United States Department of Labor
Employees' Compensation Appeals Board

N.L., Appellant	)	
	)	
and	)	**Docket No. 12-1209**
	)	**Issued: December 4, 2012**
DEPARTMENT OF THE NAVY, NAVY FACILITIES ENGINEERING COMMAND, Colts Neck, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 9, 2012 appellant, through his attorney, filed a timely appeal from a January 18, 2012 schedule award 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 the schedule award decision.

ISSUE

The issue is whether appellant has greater than three percent impairment of the right lower extremity.

On appeal, appellant's attorney asserts that, at a minimum, a conflict in medical evidence had been created between the opinions of the attending physician and an OWCP medical adviser regarding the degree of appellant's right lower extremity impairment.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On July 28, 2003 appellant, then a 48-year-old welder/boiler plant operator, filed a traumatic injury claim, alleging that he injured his right knee on July 23, 2003 while kneeling on the floor of a boxcar. The claim was accepted for right knee sprain, effusion of joint of the right lower leg, chondromalacia of right patella, aggravation of osteoarthrosis of right leg and tear of right medial cartilage or meniscus. Appellant has not worked since August 8, 2003. On May 6, 2004 Dr. Marc S. Zimmerman, a Board-certified orthopedic surgeon, performed arthroscopic and chondroplastic surgery. Appellant was placed on the periodic compensation rolls and remained on wage-loss compensation until September 30, 2010 when he retired.[2] He elected retirement benefits effective October 1, 2010.

On June 3, 2011 appellant filed a schedule award claim and submitted a January 20, 2011 report in which Dr. David Weiss, an attending osteopath, advised that appellant had reached maximum medical improvement. He noted his review of medical records including diagnostic studies. Dr. Weiss advised that a January 11, 2011 right knee x-ray demonstrated significant osteophytic changes at the distal femur and proximal lateral tibia with well-preserved joint spaces showing no narrowing or collapse. He provided right knee examination findings and advised that appellant had a lower extremity activity scale score of 73 percent. Dr. Weiss diagnosed post-traumatic internal derangement to the right knee, post-traumatic chondromalacia patella to the right knee, status post arthroscopic surgery to the right knee with patellofemoral chondroplasty on May 6, 2004 and aggravation of preexisting and age-related osteoarthritis of the right knee. He advised that, in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] under Table 16-3, Knee Regional Grid, appellant had a class 2 impairment right knee impairment, with a default rating of 20 percent. Dr. Weiss found that under Table 16-6, Table 16-7 and Table 16-8, appellant had a functional history score of 3, physical examination score of 1 and a clinical studies score of 4. He then applied the net adjustment formula and concluded that appellant had a 24 percent impairment of the right lower extremity.

In a July 20, 2011 report, Dr. Craig Uejo, Board-certified in preventive and occupational medicine and an OWCP medical adviser, indicated that maximum medical improvement was reached on January 21, 2011. He disagreed with Dr. Weiss' impairment rating, stating that it was unclear what diagnosis he had used to evaluate appellant. Dr. Uejo reported that a November 17, 2000 magnetic resonance imaging (MRI) scan of the right knee showed a full thickness cartilage defect in the patellofemoral joint and a partial thickness cartilage defect in the primary knee joint medial compartment. He indicated that, while the A.M.A., *Guides* provides ratable impairment for a full-thickness cartilage defect in the patellofemoral joint, it does not provide any ratable impairment for partial-thickness cartilage defects, as noted in the primary knee joint for this case. The medical adviser stated that therefore appellant's rating would be based on a diagnosis of patellofemoral arthritis. He went on to state that he disagreed with Dr. Weiss' assignment of a class 2 impairment because, assuming Dr. Weiss based his impairment rating on a diagnosis of patellofemoral arthritis, the arthritis section of the A.M.A.,

[2] Appellant received a $25,000.00 retirement incentive when he retired.

[3] A.M.A., *Guides* (6th ed. 2008).

Guides required a finding of "no cartilage interval" to assign class 2 and he provided no joint space measurements of the patellofemoral joint and indicated that the primary knee joint had normal joint space measurements. Dr. Uejo advised that he personally reviewed the right knee x-ray films and compared them with a left knee study also performed on January 11, 2011. He indicated that his review showed significant osteophytic changes at the distal femur and proximal lateral tibia and that the joint spaces were well preserved with no narrowing or collapse of either the medial or lateral joint compartments. Dr. Uejo opined that, since there was no evidence of x-ray narrowing of the primary or patellofemoral knee joints, Dr. Weiss' impairment was not supportable. The medical adviser indicated that, under Table 16-3, appellant had a class 1 rating for the diagnosis of patellofemoral arthritis, which had a default score of three percent, stating that this was based on the November 17, 2009 MRI scan finding of a full thickness articular cartilage defect. He assigned a grade 1 modifier for functional history, rather than a grade 3 functional history modifier assigned by Dr. Weiss, explaining that grade 1 was more consistent with Dr. Weiss' observation that appellant ambulated with a noticeable right leg limp but did not indicate that he used assistive devices such as a cane or crutch. Dr. Uejo agreed with Dr. Weiss that appellant had a grade 1 modifier for physical examination and found that a modifier for clinical studies was not applicable as the A.M.A., *Guides* indicated that it was to be excluded for a diagnosis in the arthritis section. The medical adviser applied the net adjustment formula and concluded that appellant had three percent right leg impairment.

By decision dated July 21, 2011, OWCP granted appellant a schedule award for three percent impairment of the right lower extremity, for a total of 8.64 weeks, to run from January 20 to March 21, 2011.

On July 27, 2011 appellant, through his attorney, requested a hearing. In an October 17, 2011 treatment note, Dr. Zimmerman advised that he had reviewed the impairment ratings submitted by Dr. Weiss and Dr. Uejo.[4]

At the hearing, held on November 16, 2011, appellant described the July 23, 2003 employment injury and his current medical condition. He testified that, because of weakness, he wore a knee brace 50 percent of the time and had difficulty on stairs, sitting and standing for too long and sleeping, due to pain. Appellant indicated that he could no longer participate in recreational activities such as walking on the beach, jet skiing, playing golf, riding a bicycle or playing in a band. His attorney argued that a conflict in medical evidence had been created.

Subsequent to the hearing appellant submitted a November 8, 2011 x-ray of the right knee that was interpreted by Dr. George Hobbs, a Board-certified radiologist, as showing moderate patellofemoral arthritis characterized by subchondral sclerosis and osteophytosis. He noted mild osteophytosis about the lateral compartment and identified no significant joint space narrowing within the medial or lateral compartments and minimal chondrocalcinosis within the medial compartment. No fracture or dislocation or large suprapatellar joint effusion was identified.

[4] Dr. Zimmerman also provided treatment notes dated June 24 through December 2, 2011, in which he did not comment on appellant's right knee impairment.

In an updated report dated November 15, 2011, Dr. Weiss revised his January 20, 2011 report to indicate that, in terms of activities of daily living, appellant had difficulty with self-care, going from a seated to a standing position, sleeping, sitting, standing, climbing stairs, lifting and walking greater than 15 minutes. He stated that appellant wore a brace intermittently and could no longer kneel on the right and could no longer perform recreational activities of playing drums or swimming and had difficulty with golfing and driving. Dr. Weiss further indicated that measurements of the patellofemoral space on a November 8, 2011 x-ray revealed bone-on-bone or no cartilage interval. He concluded that his impairment rating remained the same or 24 percent for the right lower extremity. In a November 16, 2011 statement, appellant indicated that he had purchased a motorized scooter since he could not walk for an extended period of time.

By decision dated January 18, 2012, an OWCP hearing representative affirmed the July 21, 2011 schedule award decision. The medical adviser found the evidence submitted subsequent to the hearing repetitive in nature. He found that Dr. Uejo's report constituted the weight of the medical evidence.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing federal regulations,[6] 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.[7] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8] For decisions issued after May 1, 2009, the sixth edition will be used.[9]

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).[10] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] Under Chapter 2.3, evaluators are directed to provide reasons for

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404 (2011).

[7] *Id*.

[8] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[9] FECA Bulletin No. 09-03 (issued March 15, 2009).

[10] A.M.A., *Guides*, *supra* note 3 at 3, section 1.3, "The ICF: A Contemporary Model of Disablement."

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

[12] *Id*. at 521.

their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[13]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[14] In determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[15]

ANALYSIS

The Board finds this case is not in posture for decision. As noted above, OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[16] In this case, while the case file was submitted to Dr. Uejo, an OWCP medical adviser, in July 2011, it was not forwarded to a medical adviser subsequent to the November 16, 2011 hearing, when appellant submitted additional medical evidence including a November 8, 2011 right knee x-ray and a revised report from Dr. Weiss. An OWCP's hearing representative did not explain why OWCP's procedures were not followed in this instance.

The case will therefore be remanded to OWCP to forward the medical evidence described above to an appropriate OWCP medical adviser for an opinion on the degree of appellant's right lower extremity impairment. After such development OWCP as deems necessary, it shall issue a merit decision regarding whether appellant is entitled to an increased schedule award.

CONCLUSION

The Board finds that the case is not in posture for decision as to the extent of appellant's right lower extremity impairment.

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

[14] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (January 2010).

[15] *Peter C. Belkind*, 56 ECAB 580 (2005).

[16] *See* Federal (FECA) Procedure Manual, *supra* note 14.

ORDER

IT IS HEREBY ORDERED THAT the January 18, 2012 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for proceedings consistent with this decision of the Board.

Issued: December 4, 2012
Washington, DC

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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