United States Department of Labor
Employees' Compensation Appeals Board

D.F., Appellant	)	
and	)	**Docket No. 16-1435**
	)	**Issued: September 6, 2017**
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, White Deer, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant[1]
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 June 29, 2016 appellant, through counsel, filed a timely appeal from a May 16, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of this case.

ISSUE

The issue is whether appellant established more than eight percent permanent impairment of the right lower extremity for which he previously received schedule awards.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

On appeal counsel contends that there is an unresolved conflict in the medical opinion evidence with regard to the extent of permanent impairment.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts as set forth in the prior Board decision are incorporated herein by reference.

The relevant facts are as follows. OWCP accepted that on May 16, 2013 appellant, then a 44-year-old correctional officer, sustained a right medial meniscus tear and right lower leg other joint derangement (patella subluxation) when his knee buckled and gave out while he was descending an incline. It authorized right knee arthroscopic surgery, which was performed on January 20, 2014.

Appellant continued to submit progress reports from his treating physician, Dr. Brian Batman, a Board-certified orthopedic surgeon. In a report dated February 11, 2014, Dr. Batman found appellant's lateral retinacular release defect was palpable, but he found minimal swelling, and no intra-articular effusion. He also found that appellant's arthroscopic portals had healed and he had full range of motion. In a report dated March 14, 2014, Dr. Batman noted that appellant was still struggling with pain, had some swelling in the lateral aspect of his patella, had quadriceps weakness and atrophy, but had good patella mobility. He also related that on examination he was able to take appellant's right knee gently through the range of motion. On April 25, 2014 Dr. Batman related that appellant had tenderness to palpation along the lateral release region and weakness in the quadriceps, but full range of motion. In another report dated August 12, 2014, he related that appellant's right knee continued to bother him, especially when he tried to run or exercise. On examination appellant still had a palpable lateral retinacular defect, with peripatellar pain, and some synovial thickening. Dr. Batman also found upon examination that appellant had full range of motion of the right knee, and no instability.

In a report dated October 6, 2014, Dr. Michael J. Platto, an examining Board-certified physiatrist, applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (6th ed. 2009) used the range of motion (ROM) method of rating impairment, and found 20 percent permanent impairment of the right lower extremity. He reported that appellant had 97 degrees right knee flexion and 0 degrees right knee extension, no definite right knee crepitus, and tenderness on palpation over the lateral and medial right knee aspects. Dr. Plato further found that motor strength was 5/5 in both legs, and right knee sensation was decreased diffusely upon pinpoint testing. He noted that, under Table 16-23, page 549 of the sixth edition of the A.M.A., *Guides*, 97 degrees flexion would be considered a mild impairment, but as appellant also lacked 18 degrees extension this would be considered a moderate impairment, resulting in 20 percent permanent right lower extremity impairment. Using Table 16-17 on page 545, Dr. Platto noted that the grade modifier of 2 under the functional history matched the finding of a moderate impairment based on range of motion. He concluded that appellant had 20 percent permanent impairment of the right lower extremity.

On October 9, 2014 appellant filed a claim for a schedule award (Form CA-7).

[3] Docket No. 15-0664 (issued January 8, 2016).

On October 27 and 28, 2014 a district medical adviser (DMA), Dr. Morley Slutsky, Board-certified in occupational medicine, reviewed the medical evidence including Dr. Platto's report and noted that accepted conditions were right knee patella subluxation and right medial meniscal tear. He recommended that, due to the inconsistent examination findings by treating physicians Dr. Platto and Dr. Batman, a second opinion examination should be obtained prior to consideration of a schedule award. In his October 28, 2014 report, Dr. Slutsky noted that Dr. Platto's examination findings differed greatly from the other physicians' examination findings. He noted that the differences in Dr. Platto's examination findings could be explained by a temporary aggravation. Dr. Slutsky, using a diagnosis-based impairment (DBI) method of evaluation, concluded that appellant had two percent permanent impairment of the right lower extremity.

In a January 8, 2015 decision, OWCP granted appellant a schedule award for two percent permanent impairment of the right lower extremity. Appellant subsequently appealed to the Board.

By decision dated January 9, 2016, the Board found that OWCP should have followed the DMA's recommendation to refer appellant for a second opinion examination. The Board remanded the case for a second opinion examination to determine appellant's right knee range of motion and whether the degree of impairment should be evaluated under the DBI or ROM method.[4]

On February 5, 2016 OWCP referred appellant to Dr. Robert F. Draper, Jr., a Board-certified orthopedic surgeon, for a second opinion evaluation. In a March 14, 2016 report, Dr. Draper, based upon a review of the medical evidence, statement of accepted facts, and physical examination, diagnosed right patella subluxation, right knee patellar chondromalacia, and reported appellant's status post right knee lateral retinacular release and patella chondroplasty. A physical examination of the right knee revealed that appellant lacked 20 degrees of extension and flexes limited to 105 degrees, that he exhibited no instability, that anterior and posterior drawer signs and Lachman's sign were negative and that he exhibited crepitus on flexion and extension of the patellofemoral joint. Dr. Draper also reported that appellant had 2.5 centimeters of right-side quadriceps atrophy.

Dr. Draper calculated his impairment rating using the DBI method of evaluation pursuant to Table 16-3 of Knee Regional Grid, Lower Extremity Impairments of the sixth edition of the A.M.A., *Guides*.[5] He explained that, based on examination findings and factors set forth in Table 16-7, page 517 of the A.M.A., *Guides*, the DBI method would best determine appellant's permanent impairment. Dr. Draper selected Class of Diagnosis (CDX) as patella subluxation and assigned a default grade of C or seven percent, for a class 1 mild problem.[6] He assigned a grade modifier of 1 for Functional History (GMFH),[7] a grade modifier of 2 due to muscle

[4] *Id.*

[5] A.M.A., *Guides* 510, Table 16-3.

[6] *Id.* at 511.

[7] *Id.* at 516, Table 16-9.

atrophy for Physical Examination (GMPE),[8] and a grade modifier of 1 for Clinical Studies (GMCS).[9] Applying the net adjustment formula, or (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (1-1) + (2-1) + (1-1) resulted in a modifier of +1, moving the default rating from C to D, equaling eight percent impairment of the right lower extremity.

OWCP subsequently referred the medical record to Dr. Arthur S. Harris, Board-certified in orthopedic surgery, another DMA for review of Dr. Draper's impairment rating.[10] In an April 8, 2016 report, Dr. Harris reviewed and concurred with Dr. Draper's impairment determination. In an April 22, 2016 report, he again concurred with Dr. Draper's impairment determination and noted that appellant had previously been granted a schedule award for two percent permanent impairment of the right lower extremity and was, therefore, entitled to an additional six percent right lower extremity impairment award. Dr. Harris found March 14, 2016, the date of Dr. Draper's report, to be the date of maximum medical improvement.

By decision dated May 16, 2016, OWCP granted appellant a schedule award for an additional six percent permanent impairment of the right lower extremity, resulting in a total award of eight percent right lower extremity permanent impairment. The award ran for 17.28 weeks from March 14 to July 12, 2016.

LEGAL PRECEDENT

Under section 8107 of FECA[11] and section 10.404 of the implementing federal regulations,[12] schedule awards are payable for permanent impairment of specified body members, functions, or organs. FECA, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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 sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[14] Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition, which is then adjusted by grade modifiers based on functional history,

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

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

[10] In both referral letters, the DMA was asked to explain "if applicable" the method chosen to rate the impairment, (*e.g.*, DBI vs ROM).

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404

[13] *D.J.*, 59 ECAB 620 2008); *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

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

physical examination, and clinical studies.[15] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[16]

Chapter 16 of the sixth edition of the A.M.A., *Guides*, pertaining to the lower extremities, provides that DBI is the method of choice for calculating impairment. Range of motion is primarily used as a physical examination adjustment factor.[17] Range of motion is only used to determine actual impairment values when it is not possible to otherwise define impairment.[18]

The A.M.A., *Guides* provide a regional grid at Table 16-3 for knee impairments.[19] The CDX is determined based on the specific diagnosis and the default value for the identified CDX is determined. The default value (grade C) may be adjusted by using grade modifiers for functional history Table 16-6, physical examination Table 16-7, and clinical studies Table 16-8. The adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[20]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed through a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with a DMA providing rationale for the percentage of impairment specified.[21]

ANALYSIS

OWCP accepted that appellant sustained a right medial meniscus tear and right lower leg other joint derangement/patella subluxation. By decision dated January 8, 2015, appellant was granted a schedule award for two percent permanent impairment of the right lower extremity.

The Board previously found that the record contained permanent impairment evaluations by appellant's treating physicians, Drs. Platto and Batman. However, neither evaluation constituted the weight of the medical evidence. The Board explained that OWCP should have followed the DMA's recommendation and referred appellant for a second opinion evaluation as Dr. Platto's examination findings were inconsistent with examination findings made by appellant's other treating physician, Dr. Batman. The case was remanded for referral to a second opinion physician to determine appellant's right knee range of motion and whether the degree of impairment should be evaluated using the DBI or the ROM method.

[15] A.M.A., *Guides* (6th ed. 2009), pp. 495-96.

[16] *Id*.

[17] *Id.* at 543.

[18] *Id.* at 497.

[19] The A.M.A., *Guides* note that the DBI is the primary method of evaluation for the leg. *Id.* at 497.

[20] The net adjustment is up to +2 (grade E) or -2 (grade A).

[21] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(e) (February 2013). *See C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

On remand OWCP referred appellant to Dr. Draper for a second opinion examination and impairment rating as instructed by the Board. In a March 14, 2016 report, Dr. Draper diagnosed right patella subluxation, right knee patellar chondromalacia, and status post right knee lateral retinacular release and patella chondroplasty. He determined the impairment rating using the DBI method of evaluation and Table 16-3 of Knee Regional Grid, Lower Extremity Impairments of the A.M.A., *Guides*.[22] Dr. Draper explained that the DBI method was chosen as it provided a more accurate impairment rating. He selected the diagnosis of patella subluxation and assigned a default grade of C or seven percent, for a class 1 mild problem.[23] Applying the net adjustment formula, or (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (1-1) + (2-1) + (1-1), resulting in a modifier of +1, moving the default C to D, equaling an eight percent impairment of the right lower extremity.

In his April 8 and 22, 2016 reports, the DMA concurred with the permanent impairment rating calculated by Dr. Draper.

The Board finds that Dr. Draper properly applied the A.M.A., *Guides* and determined that appellant had an eight percent right lower extremity permanent impairment of extremity.

Dr. Draper explained that he rated appellant's permanent impairment as a DBI for patellar subluxation as it best described appellant's impairment. He properly rated appellant's lower extremity impairment using the diagnosis-based tables and referenced the appropriate tables in evaluating examination findings.[24] Dr. Draper also provided medical rationale for the percentage of impairment in accordance with the A.M.A., *Guides.* As appellant previously received a schedule award for two percent permanent impairment of his right lower extremity, he was entitled to an additional schedule award for six percent permanent impairment.

On appeal counsel contends that there remains a conflict in the medical opinion evidence between appellant's treating physicians and Dr. Draper with respect to the application of the A.M.A., *Guides* and examination findings. The Board, in the prior appeal, noted inconsistency in physical examination findings between appellant's treating physicians, Dr. Platto and Dr. Batman, such that neither could constitute the weight of the medical evidence.

While Dr. Platto rated appellant's impairment using the ROM methodology, he explained that he did so because, while appellant's accepted diagnosis was patellar subluxation, appellant currently did not have instability of the knee. The Board notes that patellar subluxation can be rated as a DBI if no instability is present. However, it would be rated as a class 0 impairment.[25] ROM can be used as the most appropriate mechanism for grading impairment when grids refer to ROM as an alternate grading mechanism or no other DBI grading mechanism is applicable.[26]

[22] *Supra* note 5.

[23] *Supra* note 6.

[24] The A.M.A., *Guides* explain at page 497 that lower extremity impairments are evaluated as DBI. Alternative approaches are also provided for calculating impairment for peripheral nerve deficits, complex regional pain syndrome, amputation, and range of motion. ROM 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.

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

[26] *Id*. at 543.

The grid for evaluating permanent impairment of the knee, and specifically patellar subluxation does not refer to ROM as an alternate grading mechanism. Furthermore, a DBI grading mechanism is applicable for the accepted diagnosis of patellar subluxation.[27] The opinion of Dr. Platto was, therefore, insufficient to establish more than eight percent permanent impairment of the right lower extremity as the rationale he offered to rate appellant's impairment was not sufficiently rationalized.[28]

Appellant may request a schedule award or increased schedule award at any time 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 that appellant has not established more than eight percent permanent impairment of the right lower extremity for which he previously received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 16, 2016 is affirmed.

Issued: September 6, 2017
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

[27] *See D.D.*, Docket No. 11-1053 (issued April 12, 2012).

[28] *See John D. Jackson*, 55 ECAB 465 (2004) (a simple disagreement between two physicians does not, of itself, establish a conflict. To constitute a conflict of medical opinion, the opposing physician's reports must be of virtually equal weight and rationale).