United States Department of Labor
Employees' Compensation Appeals Board

K.C., Appellant	)	
and	)	**Docket No. 14-949**
	)	**Issued: August 6, 2014**
DEPARTMENT OF HEALTH & HUMAN SERVICES, INDIAN HEALTH SERVICES, Oklahoma City, OK, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 20, 2014 appellant filed a timely appeal from a February 26, 2014 merit 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 this case.

ISSUE

The issue is whether appellant has more than 26 percent impairment to his right leg.

FACTUAL HISTORY

The case was before the Board on a prior appeal. By decision dated March 25, 2005, the Board noted that appellant had sustained a right knee injury on May 2, 2003 when he twisted his knee while walking up stairs in the performance of duty.[2] The accepted conditions in the case

[1] 5 U.S.C. § 8101 *et seq.*

[2] Docket No. 05-153 (issued March 25, 2005).

are right knee internal derangement, right medial meniscus tear, traumatic arthropathy of the right lower leg and right knee loose bodies. Appellant underwent right knee arthroscopic surgery on July 2, 2003. By decision dated September 24, 2004, OWCP issued a schedule award for a 16 percent right leg permanent impairment, based on partial medial and lateral meniscectomy and arthritis. The Board affirmed the September 24, 2004 decision, finding the evidence did not establish a greater impairment. The history of the case as provided in the Board's prior decision is incorporated herein by reference.

Appellant underwent right knee surgery on March 2, 2011. He submitted a report dated May 26, 2011 from Dr. Christopher DeLoache, an attending osteopath, who opined that appellant has a 50 percent right leg impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). Dr. DeLoache stated that the impairment was based on the meniscectomies, arthritis and "impairment referable to his medial and lateral weight-bearing surfaces referable to one millimeter cartilage intervals." OWCP referred the case for a second opinion examination by Dr. Michael Smith, a Board-certified physiatrist. In a report dated July 27, 2011, Dr. Smith provided a history and results on examination, opining that appellant had a 28 percent right leg permanent impairment under the A.M.A., *Guides*. Dr. Smith found a 15 percent impairment due to arthritis, and 13 percent for partial meniscectomy. In a report dated August 5, 2011, an OWCP medical adviser opined that the impairment should be 26 percent, as the 15 and 13 percent should be combined using the chart in the A.M.A., *Guides*, rather than simply added together.

By decision dated August 23, 2011, OWCP issued a schedule award for an additional 10 percent for the right leg. The period of the award was 31.20 weeks from May 26, 2011.

The record indicates that appellant underwent additional right knee surgery on May 9, 2012. In a report dated July 13, 2012, Dr. DeLoache opined that appellant had 54 percent right leg impairment. He stated that there was a mildly objective worsening of the right knee. OWCP referred appellant for a second opinion examination by Dr. Andrew Briggeman, an osteopath. In a report dated October 26, 2012, Dr. Briggeman opined that appellant had a 20 percent right leg impairment. By report dated November 29, 2012, an OWCP medical adviser also opined that appellant had a 20 percent impairment. The medical adviser indicated that the impairment was under Table 16-3 for primary knee joint arthritis.

OWCP asked Dr. DeLoache if he agreed with the medical adviser, and Dr. DeLoache signed a brief note on December 11, 2012 indicating that he did agree with the medical adviser. The record contains a January 8, 2013 report from a medical adviser stating that Dr. DeLoache's opinion of a 54 percent impairment was not accompanied by descriptive detail. In a report dated January 14, 2013, another OWCP medical adviser stated that the weight of the evidence was represented by Dr. Briggeman.

By decision dated January 17, 2013, OWCP found that appellant was not entitled to an additional schedule award. On November 1, 2013 appellant submitted an October 9, 2013 report from Dr. M. Stephen Wilson, an orthopedic surgeon, who provided a history and results on examination. Dr. Wilson opined that, under Table 16-3, appellant had a 30 percent right leg impairment based on Table 16-3. Dr. Smith found a 20 percent impairment for two millimeter

cartilage loss, and 13 percent for "grade 3 chondromalacia of both the trochlear groove and patella." Combining the 20 and 13 resulted in a 30 percent impairment.

In a report dated November 25, 2013, an OWCP medical adviser opined that the impairment under Table 16-3 was 20 percent. The medical adviser noted that, under the A.M.A., *Guides*, one diagnosis is appropriate in applying Table 16-3. The medical adviser indicated that since appellant had already received schedule awards for a 26 percent right leg impairment, he was not entitled to an additional impairment.

By decision dated February 26, 2014, OWCP found that the medical evidence was insufficient to establish an increased schedule award.

LEGAL PRECEDENT

Section 8107 provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[3] Neither FECA nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[4] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition.[5]

With respect to knee impairment, the A.M.A., *Guides* provide a regional grid at Table 16-3. The class of impairment (CDX) is determined based on specific diagnosis, and then the default value for the identified CDX is determined. The default value (grade C) may be adjusted by using grade modifiers for Functional History (GMFH, Table 16-6), Physical Examination (GMPE, Table 16-7) and Clinical Studies (GMCS, Table 16-8). The adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[6]

ANALYSIS

In the present case, OWCP accepted that appellant sustained right knee internal derangement, right medial meniscus tear, traumatic arthropathy of the right lower leg and right knee loose bodies as a result of a May 2, 2003 employment incident. Appellant received a schedule award for a 16 percent right leg permanent impairment on September 24, 2004 and an additional 10 percent on August 23, 2011. The issue presented is whether appellant has established an increased schedule award greater than the 26 percent previously awarded.

[3] 5 U.S.C. § 8107. This section enumerates specific members or functions of the body for which a schedule award is payable and the maximum number of weeks of compensation to be paid; additional members of the body are found at 20 C.F.R. § 10.404(a).

[4] *A. George Lampo*, 45 ECAB 441 (1994).

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

[6] The net adjustment is up to +2 (grade E) or -2 (grade A).

Appellant submitted an October 9, 2013 report from Dr. Wilson opining that appellant had a 30 percent impairment under Table 16-3 of the A.M.A., *Guides*. In this regard, the Board notes that for the diagnosis "primary knee joint arthritis" and a class 2 moderate problem, the default (grade C) impairment is 20 percent. The class 2 criteria is described as two millimeter cartilage interval. Dr. Wilson then applied the net adjustment formula, using grade 2 modifiers ("moderate problem") for functional history and physical examination, with no modifier for clinical studies as this factor was used for placement in the regional grid.[7] As the net adjustment formula above indicates, there would be no adjustment from the grade C default impairment of 20 percent.

Dr. Wilson then finds appellant also has an additional 13 percent impairment under Table 16-3 for "grade 3 chondromalacia of both the trochlear groove and patella." The Board notes that Table 16-3 does not provide a specific diagnostic criteria identified as chondromalacia. It appears that Dr. Wilson was applying the diagnosis of patellofemoral arthritis, which has a class 1 default value of 3 percent for full-thickness articular defect or ununited osteochondral fracture, and 10 percent for two millimeter cartilage interval. Dr. Wilson stated that the default impairment was 10 percent in this case.

The problem with this approach is that the A.M.A., *Guides*, as noted by the medical adviser, states that in most cases, only one diagnosis in a region such as the knee will be appropriate.[8] The A.M.A., *Guides* state, for example, if there are two diagnoses such as ankle instability and tibial tendinitis, the examiner should use the diagnosis with the highest impairment rating in that region.[9] Dr. Wilson does not explain why it is appropriate to use two diagnoses in applying Table 16-3. This is particularly important here, as the two diagnoses appear to be similar and there must be explanation as to why they represent distinct impairments under the A.M.A., *Guides*.

Based on the evidence of record, the Board finds that OWCP's medical adviser provided the report with sound medical reasoning as to the degree of permanent impairment. The A.M.A., *Guides* do indicate that in most cases the diagnosis with the highest impairment rating should be used in the knee regional grid, and this would result in a 20 percent impairment based on primary knee joint arthritis. Since appellant has received schedule awards for the right leg totaling 26 percent based on the knee injury, appellant has not established entitlement to an increased schedule award in this case.

On appeal, appellant argued that the evidence shows significant arthritic changes in his knee and he felt that the medical adviser should have requested a second opinion examination. The Board notes that it is appellant's burden of proof to establish an increased schedule award.[10] In this case, OWCP followed its procedures by referring the evidence to an OWCP medical

[7] *See* A.M.A., *Guides* 515-16.

[8] *Id.* at 497.

[9] *Id.*

[10] *Edward W. Spohr*, 54 ECAB 806, 810 (2003).

adviser for review.[11] For the reasons noted above, OWCP's medical adviser provided a reasoned medical opinion that constituted the weight of the medical evidence. There was no indication that a referral for a second opinion examination was warranted in this case.[12] Appellant may at any time submit new medical evidence showing an increased permanent impairment causally related to the employment injury.[13] Based on the evidence of record, the Board finds that appellant has not established more than a 26 percent right leg permanent impairment.

CONCLUSION

The Board finds that the evidence does not establish more than a 26 percent right leg permanent impairment.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 26, 2014 is affirmed.

Issued: August 6, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

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

[12] OWCP may require an examination as frequently and at the times and places as may reasonably be required. 5 U.S.C. § 8123(a).

[13] *See Linda T. Brown*, 51 ECAB 115 (1999).