United States Department of Labor
Employees' Compensation Appeals Board

A.T., Appellant	)	
and	)	**Docket No. 17-1940**
	)	**Issued: December 20, 2018**
DEPARTMENT OF HOMELAND SECURITY, CUSTOMS & BORDER PROTECTION, Corpus Christi, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 15, 2017 appellant filed a timely appeal from an August 18, 2017 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 permanent impairment of the right lower extremity, for which he has previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On July 25, 2016 appellant, a then 45-year-old customs and border patrol officer, filed a traumatic injury claim (Form CA-1) alleging that he sustained a right knee injury when he stepped over a tree branch and into a hole causing him to fall on his right knee on the other side of the hole. OWCP accepted his claim for sprain of unspecified site of right knee and other tear of the lateral meniscus of the right knee. On November 2, 2016 appellant underwent a right knee arthroscopy with partial lateral meniscectomy and chondroplasty using abrasion and micro fracture technique and lateral compartment and patellofemoral articulation.[2]

In a November 22, 2016 report, Dr. Charles W. Breckenridge, a Board-certified orthopedic surgeon, found full extension, full flexion, mild swelling, negative McMurray testing, and minimal quadriceps atrophy. He determined that appellant was status right knee arthroscopy with partial lateral meniscectomy status post chondroplasty utilizing micro fracture technique, lateral compartment and patellofemoral articulation for traumatic chondral injuries. Dr. Breckenridge indicated that he could return to work on November 28, 2016 in a modified capacity. He noted that appellant should be able to progress with his activity in six weeks.

In a January 3, 2017 report, Dr. Breckenridge examined appellant and found that he was able to fully extend the knee and had flexion to 130 degrees. He noted that McMurray testing was negative, he had mild discomfort over the anterior aspect of the knee, and quadriceps atrophy was noted with no evidence of hip pathology. Dr. Breckenridge advised that appellant was status post right knee arthroscopy with partial lateral meniscectomy, status post chondroplasty utilizing micro fracture technique, and lateral compartment and patellofemoral articulation for traumatic chondral injuries. He explained that he reached substantial improvement to allow him to return to regular work activity. Dr. Breckenridge indicated that appellant would require further strengthening, but he advised that appellant had reached maximum medical improvement. He referred to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] Dr. Breckenridge referenced Table 16-3[4] and explained that under partial meniscectomy, medial or lateral, a default value of C was listed as a reference. He explained that with respect to quadriceps atrophy and weakness, as per the adjustment grid, the functional history would be considered a grade 2 modifier. Dr. Breckenridge also found that physical examination secondary to quadriceps atrophy would also be a grade 2 modifier. He explained that clinical studies would be utilized for the diagnosis and the default value of C would move to E. Dr. Breckenridge opined that appellant had three percent right knee permanent impairment and was released to regular work.

On April 11, 2017 appellant filed a schedule award claim (Form CA-7).

[2] Appellant had a previous left knee arthroscopy.

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

[4] *Id*. at 509.

In order to determine the nature and extent of appellant's right lower extremity impairment stemming from his accepted conditions, OWCP referred Dr. Breckenridge's report to a district medical adviser (DMA).

In a May 24, 2017 report, Dr. Jovito Estaris, a Board-certified occupational medicine physician serving as an OWCP DMA, found that appellant had two percent permanent impairment of the right lower extremity under the sixth edition of the A.M.A., *Guides*. Relying on Table 16-3 at page 509 of the A.M.A., *Guides*,[5] which rates impairments based on sensory and motor deficits, he found a diagnosis of a lateral meniscus tear of the right knee and for a meniscal injury and a partial lateral meniscectomy, appellant was a class 1 with a default value of 2. Dr. Estaris referred to Table 16-6 at 516 of the A.M.A., *Guides* for functional history. He determined that appellant had a grade modifier of 1 for pain on kneeling and no antalgic gait. Dr. Estaris referred to Table 16-7 at page 517 of the A.M.A., *Guides* for physical examination adjustment. He found that appellant had a grade modifier of 1 for muscle atrophy and full range of motion. Dr. Estaris noted that clinical studies adjustment was not utilized. He advised that the magnetic resonance imaging (MRI) scan showed a lateral meniscus tear, which when used in diagnosis and proper classification of diagnosis-based impairment (DBI) grid, resulted in (GMFH - CDX) + (GMPE - CDX) = (1-1)+(1-1) = 0. Dr. Estaris advised the net adjustment resulted in 0 = class 1 = 2 percent. He concluded that appellant had no more than two percent right lower extremity permanent impairment.

Dr. Estaris further explained that the difference in the ratings was due to the use of grade modifiers. He noted that Dr. Breckenridge used a grade modifier of 2 for functional history and mentioned muscle atrophy and weakness as criteria. However, Dr. Estaris explained that those findings were criteria for physical examination and not functional history, with no antalgic gait, so at best, it was a grade modifier of 1. He noted that the grade modifier of 2 required an antalgic limp and asymmetric shortened stance, with routine use of single gait aid (cane or crutch), which was "obviously not seen in this case." Dr. Estaris also explained that Dr. Breckenridge used a grade modifier of 2 for physical examination, but that there was a mention of atrophy with no accompanying measurement. He added that in the absence of measurement, the best fit was a grade modifier of 1. Dr. Estaris explained that there was full range of motion and this was a grade modifier of 0. Regarding clinical studies, he referred to page 500 the A.M.A., *Guides*, the first column and second paragraph and explained that in some cases, the class would be defined by physical examination findings or clinical studies results. However, when that was the case, those same findings were not used as grade modifiers to adjust the rating.

By decision dated August 18, 2017, OWCP granted appellant a schedule award for two percent permanent impairment of the right lower extremity for the period January 3 to February 12, 2017, for a total of 5.76 weeks of compensation.

LEGAL PRECEDENT

Section 8149 of FECA delegates to the Secretary of Labor the authority to prescribe rules and regulations for the administration and enforcement of FECA. The Secretary of Labor has

[5] *Id*.

vested the authority to implement the FECA program with the Director of OWCP.[6] Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.[7] 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 under the law, good administrative practice requires the use of uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[8]

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A. issued a 52-page document entitled "Clarifications and Corrections, Sixth Edition, *Guides to the Evaluation of Permanent Impairment*." The document included various changes to the original text, intended to serve as an *erratum*/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[9] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[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 knee, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[11] After the class of diagnosis (CDX) is determined from the Knee Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the grade modifier for functional history (GMFH), grade modifier for physical examination (GMPE), and grade modifier for clinical studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[13]

---

[6] *See* 20 C.F.R. §§ 1.1-1.4.

[7] For a complete loss of use of a leg, an employee shall receive 288 weeks' compensation. 5 U.S.C. § 8107(c)(1).

[8] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[9] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (March 2017).

[10] *Isidoro Rivera*, 12 ECAB 348 (1961).

[11] *See supra* note 3 at 509-11.

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

[13] *Id*. at 23-28.

In some instances, OWCP's medical adviser's opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the A.M.A., *Guide*s. In this instance, a detailed opinion by the medical adviser may constitute the weight of the medical evidence. As long as the medical adviser explains his or her opinion, shows values and computation of impairment based on the A.M.A., *Guides*, and considers each of the reported findings of impairment, his or her opinion may constitute the weight. If the attending physician misapplied the A.M.A., *Guides*, no conflict would exist because the attending physician's report would have diminished probative value and the opinion of the medical adviser would constitute the weight of medical opinion.[14]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than two percent permanent impairment of his right lower extremity, for which he received a schedule award.

In a November 22, 2016 report, Dr. Breckenridge, a Board-certified orthopedic surgeon, performed a physical examination and provided his opinion as to appellant's right lower extremity permanent impairment. Referencing Table 16-3 for the diagnosis of a partial meniscectomy, medial or lateral, he opined that appellant had three percent permanent impairment of the right knee.

In a May 24, 2017 report, Dr. Estaris serving as a DMA properly evaluated the physical examination findings contained in Dr. Breckenridge's January 3, 2017 report to find that appellant had two percent permanent impairment of her right lower extremity. He also relied upon Table 16-3.[15] Dr. Estaris explained that his difference in the ratings was due to the grade modifiers assigned. He noted that Dr. Breckenridge had used a grade modifier of 2 for functional history and mentioned muscle atrophy and weakness as criteria. However, Dr. Estaris explained that those findings were criteria for physical examination and not functional history. He advised that there was no antalgic gait, and therefore, appellant was only entitled to a grade modifier of 1. Dr. Estaris also noted that the grade modifier of 2 required an antalgic limp and asymmetric shortened stance, with routine use of single gait aid (cane or crutch), which was "obviously not seen in this case." He also explained that Dr. Breckenridge used a grade modifier of 2 for physical examination despite no indication that appellant had atrophy. Dr. Estaris added that since no measurement had been provided, the best fit was a grade modifier of 1. He explained that appellant had full range of motion and thus a grade modifier of 0. Regarding clinical studies Dr. Estaris referred to page 500 the A.M.A., *Guides* and explained that in some cases, the class would be defined by physical examination findings or clinical studies results. However, when that was the case, those same findings, could not be used as grade modifiers to adjust the rating.

[14] *Supra* note 8 at Chapter 2.810.8j (September 2010); *M.P.*, Docket No. 14-1602 (issued January 13, 2015).

[15] *Supra* note 3.

Dr. Estaris opined that appellant had two percent permanent impairment of his right lower extremity. The Board finds that the May 24, 2017 impairment rating from Dr. Estaris represents the weight of the medical evidence in this case as he properly applied the appropriate provisions of the A.M.A., *Guides* to the clinical findings of record.[16] Dr. Estaris correctly noted the errors of Dr. Breckenridge's use of the grade modifiers in his application of the A.M.A., *Guides*. As the record contains no other probative, rationalized medical opinion which indicates that appellant has greater permanent impairment of his right lower extremity based upon the A.M.A., *Guides*, appellant has not met his burden of proof to establish greater than two percent right knee permanent impairment, for which he previously received a schedule award.

On appeal appellant argues that another employee with the same modifiers and same rating received a three percent schedule award. The Board notes that the medical opinion of the DMA has fully explained the basis for his right lower extremity permanent impairment rating. As noted, appellant has not submitted medical evidence showing that he has more than two percent permanent impairment of his right lower extremity.

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 appellant has not met his burden of proof to establish more than two percent permanent impairment of the right lower extremity, for which he previously received a schedule award.

[16] *K.P.*, Docket No. 18-0777 (issued November 13, 2018); *W.M.*, Docket No. 11-1156 (issued January 27, 2012).

ORDER

IT IS HEREBY ORDERED THAT the August 18, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 20, 2018
Washington, DC

Christopher J. Godfrey, 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