United States Department of Labor
Employees' Compensation Appeals Board

S.S., Appellant	)	
and	)	**Docket No. 15-210**
	)	**Issued: March 16, 2015**
DEPARTMENT OF JUSTICE, ALCOHOL, TOBACCO, FIREARMS & EXPLOSIVES, Washington, DC, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 29, 2014 appellant filed a timely appeal from the September 9, 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 met his burden of proof to establish more than a 13 percent permanent impairment of his right leg, for which he received a schedule award.

FACTUAL HISTORY

OWCP accepted that on September 15, 2009 appellant, then a 47-year-old special agent/criminal investigator, sustained injury at work when his foot got caught in a carpet, causing him to fall. It accepted his claim for lesion of left planar nerve, left foot sprain, left lateral

[1] 5 U.S.C. §§ 8101-8193.

collateral ligament sprain, right knee old bucket handle tear of medial meniscus, right knee lateral meniscus derangement, and left plantar fibromatosis. On September 20, 2011 appellant was practicing take-down techniques during Control and Arrest Training and experienced a sharp pain in his knees. OWCP accepted his claim for bilateral knee sprains, right knee tear of the medial meniscus, right knee tear of lateral meniscus, and bilateral osteoarthritis of the lower legs.[2]

On October 1, 2012 Dr. Christian M. Peterson, an attending Board-certified orthopedic surgeon, performed OWCP-approved arthroscopic right knee surgery, including partial medial and lateral meniscectomy and microfracture repair of the lateral femoral condyle.

On July 17, 2013 appellant filed a claim (Form CA-7) alleging that he was entitled to a schedule award due to his accepted work injuries.

In a July 5, 2013 report, Dr. Peterson detailed appellant's medical history and reported his examination findings of the right knee. He diagnosed status post partial medial and lateral meniscectomy of the right knee, degenerative joint disease of the right knee, status post deep vein thrombosis of the right lower extremity, and recurrent medial meniscus tear of the right knee. Dr. Peterson indicated that he was applying the standards of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001). He found that appellant had 22 percent permanent impairment of his right leg. The 22 percent impairment resulted from the combination of 13 percent impairment for partial medial and lateral meniscal tear and 9 percent impairment for degenerative joint disease.

In a July 31, 2013 report, Dr. Kenneth D. Sawyer, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, reviewed the medical evidence of record, including the reports of Dr. Peterson. He opined that Dr. Peterson provided an improper assessment of appellant's permanent impairment. Dr. Sawyer stated that it was unclear which edition of the A.M.A., *Guides* Dr. Peterson used to calculate impairment. He felt that Dr. Peterson might have actually used the sixth edition of the A.M.A., *Guides* (6th ed. 2009) based on his use of adjustment modifiers. Dr. Sawyer asserted that Dr. Peterson improperly combined impairments for two different pathologic conditions in the right knee joint, noting that the sixth edition of the A.M.A., *Guides* provides that, in most cases, an impairment rating of only one diagnosis per region is appropriate. An impairment rating of two separate diagnoses affecting the same joint was allowed by the sixth edition of the A.M.A., *Guides* only in unusual circumstances. Dr. Sawyer recommended that a supplemental evaluation report should be obtained from Dr. Peterson or a second opinion physician, in order to obtain a proper impairment rating. This evaluation must address all the work-related medical conditions and preexisting conditions affecting both legs under the sixth edition of the A.M.A., *Guides*.

OWCP referred the case back to Dr. Peterson. In a report dated September 5, 2013, Dr. Peterson asserted that his rationale for assigning maximum medical improvement was

[2] OWCP also accepted work injuries, under different claim files (xxxxxx255 and xxxxxx731), that occurred prior to appellant's September 15, 2009 work injury. On March 13, 2006 appellant sustained right knee and leg sprains, right knee internal derangement, and medial meniscus tear of the right knee due to a motor vehicle accident. On June 11, 2007 he sustained bilateral knee sprains, right elbow sprain, loose body right upper arm, lumbosacral strain, and contusion of iliac crest due to twisting his knees and falling backwards on heavy equipment.

detailed in his prior report of July 5, 2013. He stated that there was no preexisting rating of the right knee and indicated that the prior impairment rating he provided was based on the sixth edition of the A.M.A., *Guides*. Dr. Peterson asserted that appellant's right knee condition represented a combined pathologic condition in the same joint, which is allowed in the sixth edition of the A.M.A., *Guides*. He stated that appellant was suffering from a left foot condition, which was not in his area of expertise and that he would attempt to find a different examiner to determine impairment of the left foot.

In a September 13, 2013 report, Dr. Howard B. Barker, an attending Board-certified orthopedic surgeon, evaluated appellant's left leg under the sixth edition of the A.M.A., *Guides*. He found that he had a class 1 peripheral nerve impairment and concluded that he had a one percent impairment of the left leg, under Table 16-2, based on a nerve impairment.

On October 24, 2013 Dr. Peterson asserted that appellant's left leg impairment of nine percent due to left knee deficits would be combined with his left leg impairment of one percent identified by Dr. Barker, to result in a 10 percent impairment of the left leg under the A.M.A., *Guides*.

In a December 4, 2013 report, Dr. Sawyer was unable to provide an impairment rating of the left leg based on the medical evidence of file. He recommended an evaluation by a second opinion physician, to assess impairment of the left leg based on the sixth edition of the A.M.A., *Guides*. Regarding the right leg, Dr. Sawyer stated that Dr. Peterson had failed to sufficiently support the 22 percent impairment rating he provided, which was calculated by combining impairments due to two separate diagnoses affecting the right knee joint, arthritis and meniscal tear. He argued that, although Dr. Peterson was correct to note that the sixth edition of the A.M.A., *Guides* allows for the combination of two separate diagnoses in unusual cases, there was nothing unusual about appellant's situation that would warrant this. Dr. Sawyer noted that the presence of knee osteoarthritis and meniscus pathology was common. Therefore, he provided an impairment rating based upon a single diagnosis in the right knee, partial medial and lateral meniscectomy. Dr. Sawyer provided his calculations supporting 13 percent impairment rating of the right lower extremity based on this diagnosis, finding that appellant had a Class of Diagnosis (CDX) one condition with a default value of 10 percent under Table 16-3 (Knee Regional Grid) beginning on page 509. He determined that appellant had a grade modifier of 1 for Functional History (GMFH), a grade modifier of 1 for Physical Examination (GMPE), and a grade modifier of 3 for Clinical Studies (GMCS). Application of the net adjustment formula justified a move two spaces to the right of the default value on Table 16-3 and rendering a total right leg impairment of 13 percent. Dr. Sawyer noted that appellant could also be rated for 7 percent impairment of the right leg due to right knee osteoarthritis, but asserted this could not be combined with the 13 percent impairment rating due to the meniscus pathology. Therefore, the higher rating of 13 percent was used.

In a January 14, 2014 decision, OWCP granted appellant a schedule award for 13 percent permanent impairment of his right leg. The award ran 37.44 weeks from July 5, 2013 to March 24, 2014 and was based on Dr. Sawyer's impairment evaluation of the findings reported by Dr. Peterson.

In a report dated January 23, 2014, Dr. Peterson argued that 9 percent right leg impairment for degenerative joint disease of right knee should be combined with the 13 percent

right leg impairment for right lateral and medial meniscus pathology, to reflect a total 22 percent impairment of the right leg. He argued that the A.M.A., *Guides* provided for this in the current situation, where the claimant has two separate and distinct diagnoses affecting the right knee, each significantly different and each causing impairment.

In February 2014 appellant was referred to Dr. William Dinenberg, a Board-certified orthopedic surgeon, for evaluation of his left leg impairment. In an April 22, 2014 report, Dr. Dinenberg found that appellant had 9 percent permanent impairment of his left leg due to his left knee condition and 1 percent permanent impairment of his left leg due to his left foot condition, resulting in a total left leg impairment of 10 percent under the sixth edition of the A.M.A., *Guides.*

In May 2014 OWCP referred the case file to Dr. Sawyer for an opinion regarding appellant's left leg impairment. In a June 4, 2014 report, Dr. Sawyer determined that appellant had 14 percent impairment of his left leg due to knee and foot pathology under the sixth edition of the A.M.A., *Guides*. He indicated that the date of maximum medical improvement for the left knee and foot was April 22, 2014, the date of the rating examination by Dr. Dinenberg. Dr. Sawyer stated, "It is noted that there has been a prior award of 15 percent impairment for the [left lower extremity]. That amount should be subtracted from the current rating. There would be no net increase in the prior award based on the current exam[ination] and rating."

Appellant requested a review of the written record by an OWCP hearing representative. He submitted June 25 and 30, 2014 statements in which he argued that OWCP should have accepted the impairment rating of Dr. Peterson which took into consideration his multiple impairing conditions. Appellant also submitted numerous medical reports detailing his right knee condition.

In a September 9, 2014 decision, an OWCP hearing representative affirmed OWCP's January 14, 2014 schedule award decision, finding that appellant had not shown that he has more than a 13 percent permanent impairment of his right leg. He indicated that Dr. Sawyer, the OWCP medical adviser, provided the only impairment rating of record in accordance with the standards of the sixth edition of the A.M.A., *Guides.* The hearing representative found that Dr. Peterson did not justify his use of multiple right knee diagnoses in his impairment rating calculation.

LEGAL PRECEDENT

The schedule award provision of FECA[3] and its implementing regulations[4] 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

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

appropriate standard for evaluating schedule losses.[5] The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.[6]

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.[7] After the class of diagnosis 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).[8]

The sixth edition of the A.M.A., *Guides* provides that most impairments are based on diagnosis-based impairments in which an impairment class is determined by the diagnosis and specific criteria. The impairment rating is then adjusted by nonkey factors known as grade modifiers. Alternative approaches are also provided for basing impairment on peripheral nerve deficits, complex regional pain syndrome, amputation and range of motion. Range of motion ratings cannot be combined with other approaches, with the exception of amputation. Complex regional pain syndrome ratings cannot be combined with other approaches."[9]

The A.M.A., *Guides* further provides that, in most cases, only one diagnosis in a region (*i.e.*, hip, knee, or foot/ankle) will be appropriate. If a patient has two significant diagnoses, for instance, ankle instability and posterior tibial tendinitis, the examiner should use the diagnosis with the highest impairment rating in that region that is causally related for the impairment calculation."[10] In a section entitled "Combining and Converting Impairments, it is stated:

> "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."[11]

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[5] *Id*. *See also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6 (January 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (January 2010).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

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

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

[9] *Id*. at 387.

[10] *Id.* at 497.

[11] *Id.* at 529.

ANALYSIS

OWCP accepted appellant's claim for multiple lower extremity conditions and, on January 14, 2014 decision, it granted appellant a schedule award for a 13 percent permanent impairment of his right leg. The award was based on an impairment rating conducted by Dr. Sawyer, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, who had reviewed findings reported by Dr. Peterson, an attending Board-certified orthopedic surgeon.

The Board finds that Dr. Sawyer properly rated appellant's right leg impairment and that the evidence does not show that he has more than 13 percent permanent impairment of his right leg. In his December 4, 2013 report, Dr. Sawyer provided his calculations supporting a 13 percent impairment rating of the right leg based on the diagnosis of partial lateral and medial meniscectomy, finding that appellant had a class 1 condition with a default value of 10 percent under Table 16-3 (Knee Regional Grid) beginning on page 509 of the sixth edition of the A.M.A., *Guides*. He determined that appellant had a grade modifier of 1 for functional history, a grade modifier of 1 for physical examination, and a grade modifier of 3 for clinical studies. Application of the net adjustment formula justified a move two spaces to the right of the default value on Table 16-3 which equaled a total right leg impairment of 13 percent.[12]

In several reports, Dr. Peterson argued that 9 percent right leg impairment for degenerative joint disease of the right knee should be combined with the 13 percent right leg impairment for right lateral and medial meniscus pathology, to reflect a total 22 percent impairment of the right leg. He argued that the A.M.A., *Guides* provided for this in the current situation, where the claimant has two separate and distinct diagnoses affecting the right knee, each significantly different and each causing impairment.

Before OWCP and on appeal, appellant alleged that OWCP should have accepted Dr. Peterson's impairment rating because he had multiple medical problems in his right knee. Dr. Peterson has asserted that multiple impairments should be combined to assess appellant's right leg impairment, but he has not adequately explained why appellant's medical condition justifies the rare exception from the general rule that only one diagnosis should be used.[13] Dr. Sawyer stated that Dr. Peterson had failed to sufficiently support the 22 percent impairment rating he provided, which was calculated by combining impairments due to two separate diagnoses affecting the right knee joint, arthritis and meniscal tear. Dr. Sawyer argued that, although Dr. Peterson was correct to note that the sixth edition of the A.M.A., *Guides* allows for the combination of two separate diagnoses in unusual cases, there was nothing unusual about appellant's situation that would warrant this. He noted that the presence of knee osteoarthritis and meniscus pathology was common. The Board finds that Dr. Sawyer's impairment rating was conducted in accordance with the relevant standards of the A.M.A., *Guides* and he has explained why Dr. Peterson's rating was not conducted in accordance with these standards.

The Board has held that an opinion on permanent impairment is of limited probative value if it is not derived in accordance with the standards adopted by OWCP and approved by

[12] *See supra* notes 7 and 8.

[13] *See supra* notes 9 through 11.

the Board as appropriate for evaluating schedule losses.[14] As Dr. Peterson's opinion on impairment was not derived in accordance with these standards, it was appropriate for OWCP to base its schedule award on the opinion of Dr. Sawyer, an OWCP medical adviser, who properly applied the A.M.A., *Guides.*

For these reasons, appellant has not shown that he has more than a 13 percent permanent impairment of his right leg and OWCP properly denied his claim for additional schedule award compensation. 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 did not meet his burden of proof to establish that he has more than 13 percent permanent impairment of his right leg, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the September 9, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 16, 2015
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

[14] *See James Kennedy, Jr.*, 40 ECAB 620, 626 (1989) (finding that an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's permanent impairment).