United States Department of Labor
Employees' Compensation Appeals Board

B.W., Appellant	)	
and	)	**Docket No. 14-1834**
	)	**Issued: September 18, 2015**
DEPARTMENT OF LABOR, MINE SAFETY & HEALTH ADMINISTRATION, Birmingham, AL, Employer	)	

Appearances:
Ronald K. Bruce, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 18, 2014 appellant, through counsel, filed a timely appeal from a July 23, 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 established that he has more than 10 percent permanent impairment of the right lower extremity, for which he received a schedule award.

On appeal, counsel contends that the impairment rating from appellant's attending physician should carry more weight than the impairment rating of Dr. Daniel D. Zimmerman, a Board-certified internist and OWCP medical adviser, as he has more specialized knowledge

[1] 5 U.S.C. § 8101 *et seq.*

concerning arthritis of the knee. He further contends that a conflict in the medical opinion evidence exists and a referee specialist should be appointed.

FACTUAL HISTORY

OWCP accepted that appellant, then a 65-year-old mine safety and health inspector, sustained a right knee sprain, medial meniscus tear, aggravation of degenerative osteoarthrosis, and chondromalacia patellae as a result of stepping out of a trailer and twisting his knee while in the performance of duty on January 25, 2006. OWCP authorized two arthroscopic surgeries of the right knee performed by Dr. Richard Hoblitzell, a Board-certified orthopedic surgeon, on March 30, 2006 and December 8, 2011. Appellant retired effective July 31, 2006.

On October 23, 2012 appellant, through counsel, filed a claim for a schedule award and submitted an April 11, 2012 report from Dr. Hoblitzell who opined that appellant had reached maximum medical improvement for his right knee on January 3, 2012. He indicated that appellant would eventually require joint replacement surgery of his right knee due to the progression of arthritis, but not due to his employment injury. Dr. Hoblitzell assigned appellant to class 2, grade A and found that he had a 16 percent permanent impairment of the right lower extremity based on Table 16-3, on page 510, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereafter A.M.A., *Guides*).

In an October 29, 2012 letter, OWCP requested additional evidence from appellant and afforded him 30 days to respond to its inquiries.

On February 5, 2013 Dr. Zimmerman, an OWCP medical adviser, reviewed the medical evidence of record and a statement of accepted facts. He found that Dr. Hoblitzell's impairment rating was not acceptable as it was not supported by the applicable grade modifier tables, Table 16-6, Table 16-7, and Table 16-8, of the A.M.A., *Guides*. On February 6, 2013 the medical adviser further indicated that Dr. Hoblitzell did not indicate which diagnosis from Table 16-3 of the A.M.A., *Guides* he utilized for his impairment rating. He reiterated that Dr. Hoblitzell's rating would not be acceptable, even if the diagnosis was known, because the grade modifier tables were not discussed in his April 11, 2012 report.

OWCP referred appellant to Dr. Theodore Toan Le, a Board-certified orthopedic surgeon, for a second opinion evaluation. In his April 9, 2013 report, Dr. Le reviewed appellant's medical history and a statement of accepted facts. Examination of both lower extremities revealed "a range of motion of 5 to 100 degrees on the right and 0 to 110 degrees on the left." A Permanent Impairment Worksheet indicated a total range of motion of "5-100." The right knee was somewhat painful to range of motion and there was a mild-to-moderate effusion. The knee itself was stable to varus valgus and appellant had a slight varus deformity overall. He had good pulses distally and good muscle strength with a slight decrease in muscle strength on the right due to pain and effort. Dr. Le determined that appellant had a 28 percent permanent impairment of the right lower extremity based on the diagnosis of primary knee arthritis. On June 5, 2013 he corrected his impairment rating due to the fact that there was only x-ray interpretation of the left knee, but not the right knee. Dr. Le found that appellant's primary knee arthritis was a class 3 and assigned a grade modifier of 2 for functional history and physical examination, resulting in a

final grade adjustment of A, equaling a 26 percent permanent impairment of the right lower extremity.

In an August 7, 2013 letter, Dr. Zimmerman requested an addendum report from Dr. Le regarding appellant's impairment rating. He found that Dr. Le's rating was not acceptable because it considered knee joint interval narrowing without measuring the joint space interval with a ruler graduated in millimeters as required to utilize the rating for primary knee joint arthritis or patellofemoral arthritis.

In an October 3, 2013 addendum report, Dr. Le stated that the diagnoses he used for his impairment rating were primary knee arthritis and patellofemoral arthritis. He utilized Table 16-3 based on a magnetic resonance imaging (MRI) scan report dated September 24, 2011, which showed that there was progression with cartilage damage of the posterior aspect of the weight-bearing portion of the medial femoral condyle in comparison to a previous May 14, 2008 report. There was also chondromalacia patella. Dr. Le opined that the loss of cartilage corresponded to class 2 for both the knee arthritis and patellofemoral arthritis. He corrected his impairment rating based on a grade modifier of 2 for Functional History (GMFH) and Physical Examination (GMPE), and 1 for Clinical Studies (GMCS). Dr. Le found that appellant had a 14 percent permanent impairment of the right lower extremity.

On October 21, 2013 Dr. Zimmerman again reviewed the medical evidence of record and found that in his October 3, 2013 report Dr. Le did not consider plane film x-rays, but rather chose to extrapolate a rating for joint space interval narrowing based on what he thought the joint space interspace would be due to changes in an MRI scan of the right knee. Dr. Zimmerman indicated that this method was not permitted by the A.M.A., *Guides*. Utilizing Table 16-23,[2] he determined that appellant had a 10 percent permanent impairment of the right lower extremity based on his range of motion of 100 degrees in flexion as reported by Dr. Le in his April 9, 2013 report. Dr. Zimmerman found that appellant had reached maximum medical improvement on April 9, 2013, the date of Dr. Le's second opinion examination.

By decision dated November 6, 2013, OWCP granted appellant a schedule award for 10 percent permanent impairment of the right lower extremity. The award ran for 28.8 weeks for the period April 9 through October 27, 2013.

Appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative, which was held on May 9, 2014.

By decision dated July 23, 2014, OWCP hearing representative affirmed the November 6, 2013 schedule award decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[3] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. FECA,

[2] Table 16-23, page 549 of the sixth edition of the A.M.A., *Guides* is entitled *Knee Motion Impairments.*

[3] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

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 matter 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.[4] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[5]

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).[6] Under the sixth edition, the evaluator identifies the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[7] 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.[8]

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. Chapter 16 further provides that 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."[9]

ANALYSIS

OWCP accepted a right knee sprain, medial meniscus tear, aggravation of degenerative osteoarthrosis, and chondromalacia patellae and authorized two arthroscopic surgeries of the right knee, which appellant underwent on March 30, 2006 and December 8, 2011. By decision dated November 6, 2013, it granted appellant a schedule award for 10 percent permanent

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

[5] *See R.V.*, Docket No. 10-1827 (issued April 1, 2011); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

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

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

[8] *See R.V., supra* note 5.

[9] *See* A.M.A., *Guides* 497, section 16.2.

impairment of the right lower extremity. The issue on appeal is whether appellant is entitled to a greater right lower extremity impairment schedule award.

The Board finds that the case is not in posture for a decision.

In an April 11, 2012 report, Dr. Hoblitzell, appellant's treating physician, classified his impairment as a class 2, grade A, which equated to a 16 percent permanent impairment of the right lower extremity under Table 16-3, on page 510, of the A.M.A., *Guides*.

On February 5, 2013 Dr. Zimmerman, an OWCP medical adviser, found that Dr. Hoblitzell's impairment rating was not acceptable as it was not supported by the applicable grade modifier tables, Table 16-6, Table 16-7, and Table 16-8, of the A.M.A., *Guides*. On February 6, 2013 Dr. Zimmerman further indicated that Dr. Hoblitzell had not designated which diagnosis from Table 16-3 of the A.M.A., *Guides* he utilized for his impairment rating. He reiterated that Dr. Hoblitzell's rating would not be acceptable, even if the diagnosis was known, because the grade modifier tables were not discussed in his April 11, 2012 report.

In order to determine the extent and degree of any employment-related impairment of appellant's right lower extremity, OWCP properly referred appellant to Dr. Le for a second opinion evaluation. Examination of both lower extremities revealed a range of motion of 5 to 100 degrees on the right and 0 to 110 degrees on the left. The right knee was somewhat painful to range of motion and there was a mild-to-moderate effusion. The knee itself was stable to varus valgus and appellant had a slight varus deformity overall. He had good pulses distally and good muscle strength with a slight decrease in muscle strength on the right due to pain and effort.

On August 7, 2013 Dr. Zimmerman requested an addendum report from Dr. Le regarding appellant's impairment rating. He indicated that Dr. Le's rating was not acceptable because he considered knee joint interval narrowing without measuring the joint space interval with a ruler graduated in millimeters, such was required in order to utilize the rating for primary knee joint arthritis or patellofemoral arthritis.

In an October 3, 2013 addendum report, Dr. Le stated that the diagnoses he used for his impairment rating were primary knee arthritis and patellofemoral arthritis. He clarified that he had used Table 16-3 based on an MRI scan report dated September 24, 2011, which showed that there was progression with cartilage damage of the posterior aspect of the weight-bearing portion of the medial femoral condyle in comparison to a previous May 14, 2008 report. There was also chondromalacia patella. Dr. Le opined that the loss of cartilage corresponded to class 2 for both the knee arthritis and patellofemoral arthritis. He assigned a grade modifier of 2 for functional history and physical examination, and 1 for clinical studies, and revised his impairment rating concluding that appellant had a 14 percent permanent impairment of the right lower extremity.

On October 21, 2013 Dr. Zimmerman reviewed Dr. Le's October 3, 2013 addendum report and explained that he had not used plane film x-rays in accordance with the A.M.A., *Guides* to measure the joint space interval, but rather chose to extrapolate a rating for joint space interval narrowing based on what he thought the joint space interspace was due to changes in an MRI scan of the right knee.[10] He indicated that this method was not permitted by the A.M.A.,

[10] *See* A.M.A., *Guides* 518, section 16.3c.

Guides. Dr. Zimmerman found, however, that the stand-alone range of motion measurements of Dr. Le's April 9, 2013 report, Table 16-23, page 549, could be used to find a 10 percent permanent impairment of the right lower extremity based on appellant's 100 degrees of flexion. OWCP concurred with Dr. Zimmerman and granted appellant a schedule award for 10 percent permanent impairment of the right lower extremity in its decision dated November 6, 2013.

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.[11] However, Chapter 16 further provides that 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."[12] Dr. Zimmerman provided rationalized reasons as to why he was unable to use the diagnosis-based method and properly utilized the range of motion alternative approach to evaluate appellant's impairment. The Board finds that this follows the instructions of the A.M.A., *Guides* for using the alternative range of motion method of evaluation. Nonetheless, the Board finds that appellant's range of motion was not properly measured under Chapter 16 of the A.M.A., *Guides*.

The A.M.A., *Guides* provide that, under specific circumstances, range of motion may be selected as an alternative approach in rating lower extremity impairment and cautions that an impairment rating that is calculated using range of motion stands alone and may not be combined with a diagnosis-based impairment.[13] Section 16.7b, page 544, of the A.M.A., *Guides* provides that range of motion should be measured after a warm up, that the maximum range of motion should be measured at least three times, and that the maximum measurement is used to determine range of motion measurement.[14]

In the present case, Dr. Le reported that his examination of appellant's lower extremities revealed "a range of motion of 5 to 100 degrees on the right and 0 to 110 degrees on the left." Further, the Permanent Impairment Worksheet reflects only the total range of motion of "5-100." Dr. Le did not verify that he performed all of the measurements required by section 16.7b, which states at page 517 of the A.M.A., *Guides*:

> "Range of motion is graded according to the process and the criteria specified in section 16.7. Lower extremity impairment can be evaluated by assessing the range of motion of its joints, recognizing that pain and motivation may affect the measurements. If it is clear to the evaluator that a restricted range of motion has

[11] *Id*. at 497, 544-53.

[12] *Id.*

[13] *Id*. at 390. The A.M.A., *Guides* explains that diagnoses in the grid that may be rated using range of motion are followed by an asterisk.

[14] *Id.* at 464.

an organic basis, three measurements should be obtained and the greatest range measured should be used for the determination of impairment."[15]

There is no indication that the digital range of motion measurements for each extremity reported by Dr. Le followed the procedure outlined in the A.M.A., *Guides*. As such, it is not apparent that the second opinion examiner, Dr. Le, obtained range of motion in compliance with section 16.7b.

Accordingly, the case will be remanded for OWCP to obtain further information from Dr. Le as to the protocol outlined at page 544, of the A.M.A., *Guides*. After any necessary further development, OWCP shall issue a *de novo* decision regarding permanent impairment to appellant's right lower extremity.

CONCLUSION

The Board finds that the case is not in posture for a decision. The case will be remanded for additional development.

ORDER

IT IS HEREBY ORDERED THAT the July 23, 2014 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further development consistent with this decision of the Board.

Issued: September 18, 2015
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[15] *Id.* at 510.