



## **FACTUAL HISTORY**

On December 22, 2009 appellant then a 57-year-old letter carrier, filed a traumatic injury claim alleging that on that date he fell down stairs covered with snow and dislocated his right knee. In a report dated December 24, 2009, Dr. Edward C. Rabbitt, a Board-certified orthopedic surgeon, noted appellant's history of a fall on December 22, 2009 and stated that he examined x-rays of appellant's right leg finding no fractures or dislocations. Appellant's x-rays demonstrated a small joint effusion and mild osteoarthritis of the patellofemoral compartment. Dr. Rabbitt diagnosed quadriceps tendon rupture. Appellant underwent surgical repair on December 28, 2009.

By decision dated December 31, 2009, OWCP accepted his claim for rupture of the right quadriceps tendon. Appellant returned to light-duty work on June 21, 2010.

In a report dated August 24, 2010, Dr. Rabbitt found that appellant had weakness of the quadriceps and a history of his right knee buckling while walking. He found excellent range of motion and good quadriceps definition. Dr. Rabbitt noted moderately significant patellofemoral crepitus, but stated that appellant did not seem to be particularly painful with range of motion. Appellant accepted a modified position as a city carrier on September 3, 2010.

Appellant requested a schedule award on November 16, 2010. In a report dated December 14, 2010, Dr. Rabbitt reported that appellant was doing well, but having difficulty descending stairs and building strength with weights. He stated that appellant was not achieving significant improvement in his right leg function and strength. Dr. Rabbitt found that appellant had excellent range of motion with no swelling. He reported that appellant was capable of straight leg raising and had good strength. Dr. Rabbitt noted that appellant exhibited quadriceps atrophy and crepitus with the patella with range of motion. He recommended further exercises and reexamination.

OWCP requested on November 30, 2011 that appellant provide medical evidence that his condition had reached maximum medical improvement. It stated that it could take no action on his claim for a schedule award.

Dr. Rabbitt completed a report on February 21, 2012 and diagnosed rupture of the quadriceps tendon. He found no swelling, instability, subluxation, or laxity with normal sensation. Dr. Rabbitt reported crepitus with normal strength and muscle tone. He noted that appellant's right knee continued to buckle and give way while going down stairs. Dr. Rabbitt stated that appellant had reached maximum medical improvement. He examined appellant on September 7, 2012 and stated that appellant continued to report difficulty descending stairs as his quadriceps was not as strong as it was before the accident. Dr. Rabbitt repeated his previous findings on physical examination.

Appellant again requested a schedule award on March 7, 2013. In a letter dated March 18, 2013, OWCP informed appellant that in order to establish his claim for permanent impairment he should submit medical evidence of maximum medical improvement, detailed findings on examination and an impairment rating in accordance with the sixth edition of the

American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).<sup>2</sup>

By decision dated May 14, 2013, OWCP denied appellant's claim for a schedule award as he failed to submit the necessary medical evidence to establish a permanent impairment in accordance with FECA.

Appellant again requested a schedule award on May 14, 2013. In a letter dated May 20, 2013, OWCP again informed him of the medical evidence necessary to establish his claim for a schedule award. It denied appellant's request for a schedule award by decision dated July 31, 2013. Appellant requested an oral hearing from OWCP's Branch of Hearings and Review on August 5, 2013.

In a report dated November 6, 2013, Dr. Rabbitt diagnosed work-related quadriceps tendon rupture. He reported that he had performed surgery, but appellant continued to exhibit static mild weakness in the quadriceps on the right and patellofemoral crepitus following maximum medical improvement. Dr. Rabbitt noted that appellant demonstrated mild extension lag. He stated, "In regard to his disability rating, I am referencing the A.M.A., *Guides* sixth edition page 509.<sup>3</sup> Using the ruptured tendon as well as the modifier for moderate problems, I would rate him as having a 20 percent partial permanent disability of his right lower extremity."

Appellant testified at the oral hearing on January 16, 2014. He stated that Dr. Rabbitt's report should be sufficient to establish his schedule award claim. The hearing representative requested further information from Dr. Rabbitt regarding how he reached his impairment rating under the A.M.A., *Guides*.

By decision dated April 3, 2014, OWCP hearing representative found that the case was not in posture for a decision and directed OWCP to refer Dr. Rabbitt's report to a medical adviser to evaluate the evidence for schedule award purposes.

In a report dated December 6, 2014, OWCP medical adviser noted that the table cited by Dr. Rabbitt did not provide for 20 percent impairment of the lower extremity due to a ruptured tendon and that the maximum impairment rating for this condition was 13 percent due to moderate motion deficits or significant weakness. He applied the A.M.A., *Guides* to Dr. Rabbitt's findings on physical examination including static mild weakness in the quadriceps, patellofemoral crepitus, and mild weakness. OWCP medical adviser opined that appellant would fall in a class 1 category with a default impairment rating of two percent. He stated, "Impairments from 5 percent to 13 percent would include motion deficits which were not described in Dr. Rabbitt's report." OWCP medical adviser concluded that appellant had two percent impairment of the right lower extremity based on the medical evidence in the record and that he reached maximum medical improvement on January 1, 2012.

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<sup>2</sup> See 20 C.F.R. § 10.404. For impairment ratings calculated on and after May 1, 2009, OWCP should advise any physician evaluating permanent impairment to use the sixth edition. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.5.a (February 2013).

<sup>3</sup> A.M.A., *Guides* 509, Table 16-3 Knee Regional Grid.

By decision dated March 19, 2015, OWCP granted appellant a schedule award for two percent permanent impairment of his right lower extremity.

### **LEGAL PRECEDENT**

The schedule award provision of FECA<sup>4</sup> and its implementing regulations<sup>5</sup> set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss or loss of use of scheduled members or functions of the body. FECA, 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 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. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.<sup>6</sup>

In addressing lower extremity impairments, the sixth edition of the A.M.A., *Guides* requires identifying the impairment for the Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).<sup>7</sup>

### **ANALYSIS**

The Board finds that appellant has no more than two percent permanent impairment of his right lower extremity for which he has received a schedule award.

In support of his claim for a schedule award, appellant submitted a series of reports from Dr. Rabbitt. On August 24, 2010 Dr. Rabbitt reported that appellant's right lower extremity demonstrated excellent range of motion. In a report dated February 21, 2012, he opined that appellant had reached maximum medical improvement with no swelling, instability, subluxation, or laxity, and with normal sensation in his right lower extremity. Dr. Rabbitt reported crepitus with normal strength and muscle tone. On November 6, 2013 he found that appellant continued to exhibit static mild weakness in the quadriceps on the right and patellofemoral crepitus following maximum medical improvement. Dr. Rabbitt noted that appellant demonstrated mild extension lag. He stated, "In regard to his disability rating, I am referring [to] the A.M.A., *Guides* sixth edition page 509."<sup>8</sup> Using the ruptured tendon as well as the modifier for moderate

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<sup>4</sup> 5 U.S.C. §§ 8101-8193, 8107.

<sup>5</sup> 20 C.F.R. § 10.404.

<sup>6</sup> For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6<sup>th</sup> ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

<sup>7</sup> A.M.A., *Guides* 521. *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

<sup>8</sup> *Id.* at 509, Table 16-3 Knee Regional Grid.

problems, I would rate him as having a 20 percent partial permanent disability of his right lower extremity.”

OWCP medical adviser reviewed Dr. Rabbitt’s reports and applied the A.M.A., *Guides* noting that Table 16-3, which was appropriately cited by Dr. Rabbitt, did not provide for 20 percent impairment of the lower extremity due to a ruptured tendon.<sup>9</sup> Rather, this table provides a maximum impairment rating of 13 percent for a tendon rupture with moderate motion deficits or significant weakness. The medical adviser indicated that Dr. Rabbit found that appellant had static to mild weakness. Based on that description he placed appellant in the class 1 category giving him a two percent impairment rating. The Board finds that Dr. Rabbitt’s reports did not support physical findings of moderate motion deficits or significant weakness. Dr. Rabbitt stated that appellant had excellent range of motion and repeatedly stated that appellant had normal muscle tone with mild weakness. As his impairment rating did not comport with the A.M.A., *Guides*, OWCP properly relied on the findings and conclusions of its medical adviser. It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his or her opinion is of diminished probative value in establishing the degree of permanent impairment and OWCP may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings of the attending physician.<sup>10</sup> The Board finds, contrary to appellant’s argument on appeal, that the weight of the medical evidence in this case rests with OWCP medical adviser who properly applied the A.M.A., *Guides* to Dr. Rabbitt’s physical findings and reached an impairment rating of two percent of the right lower extremity.

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 has no more than two percent permanent impairment of his right lower extremity for which he received a schedule award.

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<sup>9</sup> *Id.*

<sup>10</sup> *Linda Beale, 57 ECAB 429 (2006).*

**ORDER**

**IT IS HEREBY ORDERED THAT** the March 19, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 3, 2015  
Washington, DC

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

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

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