left leg impairment under the sixth edition of the A.M.A., *Guides* for left knee arthroplasty. The medical adviser noted that, with regard to the range of motion methodology, the objective findings showed that there was almost full extension and 125 degrees of flexion, which did not meet the threshold of ratable impairment pursuant to Table 16-23, Knee Motion Impairments.

[6] *Id.* at 509.

[7] *Supra* note 5.

In a decision dated March 15, 2011, OWCP granted appellant a schedule award for 23 percent impairment of the left lower extremity. The period of the award was from October 7, 2010 to January 13, 2012.

On September 4, 2011 appellant requested reconsideration. He submitted x-rays of both knees dated April 12, 2007 to November 10, 2008 and previously of record. Appellant was treated by Dr. McGuirk through September 22, 2011 for painful right hip pain. Dr. McGuirk diagnosed sprain of the hip/thigh, spondylosis of the lumbar spine and possible avascular necrosis of the right hip. He injected appellant's right hip with lidocaine. A magnetic resonance imaging scan of the lower extremities revealed trochanteric bursitis.

In a June 3, 2012 report, Dr. Robert Y. Pick an OWCP medical adviser, reviewed the medical record and noted that subsequent to the December 21, 2010 report of Dr. Brigham, the submitted medical reports related to appellant's hip and back with no reference to the left knee. Therefore, he found no basis to warrant a change in the prior impairment rating for the left knee.

On June 5, 2012 OWCP denied appellant's claim for an additional schedule award.

LEGAL PRECEDENT

The schedule award provision of FECA[8] and its implementing federal regulations,[9] 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.[10] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[11] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[12]

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).[13] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] *Id.* at § 10.404(a).

[11] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[12] FECA Bulletin No. 09-03 (issued March 15, 2009).

[13] A.M.A., *Guides* 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

Clinical Studies (GMCS).[14] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[15] The grade modifiers are used on the net adjustment formula described above to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down the default value C, by the calculated net adjustment.[16]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical consultant for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with OWCP's medical consultant providing rationale for the percentage of impairment specified.[17]

ANALYSIS

The sixth edition of the A.M.A., *Guides* provides that lower extremity impairments be classified by diagnosis, which is then adjusted by grade modifiers according to the formula noted above.[18] Appellant's accepted conditions included bilateral contusion of the knees, bilateral knee strains, abrasion of the hip and leg and permanent aggravation of the left knee osteoarthritis. OWCP authorized a total left knee replacement was performed on December 2, 2008. On March 15, 2011 appellant was granted a schedule award for 23 percent permanent impairment of the left lower extremity using the applicable table of the sixth edition of the A.M.A., *Guides*. The section of the A.M.A., *Guides* which rates diagnosis-based impairments for the lower extremities is located at Chapter 16, which states at page 497, section 16.2a that impairments are defined by class and grade.

The Board has carefully reviewed Dr. McGuirk's reports dated February 9 and March 9, 2010 and notes that he did not adequately explain how his determination was reached in accordance with the relevant standards of the A.M.A., *Guides*.[19] Dr. McGuirk opined that appellant sustained 15 percent impairment of the left lower extremity in accordance with the A.M.A., *Guides.* He explained that, under Table 16-3, Knee Regional Grid, Total Knee Replacement, appellant was a class 3. Dr. McGuirk utilized the net adjustment formula to find a net adjustment of +2.[20] However, the Board notes that he did not specifically explain how he determined that appellant qualified for class 3 under the Knee Regional Grid, especially in light of the lack of specific findings. Rather, Dr. McGuirk noted findings of stiffness, weakness,

[14] *Id.* at 494-531.

[15] *Id.* at 521.

[16] *Id*. at 497.

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

[18] *Supra* notes 13, 14.

[19] *See Tonya R. Bell*, 43 ECAB 845, 849 (1992).

[20] The Board notes that Dr. McGuirk incorrectly noted the impairment rating under Table 16-3, Knee Regional Grid, Total Knee Replacement, class 3 was 15 percent. Rather, the default (grade C) rating would be 37 percent and the grade D rating would be 40 percent.

inability to kneel and difficulty in bending, squatting and climbing. Additionally, on the permanent impairment worksheet summary, Dr. McGuirk noted diagnosis-based impairment of 16 percent for the left extremity and range of motion impairment of 10 percent for a combined impairment of 26 percent impairment of the left upper extremity. However, Dr. McGuirk did not explain how he calculated 16 percent diagnosis-based impairment for the left leg, which was inconsistent with his prior finding of 15 percent diagnosis-based impairment. Further, he included 10 percent impairment for range of motion deficit in a final combined rating of 26 percent left leg impairment but failed to provide the physical findings and calculations to support this rating. Ratings based on range of motion impairment, when allowed under the A.M.A., *Guides*, are stand alone and cannot be combined with other approaches.[21] Therefore, the Board finds that Dr. McGuirk did not properly follow the A.M.A., *Guides*. An attending physician's report is of diminished probative value when the A.M.A., *Guides* are not properly followed.[22]

Although an April 30, 2010 report from Dr. Levine found 43 percent left leg impairment, this report is of limited probative value. The Board notes that the medical adviser did not adequately explain his rating in accordance with the relevant standards of the A.M.A., *Guides*.[23] He explained that, under Table 16-3, Knee Regional Grid, Total Knee Replacement, appellant was a class 3 with a default impairment of 37 percent.[24] The medical adviser utilized the net adjustment formula to find a net adjustment to a grade D with 43 percent leg impairment.[25] However, the Board notes that he did not address any findings that supported a class 3 finding and appeared to be repeating what Dr. McGuirk stated with regard to modifiers and appellant's class. Moreover, the medical adviser also combined a diagnosis-based estimate with a loss of range of motion rating. Therefore, the Board finds that Dr. Levine did not adequately rate impairment in conformance with the A.M.A., *Guides.*

OWCP referred appellant to Dr. Brigham who issued a report dated December 21, 2010. Dr. Brigham noted that Dr. McGuirk's examination revealed range of motion was 125 degrees for the left knee, there was no instability of the knee and no documentation that the prosthesis was malaligned. Based on these findings and using the formula noted above with the net adjustment formula outlined at pages 516-18 and 521-22 of the A.M.A., *Guides*, under Table 16-3, Knee Regional Grid,[26] appellant's impairing diagnosis was total left knee replacement, which he rated as class 2, good results (good position, stable and functions) with default impairment of 25 percent of the leg. Dr. Brigham explained that appellant was appropriately classified as class

[21] A.M.A., *Guides* 497, 16.2 diagnosis-based impairment, which provides range of motion ratings are used primarily as a physical examination adjustment factor and is only used to determine actual impairment values when it is not possible to otherwise define impairment. It also provides that ratings based on range of motion cannot be combined with other approaches.

[22] *See Paul R. Evans, Jr.*, 44 ECAB 646 (1993); *John Constantin*, 39 ECAB 1090 (1988) (medical report not explaining how the A.M.A., *Guides* are utilized is of little probative value).

[23] *See Tonya R. Bell*, 43 ECAB 845, 849 (1992).

[24] *Supra* note 4.

[25] Grade D on page 511 for a class 3 total knee replacement is actually 40 percent impairment.

[26] *Supra* note 3 at 509.

2 based on Dr. McGuirk's examination findings, which revealed no instability of the left knee and no documented malalignment of the prosthesis. He applied the modifiers for functional history, physical examination and clinical studies found in Table 16-6, Table 16-7 and Table 16-8.[27] Dr. Brigham rated a functional history modifier zero, a physical examination modifier one and zero for clinical studies. He applied the net adjustment formula to arrive at a -1 net adjustment which yields 23 percent left lower impairment under the sixth edition of the A.M.A., *Guides*.[28] Dr. Brigham noted that, with regard to the range of motion methodology, the objective findings demonstrated that there was almost full extension and 125 degrees of flexion, which did not meet the threshold of ratable impairment pursuant to Table 16-23, Knee Motion Impairments. Dr. Pick reviewed the matter on June 3, 2012 and determined that there was no basis for any additional impairment.[29]

The Board finds that the opinion of Dr. Brigham is sufficiently well rationalized and based upon a proper factual background such that it establishes that appellant sustained 23 percent permanent impairment of the left leg. Dr. Brigham opined that to a reasonable degree of medical certainty appellant sustained 23 percent impairment of the left lower extremity in accordance with the A.M.A., *Guides.* There is no evidence which supports that appellant sustained a higher impairment which properly utilizes the A.M.A., *Guides.*

As appellant did not submit any medical evidence to support an additional schedule award greater than the 23 percent for the left lower extremity already awarded, the Board will affirm OWCP's June 5, 2012 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 23 percent impairment of the left lower extremity, for which he received a schedule award.

[27] A.M.A., *Guides* 516-19.

[28] *Id*.

[29] Medical evidence submitted by appellant after the March 15, 2011 schedule award decision did not specifically address how, under the A.M.A., *Guides*, he had any additional impairment of the left leg.

ORDER

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

Issued: May 9, 2013
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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