United States Department of Labor
Employees' Compensation Appeals Board

D.L., Appellant	)	
and	)	**Docket No. 18-0046**
	)	**Issued: June 6, 2018**
DEPARTMENT OF HOMELAND SECURITY, FEDERAL AIR MARSHAL SERVICE, Orlando, FL, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 6, 2017 appellant filed a timely appeal from a September 13, 2017 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]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The record provided to the Board includes evidence received after OWCP issued its September 13, 2017 decision. The Board's jurisdiction is limited to the evidence that was in the case record at the time of OWCP's final decision. Therefore, the Board is precluded from reviewing this additional evidence for the first time on appeal. 20 C.F.R. § 501.2(c)(1).

ISSUE

The issue is whether appellant has more than 10 percent permanent impairment of the left lower extremity and more than two percent permanent impairment of the right lower extremity for which she previously received schedule awards.

FACTUAL HISTORY

On May 14, 2013 appellant, then a 47-year-old federal air marshal, filed an occupational disease claim (Form CA-2) alleging that she sustained an aggravation of a right knee condition caused or aggravated by factors of her federal employment. She related that she fell on January 6, 2010, injuring her right knee, right arm, and left foot, but she did not receive treatment for her right knee condition at the time of injury.[3] Appellant stopped work on February 18, 2013 and returned to work on March 14, 2014.

OWCP accepted the claim for bilateral aggravation of internal derangement of the medial meniscus of the knees, right chondromalacia patellae, and derangement of the left meniscus.

A magnetic resonance imaging (MRI) scan of the right knee, obtained on December 19, 2013, revealed fluid collection with prepatellar subcutaneous edema, joint effusion, and a large medial popliteal cyst, a tear of the posterior horn of the lateral meniscus, a bone bruise of the posterolateral tibial plateau, and joint space narrowing, particularly in the lateral compartment. A December 5, 2014 MRI scan of the right knee demonstrated a tear of the posterior horn of the medial meniscus, moderate osteoarthritis, and grade three-to-four chondromalacia patellae.

On February 27, 2015 Dr. Raymond Delorenzi, a Board-certified orthopedic surgeon, performed a left diagnostic arthroscopy with a partial lateral meniscectomy, chondroplasty of the patellofemoral joint, a medial meniscus repair, and limited synovectomy. On September 25, 2015 he performed a right partial medial meniscectomy, chondroplasty of the patella, and a limited synovectomy.

In an impairment evaluation dated March 1, 2016, Dr. Samy F. Bishai, an orthopedic surgeon, discussed appellant's left knee pain and difficulty with activities subsequent to her February 27, 2015 surgery. On examination of the knees, he found swelling due to effusion and tenderness over the patella and medial and lateral joint line. Dr. Bishai measured negative 10 degrees extension lag and 100 degrees flexion of the left knee and 10 degrees extension lag and 100 degrees flexion of the right knee. He diagnosed internal derangement of the right knee, a torn right medial meniscus, right patella chondromalacia, internal derangement of the left knee, a torn posterior horn of the left lateral meniscus, moderate bilateral osteoarthritis of the knee joints, an aggravation of left foot plantar fasciitis, and status post-surgery of the left knee joint. Dr. Bishai opined that appellant had reached maximum medical improvement (MMI) of the left knee joint, but not of the right knee joint. Citing Table 16-23 on page 549 of the sixth edition of the American

[3] The employing establishment advised that she had a prior accepted claim under OWCP File No. xxxxxx366 for plantar fibromatosis and contusion of the left foot.

Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[4] he found that appellant had 10 percent lower extremity permanent impairment due to negative 10 degrees of extension lag in flexion contracture of the left knee.

On April 25, 2016 appellant filed a claim for compensation (Form CA-7) requesting a schedule award.[5]

An OWCP medical adviser reviewed the evidence on June 21, 2016 and found that Dr. Bishai's opinion was insufficient to support an impairment rating as there was no evidence that he used the methodology for measuring range of motion set forth on page 464 of the A.M.A., *Guides*. He advised that OWCP should request that Dr. Bishai provide range of motion (ROM) measurements of the affected knee in accordance with the A.M.A., *Guides*.

By letter dated June 29, 2016, OWCP requested that Dr. Bishai provide additional information regarding the extent of appellant's permanent impairment under the A.M.A., *Guides*. It enclosed the report from OWCP's medical adviser for his consideration.

OWCP did not receive a response from Dr. Bishai. On December 15, 2016 it referred appellant to Dr. Brian S. Ziegler, a Board-certified orthopedic surgeon, for a second opinion examination to determine the extent of any employment-related permanent impairment.

In a report dated February 14, 2017, Dr. Ziegler reviewed appellant's history of a January 6, 2010 injury to her right knee and subsequent development of left knee pain. On examination, he found tenderness along the medial joint line of the left knee, no effusion or crepitation, and stability to varus and valgus stress testing. Dr. Ziegler further found tenderness along the medial and lateral right joint lines with good stability and no effusion. He measured ROM bilaterally as 0 degrees extension and 110 degrees flexion after testing three times. Dr. Ziegler found full motor strength of the lower extremities with intact sensation and opined that appellant had reached MMI.

Using Table 16-3 on page 509 of the A.M.A., *Guides*, Dr. Ziegler determined that appellant had 10 percent left lower extremity permanent impairment due to her partial medial and lateral meniscectomy. He advised that using Table 16-23 on page 549 for range of motion would also yield 10 percent impairment, noting that a mild impairment of knee flexion was 80 to 109 degrees. Dr. Ziegler related, "This claimant's knee [ROM] measured 110 degrees; however, the one degree difference is still within the range of error of goniometric measurement."

For the right knee, Dr. Ziegler opined that appellant had three percent permanent impairment of the right lower extremity under Table 16-3 due to her partial medial meniscectomy and chondroplasty of the patella. He noted, however, that as her ROM was limited to 110 degrees

[4] A.M.A., *Guides* (6th ed. 2009).

[5] By letter dated April 28, 2016, OWCP requested that Dr. Delorenzi provide an impairment evaluation due to appellant's accepted right and left knee conditions in accordance with the A.M.A., *Guides*. In response, appellant advised OWCP that Dr. Delorenzi was her surgeon rather than her attending physician, and that her primary physician was Dr. Bishai.

flexion, it was more appropriate to rate her impairment using ROM methodology. Dr. Ziegler related:

> "Based on [T]able 16-23 flexion limited to 109 degrees is assigned a mild category of impairment, of 10 [percent] impairment of the right lower extremity. Since claimant's measured knee flexion was 110 degrees and this one degree difference is within the error of measurement of goniometric testing, I feel the most appropriate impairment rating for claimant's right knee is 10 [percent] impairment of the right lower extremity based on [T]able 16-23."

An OWCP medical adviser reviewed the evidence on March 31, 2017. He noted that Dr. Ziegler calculated the impairment using Table 16-23 of the A.M.A., *Guides*, relevant to determining knee impairments based on loss of ROM. The medical adviser found that 110 degrees of ROM yielded no impairment. He noted that Dr. Ziegler found a one degree measurement error and used 109 degrees to rate the impairment rather than the actual measurement as required under the A.M.A., *Guides*. Referencing Table 16-3 on page 509, Knee Regional Grid, the medical adviser identified the right knee diagnosis as a class one partial medial meniscectomy, which yielded a default value of two percent. He applied a grade modifier of zero for functional history based on appellant's normal gait, a grade modifier of two for physical examination findings, and determined that a grade modifier for clinical studies was not applicable based on the lack of current studies. The medical adviser utilized the net adjustment formula and found no change from the default value of two percent.

For the left knee, OWCP's medical adviser identified the diagnosis as a partial lateral meniscectomy and medial meniscal repair using Table 16-3, which yielded a default value of 10 percent. He applied a grade modifier of zero for functional history, two for physical examination, and found clinical studies were inapplicable, to find no change from the default value after using the net adjustment formula. The medical adviser concluded that appellant had 10 percent permanent impairment of the left lower extremity and two percent permanent impairment of the right lower extremity.

OWCP, on April 7, 2017, requested clarification from Dr. Ziegler regarding the extent of permanent impairment. It enclosed the March 31, 2017 report from OWCP's medical adviser for his review.

In a supplemental report dated June 28, 2017, Dr. Ziegler advised that he had reviewed OWCP's medical adviser's report finding that he erred in lowering the ROM from 110 to 109 degrees in rating the extent of appellant's right lower extremity impairment. He disagreed with the medical adviser's finding. Dr. Ziegler related:

> "When I measured the claimant's right knee [ROM], the goniometer read between the 105 and 110 degree mark but closer to the 110 degree mark. Thus, I chose 110 degree maximum flexion [ROM] to place in my report. At that time, I was unaware of [the] 109 degree threshold for assigning an impairment using the [ROM] method. Because her observed [ROM] fell between the 105 and 110 mark on the goniometer but was less than the 110 mark itself, [i]t would be more accurate in my opinion to

assign this claimant a right knee [ROM] of 109 degrees as indicated in my initial report['s] conclusion."

Dr. Ziegler again determined that appellant had 10 percent permanent impairment of the right lower extremity.

On July 17, 2017 OWCP's medical adviser reviewed the evidence and maintained that Dr. Ziegler initially found that appellant's ROM was 110 degrees, which was within the margin of error, but subsequently indicated that he measured ROM as 109 degrees. He concluded that Dr. Ziegler's explanation was inconsistent. The medical adviser again opined that appellant had two percent permanent impairment of the right lower extremity using the diagnosis-based impairment (DBI) method.

By decision dated September 13, 2017, OWCP granted appellant schedule award for 10 percent permanent impairment of the left leg and 2 percent permanent impairment of the right leg. The period of the award ran for 34.56 weeks from February 14 to October 13, 2017.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing federal regulations,[7] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9]

The sixth edition requires identifying the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[10] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

ANALYSIS

OWCP accepted that appellant sustained an employment-related aggravation of internal derangement of the bilateral knees, right chondromalacia patellae, and derangement of the left meniscus. On February 27, 2015 appellant underwent a left knee partial lateral meniscectomy,

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id.* at § 10.404(a).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[10] A.M.A., *Guides* 494-531.

chondroplasty of the patellofemoral joint, a medial meniscus repair, and a limited synovectomy. Appellant filed a schedule award claim on April 25, 2016.

In a March 1, 2016 impairment evaluation, Dr. Bishai measured ROM of the left knee as 100 degrees flexion and negative 10 degrees extension. He found that appellant had reached MMI regarding the left, but not the right knee. Dr. Bishai found that, according to Table 16-23 on page 549 of the A.M.A., *Guides*, she had 10 percent permanent impairment of the left lower extremity due to a loss of 10 degrees of extension lag in flexion contracture.

An OWCP medical adviser, on June 21, 2016, found that Dr. Bishai's report failed to conform to the A.M.A., *Guides* as there was no evidence that he performed three measurements of ROM prior to rating appellant's impairment. As noted by the medical adviser, the A.M.A., *Guides* provides that the examiner should record active measurements for three separate ROM efforts.[11] Consequently, the impairment rating by Dr. Bishai is of diminished probative value.[12]

OWCP referred appellant to Dr. Ziegler for an impairment evaluation. On February 14, 2017 Dr. Ziegler found medial joint line tenderness of the left knee with no effusion, crepitation, or instability. He measured ROM as 0 degrees extension and 110 degrees flexion. Applying Table 16-3 on page 509 of the A.M.A., *Guides*, Dr. Ziegler found that appellant had 10 percent permanent impairment of the left lower extremity due to her partial medial and lateral meniscectomy. He also noted that she had 10 percent left lower extremity impairment due to loss of motion.

On March 31, 2017 an OWCP medical adviser concurred with Dr. Ziegler's finding of 10 percent left lower extremity impairment. He identified the diagnosis as a partial lateral meniscectomy and medial meniscal repair, which yielded a default value of 10 percent using Table 16-3. The medical adviser applied a grade modifier of zero for functional history based on appellant's normal gait, a grade modifier of two for physical examination findings on palpation, and found that clinical studies were inapplicable. He used the net adjustment formula and found no adjustment from the default value of 10 percent.[13] There is no probative medical evidence in conformance with the A.M.A., *Guides* establishing that appellant has more than 10 percent permanent impairment of the left lower extremity.

In his February 14, 2017 report, Dr. Ziegler also found that appellant had reached MMI for her right knee condition. He measured ROM of the right knee as zero degrees extension and 110 degrees flexion after three measurements. Dr. Ziegler further found right knee medial and lateral joint line tenderness, but no instability or effusion. Under Table 16-3, he found that appellant had three percent right lower extremity impairment due to her partial medial meniscectomy and patella chondroplasty. Dr. Ziegler determined, however, that it was more appropriate to rate the extent of her permanent impairment using Table 16-23 on page 549 of the A.M.A., *Guides*, relevant to impairment due to loss of motion. He indicated that he measured her knee flexion at 110 degrees,

[11] A.M.A., *Guides* 464.

[12] *See A.R.*, Docket No. 15-1694 (issued February 9, 2016).

[13] Utilizing the net adjustment formula discussed above, (GMFH-CDX) + (GMPE-CDX), or (0-1) + (2-1) = 0, yielded a zero adjustment.

noting that knee flexion of 109 degrees constituted 10 percent impairment. Dr. Ziegler found that this was within the error of measurement of goniometric testing, and concluded that appellant had 10 percent permanent impairment of the right knee due to loss of ROM.

On March 31, 2017 an OWCP medical adviser disagreed with Dr. Ziegler's use of 109 degrees to rate appellant's permanent impairment using ROM, noting that he should have used the actual measurement obtained of 110 degrees, which he advised yielded no impairment according to Table 16-23. He found that appellant had two percent permanent impairment of the right lower extremity due to her partial medial meniscectomy under Table 16-3.

Dr. Ziegler, in a June 28, 2017 supplemental report, reviewed OWCP's medical adviser's opinion and disagreed with his determination that he erroneously lowered appellant's ROM measurement for flexion from 110 degrees to 109 degrees. He explained that when he measured her ROM, the mark on the goniometer was less than 110 degrees, and instead between 105 and 110 degrees. Dr. Ziegler asserted that it was more accurate to rate appellant's ROM as 109 degrees as found in its initial report. He again concluded that she had 10 percent permanent impairment of the right lower extremity.

On July 17, 2017 OWCP's medical adviser again disagreed with Dr. Ziegler's use of 109 degrees to rate appellant's impairment, asserting that he provided inconsistent explanations for his use of this measurement. The Board finds, however, that the medical adviser did not provide adequate rationale for rejecting the impairment rating of Dr. Ziegler.[14] Dr. Ziegler explained why he used 109 degrees, initially noting that it was within the margin of error of the goniometer and subsequently clarifying that appellant's right knee flexion measured less than 110 degrees, and was thus accurately rated as 10 percent permanent impairment under Table 16-23. The Board will thus modify the September 13, 2017 decision to find that appellant has a total of 10 percent permanent impairment of her right lower extremity, or an additional 8 percent permanent impairment.

Appellant may request a schedule award or increased schedule award at any time 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 has no more than 10 percent permanent impairment of the left lower extremity for which she previously received a schedule award. The Board further finds that she has established a total of 10 percent permanent impairment of the right lower extremity.

[14] *See generally W.M.*, Docket No. 07-1455 (issued July 18, 2008).

ORDER

IT IS HEREBY ORDERED THAT the September 13, 2017 decision of the Office of Workers' Compensation Programs is affirmed, as modified.

Issued: June 6, 2018
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board