United States Department of Labor
Employees' Compensation Appeals Board

J.Y., Appellant	)	
and	)	**Docket No. 14-1807**
	)	**Issued: March 9, 2015**
GENERAL SERVICES ADMINISTRATION, PUBLIC BUILDINGS SERVICE, Kansas City, MO, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On August 13, 2014 appellant filed a timely appeal from a February 20, 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.[2]

ISSUE

The issue is whether appellant established more than a one percent permanent impairment of the right lower extremity and a three percent permanent impairment of the left lower extremity, for which he received schedule awards.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the issuance of the February 20, 2014 OWCP decision, appellant submitted new evidence. The Board is precluded from reviewing evidence which was not before OWCP at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c)(1).

On appeal appellant contends that he is entitled to a greater percentage of permanent impairment because of the July 23, 2011 report from Dr. Allison Edwards, a Board-certified internist.

FACTUAL HISTORY

OWCP accepted that appellant, then a 39-year-old heating, ventilating, and air conditioning (HVAC) mechanic work leader, sustained bilateral chondromalacia patellae on June 17, 2003 when slipped and fell down off some steps while in the performance of duty. It authorized left knee arthroscopic surgery.

On June 10, 2011 appellant filed a claim for a schedule award and submitted a November 9, 2010 report from Dr. Olumuyiwa Paul, a Board-certified orthopedic surgeon, who opined that appellant had a three percent permanent impairment of the left lower extremity and a three percent permanent impairment of the right lower extremity under Table 16-3[3] of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). Dr. Paul indicated that he used the diagnosis-based impairment method to determine appellant's impairment rating based on the diagnosis of patellofemoral arthritis as patellofemoral pain was not specifically listed in the *Knee Regional Grid* and this was the most similar diagnosis listed.

On July 13, 2011 OWCP medical adviser, Dr. Christopher R. Brigham, reviewed the medical evidence of record and a statement of accepted facts. He reviewed Dr. Paul's November 9, 2010 report and explained that Dr. Paul utilized the incorrect diagnosis for rating appellant's injury. Dr. Brigham indicated that the arthritis section should not have been used as it was not supported by the objective findings as there were "no radiographic abnormalities." He explained that the impairment should have been rated on the basis of residual pain with history of direct contusion to the knee. Dr. Brigham determined that the date of maximum medical improvement was February 3, 2010. He placed appellant in a diagnosis class 1 rating for residual pain under Table 16-3, *Knee Regional Grid*, of the sixth edition of the A.M.A., *Guides*. Dr. Brigham assigned a grade modifier of 1 for Functional History (GMFH) for "mild problems," a grade modifier of 2 for Physical Examination (GMPE) on the basis that the physical examination revealed crepitus bilaterally, and a grade modifier of zero for Clinical Studies (GMCS) as clinical studies revealed no abnormal findings. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), he found that (1-1) + (2-1) + (0-1) resulted in a net grade modifier of zero, resulting in an impairment class 1, grade C, equaling a one percent permanent impairment of the right and left lower extremities.

In a July 23, 2011 report, Dr. Allison R. Edwards, a Board-certified internist, indicated that appellant had been her patient for over 13 years and she had watched his knees get progressively worse over time. She stated that his original injury stemmed from his fall from a ladder on June 17, 2003. Dr. Edwards found pain on medial and lateral palpation of both knee joints, residual fluid in the right knee joint, and both knee joints were positive for crepitations. She determined that appellant had reached maximum medical improvement in January 2010.

[3] Table 16-3, pages 509-11 of the sixth edition of the A.M.A., *Guides* is entitled *Knee Regional Grid -- Lower Extremity Impairments.*

Dr. Edwards opined that, under Table 16-3 of the A.M.A., *Guides*, the diagnosis of chondromalacia patellae was not listed so the diagnosis of meniscal injury was used instead. The magnetic resonance imaging (MRI) scan studies of appellant's knees showed a horizontal longitudinal oblique tear of the posterior horn and body of the medial meniscus of his left and right knees, which "could represent mild free edge degenerative tearing." There was also associated mild heterogeneity of the medial femoral condyle cartilage that "could represent early degenerative changes in that right knee." The right knee was also positive for fluid. Dr. Edwards concluded that appellant had a class 1 diagnosis, a net adjustment of 2 for the left knee and 1 for the right knee, equaling a seven percent permanent impairment of the left lower extremity and a six percent permanent impairment of the right lower extremity.

By decision dated August 25, 2011, OWCP granted appellant a schedule award for one percent permanent impairment to the right lower extremity and one percent permanent impairment to the left lower extremity. The award ran for 5.76 weeks for the period February 3 through March 15, 2010.

On August 30, 2011 appellant requested reconsideration and submitted a July 18, 2011 MRI scan of the left knee which showed a normal patellofemoral retinaculum, cartilage surfaces within normal limits, and medial and lateral meniscus tears.

By decision dated November 25, 2011, OWCP denied modification of its August 25, 2011 decision. It found that Dr. Edwards' report was based on an inaccurate history, as she believed appellant had fallen off a ladder. Further, OWCP found that the impairment rating was based on meniscus tear, which had never been accepted. Thus, the weight of evidence was found to be with Dr. Brigham.

In an appeal request form received by OWCP on September 1, 2011, appellant requested reconsideration of the August 25, 2011 decision, claiming that the premium pay had not been included in his pay rate for the schedule award. He submitted payroll reports.

By decision dated February 29, 2012, OWCP modified its August 25, 2011 decision to include the premium pay for appellant's third shift differential in his weekly pay rate.

On April 20, 2012 appellant requested reconsideration of the August 25, 2011 schedule award and submitted reports dated January 16 through April 13, 2012 from Dr. Jerry Farber, a Board-certified orthopedic surgeon, who diagnosed chronic post-traumatic patellar tendinitis with tears of the medial and lateral menisci and early arthritis and indicated that appellant had evidence of chondromalacia of the patella. Dr. Farber also submitted a July 18, 2011 MRI scan of the right knee which revealed normal patellofemoral cartilage, mild free edge irregularity of the body of the medial meniscus, and small joint effusion.

By decision dated July 13, 2012, OWCP denied appellant's request for reconsideration of the schedule award without considering the merits, finding that he had not submitted pertinent new and relevant evidence and had not shown that it erroneously applied or interpreted a point of law not previously considered. It found he had failed to offer a new impairment rating.

On July 12, 2013 appellant requested reconsideration and submitted a June 26, 2013 report from Dr. Paul who disagreed with Dr. Brigham's impairment rating and argued that the

diagnosis of knee contusions was incongruous with appellant's medical history. Dr. Paul explained that, since patellofemoral arthritis fell within the spectrum of clinical abnormalities known as chondromalacia patella, his decision to use this diagnosis as the basis for rendering appellant's impairment rating was valid and recommended in accordance with the A.M.A., *Guides*.

By decision dated July 18, 2013, OWCP denied modification of its August 25, 2011 schedule award decision. It found that Dr. Paul's report did not meet any of the requirements for an impairment rating. OWCP did not reference the date of maximum medical improvement; it did not provide an impairment rating; and did not provide a diagnosis pertinent to the accepted injuries.

On July 20, 2013 appellant requested reconsideration and submitted a May 6, 2013 report from Dr. Paul diagnosing bilateral chondromalacia patellae and a June 21, 2012 report from Dr. R. Frank Henn, III, a Board-certified orthopedic surgeon, diagnosing left knee degenerative medial meniscus tear.

By decision dated September 13, 2013, OWCP denied modification of its August 25, 2011 schedule award decision, because the new evidence failed to give new findings not previously considered to support additional impairment.

On October 30, 2013 appellant requested reconsideration and submitted a September 9, 2013 report from Dr. Kathleen Fink, a Board-certified physiatrist, who diagnosed bilateral chondromalacia patella and meniscus tear.

On January 28, 2014 OWCP forwarded the case to an OWCP medical adviser. It asked him to review especially Dr. Paul's November 9, 2010 report and Dr. Brigham's July 13, 2011 report as well as the June 26, 2013 rebuttal report of Dr. Paul.

On January 29, 2014 Dr. Lawrence A. Manning, an OWCP medical adviser reviewed the medical record and determined that the date of maximum medical improvement was June 17, 2004, one year from the date of injury. He found that the A.M.A., *Guides* required radiographic findings of knee arthritis with at least three millimeter of cartilage narrowing in the patellofemoral joint and; therefore, Dr. Paul's impairment rating based on the diagnosis of patellofemoral arthritis did not follow the sixth edition of the A.M.A., *Guides*. Dr. Manning indicated that the diagnosis of knee contusion was appropriate given the lack of x-ray findings for patellofemoral arthritis and the July 18, 2011 MRI scans which revealed patellofemoral cartilage within normal limits. Utilizing Table 16-3, he concluded that appellant had a one percent permanent impairment of the right knee based on the diagnosis of contusion as there was no evidence of patellofemoral joint space narrowing or full thickness chondral loss. Dr. Manning further found that appellant had a three percent permanent impairment of the left knee based on the July 18, 2011 MRI scan revealing a medial and lateral meniscus tear along with the knee contusion under Table 16-3 of the A.M.A., *Guides*.

By decision dated February 20, 2014, OWCP expanded appellant's claim to include medial meniscus tear of the left knee and modified the August 25, 2011 schedule award decision. It granted him a schedule award for a three percent permanent impairment to the left lower

extremity. OWCP noted that the one percent permanent impairment previously awarded would be subtracted for a total additional left lower extremity impairment of two percent. The award ran for 5.76 weeks for the period April 26 through June 5, 2010.

LEGAL PRECEDENT

The schedule award provisions of FECA[4] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a mater which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized 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 OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[5] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[6]

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).[7] Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[8] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX). Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[9]

Section 8123(a) provides that, if there is a disagreement between the physician making the examination for the United States and the physician of the employing establishment, the Secretary shall appoint a third physician of the employee to make an examination.[10] The implementing regulations state that, if a conflict exists between the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to

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[4] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[5] *See Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5.a (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[7] A.M.A., *Guides* (6th ed. 2009), page 3, section 1.3, *The of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement*.

[8] *Id.* at 494-531 (6th ed. 2009).

[9] *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[10] *Supra note* 1 at § 8123(a),

make an examination. This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty who has no prior connection with the case.[11]

ANALYSIS

On appeal appellant contends that he is entitled to a greater percentage of permanent impairment than that award by OWCP based on the July 23, 2011 report from Dr. Edwards. OWCP initially accepted his claim for bilateral chondromalacia patellae due to a slip and fall on June 17, 2003. In an August 25, 2011 decision, it granted appellant a schedule award for one percent permanent impairment to the right lower extremity and one percent permanent impairment to the left lower extremity. Subsequently, in its decision dated February 20, 2014, OWCP accepted left knee medial meniscus tear and modified the August 25, 2011 schedule award decision to grant appellant a schedule award for a three percent permanent impairment to the left lower extremity. Appellant claimed entitlement to increased schedule award compensation.

In her July 23, 2011 report, Dr. Edwards opined that, under Table 16-3 of the A.M.A., *Guides*, appellant had meniscal tears in both knees based on the July 18, 2011 MRI scans. She concluded that appellant had a class 1 diagnosis, with a net adjustment of 2 for the left knee and 1 for the right knee, equaling a seven percent permanent impairment of the left lower extremity and a six percent permanent impairment of the right lower extremity. On January 29, 2014 Dr. Manning found that appellant had a three percent permanent impairment of the left knee based on the July 18, 2011 MRI scan revealing a medial and lateral meniscus tear along with the knee contusion under Table 16-3 of the A.M.A., *Guides*.

OWCP than accepted the left knee medial meniscus tear and increased the impairment rating to three percent for the left lower extremity. Now that the meniscus tear has been accepted, a conflict has been created between Dr. Manning's three percent impairment and Dr. Edwards' seven percent impairment.[12]

Section 8123(a) provides that, if there is disagreement between the physician for the United States, and the physician of the employing establishment, the Secretary shall appoint a third physician who shall make an examination.[13] The case shall, therefore, be remanded for OWCP to refer appellant for an impartial medical examination on the issue of the extent of the left lower extremity. As OWCP has not accepted meniscus tear of the right knee, the Board finds the weight of the evidence rest with the report of Dr. Manning and the Board affirms the rating for the right lower extremity.

[11] 20 C.F.R. § 10.321.

[12] *See supra* note 9.

[13] *Supra* note 10.

CONCLUSION

The Board finds that OWCP properly determined that appellant had one percent permanent impairment of the right lower extremity. As to the left lower extremity, the case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the February 20, 2014 decision of the Office of Workers' Compensation Programs is affirmed as to the right lower extremity and remanded as to the left lower extremity for further action consistent with this decision of the Board.

Issued: March 9, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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