United States Department of Labor
Employees' Compensation Appeals Board

M.K., Appellant	)	
and	)	**Docket No. 11-728**
	)	**Issued: February 13, 2012**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Lyons, 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:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 31, 2001 appellant, through her attorney, filed a timely appeal from a November 10, 2010 decision of the Office of Workers' Compensation Programs (OWCP) concerning a schedule award. 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 has more than a 20 percent permanent impairment of the left lower extremity, for which she received a schedule award.

On appeal, appellant's counsel contends that further development of the medical evidence is required and that OWCP erred in relying upon the opinion of an OWCP medical adviser in reaching the schedule award determination. At a minimum, counsel contends there is a conflict

[1] 5 U.S.C. § 8101 *et seq.*

in the medical opinion evidence between appellant's attending physician and the medical adviser.

FACTUAL HISTORY

On November 9, 2000 appellant, then a 52-year-old nursing assistant, filed a traumatic injury claim alleging that on October 16, 2000 she tore cartilage in her left knee when she stood up and her left knee was hyperextended. OWCP accepted the claim for left knee medial meniscus tear, which was expanded to include the condition of aggravation of preexisting left knee osteoarthritis. On February 14, 2004 appellant filed a claim for a schedule award.

Appellant submitted a November 19, 2003 report from Dr. David Weiss, an osteopath, who provided an impairment rating under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] Dr. Weiss concluded that she had a total 30 percent left lower extremity impairment using Table 17-8, page 532 and Figure 18-1, page 574. He indicated that appellant reached maximum medical improvement on November 19, 2003.

In a February 6, 2009 report, Dr. James W. Dyer, a Board-certified orthopedic surgeon and an OWCP medical adviser, concluded that appellant had a two percent impairment of her left lower extremity using the fifth edition of the A.M.A., *Guides*. Using Table 17-33, page 546, he concluded that appellant had a two percent left lower extremity impairment due to her partial meniscectomy.

By decision dated April 30, 2009, OWCP granted appellant a schedule award for a two percent permanent impairment of the left lower extremity.

In a letter dated May 13, 2009, appellant's counsel requested an oral hearing before an OWCP hearing representative.

By decision dated August 14, 2009, an OWCP hearing representative vacated the April 30, 2009 decision and remanded the case for OWCP to obtain x-ray interpretations as appellant's claim included the condition of arthritis.

In a March 9, 2010 report, Dr. Stephen C. Allen, a second opinion Board-certified orthopedic surgeon, reviewed the medical evidence, a March 8, 2010 x-ray interpretation and statement of accepted facts and provided physical findings. Diagnoses included left knee post-traumatic arthrosis secondary to cartilage trauma and removal, left knee patellofemoral arthrosis, pes planus, right shoulder impingement and ulnar nerve palsy. A review of a March 9, 2010 x-ray interpretation of the left knee revealed a 50 percent loss of lateral facet patellofemoral joint space and medial joint space or 1.5 millimeter joint space loss. Using Table 16-3, page 511, Dr. Allen found a 25 percent left lower extremity impairment due to appellant's primary knee arthritis based on a class 2 to 3 and grade E to A. Next, he found a 13 percent left knee impairment for patellofemoral arthritis based on a class 1 to 2 and grade E to A. Dr. Allen then

[2] A.M.A., *Guides* (5th ed.).

combined the impairment ratings for appellant's left knee primary arthritis and patellofemoral arthritis to find a total 35 percent left lower extremity impairment.

In a March 19, 2010 report, Dr. Dyer, an OWCP medical adviser reviewed Dr. Allen's report and concluded that appellant only had a 20 percent left lower extremity impairment. He related that Dr. Allen incorrectly combined impairment ratings for her primary knee arthritis and her patellofemoral arthritis. Dr. Dyer noted that page 499 of the A.M.A., *Guides* provides that, if more than one diagnosis in a region can be used, the one that provides the most clinically accurate and causally-related impairment rating should be used. He opined that impairment under the arthritis section yielded greater impairment and was appropriate. Dr. Dyer noted that, using the section for arthritis in Table 16-3, page 511 of the A.M.A., *Guides*, the diagnosis of primary left knee joint arthritis was a class 2 rating with a default score of 20 percent lower extremity impairment based on a grade C for diagnosis of 2 millimeter cartilage interval and modifiers of 2 for functional history, 2 for physical examination and 2 for clinical studies.

By decision dated March 25, 2010, OWCP granted appellant a schedule award for a 20 percent permanent impairment of the left lower extremity.

On April 22, 2010 appellant's counsel requested an oral hearing, which was held before an OWCP hearing representative on August 24, 2010

On September 17, 2010 OWCP received Dr. Weiss' updated September 3, 2010 schedule award report using the sixth edition of the A.M.A., *Guides*. Dr. Weiss found a 26 percent left lower extremity impairment for appellant's left knee joint arthritis using Table 16-3, page 511. In reaching this determination, he determined that she had class 3 or 30 percent impairment.[3] Dr. Weiss found a modifier of 1 for family history, a modifier of 2 for physical examination and a modifier of 0 for clinical studies, which resulted in a net adjust of -2 and reduced the left lower extremity impairment to 26 percent. Next, he concluded that there was a 20 percent left lower extremity impairment due to a class 2 patellofemoral arthritis with a default value of 20 percent. Dr. Weiss found a grade modifier of 2 for family history and a grade modifier of 2 for physical examination resulting in a net adjustment of 0. He combined the impairment ratings of 26 percent for her left knee joint arthritis and 20 percent patellofemoral arthritis resulting in a total 41 percent left lower extremity impairment.

By decision dated November 10, 2010, an OWCP hearing representative affirmed the March 25, 2010 schedule award decision. The hearing representative found Dr. Weiss' impairment rating to be of diminished probative value as he combined impairment ratings for appellant's left knee arthritis condition which was contrary to the instructions found in the A.M.A., *Guides* at 497.

[3] The Board notes that, although Dr. Weiss indicated a class E for 30 percent impairment, it is clear he meant class 3.

LEGAL PRECEDENT

The schedule award provision of FECA[4] and its implementing regulations[5] 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 appropriate standard for evaluating schedule losses.[6] Effective May 1, 2009, OWCP adopted the sixth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[7]

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.[8] After the class of diagnosis (CDX) 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 (GMFH), grade modifier for Physical Examination (GMPE) and grade modifier for Clinical Studies (GMCS). The net adjustment formula is GMFH - CDX + GMPE - CDX + GMCS - CDX.[9] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[10]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed through an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.[11]

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[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id. See C.M.*, Docket No. 09-1268 (issued January 22, 2010); *Billy B. Scoles*, 57 ECAB 258 (2005).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claim*, Chapter 2.808.6.6a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

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

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

[10] *Id.* at 523-28.

[11] *See* Federal (FECA) Procedure Manual, *supra* note 7, Chapter 2.808.6(d) (January 2010). *See Frantz Ghassan*, 57 ECAB 349 (2006); *C.K.*, Docket No. 09-2371 (issued August 18, 2010).

ANALYSIS

The sixth edition of the A.M.A., *Guides* provides that lower extremity impairments be classified by diagnosis which is then adjusted by grade modifiers according to the formula noted above.[12] Appellant's accepted diagnosed conditions were left knee medial meniscus tear and preexisting left knee osteoarthritis. The Board finds that this case is not in posture for decision.

The evidence relevant to the impairment rating for appellant's left lower extremity include reports from Drs. Allen, Weiss and Dyer, an OWCP medical adviser. Dr. Weiss, appellant's attending physician, combined the impairment ratings for left knee primary joint arthritis impairment and left patellofemoral arthritis and concluded that appellant had a 41 percent left lower extremity impairment using Table 16-3, page 511. The A.M.A., *Guides* state arthritis in two separate compartments of the same knee is not to be combined in an impairment rating.[13] The report by Dr. Weiss is of diminished probative value regarding the impairment rating as the physician did not make it in conformance with the A.M.A., *Guides* as he combined arthritis impairments for two parts of the knee whereas section 16.2a and 16.3f of the A.M.A., *Guides* precludes such use.[14]

Similarly, Dr. Allen, the second opinion physician, inappropriately combined the same arthritis impairments. He concluded that appellant had a 35 percent left lower extremity impairment using Table 16-3, page 511 to determine the impairment for her left knee primary joint arthritis impairment and left patellofemoral arthritis and the combining of these impairments. As in the case of Dr. Weiss, Dr. Allen's report is also of diminished probative value as his impairment rating resulted from combining arthritis impairments for the same two parts of the knee precluded by sections 16.2a and 16.3f of the A.M.A., *Guides.*[15] *A*s OWCP selected Dr. Allen to provide a second opinion regarding the extent and degree of any permanent impairment, it was obliged to further develop the medical evidence. Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter.[16] While appellant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.[17] Accordingly, once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[18] As it

[12] *Supra* notes 9 and 10.

[13] A.M.A., *Guides* 499.

[14] *Id.* at 499, 529. *See I.F.*, Docket No. 08-2321 (issued May 21, 2009) (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 diminished probative value in determining the extent of permanent impairment).

[15] *Supra* note 13.

[16] *R.B.*, Docket No. 08-1662 (issued December 18, 2008); *A.A.*, 59 ECAB 726 (2008); *Donald R. Gervasi*, 57 ECAB 281 (2005); *Vanessa Young*, 55 ECAB 575 (2004)

[17] *D.N.*, 59 ECAB 576 (2008); *Richard E. Simpson*, 55 ECAB 490 (2004).

[18] *See A.A.*, *supra* note 16; *Melvin James*, 55 ECAB 406 (2004).

undertook development of the medical evidence by referring appellant to Dr. Allen, it had an obligation to secure a report adequately addressing the relevant issue.[19]

With respect to the impairment determination for primary joint arthritis, Dr. Dyer utilized the findings provided by Dr. Allen. He noted that x-rays of the left knee revealed a 1.5 millimeter cartilage interval for primary joint arthritis. Dr. Dyer referred to Table 16-3, page 511 and advised that appellant would fall into a class 2 for a 1.5 millimeter full thickness cartilage defect and applied a grade C, the default value for 20 percent impairment. However, the Board finds that it is unclear how Dr. Dyer arrived at this determination. The Board notes that Table 16-3, page 511 of the A.M.A., *Guides* provides that primary knee arthritis with a two millimeter cartilage interval is a class 2 and that a one millimeter cartilage interval is a class 3. Dr. Dyer did not explain why he chose a class 2 when x-ray interpretation revealed a cartilage value between class 2 and class 3. His report is therefore of limited probative value.

The Board finds that there is no rating of record currently in conformance with the A.M.A., *Guides.* The case shall be remanded to OWCP for a supplemental opinion from Dr. Allen, instructing him that the A.M.A., *Guides* state that arthritis in two separate compartments of the same knee is not to be combined in an impairment rating. If Dr. Allen is unwilling or unable to clarify and elaborate on his opinion, the case should be referred to another appropriate specialist. After such further development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

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

[19] *Id.*; *see also Peter C. Belkind,* 56 ECAB 580 (2005).

ORDER

IT IS HEREBY ORDERED THAT decision of the Office of Workers' Compensation Programs dated November 10, 2010 is set aside and the case remanded for further proceedings consistent with the above opinion.

Issued: February 13, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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