United States Department of Labor
Employees' Compensation Appeals Board

M.T., Appellant	)	
and	)	
DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SAFETY ADMINISTRATION, Philadelphia, PA, Employer	)	**Docket No. 13-983** **Issued: October 25, 2013**

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On March 18, 2013 appellant, through counsel, filed a timely appeal from a January 15, 2013 schedule award decision of the Office of Workers' Compensation Programs (OWCP). 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 schedule award decision.

ISSUE

The issue is whether appellant met her burden of proof to establish more than 17 percent impairment of the left lower extremity for which she received schedule awards.

On appeal, appellant's attorney asserts that a conflict in medical evidence has been created between the opinions of the attending physician and an OWCP medical adviser regarding the degree of appellant's left lower extremity impairment.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On February 12, 2005 appellant, then a 45-year-old transportation security screener, injured her left knee when she tripped and fell at work. A March 24, 2005 magnetic resonance imaging (MRI) scan study of the left knee demonstrated degenerative joint disease throughout the knee with chondromalacia patella, an undersurface tear of the posterior horn of the medial meniscus and an associated Baker's cyst. An x-ray of the left knee on April 20, 2005 demonstrated degenerative changes.

On May 23, 2005 OWCP accepted that appellant sustained a sprain/strain of the left knee/leg and hip/thigh region and a medial meniscus tear. Appellant received appropriate continuation of pay and compensation and was placed on the periodic compensation rolls.[2] Left knee arthroscopic surgery was authorized on December 28, 2005.

In July 2006, OWCP determined that a conflict in medical evidence had been created between the opinions of appellant's attending physician, Dr. Joseph Bernstein, and Dr. Kevin F. Hanley, an OWCP referral physician regarding whether she could return to full-time work. It referred her to Dr. Joseph A. Jelen, Jr., for an impartial evaluation.[3] Dr. Jelen provided an August 30, 2006 report, in which he advised that she could work eight hours a day. Appellant was referred for vocational rehabilitation in March 2007. In a decision dated April 4, 2008, OWCP found that the weight of the medical evidence rested with the opinion of Dr. Jelen and reduced her compensation benefits, effective April 13, 2008, based on her capacity to earn wages as a full-time cashier.

Appellant retired and elected civil service retirement benefits, effective February 15, 2009. On April 2, 2010 she submitted a schedule award claim and a January 19, 2010 report in which Dr. Nicholas Diamond, an osteopath, evaluated her left leg in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] Dr. Diamond indicated that appellant had a class 1 left hip strain and class 1 left patellofemoral arthritis. He applied the net adjustment formula and concluded that, under Table 16-4, Hip Regional Grid, she had one percent impairment and that, under Table 16-3, Knee Regional Grid, she had five percent impairment, for a combined six percent impairment of the left lower extremity.

On April 28, 2010 Dr. Morley Slutsky, Board-certified in occupational and preventive medicine and an OWCP medical adviser, reviewed the medical record including Dr. Diamond's report. The medical adviser indicated that maximum medical improvement was reached on January 19, 2010. He stated that appellant was not entitled to an impairment rating for a left hip condition because her hip condition had resolved with no objective abnormalities. For the left knee, Dr. Slutsky noted diagnoses of left knee patellofemoral arthritis and a medial meniscal tear

[2] The record reflects that appellant had a second job as a cashier with the Philadelphia Parking Authority. She returned to this sedentary position in October 2005.

[3] All three physicians are Board-certified in orthopedic surgery.

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

and that the arthritis condition was the most impairing. He disagreed with Dr. Diamond's assessment and concluded that appellant had a four percent left leg impairment.

On May 24, 2010 appellant was granted a schedule award for a four percent impairment of the left leg. Appellant's attorney timely requested a hearing and submitted x-ray studies dated July 23, 2010. A lumbar spine study showed degenerative changes involving the entire lumbar spine. A pelvis/hip study demonstrated minimal degenerative changes of both hips. The right knee demonstrated osteoarthritic changes and the left knee demonstrated progression of degenerative changes.

Subsequent to the hearing, held on September 21, 2010, appellant submitted a July 23, 2010 report, in which Dr. Menachem M. Meller, a Board-certified orthopedic surgeon, advised that she was last seen by Dr. Bernstein on August 25, 2008. Dr. Meller indicated that she did not have an antalgic limp and that there was no localized tenderness or spasm on examination of the left knee. He advised that appellant had functional hip, knee and ankle motion, normal sensation at L1 through S1 and no focal motor deficits. Dr. Meller reviewed the x-ray studies, noting that there had been progression of degenerative changes of the left knee when compared to the April 20, 2005 MRI scan study. He concluded that he saw nothing in terms of meniscal pathology, indicating that appellant had osteoarthritis and perhaps L5 radiculitis.

On September 20, 2010 Dr. Diamond revised his January 19, 2010 report. He indicated that he had reviewed the July 23, 2010 x-rays and again opined that appellant had one percent impairment of the left leg due to hip strain. For the left knee, appellant now had a class 2 impairment for a default value of 15 percent. Dr. Diamond additionally found that she had a class 1 impairment due to primary knee joint arthritis and, after applying the net adjustment formula, found that she had nine percent impairment due to primary left knee joint arthritis. He stated that appellant had a combined 24 percent impairment of the left leg.

By decision dated November 30, 2010, an OWCP hearing representative remanded the case for an OWCP medical adviser to review the additional medical evidence.

In a December 10, 2010 report, Dr. Craig Uejo, Board-certified in preventive and occupational medicine and an OWCP medical adviser, reviewed the medical evidence including Dr. Diamond's reports. The medical adviser indicated that maximum medical improvement was reached on January 19, 2010. He stated that Dr. Diamond incorrectly assigned left knee impairment for primary knee arthritis and for patellofemoral knee arthritis and then combined values. Dr. Uejo noted that the A.M.A., *Guides* provides that only one diagnosis can be considered per region, which in this case is the knee. The medical adviser found that, under Table 16-3, Knee Regional Grid, the diagnosis of primary knee joint arthritis with a three millimeter cartilage interval yielded a class 1 rating with a default rating of 7 percent whereas the diagnosis of patellofemoral arthritis with a one millimeter cartilage interval yielded a class 2 rating with a default score of 15 percent and that, since the patellofemoral rating was higher, it was to be used to rate lower extremity impairment. He found a functional history modifier of 2, based on a reported lower extremity activity scale score of 45 percent, which was consistent with a moderate deficit; a physical examination modifier of 1, based on mild motion deficits and no modifier for clinical studies. The medical adviser applied the net adjustment formula and concluded that appellant had 14 percent left leg impairment under the diagnosis-based method.

Dr. Uejo noted that, under the A.M.A., *Guides*, the range of motion method could not be combined with any other impairment method. He indicated that, under Table 16-23, Knee Motion Impairments, 105 degrees of knee flexion yielded 10 percent lower extremity impairment and, because the diagnosis-based method yielded a higher rating, it was used. The medical adviser further indicated that, under Table 16-4, Hip Regional Grid, for a diagnosis of strain, appellant had a class 1 rating with a default score of one percent. He indicated that she was not entitled to grade modifiers for functional history, physical examination and clinical studies and concluded that he had a one percent leg impairment based on Table 16-4. For the range of motion method, Dr. Uejo found no ratable impairment under Table 16-24, Hip Motion Impairments, noting that Dr. Diamond found normal hip motion. He concluded that the 14 percent lower extremity impairment for patellofemoral arthritis was the primary lower extremity impairment for the knee which, when combined with the 1 percent hip impairment, resulted in a total left leg impairment of 15 percent and when the prior award of 4 percent was subtracted, yielded an additional 11 percent impairment of the left leg.

On December 14, 2010 appellant was granted a schedule award for an additional 11 percent impairment, for a total 15 percent impairment of the left leg. OWCP found that Dr. Uejo properly calculated her schedule award in accordance with the sixth edition of the A.M.A., *Guides*. On December 20, 2010 appellant, through her attorney, requested a hearing and resubmitted medical evidence previously of record.

After a June 21, 2011 hearing, appellant submitted a June 15, 2011 report, in which Dr. Diamond noted his review of and disagreement with Dr. Uejo's report. Dr. Diamond indicated that taking his examination findings of January 19, 2010 into consideration, a grade modifier for physical examination grade 2 would be more accurate. He further noted that the March 24, 2005 MRI scan of the left knee revealed degenerative joint disease, chondromalacia patella and a tear of the posterior horn of the medial meniscus and that, at the time of his 2010 evaluation, appellant was five years post injury and continued to have daily and constant left knee pain with instability. Dr. Diamond opined that the patellofemoral problem was just as significant as the primary knee joint arthritis and, therefore, both conditions should be rated.

In a September 1, 2011 decision, an OWCP hearing representative remanded the case to OWCP. On remand, OWCP was to prepare a new statement of accepted facts and refer the entire case record to an OWCP medical adviser for review on the issue of whether appellant had left lower extremity impairment greater than the 15 percent previously awarded.

On September 9, 2011 OWCP forwarded an amended statement of accepted facts and medical record to Dr. Arnold T. Berman, a Board-certified orthopedic surgeon and an OWCP medical adviser, who was asked to provide an opinion regarding appellant's left leg impairment.

In a September 17, 2011 report, Dr. Berman noted reviewing the statement of accepted facts and medical record. He indicated that the basic issue was whether appellant should receive a schedule award for both patellofemoral arthritic disease of the knee and for primary knee joint arthritis and further, what was the role of a range of motion calculation. The medical adviser indicated that the only physical examination under consideration was that done by Dr. Diamond, whose measurements under Table 16-23, Knee Regional Grid, yielded 105 degrees of flexion, which equaled 10 percent leg impairment. He noted that range of motion impairment could not

be combined with diagnosis-based or other calculations under the A.M.A., *Guides*. Regarding the choice of diagnosis for diagnosis-based consideration, Dr. Berman noted that appellant had left knee osteoarthritis and that, as was typically the case, it affected both the tibiofemoral joint of the knee and patellofemoral articulation, both of which were part of the knee joint. The medical adviser indicated that the patellofemoral articulation showed a cartilage interval of one millimeter, which indicated that the patellofemoral articulation was affected to a greater degree than the tibiofemoral area, which had a cartilage interval of three millimeters, which was almost normal and would yield a lower impairment rating than that for the patellofemoral arthritis diagnosis, which had a more severe arthritic involvement and would result in greater impairment than the primary knee arthritis diagnosis. Dr. Berman found that, under Table 16-3, a one millimeter cartilage interval of the patellofemoral articulation resulted in a class 2 designation, grade C, for 15 percent impairment of the left lower extremity. He explained that section 16.3F of the A.M.A., *Guides* clearly indicated that, when there were multiple diagnoses, the most impairing diagnosis was rated because it was probable that it would incorporate the functional losses of the less-impairing diagnosis and in this case, the severe patellofemoral arthritis yielded a greater impairment under Table 16-3 than did the much milder diagnosis of primary knee arthritis. Dr. Berman opined that it would be highly inappropriate to include both diagnoses since, for all practical purposes, they were mutually inclusive and would be duplicative if both were included because this case did not rate the exception of a rare case of complex injury or occupational exposure that would support combining the multiple impairments in a single region. He further indicated that the medial meniscus tear diagnosis seen on the March 24, 2005 MRI scan study would not yield greater impairment and that patellofemoral disease was the primary diagnosis and, therefore, the only diagnosis to be utilized in rating appellant's left lower extremity impairment. Dr. Berman agreed with Dr. Diamond that appellant had a grade modifier of 2 for functional history and physical examination and that appellant had a grade modifier of 3 for clinical studies. The medical adviser applied the net adjustment formula, which increased her impairment from 15 to 16 percent. Dr. Berman agreed with Dr. Uejo that appellant had one percent impairment for left hip strain under Table 16-4, Hip Regional Grid. He concluded that, when the 16 percent knee impairment was combined with 1 percent hip impairment, this totaled 17 percent left leg impairment, with a January 19, 2010 date of maximum medical improvement. The medical adviser also recommended that the accepted conditions be expanded to include chondromalacia of the patella and osteoarthritis of the left knee.

On September 22, 2011 appellant was granted a schedule award for an additional 2 percent impairment, for a total 17 percent impairment of the left lower extremity. In correspondence dated September 22, 2011, OWCP additionally accepted left chondromalacia patella and localized primary osteoarthritis of the lower left leg.

On September 28, 2011 appellant's attorney requested a hearing and submitted a February 10, 2012 report, in which Dr. Diamond repeated his January 19, 2010 examination findings and his impairment rating of one percent for left hip strain. Dr. Diamond indicated that, for the left knee, a January 31, 2012 left knee x-ray showed a three centimeter measurement of medial joint space, a three centimeter measurement of lateral joint space and bone-on-bone measure of patellofemoral space. He indicated that appellant had a class 2 left knee patellofemoral arthritis of 20 percent with modifiers of 2 for functional history and physical examination and a zero modifier for clinical studies. Dr. Diamond applied the net adjustment formula to find a zero adjustment. He also found a class 1 impairment for primary left joint

arthritis, with the same grade modifiers. After applying the net adjustment formula, Dr. Diamond advised that appellant had a nine percent impairment of the left leg due to primary knee joint arthritis. He combined the impairments for patellofemoral arthritis and primary left knee joint arthritis, for a combined left lower extremity impairment of 27 percent.

A February 16, 2012 left knee MRI scan study showed knee arthropathy with severe lateral patellofemoral chondromalacia, a small meniscal tear and a complex Baker's cyst.

Subsequent to the February 27, 2012 hearing, appellant submitted bilateral knee x-rays dated January 31, 2012. Both knees demonstrated degenerative changes. The left knee showed joint surface sclerosis and narrowing of all compartments and narrowing especially of the patellofemoral compartment.

By decision dated May 7, 2012, an OWCP hearing representative remanded the case to OWCP. On remand, OWCP was to prepare a new statement of accepted facts that included the accepted conditions of chondromalacia patella, left and osteoarthritis of the left knee and refer it and the record to the medical adviser for review on the issue of whether had a left lower extremity impairment greater than the 17 percent previously awarded.

On remand, OWCP prepared an updated statement of accepted facts and referred the record to Dr. Berman, an OWCP medical adviser, for review. In a June 4, 2012 report, the medical adviser noted his prior report and indicated that the January 31, 2012 left knee x-ray demonstrated moderate degenerative change on the left, slightly increased and that the February 16, 2012 MRI scan study demonstrated arthropathy with severe lateral patellofemoral chondromalacia, a small central free-edge tear of the lateral meniscus and a complex Baker's cyst. He also reviewed Dr. Diamond's February 10, 2012 report, noting that Dr. Diamond rated both patellofemoral and overall osteoarthritis of the knee. Dr. Berman reiterated his previous opinion, that the sixth edition indicates that when there are multiple diagnoses within a specific region, the most impairing diagnosis is to be rated and, therefore, it would not be appropriate to include both patellofemoral and generalized osteoarthritis of the knee in the instant case where the overwhelming presentation was patellofemoral arthritis and it would be duplicative to include a second diagnosis. The medical adviser opined that, based upon his clinical experience as an orthopedic surgeon, appellant's left knee condition did not meet the criteria of the A.M.A., *Guides*, for a rare instance of complex injury or occupational exposure within a single region where the most impairing diagnosis does not accurately reflect the losses because, in this case, the most impairing diagnosis accurately reflected the losses. Dr. Berman found that, based upon his further review, appellant did not have left leg impairment greater than 17 percent.

In a June 6, 2012 decision, OWCP found that appellant was not entitled to an additional schedule award for a left leg impairment. On June 12, 2012 appellant, through her attorney, requested a hearing.[5] Evidence previously of record was resubmitted. In reports dated May 2 and October 11, 2012, Dr. Meller provided examination findings and advised that appellant had three-compartment osteoarthritis with patellofemoral compartment degeneration. He indicated that a February 16, 2012 MRI scan study revealed left knee arthropathy with severe lateral

[5] The hearing request was changed to a request for review of the written record.

patellofemoral chondromalacia, a small tear of the lateral meniscus and a complex Baker's cyst. Dr. Meller recommended additional arthroscopic surgery.

On January 3, 2013 OWCP authorized left knee arthroscopic surgery. In a January 15, 2013 decision, an OWCP hearing representative affirmed the June 6, 2012 decision.

LEGAL PRECEDENT

The schedule award provision of FECA[6] and its implementing federal regulations,[7] 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.[8] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9] For decisions issued after May 1, 2009, the sixth edition will be used.[10]

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).[11] 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 Clinical Studies (GMCS).[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[14]

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

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id*. at § 10.404(a).

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

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

[11] A.M.A., *Guides*, *supra* note 5 at 4, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

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

[13] *Id*. at 521.

[14] *Id*. at 23-28.

providing rationale for the percentage of impairment specified.[15] In determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[16]

ANALYSIS

The Board finds this case is not in posture for decision regarding appellant's left knee impairment. The Board initially finds that Dr. Berman, an OWCP medical adviser, was correct in his analysis of section 16.3f of the A.M.A., *Guides* which states:

> "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."[17]

In his February 10, 2012 report, Dr. Diamond, who had not examined appellant since January 2010, merely advised that, after review of left knee x-rays dated January 31, 2012, appellant had a grade 2, left knee impairment of 20 percent due to patellofemoral arthritis and a 9 percent left knee impairment due to primary left knee joint arthritis. In his June 4, 2012 report, Dr. Berman, the medical adviser, indicated that it would not be appropriate to include both patellofemoral and generalized osteoarthritis of the knee in the instant case, where the overwhelming presentation was patellofemoral arthritis and it would be duplicative to include a second diagnosis. Dr. Diamond presented no explanation as to why appellant's left knee condition was a rare case of complex injury or occupational exposure such that both a diagnosis of patellofemoral arthritis and a diagnosis of primary left knee joint arthritis should be rated. His opinion is, therefore, insufficient to establish that appellant is entitled to a schedule award based on both diagnoses.

The Board finds this case is not in posture for decision regarding the degree of appellant's left knee impairment due to the diagnosis of patellofemoral arthritis, the most impairing diagnosis of appellant's left knee. Table 16-3, Knee Regional Grid, provides the diagnostic criteria for rating a knee impairment. The section on patellofemoral arthritis indicates that, for a class 1 impairment, there must be at least a two millimeter cartilage interval and for a class 2 impairment, the cartilage interval ranges from no interval to one millimeter.[18] In his February 10, 2012 report, Dr. Diamond indicated that, upon his review of the January 31, 2012 left knee x-ray, appellant demonstrated bone-on-bone or no cartilage interval of the patellofemoral space. In his June 4, 2012 report, Dr. Berman, the medical adviser, indicated that the January 31, 2012 left knee x-ray demonstrated a moderate degenerative change, slightly increased. The medical adviser, however, did not provide an opinion regarding the specific

[15] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

[16] *Peter C. Belkind*, 56 ECAB 580 (2005).

[17] A.M.A., *Guides*, *supra* note 5 at 529.

[18] *Id*. at 511.

measurement of the patellofemoral cartilage defect and merely indicated that, based on his September 17, 2011 report, based on a one millimeter cartilage interval, appellant had 17 percent left lower extremity impairment.

Because Dr. Berman did not indicate the exact patellofemoral cartilage interval measurement in his June 4, 2012 report, the Board finds this case must be remanded to OWCP to obtain a supplementary report from him. If necessary, the medical adviser should obtain the x-ray films.[19] After this and such further development as OWCP deems necessary, OWCP shall issue an appropriate merit decision on the issue of appellant's entitlement to a left lower extremity schedule award.

CONCLUSION

The Board finds this case is not in posture for decision regarding appellant's left lower extremity impairment.

ORDER

IT IS HEREBY ORDERED THAT the January 15, 2013 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: October 25, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

[19] The January 31, 2012 x-ray report does not contain patellofemoral interval space measurements.