United States Department of Labor
Employees' Compensation Appeals Board

T.P., Appellant	)	
	)	**Docket No. 15-1592**
and	)	**Issued: February 12, 2016**
DEPARTMENT OF ENERGY, WESTERN AREA POWER ADMINISTRATION, Cheyenne, WY, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On July 21, 2015 appellant, through counsel, filed a timely appeal from a May 15, 2015 merit 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 this case.

ISSUE

The issue is whether appellant has met his burden of proof to establish more than two percent impairment of the right leg, for which he received a schedule award.

On appeal, counsel contends that appellant has greater impairment. He requests that the Board remand the case and direct OWCP to approve an impairment rating as outlined by an OWCP referral physician.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on June 21, 2013 appellant, then a 43-year-old journeyman lineman, sustained right ankle sprain, right knee contusion, and right lateral meniscus derangement when he fell 25 to 30 feet from a power pole.[2] It authorized right knee arthroscopy with partial lateral meniscectomy and anteromedial plica resection, and right knee chondroplasty, undersurface patella, medial femoral condyle, and lateral tibial plateau performed on February 5, 2014 by Dr. Ryan L. Hartman, a Board-certified orthopedic surgeon.

On August 11, 2014 appellant filed a claim for a schedule award (Form CA-7) and submitted an impairment evaluation dated May 30, 2014 in which Dr. Kevin J. O'Toole, an attending physician Board-certified in occupational medicine, described his accepted right knee injuries. Dr. O'Toole examined the right and left knees. The right knee was without effusion. Active range of motion was measured in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). Dr. O'Toole found appellant's effort to be self-limited. Passive motion during McMurray's testing showed movement well beyond his active endpoints, completely without resistance. Dr. O'Toole, therefore, relied on right knee measurements last reported by Dr. Hartman who found full extension and 128 degrees of flexion. The left knee measured +15 degrees of extension and 128 degrees of flexion. Suprapatellar circumference was measured at 20.5 inches in both legs. There was no joint line tenderness. Patellar grind was negative. The calf was supple and nontender. Dr. O'Toole assessed status post right knee arthroscopy which included chondroplasty for grade 3 changes of the lateral tibial plateau and grade 3 changes of the lateral patellar facet, medial femoral condyle, and undersurface of the patella. He also assessed status post "15 percent lateral meniscectomy" and status post resection of anteromedial plica.

Dr. O'Toole noted that appellant had completed postoperative rehabilitation, was released to full duty, and had reached maximum medical improvement as determined by Dr. Hartman and Dr. Tracey L. Stefanon, a physician Board-certified in occupational medicine.[3]

Dr. O'Toole rated appellant's impairment under the sixth edition of the A.M.A., *Guides*.[4] He noted that, under Table 16-3, Knee Regional Grid, the most appropriate category would be for the diagnosis of primary knee joint arthritis as it was the most serious condition. Dr. O'Toole advised that appellant had a class 1 impairment due to a three-millimeter cartilage interval, full-thickness articular cartilage defect with a default value of seven percent. He found a grade modifier 1 for Functional History (GMFH) based on appellant's responses to a lower limb questionnaire in which he reported moderate pain going up or down stairs. Dr. O'Toole expected these symptoms to improve with time. He found a grade modifier 0 for Physical Examination (GMPE) as appellant's physical examination findings were consistently unremarkable compared to the examinations performed by Drs. Hartman and Stefanon.

[2] Appellant stopped work on June 21, 2013 and returned to full-time, light-duty work on July 29, 2013. As of September 4, 2013 he performed full-time work with no restrictions.

[3] On May 5, 2014 Dr. Hartman released appellant to return to full-duty work with no restrictions or need for further medical treatment.

[4] A.M.A., *Guides* (6th ed. 2009).

Dr. O'Toole found a grade modifier 2 for Clinical Studies (GMCS) as magnetic resonance imaging (MRI) scan findings were consistent with his diagnosis with moderate changes evident. He then applied the net adjustment formula and concluded that appellant had seven percent right lower extremity permanent impairment which represented three percent whole person impairment.

In an August 26, 2014 report, Dr. Morley Slutsky, a physician Board-certified in occupational medicine and an OWCP medical adviser, reviewed the medical record, including Dr. O'Toole's May 30, 2014 report. He noted that Dr. O'Toole rated appellant as if he had a full thickness articular cartilage defect or three millimeters of joint space narrowing in the right knee joint. Dr. Slutsky advised that the right knee surgical report identified grade 3 changes equivalent to partial thickness articular cartilage defects and not full thickness defects. He related that Dr. O'Toole did not document the knee x-rays performed on May 30, 2014 and joint space measurements taken in all three knee compartments. Dr. Slutsky suggested that he be asked whether he performed right knee x-rays on May 30, 2014 and if so, to provide his measurements for all three right knee compartments. If Dr. O'Toole had not performed such x-rays, then he should be asked to explain how he determined that there were three millimeters of joint space narrowing in the primary knee joint.

Dr. Slutsky used the diagnosis-based method in the sixth edition of the A.M.A., *Guides* to rate impairment of appellant's right knee with a diagnosis of partial lateral meniscectomy, the most impairing diagnosis, which resulted in a class 1 impairment. He found a grade modifier 1 for functional history under Table 16-6, page 516 and a grade modifier 0 for physical examination under Table 16-7, page 517. Dr. Slutsky found that no grade modifier was applicable for clinical studies. He applied the net adjustment formula and found that appellant had two percent right leg impairment which represented three percent whole person impairment. Dr. Slutsky concluded that appellant reached maximum medical improvement on May 30, 2014.

By letter dated March 12, 2015, QTC Medical Services, OWCP's medical appointment scheduler, referred appellant, together with the case record, a list of questions, and a statement of accepted facts, to Dr. John D. Douthit, a Board-certified orthopedic surgeon, for a second opinion evaluation.[5]

In an April 6, 2015 report, Dr. Douthit noted examining appellant on April 2, 2014. He reviewed appellant's history and the medical record. On examination, Dr. Douthit found that appellant was overweight and had a slight limp favoring his left leg. Appellant had mild stiffness of the back, but full range of motion of the hips and ankles. Right knee range of motion was 10/100 degrees and left knee range of motion was 0/130 degrees. Appellant could squat only to 90 degrees. His knee was stable. There was no joint effusion. There was 1+ crepitation of the right patellofemoral joint and 1+ crepitation of the left patellofemoral joint. No instability was noted. Drawer signs and a Lachman sign test were negative. Dr. Douthit summarized that

[5] The Board notes that appellant was originally referred to Dr. Alfred C. Lotman, a Board-certified orthopedic surgeon, for a second opinion evaluation, but his appointment was cancelled because Dr. Lotman did not perform impairment rating evaluations. Dr. Lotman was then referred him to Dr. Dirk W. Dolbeare, a Board-certified orthopedic surgeon, however, QTC Medical Services cancelled his appointment.

appellant had significant chondromalacia of the medial, femoral, and patellofemoral joints as noted on the arthroscopic report and confirmed by the prior MRI scan.

Dr. Douthit reviewed postoperative records and advised that appellant had never recovered to full function. He found that appellant had reached maximum medical improvement some time ago. There was documentation that appellant had chondromalacia tricompartmental of the right knee. He also had debridement with minimal lateral meniscectomy, persistent knee pain, and limited restricted motion. Appellant lacked 10 degrees of extension and only had 100 degrees of flexion. He had a slight limp and was unable to return to work as a lineman because he could not climb with his right knee difficulties. Dr. Douthit reviewed comparative right and left knee x-rays and found no difference in the joint space. He measured both joint spaces at five millimeters, but found no narrowing. There was also no narrowing of the patellofemoral joint space. Dr. Douthit advised that it was evident from the objective arthroscopic findings that appellant had a degree of chondromalacia of the joint surfaces not yet evident by narrowing of the joint based on his x-rays and early osteoarthritis. He noted that the sixth edition of the A.M.A., *Guides*, specified that there must be joint space narrowing on weight-bearing x-rays to use the regional grid and diagnostic criteria for arthritis. The A.M.A., *Guides*, suggested alternatives, but Dr. Douthit was unable to find a satisfactory and consistent alternative diagnosis-based rating. The only alternative method for rating appellant's right knee impairment was the stand-alone loss of motion method noted in sections 16.23 and 16.25 of the A.M.A., *Guides*. Dr. Douthit determined that 100 degrees of flexion and -10 degrees of extension yielded 10 percent impairment of the right knee for mild loss of motion. He further determined that his functional, clinical, and physical findings correlated with a mild restriction of joint motion and there was no adjustment up or down. Dr. Douthit concluded that the diagnostic method of using regional grids was inequitable as appellant had no measureable joint space narrowing.

On April 24, 2015 Dr. Slutsky again reviewed the medical record, including Dr. Douthit's April 6, 2015 findings. He disagreed with Dr. Douthit's 10 percent permanent impairment rating of the right lower extremity as it was based on the range of motion method using invalid right knee range of motion measurements and a different diagnosis. Dr. Slutsky noted range of motion measurements taken during appellant's previous examinations on December 30, 2013 to February 9, 2015, including Dr. O'Toole's May 30, 2014 measurements. He found that his best range of motion was within normal limits (no extension lag and flexion of at least 110 degrees or greater) based on the medical documents from more than one year ago. This was in contrast to Dr. Douthit's findings of right knee motion of -10 to 100 degrees.

Dr. Slutsky advised that his findings may represent a temporary exacerbation of appellant's condition, but did not reflect consistent range of motion findings and appellant's best effort. Thus, he opined that Dr. Douthit's use of range of motion measurements to rate impairment of the knee was based on inconsistent and unreliable findings. Additionally, Dr. Slutsky documented only one set of measurements, while the A.M.A., *Guides*, required that three tests of active range of motion measurements be obtained, and the greatest number be used for final rating calculations. Further, he reported that the A.M.A., *Guides*, indicate that range of motion be used primarily as a grade modifier and not as the primary impairment method. Dr. Slutsky reiterated his prior impairment calculations based on a diagnosis of partial lateral meniscectomy and concluded that appellant had two percent right leg impairment. He advised that appellant reached maximum medical improvement on April 2, 2015 the date of Dr. Douthit's

evaluation. Dr. Slutsky related that Dr. Douthit provided a detailed examination which allowed him to find that appellant's right knee condition had stabilized at that time and no further treatment was planned. He concluded that appellant's condition was not expected to change significantly from the date of maximum medical improvement.

In a May 15, 2015 decision, OWCP granted appellant a schedule award for two percent impairment of the right lower extremity based on Dr. Slutsky's opinion.

LEGAL PRECEDENT

The schedule award provision of FECA[6] and its implementing federal regulations set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members, functions, and organs of the body. FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[7] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[8] For decisions issued after May 1, 2009, the sixth edition is used to calculate schedule awards.[9] It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[10]

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 ankle, the relevant portion of the leg (foot) for the present case, reference is made to Table 16-2 (Foot and Ankle Regional Grid) beginning on page 501.[11] After the Class of Diagnosis (CDX) is determined from the Foot and Ankle Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the grade modifier for functional history, grade modifier for physical examination and grade modifier for clinical studies. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[12] Under Chapter 2.3, evaluators are directed to provide reasons

[6] 5 U.S.C. § 8107.

[7] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[8] *Id.*

[9] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3, Exhibit 1 (January 2010); *id.*, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

[10] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); *id.*, Chapter 3.700.3.a.3 (January 2010). This portion of OWCP procedures provide that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

[11] *See* A.M.A., *Guides* 501-7 (6th ed. 2008).

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

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

Chapter 16 of the sixth edition of the A.M.A., *Guides*, pertaining to the lower extremities, provides that diagnosis-based impairment is "the primary method of calculation for the lower limb" and that most impairments are based on the diagnosis-based impairment where impairment class is determined by the diagnosis and specific criteria as adjusted by the grade modifiers for functional history, physical examination and clinical studies. Chapter 16 further provides:

> "Alternative approaches are also provided for calculating impairment for peripheral nerve deficits, complex regional pain syndrome, amputation and range of motion. 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."[14]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a 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.[15]

ANALYSIS

The Board finds that appellant has no more than two percent impairment of the right leg. OWCP accepted his claim for right ankle sprain, right knee contusion, and right lateral meniscus derangement. It authorized right knee arthroscopy performed on February 5, 2014. The Board finds that the weight of the medical evidence rests with the opinion of Dr. Slutsky, OWCP's medical adviser, who provided the only impairment rating that properly applied the sixth edition of the A.M.A., *Guides*.

In a May 30, 2014 report, Dr. O'Toole, appellant's treating physician, diagnosed primary knee arthritis (a three-millimeter cartilage full-thickness articular cartilage defect) and found that appellant had reached maximum medical improvement on that day. He classified his impairment as a class 1 default value of seven percent under Table 16-3, on page 510, of the A.M.A., *Guides*. Dr. O'Toole found a grade modifier 1 for functional history as appellant had moderate pain going up or down stairs, but no other activity problems. He found a grade modifier 0 for physical examination as his findings were consistently unremarkable compared to those of Drs. Harman and Stefanon. Dr. O'Toole found a grade modifier 2 for clinical studies as MRI scan findings were consistent with his diagnosis with moderate changes evidence. Applying the net adjustment formula resulted in a net adjustment of zero or a grade C impairment which equated to a seven percent of the right lower extremity.

[13] *Id.* at 23-8.

[14] *Id.* at 497, 544-53.

[15] *See supra* note 10, Chapter 2.808.6(f) (February 2013).

On August 26, 2014 Dr. Slutsky reviewed the medical record, including Dr. O'Toole's report. He found that Dr. O'Toole's impairment rating was not acceptable as it was based on a diagnosis of full-thickness articular cartilage defect and/or three millimeters of joint space narrowing in the primary joint of the right knee rather than a diagnosis of partial thickness articular cartilage defect as indicated by the February 5, 2014 surgical report. Dr. Slutsky further found that Dr. O'Toole had not provided specific joint space measurements in all three knee compartments. He used the diagnosis-based method in the sixth edition of the A.M.A., *Guides*, to rate appellant's impairment. Dr. Slutsky determined that a diagnosis of partial lateral meniscectomy resulted in a class 1 impairment. He found a grade modifier 1 for functional history under Table 16-6, page 516, and a grade modifier 0 for physical examination under Table 16-7, page 517. Dr. Slutsky found that no grade modifier was applicable for clinical studies. He applied the net adjustment formula and concluded that appellant had two percent right lower extremity impairment based on findings in Dr. O'Toole's evaluation.

To determine the extent and degree of any employment-related impairment of appellant's right lower extremity, OWCP referred appellant to Dr. Douthit for a second opinion evaluation. Examination of both knees revealed a range of motion of 10/100 degrees on the right and 0/130 degrees on the left. Appellant could squat only to 90 degrees. His knee was stable. There was no joint effusion. There was 1+ crepitation each of the right and left patellofemoral joints. No instability was noted. Drawer signs and a Lachman sign test were negative. Dr. Douthit determined that 100 degrees of flexion and -10 degrees of extension yielded 10 percent permanent impairment of the right lower extremity under the sixth edition of the A.M.A., *Guides*. He advised that the diagnosed-based method was not equitable to rate appellant's impairment as there was no measureable joint space narrowing.

On April 24, 2015 Dr. Slutsky reviewed the medical record, including Dr. Douthit's April 6, 2015 report and disagreed with his 10 percent right leg impairment rating. He explained that Dr. Douthit used invalid range of motion measurements, noting that previous measurements including those from Dr. O'Toole's May 30, 2014 evaluation were within normal limits. Dr. Slutsky related that his right knee range of motion findings of -10 to 100 degrees may represent a temporary exacerbation of appellant's condition, but did not reflect consistent range of motion findings and his best effort. He reasoned that, under the A.M.A., *Guides*, the diagnosis-based method was the preferred method for rating impairment while range of motion was used primarily as a grade modifier. Dr. Slutsky reiterated his prior calculations as set forth in his prior report of August 26, 2014, and concluded that appellant had two percent impairment of his right lower extremity under the A.M.A., *Guides*.

The Board finds that Dr. Slutsky properly reviewed the medical record and evaluated appellant's right lower extremity impairment in accordance with the A.M.A., *Guides*. There is no medical evidence in conformance with the A.M.A., *Guides* showing a greater impairment. Appellant has not met his burden of proof to establish greater than two percent right leg impairment.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish more than two percent impairment of the right leg, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the May 15, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 12, 2016
Washington, DC

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

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board