United States Department of Labor
Employees' Compensation Appeals Board

E.B., Appellant	)	
	)	
and	)	**Docket No. 13-2131**
	)	**Issued: September 10, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Pittsburgh, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
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 September 17, 2013 appellant filed a timely appeal from the May 8, 2013 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 met his burden of proof to establish that he has more than a two percent permanent impairment of his right leg, for which he received a schedule award.

FACTUAL HISTORY

On June 27, 2012 appellant, then a 42-year-old letter carrier, filed an occupational disease claim alleging that he sustained osteoarthritis of his right knee due to the walking duties required by his job. He first became aware of his claimed condition on February 6, 2010 and first realized

[1] 5 U.S.C. §§ 8101-8193.

that it was caused or aggravated by his work on January 12, 2012. Appellant did not stop work.[2] In an accompanying statement, he advised that he first noticed that his right knee was hurting on February 6, 2010 when he had to walk through deep snow to deliver the mail. Appellant believed that his right knee condition was caused by his job requirements, including engaging in excessive walking and walking on uneven terrain and slippery surfaces.

In a May 5, 2012 report, Dr. Patrick J. McMahon, an attending Board-certified orthopedic surgeon, discussed appellant's medical history, including right knee pain associated with his work duties since February 2010. He noted that x-rays showed arthritis and signs of prior surgery in appellant's right knee. Dr. McMahon stated that, on examination, appellant reported tenderness over the right medial joint line of his right knee, but no tenderness over the right lateral joint line. Strength in appellant's right knee was normal and there was mild effusion.

OWCP accepted that appellant sustained aggravation of joint effusion of his right knee.

In a report dated February 21, 2013, Dr. Michael J. Platto, an attending Board-certified physical medicine and rehabilitation physician, detailed findings of his physical examination of appellant. He exhibited normal posture and gait and was able to squat down and get back up again independently. Dr. Platto had 100 degrees of active flexion of the right knee and 0 degrees of extension. He stated that appellant had moderate-to-severe crepitus in the right knee, motor strength was 5/5 in both legs and sensation was intact upon pinpoint testing. Appellant had a 13 degree varus deformity of his right knee. Dr. Platto provided an impairment rating evaluation for appellant's right leg. He noted that, under Table 16-3 (Knee Regional Grid) on page 509 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009), the most appropriate diagnosis would be for a class 1 total meniscectomy (medial or lateral) or meniscal transplant (allograft). Dr. Platto noted that multiple diagnoses could be applied, including anterior cruciate repair; but due to the lack of instability appellant would not qualify for an impairment based on this diagnosis. He stated that degenerative joint disease of the right knee could be considered, but that appellant's 7.4 millimeter medial joint space observed on x-rays would not qualify him for a schedule award because Table 16-3 on page 511 of the sixth edition of the A.M.A., *Guides* only provided impairment for a three millimeter cartilage interval or less. Dr. Platto concluded that appellant's meniscus injury was the most appropriate diagnosis for rating his right leg impairment under Table 16-3. Under Table 16-6 on page 516, appellant's American Academy of Orthopedic Surgery scale score of 66 and his normal posture and gait without orthosis meant that he had a grade modifier 0 for Functional History (GMFH). Under Table 16-7 on page 517, he had moderate palpatory findings in terms of crepitus, pain to palpation and mild restriction upon knee flexion which warranted a grade modifier 1 for Physical Examination (GMPE).

Dr. Platto also found that appellant had a 13 degree varus deformity of the right knee, noting that the sixth edition of the A.M.A., *Guides* does not contain a table which gives a

[2] Appellant originally sustained a twisting injury to his right knee in 1997 when he punched a punching bag while serving in the U.S. Army. He had previously undergone right knee surgery, including anterior cruciate ligament repair and medial meniscectomy in April 1997, meniscectomy in April 2001, anterior cruciate cadaver repair and cadaver meniscus replacement in March 2002 and medial meniscectomy and microfracture surgery in December 2003.

specific rating for varus deformity. He stated that Table 17-10 on page 537 of the fifth edition of the A.M.A., *Guides* stated that a 13 degree varus deformity would be a severe impairment warranting a grade modifier 3. Dr. Platto stated that appellant did not have a grade modifier for Clinical Studies (GMCS) because x-ray and magnetic resonance imaging (MRI) scan reports were used to make the definition of class. He applied the net adjustment formula to find a net adjustment modifier of +1 which meant that, after moving one place to the right of the seven percent default value found on Table 16-3, appellant had a diagnosis-based impairment rating of eight percent for his right leg. Dr. Platto stated that page 543 of the sixth edition provided, if active range of motion impairment percentage is greater than the percentage impairment derived from a diagnosis-based class, then the impairment is rated by range of motion as a stand-alone rating. Under Table 16-23 on page 549, appellant's 100 degrees of active flexion of his right knee warranted a 10 percent rating for his right leg. Under Table 16-17 on page 545, he had a grade modifier 0 for functional history and therefore the total impairment of his right leg, based on the range-of-motion method, was 10 percent.[3]

On March 15, 2013 appellant filed a claim for a schedule award due to his accepted work injury.

On April 14, 2013 Dr. Arnold T. Berman, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, noted that Dr. Platto made reference to the standards of both the fifth and sixth editions of the A.M.A., *Guides*, but stated that this was "not appropriate and invalidates his recommendation since only [the sixth edition of the A.M.A., *Guides*] is appropriately used for this calculation." He noted that the only accepted condition for appellant's claim was aggravation of joint effusion of the right knee. Dr. Berman stated that this was based upon a knee sprain and did not constitute an aggravation of osteoarthritis since the "accepted condition does not state that it is aggravation of osteoarthritis." He recommend that appellant receive a schedule award for the right knee based upon Table 16-3 on page 509 of the sixth edition of the A.M.A., *Guides* for the class 1 diagnosis of "Strain; tendinitis" which involved "palpatory findings and/or radiologic findings." Dr. Berman determined that appellant fell under the default value of two percent of the right leg. Under Table 16-6, Table 16-7 and Table 16-8 on pages 516 through 520 of the sixth edition, appellant had a grade modifier 1 for functional history adjustment, grade modifier 1 for physical examination and grade modifier 1 for clinical studies. Application of the net adjustment formula meant that there was zero adjustment from the two percent default value. Dr. Berman stated that appellant reached maximum medical improvement on February 21, 2013 and concluded that the total impairment of his right leg was two percent.

In a May 8, 2013 decision, OWCP granted appellant a schedule award for a two percent permanent impairment of his right leg. The award ran for 5.76 weeks from February 21 to April 2, 2013 and was based on Dr. Berman's impairment rating using the physical findings by Dr. Platto.

[3] In a May 30, 2013 report, Dr. McMahon indicated that appellant had trace effusion in his right knee.

LEGAL PRECEDENT

The schedule award provision of FECA[4] and its implementing regulations[5] 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 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. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[6] For OWCP decisions issued on or after May 1, 2009, the sixth edition of the A.M.A., *Guides* (6th ed. 2009) is used for evaluating permanent impairment.[7]

In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the knee, the relevant portion of the leg for the present case, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[8] After the class of diagnosis (CDX) is determined from the Knee Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the grade modifier for functional history, grade modifier for physical examination and grade modifier for clinical studies. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[9] 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.[10]

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.[11] There is no basis for including subsequently acquired conditions.[12]

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[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404 (1999).

[6] *Id*.

[7] *See* FECA Bulletin No. 9-03 (issued March 15, 2009). For OWCP decisions issued before May 1, 2009, the fifth edition of the A.M.A., *Guides* (5th ed. 2001) is used.

[8] *See* A.M.A., *Guides* 509-11 (6th ed. 2009).

[9] *Id.* at 515-22.

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

[11] *D.F.*, 59 ECAB 288 (2007); *Kenneth E. Leone*, 46 ECAB 133 (1994).

[12] *R.G.*, Docket No. 13-220 (issued May 9, 2013).

When a claimant does not demonstrate any permanent impairment caused by the accepted exposure, the claim is not ripe for consideration of any preexisting impairment.[13] OWCP procedures provide:

> "Impairment ratings for schedule awards include those conditions accepted by the OWCP as job-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. There are no provisions for apportionment under FECA. Rated impairment should reflect the total loss as evaluated for the schedule member at the time of the rating exam[ination].[14]

Chapter 16 of the sixth edition of the A.M.A., *Guides,* pertaining to the lower extremities, provides that diagnosis-based impairment is "the primary method of calculation for the lower limb" and that most impairments are based on the diagnosis-based impairment where impairment class is determined by the diagnosis and specific criteria as adjusted by the grade modifiers for functional history, physical examination and clinical studies.[15] Chapter 16 further provides:

> "Alternative approaches are also provided for calculating impairment for peripheral nerve deficits, complex regional pain syndrome, amputation and range of motion. Range of motion is primarily used as a physical examination adjustment factor and is only used to determine actual impairment values when it is not possible to otherwise define impairment."[16]

Chapter 15 of the A.M.A., *Guides*, pertaining to the upper extremities, provides that the range of motion method for evaluating permanent impairment of the upper extremities may be used to determine actual impairment values where a diagnosis-based impairment grid permits its use.[17] When the diagnosis-based impairment grid permits such use, as evidenced by an asterisk (*) with explanatory text, the range of motion method is a stand-alone method for determining impairment and is not combined with the diagnosis-based impairment.[18] The Board notes, however, that the diagnosis-based grids of Chapter 16 do not contain any asterisks with explanatory text providing for use of the range of motion method to evaluate permanent impairment of the lower extremities.[19] With respect to rating of the lower extremities, the

[13] *Thomas P. Lavin,* 57 ECAB 353 (2006).

[14] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(d) (February 2013).

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

[16] *Id*.

[17] *Id.* at 387.

[18] *Id.* at 391-405.

[19] *Id.* at 501-15.

Summary portion of Chapter 16 states, "Only, if no other approach is available to rating, calculate impairment based on range of motion as explained in Section 16.7."[20]

While the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[21] Accordingly, once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[22]

ANALYSIS

OWCP accepted that appellant sustained aggravation of joint effusion of his right knee.[23] In a May 8, 2013 decision, it granted him a schedule award for a two percent permanent impairment of his right leg. The award was based on the impairment rating of Dr. Berman, a Board-certified orthopedic surgeon serving as an OWCP medical adviser. Dr. Berman used the physical findings of Dr. Platto, an attending Board-certified physical medicine and rehabilitation physician.

The Board finds that the case is not in posture for decision regarding whether appellant has more than a two percent permanent impairment of his right leg, for which he received a schedule award.

On appeal, counsel argued that appellant had a 10 percent permanent impairment of his right leg given that Dr. Platto found such an impairment on February 21, 2013 due to limited right knee motion, as calculated under Section 16.7 of the A.M.A., *Guides.* Chapter 16 of the sixth edition of the A.M.A., *Guides,* pertaining to the lower extremities, provides that diagnosis-based impairment is the primary method of calculation for the lower limb. The range of motion rating method is primarily used as a physical examination adjustment factor and is only used to determine actual impairment values when it is not possible to otherwise define impairment under the diagnosis-based rating method.[24] The Board notes that Dr. Platto did not adequately explain why it was appropriate to use the range of motion rating method in this case. Moreover, it was not appropriate for Dr. Platto to use the fifth edition of the A.M.A., *Guides* when he derived grade modifiers because the sixth edition of the A.M.A., *Guides* was in effect as the time of his February 21, 2013 evaluation.[25]

[20] Section 16.7 of Chapter 16 (entitled "Range of Motion Impairment") provides, "This section is to be used as a stand-alone rating when other grids refer you to this section or no other diagnosis-based sections of this chapter are applicable for impairment rating of a condition." *Id.* at 543.

[21] *Russell F. Polhemus,* 32 ECAB 1066 (1981).

[22] *See Robert F. Hart,* 36 ECAB 186 (1984).

[23] Appellant had previously undergone right knee surgery, anterior cruciate ligament repair and medial meniscectomy in April 1997, meniscectomy in April 2001, anterior cruciate cadaver repair and cadaver meniscus replacement in March 2002 and medial meniscectomy and microfracture surgery in December 2003.

[24] *See supra* notes 15 through 20.

[25] *See supra* note 7.

In determining that appellant had a two percent permanent impairment of his right leg, Dr. Berman stated that, under Table 16-3 on page 509 of the sixth edition of the A.M.A., *Guides*, he should be rated under the diagnosis-based condition of "Strain; tendinitis" of the right knee. He found that this condition fell under class 1 and had a default value of two percent of the right leg.[26] The Board notes, however, that Dr. Berman did not adequately explain why he chose to rate appellant's right knee impairment under the diagnosis-based condition of "Strain; tendinitis" given that appellant's claim had been accepted for aggravation of joint effusion of his right knee. Dr. Berman advised that appellant's accepted condition was "based upon a knee sprain," but his claim was not accepted for this particular medical condition. Under the A.M.A., *Guides*, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[27] Dr. Berman noted that a claimant fell under class 1 for "Strain; tendinitis" on Table 16-3 for "palpatory findings and/or radiologic findings," but he did not explain how appellant's specific findings met this requirement. It is also noted that appellant had multiple right knee surgeries prior to sustaining the accepted condition of aggravation of joint effusion of his right knee. 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.[28]

Therefore, the case shall be remanded to OWCP in order to request that Dr. Berman or, if appropriate, another medical specialist, provide additional clarification of these matters pertaining to appellant's right knee impairment.[29] After this development directed by the Board, OWCP shall issue an appropriate decision regarding appellant's entitlement to schedule award compensation.

CONCLUSION

The Board finds that the case is not in posture for decision regarding whether appellant has more than a two percent permanent impairment of his right leg, for which he received a schedule award.

[26] Dr. Berman further indicated that, under Table 16-6, Table 16-7 and Table 16-8 on pages 516 through 519 of the sixth edition, appellant had a grade modifier 1 for functional history adjustment, grade modifier 1 for physical examination and grade modifier 1 for clinical studies. He stated that application of the net adjustment formula meant that there was no movement from the default value of two percent for appellant's right leg and concluded that the total impairment of his right leg was two percent.

[27] *See supra* note 10.

[28] *See supra* notes 11 through 14.

[29] On appeal, counsel argued that appellant had a 10 percent permanent impairment of his right leg given that Dr. Platto found such an impairment on February 21, 2013 due to limited right knee motion, as calculated under Section 16.7 of the A.M.A., *Guides.* Chapter 16 of the sixth edition of the A.M.A., *Guides,* pertaining to the lower extremities, provides that diagnosis-based impairment is the primary method of calculation for the lower limb. The range of motion rating method is primarily used as a physical examination adjustment factor and is only used to determine actual impairment values when it is not possible to otherwise define impairment under the diagnosis-based rating method. The Board notes that Dr. Platto did not adequately explain why it was appropriate to use the range of motion rating method in this case. Moreover, it was not appropriate for Dr. Platto to use the fifth edition of the A.M.A., *Guides* when he derived grade modifiers because the sixth edition of the A.M.A., *Guides* was in effect at the time of his February 21, 2013 evaluation.

ORDER

IT IS HEREBY ORDERED THAT the May 8, 2012 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: September 10, 2014
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