United States Department of Labor
Employees' Compensation Appeals Board

J.G., Appellant **and** **DEPARTMENT OF THE ARMY, U.S. ARMY MATERIEL COMMAND, McAlester, OK, Employer**	)))))))))	**Docket No. 13-1262** **Issued: December 9, 2013**

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 26, 2013 appellant filed a timely appeal from a March 19, 2013 decision of the Office of Workers' Compensation Programs (OWCP) regarding 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.[2]

ISSUE

The issue is whether appellant established that he sustained more than a two percent permanent impairment of the right leg, for which he received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the issuance of the March 19, 2013 OWCP decision, appellant submitted new evidence. The Board is precluded from reviewing evidence which was not before OWCP at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c)(1).

FACTUAL HISTORY

OWCP accepted that appellant, then a 42-year-old motor vehicle operator, sustained a right knee sprain, lateral collateral and cruciate ligaments, other internal derangement of right knee and right chondromalacia patella while moving heavy furniture in the performance of duty on October 5, 2008. It authorized surgery which he underwent on October 25, 2011 and he was subsequently placed on the periodic rolls. Appellant returned to full-time, light-duty work with restrictions effective November 14, 2011.[3]

On February 7, 2012 appellant filed a claim for a schedule award. In a January 20, 2012 report, Dr. John Hughes, a Board-certified orthopedic surgeon, found that appellant had a 13 percent permanent impairment of the right leg based on the Knee Regional Grid,[4] on page 509, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). He placed appellant in class 1 based on his diagnosis of plica with inflammatory right knee joint disease and indicated that he had a combination strain and sprain linked with this diagnosis although that did not lead to his scope procedure.

On February 29, 2012 Dr. Ronald Blum, a Board-certified orthopedic surgeon and OWCP medical adviser, reviewed the medical evidence of record and a statement of accepted facts. He addressed Dr. Hughes' January 20, 2012 report and explained that he erroneously recommended a 13 percent impairment rating for the right lower extremity which was the maximum recommended under class 1 diagnoses. Dr. Blum noted that the specific range for soft tissue changes such as plica equated to a one to two percent impairment rating under the sixth edition of the A.M.A., *Guides*. He stated that the descriptions of abnormality provided by Dr. Hughes were not adequate to allow him to recommend impairment in appellant's case.

In an April 3, 2012 letter, OWCP requested a supplemental report from Dr. Hughes regarding appellant's impairment rating.

In a May 11, 2012 report, Dr. Hughes explained that appellant was dealing with soft tissue changes and he "just simply thought that [appellant] had enough symptomology and ongoing problems in his knee to warrant a 13 percent impairment rating" and felt that "a one percent impairment rating [was] totally inappropriate." Appellant also submitted physical therapy notes dated November 11, 2011 through February 26, 2013.

In reports dated August 22, 2011 through February 27, 2013, Dr. Ronald S. LaButti, a Board-certified orthopedic surgeon, diagnosed synovial impingement in the right knee, quadriceps dysfunction and dynamic patellofemoral maltracking. Upon examination of the right knee and lower extremity, he found no appreciable joint effusion, no warmth, erythema or induration. Appellant had some subjective complaints of pain along the medial joint line with

[3] By decision dated November 21, 2011, OWCP made a preliminary determination that appellant received an overpayment of compensation in the amount of $535.02 which appellant repaid in full by check dated November 28, 2011.

[4] Table 16-3, pages 509-511 of the sixth edition of the A.M.A., *Guides* is entitled *Knee Regional Grid -- Lower Extremity Impairments.*

palpation. McMurray's test was negative for snapping and positive for pain. The patella tracked normally with active extension of the knee and there was no substantial patellofemoral crepitus with patellofemoral grind. Dr. LaButti stated that a magnetic resonance imaging (MRI) scan showed no intra-articular pathology and appellant had no significant subjective findings on clinical examination that would correlate with his subjective complaints. He opined that appellant had reached maximum medical improvement and released him to work without restrictions.

A January 9, 2013 MRI scan of the right knee showed evidence of prior arthroscopic knee surgery, mild anterior cruciate ligament (ACL) sprain, small joint effusion and mild marrow edema in the anterior femur.

Appellant submitted reports dated May 2, 2012 through January 9, 2013 from Dr. Don Barney, a family practitioner, who diagnosed chondromalacia patella, bursitis of the right knee, postarthroscopic examination, joint aspiration, removal of plica and surgery performed by Dr. LaButti, cruciate ligament tear, chronic strain of the right knee, degenerative joint disease of the right knee and degenerative changes of the ligaments of the anterolateral medial aspect of the knee. Dr. Barney noted that appellant was seen by Dr. Hughes for the purpose of a disability examination and was given a 13 percent rating. He stated that Dr. Blum gave appellant a two percent impairment rating without seeing him and recommended a second opinion examination.

OWCP referred appellant, together with a statement of accepted facts and medical records, to Dr. Timothy Pettingell, a Board-certified physiatrist, for a second opinion evaluation. In a January 24, 2013 report, Dr. Pettingell advised that appellant had permanent impairment based on the sixth edition of the A.M.A., *Guides*. He stated that appellant medically retired in October 2012 and that the date of maximum medical improvement was December 30, 2011. Dr. Pettingell found no objective medical evidence that appellant suffered a tear of the right ACL/posterior cruciate ligament (PCL)/medial collateral ligament (MCL)/lateral collateral ligament (LCL) or medial/lateral meniscal pathology. Appellant was status postarthroscopic surgery for hypertrophy of the synovium and symptomatic medial plica. Dr. Pettingell found no tenderness with palpation of the medial or lateral joint line. McMurray's testing was asymptomatic. Active patellofemoral loading demonstrated no palpable patella crepitation. There was no tenderness with palpation of the quadriceps or patellar tendon. Lachman's testing demonstrated a firm endpoint. Anterior and posterior drawer testing demonstrated no instability. There was no instability with varus and valgus stressing in both the flexed and knee-extended position and no knee joint effusion or Baker's cyst. Dr. Pettingell placed appellant in a class 1, default grade C per page 509, Table 16-3 of the A.M.A., *Guides* for soft tissue pathology with range of motion deficits. He assigned appellant a functional history adjustment grade modifier 2 regarding the use of a knee brace/orthotic. Dr. Pettingell assigned physical examination adjustment grade modifier 1 under Table 16-7, utilizing Table 16-23 as a guideline regarding -8 degrees full extension. Dr. Pettingell assigned clinical studies adjustment grade modifier 1 per Table 16-8 as an MRI scan confirmed mild pathology. He concluded that appellant had a two percent right lower extremity impairment regarding soft tissue lesion/synovium/plica.

On February 28, 2013 Dr. Michael M. Katz, a Board-certified orthopedic surgeon and OWCP medical adviser, reviewed the medical record. He determined that the date of maximum medical improvement was January 20, 2012. Dr. Katz concurred with Dr. Pettingell's

impairment rating. He opined that, according to Table 16-3,[5] appellant's bursitis, plica, soft tissue lesion and consistent motion deficits placed him in class 1, default value two percent impairment. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), OWCP's medical adviser found that (2-1) + (1-1) + (1-1) resulted in a net grade modifier of 1, resulting in an impairment class 1, grade D, equaling a two percent permanent impairment of the right lower extremity.

By decision dated March 19, 2013, OWCP granted appellant a schedule award for two percent permanent impairment of the right lower extremity. The award ran for 5.76 weeks for the period January 20 through February 29, 2012.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] provide for compensation to employees sustaining impairment from loss or loss of use of specified members 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 mater 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.[7] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[8]

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).[9] Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[10] 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.[11]

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[5] *Id.*

[6] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

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

[8] 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).

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

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

[11] *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

ANALYSIS

OWCP accepted that appellant sustained a right knee sprain, lateral collateral and cruciate ligaments, other internal derangement of right knee and right chondromalacia patella on October 5, 2008. Appellant underwent surgery on October 25, 2011. He claimed a schedule award on February 7, 2012. Appellant's attending physician, Dr. Hughes, placed appellant in class 1 based on the Knee Regional Grid, Table 16-3, page 509 of the sixth edition of the A.M.A., *Guides* resulting from his diagnosis of plica and inflammatory joint knee disease. He concluded that appellant had a 13 percent impairment. The Board notes, however, that the maximum the A.M.A., *Guides* allow for bursitis, plica or other soft tissue lesion is a two percent impairment. When asked by OWCP for a supplemental opinion regarding the proposed 13 percent impairment, Dr. Hughes replied that he "just simply thought that [appellant] had enough symptomology and ongoing problems in his knee to warrant a 13 percent rating." He added that the one percent impairment rating of Dr. Blum, was inappropriate. Dr. Blum had reported that the range of impairment for soft tissue changes such as plica was from one to two percent impairment. He went on to explain that Dr. Hughes' report did not conform to the A.M.A., *Guides* as his findings on examination did not support the percentage of impairment determined. Dr. Blum concluded that Dr. Hughes' report could not be used as a basis for an impairment rating.

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. Pettingell for a second opinion evaluation. Dr. Pettingell examined appellant on January 24, 2013 and concluded that he had a two percent permanent impairment of the right lower extremity. He found no objective medical evidence that appellant suffered a tear of the right ACL/PCL/MCL/LCL or medial/lateral meniscal pathology. Appellant was status-post arthroscopic surgery for hypertrophy of the synovium and symptomatic medial plica. Dr. Pettingell found no tenderness with palpation of the medial or lateral joint line. McMurray's testing was asymptomatic. Active patellofemoral loading demonstrated no palpable patella crepitation. There was no tenderness with palpation of the quadriceps or patellar tendon. Lachman's testing demonstrated a firm endpoint. Anterior and posterior drawer testing demonstrated no instability. There was no instability with varus and valgus stressing in both the flexed and knee-extended position and no knee joint effusion or Baker's cyst. Dr. Pettingell placed appellant in a class 1, default grade C per page 509, Table 16-3 of the A.M.A., *Guides* for soft tissue pathology with range of motion deficits. He assigned appellant a functional history adjustment grade modifier 2 regarding the use of a knee brace/orthotic. Dr. Pettingell assigned physical examination adjustment grade modifier 1 under Table 16-7, utilizing Table 16-23 as a guideline regarding -eight degrees full extension. He assigned clinical studies adjustment grade modifier 1 per Table 16-8 as an MRI scan confirmed mild pathology. Dr. Pettingell concluded that appellant had a two percent right lower extremity impairment regarding soft tissue lesion/synovium/plica.

Dr. Katz reviewed the clinical findings of Dr. Pettingell on February 28, 2013 and determined that the date of maximum medical improvement was January 20, 2012. He concurred with Dr. Pettingell's impairment rating. Dr. Katz opined that, according to Table 16-

3,[12] appellant's bursitis, plica, soft tissue lesion and consistent motion deficits placed him in class 1, default value two percent impairment. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), OWCP's medical adviser found that (2-1) + (1-1) + (1-1) resulted in a net grade modifier of 1, resulting in an impairment class 1, grade D, equaling a two percent permanent impairment of the right lower extremity.

The Board finds that OWCP's medical adviser applied the appropriate tables and grading schemes of the sixth edition of the A.M.A., *Guides* to Dr. Pettingell's clinical findings. Dr. Katz agreed with the rating of Dr. Pettingell. There is no medical evidence of record utilizing the appropriate tables of the sixth edition of the A.M.A., *Guides* demonstrating a greater percentage of permanent impairment. Dr. Blum explained that Dr. Hughes' 13 percent impairment rating for the right lower extremity was erroneous as the range for soft tissue changes such as plica was one to two percent impairment under the six edition of the A.M.A., *Guides*. Therefore, OWCP properly relied on the medical adviser's assessment of a two percent permanent impairment of the right lower extremity.[13]

As the reports from Drs. LaButti and Barney do not provide an impairment rating based on the sixth edition of the A.M.A., *Guides*, the Board finds that they lack probative value and are insufficient to establish appellant's claim. The January 9, 2013 MRI scan is diagnostic in nature and the physical therapy notes dated November 11, 2011 through February 26, 2013 do not constitute medical evidence as they were not prepared by a physician.[14] Therefore, they are insufficient to establish greater impairment.

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 not established that he sustained more than a two percent permanent impairment of the right lower extremity, for which he received a schedule award.

[12] *Supra* note 4.

[13] *See M.T.*, Docket No. 11-1244 (issued January 3, 2012).

[14] Physical therapists are not physicians under FECA. *See* 5 U.S.C. § 8101(2).

ORDER

IT IS HEREBY ORDERED THAT the March 19, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 9, 2013
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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