United States Department of Labor
Employees' Compensation Appeals Board

C.K., Appellant	)	
	)	**Docket No. 12-1557**
and	)	**Issued: March 11, 2013**
	)	
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, Petersburg, VA, Employer	)	

Appearances:
Alan J. Shapiro, 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 July 10, 2012 appellant, through his attorney, filed a timely appeal from the Office of Workers' Compensation Programs' (OWCP) decisions dated January 24 and June 28, 2012. 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 two percent impairment of his left leg.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On July 7, 2008 appellant, a 37-year-old correctional officer, injured his left knee when he slipped and fell to the floor. OWCP accepted the claim for sprain of the left cruciate ligament and torn medial meniscus of the left knee. On November 21, 2008 Dr. Geoffrey B. Higgs, Board-certified in sports medicine and a specialist in orthopedic surgery, performed a left knee anterior cruciate ligament/autograft hamstring reconstruction procedure. On September 9, 2009 he performed surgery for open hardware removal of the tibial anterior cruciate ligament fixation, a bursectomy involving the pes anserinus bursa and a release of fibrous adhesions, and notchplasty of lysis of adhesions with infrapatellar capsular release for left knee notch impingement and arthrofibrosis. Both of these procedures were authorized by OWCP.

In an August 23, 2010 report, Dr. Higgs rated a 13 percent impairment of the left leg pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (sixth edition) (A.M.A., *Guides*). He stated that appellant had undergone two operations, one to reconstruct his anterior cruciate ligament and the other to release adhesions associated with the pes anserinus bursa region and perform a notch plasty and intra-articular adhesions. Dr. Higgs advised that appellant had residual pain associated with the fibrosis of the pes anserinus bursa and associated tendons which precluded him from performing preinjury activities.

Dr. Higgs found that appellant had a stable ligamentous examination with full range of motion and strength. He rated a five percent impairment for fibrosis and scar tissue over the medial aspect of his leg and an eight percent impairment for pain. Dr. Higgs used the Combined Values Chart at page 604 of the A.M.A., *Guides* to arrive at the 13 percent left leg rating.

On September 23, 2010 appellant filed a Form CA-7 claim for a schedule award.

In a report dated March 11, 2011, Dr. Christopher Brigham, Board-certified in occupational medicine and an OWCP medical consultant, found that Dr. Higgs' impairment rating was not in conformance with the A.M.A., *Guides*. Dr. Higgs applied the proper tables and protocols of the A.M.A., *Guides*. Dr. Brigham found that appellant had a one percent impairment of the left leg pursuant to the sixth edition of the A.M.A., *Guides*. He stated that, under Table 16-3, Knee Regional Grid, Lower Extremity Impairments, at page 509 of the A.M.A., *Guides*,[2] the section pertaining to muscle/tendon impairments, appellant's left knee strain yielded a class 1 rating for strain, which had a default score of two percent lower extremity impairment based on "palpatory findings," for a mild problem.[3] Using the Adjustment Grid, Functional History, at Table 16-6, page 516 of the A.M.A., *Guides*,[4] Dr. Brigham found that

[2] A.M.A., *Guides* 509.

[3] The Board notes that, although appellant underwent two surgeries for anterior cruciate surgery on his left knee, both of which were authorized by OWCP, Dr. Brigham chose to rate his diagnosis-based impairment based on appellant's accepted left knee strain condition. Dr. Brigham stated in his discussion of maximum medical improvement that "the ratable condition is stabilized and unlikely to change substantially in the next year, with or without medical treatment."

[4] A.M.A., *Guides* 516.

appellant had a grade modifier of zero for functional history, noting that he had complaints of pain but walked with a normal gait pattern; with regard to physical examination, Dr. Brigham assigned a grade modifier of zero because there were no abnormal findings on examination, pursuant to Table 16-7, section 16.3b, page 517 of page 509 of the A.M.A., *Guides*, the tables pertaining to rating lower extremity impairments based on physical examination. He stated that the tenderness Dr. Higgs noted on examination was already accounted for in the specific diagnosis, as this was a factor to determine proper class placement. Dr. Brigham found no grade modifier for clinical studies pursuant to section 16.3c and Table 16-8, page 519 of the A.M.A., *Guides*[5] since there were postsurgical clinical studies.

Based on the above findings Dr. Brigham compared the net adjustments from functional history and physical examination grade modifiers of zero and an inapplicable grade modifier for clinical studies at the net adjustment formula at page 521 of the A.M.A., *Guides*. This yielded a diagnosis of class 1, mild problem, of minus two, for a grade A, one percent lower extremity impairment.[6] The Board notes that, although appellant underwent two surgeries for anterior cruciate surgery on his left knee, both of which were authorized by OWCP, Dr. Brigham chose to rate his diagnosis-based impairment based on appellant's accepted left knee strain condition. He stated in his discussion of maximum medical improvement that "the ratable condition is stabilized and unlikely to change substantially in the next year, with or without medical treatment."

By decision dated March 17, 2011, OWCP granted appellant a schedule award for a one percent permanent impairment of the left lower extremity for the period August 11 to 31, 2011, for a total of 2.88 weeks of compensation.

On March 31, 2011 appellant requested an oral hearing, which was held on July 12, 2011.

In a report dated July 1, 2011, Dr. Stuart J. Goodman, a specialist in neurology, found that appellant had a 13 percent left lower extremity impairment pursuant to the sixth edition of the A.M.A., *Guides*. He advised that appellant had residual pain, discomfort and hyperesthesia in the surgical site, with laxity of the patella joint and weakness. Dr. Goodman noted that appellant had been unable to return back to his baseline physical status and could not engage in his usual activities. He rated a 10 percent impairment for loss of range of motion pursuant to Table 16-23, Knee Motion Impairment, at page 549 of the A.M.A., *Guides*,[7] which translated to a class 1, 13 percent impairment at Table 16-25, Range of Motion, at page 550 of the A.M.A., *Guides*[8]; this rating was consistent with a grade 1 impairment for physical examination adjustment at Table 16-7. Dr. Goodman further found that appellant's meniscal tear and surgery elevated this to a grade 2 impairment, which yielded a 13 percent left lower extremity permanent impairment.

[5] *Id.* at 519.

[6] *Id.* at 521.

[7] *Id.* at 523.

[8] *Id.* at 550.

By decision September 28, 2011, an OWCP hearing representative set aside the March 17, 2011 decision, finding that Dr. Goodman's July 1, 2011 report was sufficient to warrant further development of the medical evidence.

In a report dated December 22, 2012, Dr. Morley Slutsky, Board-certified in orthopedic surgery and an OWCP medical adviser, reviewed Dr. Goodman's July 1, 2011 report. He found that it presented sufficient evidence for an additional one percent left lower extremity impairment rating under the A.M.A., *Guides*, based upon the condition of left knee strain/sprain. Dr. Slutsky found that Dr. Goodman's rating for loss of range of motion was not in conformance with the A.M.A., *Guides* because he did not state that he performed three measurements, using a goniometer, as mandated by section 16.3b, page 517 of the A.M.A., *Guides*.[9] Further, the A.M.A., *Guides* provided that a range of motion impairment should not be combined with the diagnosed-based impairment. Dr. Slutsky found that the measurements for grade modifier Dr. Goodman used were not valid because he failed to compare the total values for the foot/ankle, knee, or hip to the criteria in section 16-7, page 543[10] to define the range of motion grade modifier.

By decision dated January 24, 2012, OWCP granted appellant a schedule award for an additional one percent permanent impairment of the left lower extremity for the period August 11 to 31, 2011, for a total of 2.88 weeks of compensation.

By letter dated January 30, 2012, appellant's attorney requested an oral hearing, which was held on April 16, 2012.

By decision dated June 28, 2012, an OWCP hearing representative affirmed the January 12, 2012 schedule award decision.

LEGAL PRECEDENT

The schedule award provision of FECA[11] and its implementing regulations[12] 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.[13] The claimant has the burden of proving

[9] *Id.* at 517.

[10] *Id.* at 543.

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404. Effective May 1, 2009, OWCP began using the A.M.A., *Guides* (6th ed. 2009).

[13] *Id.*

that the condition for which a schedule award is sought is causally related to his or her employment.[14]

ANALYSIS

OWCP accepted the conditions of sprain of the left cruciate ligament and torn medial meniscus of the left knee. It granted appellant schedule awards totaling two percent impairment of the left leg, relying on ratings from Drs. Brigham and Slutsky.

The Board notes that the A.M.A., *Guides* directs examiners to rate diagnosis-based impairments for the lower extremities pursuant to Chapter 16, which states at page 497, section 16.2a that impairments are defined by class and grade.[15] In accordance with this section the examiner is instructed to utilize the net adjustment formula outlined at pages 521-22 of the A.M.A., *Guides*,[16] to obtain the proper impairment rating. In a March 11, 2011 report, Dr. Brigham reviewed the August 23, 2010 report from Dr. Higgs, appellant's attending physician and surgeon, who performed two procedures on his left knee. He noted that Dr. Higgs failed to correlate his findings to the applicable tables and figures of the A.M.A., *Guides* to rate 13 percent left leg impairment. Dr. Brigham found that appellant had a one percent impairment of the left leg based on the Knee Regional Grid, Lower Extremity Impairments at Table 16-3, page 509 of the A.M.A., *Guides*. He applied the section on muscle/tendon impairments and found that appellant had a class 1 rating for left knee strain, a default score of two percent lower extremity impairment based on palpatory findings. Dr. Brigham then utilized the net adjustment formula, applying the grade modifiers of zero for functional history and physical examination and no grade modifier for clinical studies; he compared these net adjustments and calculated the diagnosis for class 1 of minus two; for a grade A, one percent lower extremity impairment. Based on his report, OWCP determined that appellant had a one percent impairment of the left leg, as he calculated this rating based on the applicable protocols and tables of the sixth edition of the A.M.A., *Guides*. Dr. Brigham applied the diagnosis-based impairment method for appellant's accepted left knee strain condition, rather than rating the two surgeries he underwent to repair his anterior cruciate and torn medial meniscus. He based the rating on the fact that appellant's left knee had stabilized following the surgeries, which were performed in November 2008 and September 2009.

The Board also finds that had appellant's impairment been rated for his torn medial meniscus, instead of the sprain, the impairment rating would have been the same. Pursuant to Table 16-3, the default rating for meniscal injury with tear, or repair is also two percent.[17]

[14] *Veronica Williams*, 56 ECAB 367, 370 (2005).

[15] A.M.A., *Guides* 497.

[16] *Id.* at 521-22.

[17] The Board notes that Dr. Goodman provided an impairment rating for appellant's accepted torn meniscus condition, the only such rating in the instant record. This rating is not applicable, however, as it was based on the range of motion method used by Dr. Goodman which Dr. Slutsky properly rejected for the reasons stated above.

Appellant sought an additional schedule award and submitted the July 1, 2011 report of Dr. Goodman, who also rated a 13 percent impairment of the left leg based on loss of range of motion in the left knee, augmented by his meniscal tear and surgery, which elevated the impairment to a grade 2, 13 percent impairment. On December 22, 2011 Dr. Slutsky reviewed Dr. Goodman's report. He stated that he relied on Dr. Brigham's report but rated an additional one percent impairment for the condition of left knee strain/sprain, to find a total two percent impairment. Dr. Slutsky found that Dr. Goodman's rating for loss of range of motion was not in conformance with the A.M.A., *Guides* because he did not indicate that he performed three measurements, using a goniometer, as mandated by section 16.3b, page 517 of the A.M.A., *Guides*; because the A.M.A., *Guides* state that a range of motion impairment should not be combined with the diagnosed-based impairment; and because Dr. Goodman failed to compare the total values for the foot/ankle, knee, or hip to the criteria in section 16-7, page 543 to define the range of motion grade modifier. Dr. Goodman did not verify that he performed all of the measurements required by section 16.7b, which states at page 517 of the A.M.A., *Guides*:

> "Range of motion is graded according to the process and the criteria specified in section 16.7. Lower extremity impairment can be evaluated by assessing the range of motion of its joints, recognizing that pain and motivation may affect the measurements. If it is clear to the evaluator that a restricted range of motion has an organic basis, three measurements should be obtained and the greatest range measured should be used for the determination of impairment."[18]

In addition, as noted by Dr. Slutsky, section 16-2, page 497 of the A.M.A., *Guides*, Diagnosis-Based Impairment, states:

> "Most impairments are based on the [d]iagnosis-based [i]mpairment where impairment class is determined by the diagnosis and specific criteria.... Range of motion is primarily used as a physical examination adjustment factor and is only used to determine actual impairment values when it is not possible to otherwise define impairment. Ratings based on range of motion ... cannot be combined with other approaches."

Dr. Slutsky properly relied on a diagnosis-based method for rating appellant's accepted left knee strain. While Dr. Goodman found that appellant had a 13 percent left lower extremity impairment, his rating is of diminished probative weight as he did not utilize the proper methods to correlate this rating to the applicable protocols of the sixth edition of the A.M.A., *Guides*.[19]

While the record documents that appellant has an accepted cruciate injury, a diagnosis-based impairment can only be granted for a cruciate injury if measured laxity is present. As the medical record does not substantiate laxity, appellant's permanent impairment was not evaluated for this diagnosis. OWCP's medical adviser provided an impairment rating in accordance with

[18] A.M.A., *Guides* 510.

[19] The Board notes that a description of appellant's impairment must be obtained from appellant's physician, which must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations. *See Peter C. Belkind*, 56 ECAB 580, 585 (2005).

its applicable protocols and tables. It properly granted a schedule award for a two percent left lower extremity impairment in its January 24, 2012 decision.

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 more than a two percent impairment of his left leg.

ORDER

IT IS HEREBY ORDERED THAT the June 28 and January 24, 2012 decisions of the Office of Workers' Compensation Programs be affirmed.

Issued: March 11, 2013
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