# United States Department of Labor
# Employees' Compensation Appeals Board

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| **T.R., Appellant** | ) | |
| **and** | ) | **Docket No. 15-1862** |
| | ) | **Issued: March 24, 2016** |
| **DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, Marion, IL, Employer** | ) | |

*Appearances:*
*Alan J. Shapiro, Esq.*, for the appellant
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

### ***JURISDICTION***

On September 15, 2015 appellant, through counsel, filed a timely appeal from a May 7, 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 more than two percent permanent impairment of his right lower extremity for which he received a schedule award.

### ***FACTUAL HISTORY***

On March 18, 2010 appellant, then a 47-year-old correctional officer, sustained a right knee injury when he was packing inmate property and kneeled down on a plastic hair comb.

[1] 5 U.S.C. § 8101 *et seq.*

OWCP accepted the claim for right tear of lateral meniscus knee and right cruciate ligament knee sprain.

On May 27, 2010 appellant underwent resection of torn lateral meniscus and reconstruction of anterior cruciate ligament (ACL). On December 6, 2011 he underwent removal of hardware, curettage of cyst in the femur, and tibia and bone grafting. On May 29, 2012 appellant underwent revision of ACL reconstruction. OWCP authorized the above-referenced surgeries.

In a report dated July 3, 2013, Dr. Todd M. Wente, a Board-certified orthopedic surgeon, related that appellant's right knee ACL reconstruction occurred one year ago, and that appellant currently had good and bad days in terms of pain. He examined appellant's right knee and found no effusion, stable graft, and solid endpoint, with no pivot shift or glide. Dr. Wente also related that appellant had excellent quad strength, full flexion and retained range of motion of the right knee. He concluded that appellant had probably reached maximum medical improvement (MMI).

On January 17, 2014 appellant filed a claim for a schedule award (Form CA-7).

By letter dated January 27, 2014, OWCP requested that appellant submit an impairment rating from his attending physician in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009) (A.M.A., *Guides*). It provided him 30 days to submit the requested impairment evaluation.

In support of his schedule award claim, appellant submitted a February 12, 2014 medical report from Dr. Neil Allen, Board-certified in internal medicine and neurology. Dr. Allen provided a history of the March 18, 2010 employment injury, review of diagnostic testing, and findings on physical examination. He noted a diagnosis of right cruciate ligament sprain of knee and right tear of lateral meniscus of knee.

Using the sixth edition of the A.M.A., *Guides*,[2] Dr. Allen opined that appellant had nine percent permanent impairment of the right lower extremity. According to Table 16-3 (Knee Regional Grid) on page 511, he utilized historical data and medical records to determine class 1 diagnosis-based impairment, which yielded a default value of seven percent. Dr. Allen noted that physical examination revealed negative for instability, negative Lachman's, normal range of motion, and negative for muscle atrophy. He assigned a grade modifier of 2 for physical examination based on moderate palpatory findings which were consistently documented and supported by observed abnormalities.[3] Dr. Allen determined that functional history yielded a grade modifier of 1 based on the AAOS Lower Limb Questionnaire score of 52 and antalgic gait.[4] Clinical studies were assigned a grade modifier of 2 based on a March 31, 2010 magnetic resonance imaging (MRI) scan of the right knee which revealed a complete tear of the ACL and a tear of the posterior and anterior horn of the lateral meniscus. A January 30, 2012

[2] A.M.A., *Guides* (2009).

[3] *Id.* at 517, Table 16-7.

[4] *Id.* at 516, Table 16-6.

computerized tomography (CT) scan revealed postoperative changes most compatible with ACL reconstruction.[5] Applying the net adjustment formula, Dr. Allen subtracted 1, the numerical value of the class, from the numerical value of the grade modifier for each applicable component (physical examination, functional history, and clinical studies) and then added those values, resulting in a net adjustment of 2 ((2-1) + (1-1) + (2-1)).[6] Application of the net adjustment formula meant that movement was warranted two places to the right of class 1 default value grade C to grade E for nine percent right lower extremity impairment.[7]

OWCP routed Dr. Allen's report, a statement of accepted facts (SOAF), and the case file to Dr. Michael Hellman, an orthopedic surgeon and OWCP district medical adviser (DMA), for review and a determination on whether appellant sustained a permanent partial impairment of the right lower extremity and date of MMI.

In a September 2, 2014 report, Dr. Hellman reported that the file was reviewed for the purpose of determining permanent impairment of the right lower extremity due to a tear of the lateral meniscus and sprain of cruciate ligament which had been accepted as work related. He noted that appellant underwent ACL reconstruction and partial meniscectomy of the lateral meniscus and a later revision of ACL reconstruction. Dr. Wente's July 3, 2013 report stated that appellant had no pivot shift or pivot glide and a stable Lachman's test with a firm endpoint. Utilizing Table 16-3 of the A.M.A., *Guides,* appellant's diagnosis was class 0 with a value of zero percent.[8] Per section 6.3f, Dr. Hellman utilized the most impairing diagnosis within the region which appeared to be the lateral meniscal tear since the ACL reconstruction was a success. In accordance with Table 16-3 for meniscal injury diagnosis, appellant was assigned class 1, grade C with a default value of two percent.[9] Appellant was assigned a grade modifier of 1 for functional history due to regular duty without orthotics, no instability, and occasional pain. Physical examination was assigned a grade modifier of 1 for findings of tenderness over the medial incision. Clinical studies were assigned a grade modifier of 2 based on an MRI scan which revealed complete tear of ACL and posterior horn lateral meniscus tear.[10] Utilizing the net adjustment formula resulted in 1 ((1-1) + (1-1) + (2-1)) indicating that movement was warranted one place to the right of class 1 default value grade C to grade D for two percent lower right extremity impairment.[11] MMI was noted as July 3, 2014.

Dr. Hellman noted that his impairment rating differed from that of Dr. Allen's. He explained that Dr. Allen utilized the diagnosis of right knee arthritis for his impairment rating.

[5] *Id.* at 519, Table 16-8.

[6] *Id.* at 521.

[7] *Id.* at 521.

[8] *Id.* at 510.

[9] *Id.* at 509.

[10] *Supra* note 5.

[11] *Supra* note 9.

Dr. Hellman noted that his impairment rating utilizing the diagnosis of lateral meniscal tear better reflected the work-related injury and appellant's subsequent impairment.

By decision dated September 23, 2014, OWCP granted appellant a schedule award for two percent permanent impairment of the right lower extremity. It found that the weight of the medical evidence rested with Dr. Hellman serving as the OWCP DMA. The date of MMI was noted as July 3, 2014. The award covered a period of 5.76 weeks from July 3 to August 12, 2014.

On September 29, 2014 appellant, through counsel, requested an oral hearing before an OWCP hearing representative.

At the March 23, 2015 hearing, counsel argued that Dr. Allen's impairment rating was not based on arthritis of the right knee, and that Table 16-3 (Regional Knee Grid) contains many different diagnosis-based impairments. He stated that appellant should be awarded nine percent right lower extremity impairment due to his multiple surgeries and that the DMA incorrectly determined that his rating was based on arthritis as Dr. Allen made no mention of that impairment.

By decision dated May 7, 2015, the hearing representative affirmed OWCP's September 23, 2014 schedule award decision. He noted that the weight of the medical opinion evidence rested with Dr. Hellman serving as the OWCP DMA who properly applied the A.M.A., *Guides* to Dr. Allen's clinical findings.

## ***LEGAL PRECEDENT***

The schedule award provision of FECA and its implementing regulations 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.[12] 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 A.M.A., *Guides* provide a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF). For lower extremity impairments, the evaluator identifies the impairment Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[14] The net adjustment formula is

[12] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[13] *K.H.*, Docket No. 09-341 (issued December 30, 2011). For decisions issued after May 1, 2009, the sixth edition will be applied. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

[14] *Supra* note 2 at 493-531.

(GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[15] Evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[16]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP 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.[17]

## ***ANALYSIS***

OWCP accepted appellant's claim for right tear of lateral meniscus of knee and right cruciate ligament sprain of knee. It approved surgery for resection of torn lateral meniscus and reconstruction of ACL, removal of hardware, curettage of cyst in the femur, tibia and bone grafting, and revision of ACL reconstruction. The issue is whether appellant has more than two percent permanent impairment of the right lower extremity for which he received a schedule award. The Board finds that appellant has not met his burden of proof to establish that he has impairment of the right lower extremity greater than the two percent previously awarded.

In a February 12, 2014 medical report, Dr. Allen opined that appellant had nine percent permanent impairment of the right lower extremity. According to Table 16-3 (Knee Regional Grid) on page 511, he utilized historical data and medical records to determine class 1 diagnosis-based impairment which yielded a default value of seven percent. Applying the net adjustment formula, Dr. Allen subtracted 1, the numerical value of the class, from the numerical value of the grade modifier for each applicable component (physical examination, functional history, and clinical studies) and then added those values, resulting in a net adjustment of 2 ((2-1) + (1-1) + (2-1)).[18] Application of the net adjustment formula meant that movement was warranted two places to the right of class 1 default value grade C to grade E for nine percent lower extremity impairment.

Dr. Hellman, serving as the OWCP DMA, reviewed Dr. Allen's report and disagreed with his nine percent impairment rating, stating that the physician did not properly utilize the A.M.A., *Guides* as he based his impairment rating on arthritis of the knee, a condition not accepted as work related. Dr. Hellman referred to Table 16-3 for a meniscal injury to determine the diagnosis as class 1, grade C with a default value of two percent. Applying the net adjustment formula resulted in 1 ((1-1) + (1-1) + (2-1)) indicating that movement was warranted

[15] *Supra* note 6.

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

[17] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (February 2013).

[18] *Supra* note 6.

one place to the right of class 1 default value grade C to grade D for two percent lower extremity impairment.[19] MMI was noted as July 3, 2014.

The Board finds that the opinion of Dr. Hellman is thorough and well rationalized.[20] Dr. Hellman utilized the case record to find two percent impairment of the right lower extremity. Counsel for appellant argues that Dr. Allen did not base his impairment rating on arthritis and that Table 16-3 (Knee Regional Grid) contained various diagnoses spanning over three pages. The Board notes that Dr. Allen specifically cited page 511 of Table 16-3 (Knee Regional Grid) to determine class 1 diagnosis-based impairment which yielded a default value of seven percent. The only diagnosis with a class 1 default value of seven percent on page 511 is primary knee joint arthritis. Dr. Allen in his February 12, 2014 report never mentioned a condition of joint arthritis, however, his calculations reflect that diagnosis and subsequent permanent impairment rating. As such, his report is devoid of his rationale for his use of what appears to be a diagnosis of knee joint arthritis in his impairment rating.

Board precedent is well settled that when an attending physician's report gives an estimate of impairment but does not address how the estimate is based upon the A.M.A., *Guides*, OWCP may follow the advice of its DMA where he or she has properly applied the A.M.A., *Guides*.[21] Dr. Hellman properly utilized Table 16-3 of the A.M.A., *Guides* finding class 1 grade D meniscal injury resulting in a schedule award for two percent permanent impairment of the right lower extremity.[22]

Accordingly, the Board finds Dr. Hellman correctly applied the A.M.A., *Guides* to find that appellant had two percent permanent impairment of the right knee, for which he received a schedule award.[23] Appellant has not submitted sufficient evidence to establish that he has more than two percent impairment to the right lower extremity.[24]

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 has more than two percent permanent impairment of the right lower extremity for which he received a schedule award.

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[19] *Id.*

[20] *Supra* note 18.

[21] *See Ronald J. Pavlik*, 33 ECAB 1596 (1982); *Robert R. Snow*, 33 ECAB 656 (1982); *Quincy E. Malone*, 31 ECAB 846 (1980).

[22] *Supra* note 9.

[23] *Y.K.*, Docket No. 11-1623 (issued June 25, 2012).

[24] *J.S.*, Docket No. 12-1170 (issued November 9, 2012); *J.J.*, Docket No. 10-839 (issued December 23, 2010).

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the Office of Workers' Compensation Programs' decision dated May 7, 2015 is affirmed.

Issued: March 24, 2016
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board