United States Department of Labor
Employees' Compensation Appeals Board

D.F., Appellant	)	
and	)	**Docket No. 15-0664**
	)	**Issued: January 8, 2016**
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, White Deer, PA, 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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On January 11, 2015 appellant, through counsel, filed a timely appeal of a January 8, 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 established that he has more than two percent right lower extremity permanent impairment, for which he received a schedule award.

On appeal counsel contends that OWCP erroneously discredited the impairment rating conducted on behalf of appellant as the physician provided a valid reason for using the range of motion record. He also argues that an OWCP medical adviser incorrectly used a condition that was not accepted to minimize appellant's impairment rating.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On May 21, 2013 appellant, then a 44-year-old correctional officer, filed a traumatic injury claim (Form CA-1) alleging that on May 16, 2013 he sustained a right knee injury when his knee buckled and gave out while he was walking down an incline. OWCP accepted the claim for right medial meniscus tear and right lower leg other joint derangement (patella subluxation) and authorized right knee arthroscopic surgery, which was performed on January 20, 2014.

OWCP received progress reports from appellant's treating physician, Dr. Brian Batman, a Board-certified orthopedic surgeon. In a report dated February 11, 2014, two weeks following appellant's right knee procedure, Dr. Batman related that on examination appellant's lateral retinacular release defect was palpable, he had minimal swelling, and no intra-articular effusion. He also related that appellant's arthroscopic portals had healed and he had full range of motion. In a report dated March 14, 2014, Dr. Batman related that appellant was still struggling with pain, still had a little bit of swelling in the lateral aspect of his patella, had some 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 Dr. Batman still had a palpable lateral retinacular defect, with peripatellar pain, and some synovial thickening. He also found that appellant had full range of motion of the right knee, and no instability.

On October 9, 2014 appellant filed a claim for a schedule award.

In a report dated October 6, 2014, Dr. Michael J. Platto, a Board-certified physiatrist, examined appellant at the request of appellant's counsel. He related that on examination appellant exhibited no need for any ambulatory assistive device and was able to get off and on the examination table without assistance. Dr. Platto reported that appellant had 97 degrees right knee flexion and 0 degrees right knee extension. He stated that appellant had no definite right knee crepitus, tenderness on palpation over the lateral and medial right knee aspects, motor strength was 5/5 in both legs, and right knee sensation was decreased diffusely upon pinpoint testing. Dr. Platto noted that, under Table 16-23, page 549 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009), that 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. Thus Dr. Platto found 20 percent right lower extremity impairment.

Dr. Platto explained that the sixth edition of the A.M.A., *Guides* allowed lower extremity impairment to be evaluated under the range of motion section if other grids referred to the range of motion section, or no other diagnosis-based section of the lower extremity chapter was applicable for rating the medical condition. He then explained that he did not feel that any other diagnosis-based section was applicable because appellant was diagnosed with patella subluxation or dislocation, but at the current time there was no instablility of the knee. Dr. Platto noted that

no meniscal injury was noted at the time of appellant's surgery, and that appellant's other diagnosis of chondromalacia was not a diagnosis listed under Table 16-3. Therefore he concluded that range of motion was the most applicable rating method.

On October 27 and 28, 2014 an OWCP medical adviser reviewed the medical evidence including Dr. Platto's report and noted that the accepted conditions were right knee patella subluxation and right medial meniscal tear. He noted that Dr. Platto's physical examination findings were inconsistent with the examination findings of the treating physicians as they found full range of motion. If there was further controversy, the medical adviser recommended that second opinion should be obtained prior to consideration of granting a schedule award to determine what appellant's "consistent knee findings are." He determined that the diagnosis was residual right knee sprain and recommended that appellant receive a schedule award for the right knee based upon Table 16-3, pages 509-11, class 1 knee strain. The medical adviser determined that appellant fell under the default value of two percent of the right leg. Under Table 16-8, page 519, appellant had a grade modifier 1 for functional history adjustment, grade modifier 2 for physical examination and grade modifier 1 for clinical studies. Application of the net adjustment formula meant that there was a net adjustment of one which moved the default grade of C to D resulting in two percent right lower extremity impairment. The medical adviser noted that appellant reached maximum medical improvement on August 12, 2014 and concluded that the total impairment of his right leg was two percent.

In a January 8, 2015 decision, OWCP granted appellant a schedule award for two percent permanent impairment of the right lower extremity. The award ran for 5.76 weeks from August 12 to September 21, 2014 and was based on the medical adviser's impairment rating.

LEGAL PRECEDENT

Under section 8107 of FECA[2] and section 10.404 of the implementing federal regulations,[3] 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.[4]

The sixth edition of 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).[5] Under the sixth edition, the evaluator identifies the impairment Class of

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404

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

[5] 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.

Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[6] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[7]

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. It further provides that 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.[8] The A.M.A., *Guides* however also explain that some of the diagnosis-based grids refer to the range of motion section when that is the most appropriate mechanism for grading the impairment. This section is to be used as a stand-alone rating when other grids refer to this section or no other diagnosis-based sections of the chapter are applicable for impairment rating of a condition.[9]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed through an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.[10]

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, it granted him a schedule award for two percent permanent right lower extremity impairment. The award was based on the impairment rating of an OWCP medical adviser. The medical adviser reviewed the findings of Dr. Batman and Dr. Platto.

The Board finds that this case is not in posture for decision.

The sixth edition of the A.M.A., *Guides* state that most impairment values for the lower extremity are calculated using the diagnosis-based impairment method of evaluation.[11] On the other hand, range of motion based impairment may be used as a stand-alone rating when other

[6] A.M.A., *Guides* (6th ed. 2009), pp. 383-419.

[7] *Id.* at 411.

[8] *Id.* at 497, section 16.2.

[9] *Id.* at 543.

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

[11] A.M.A., *Guides* 495.

grids refer the evaluator to this method or when no other diagnosis-based sections are applicable for impairment rating of a condition.[12] A range of motion impairment stands alone and is not combined with diagnosis impairment.[13]

Dr. Platto rated appellant's right knee permanent impairment using his range of motion findings, after explaining why a diagnosis-based impairment evaluation was not preferred in this case. However, the medical adviser determined that Dr. Platto's range of motion findings were in conflict with prior examinations of Dr. Batman. The medical adviser recommended a second opinion because the range of motion findings proposed by Dr. Platto did not appear to be consistent with earlier reports. An OWCP medical examiner did not examine appellant. The Board finds that OWCP should have followed the medical adviser's recommendation and referred appellant for a second opinion evaluation. The second opinion evaluation should determine appellant's right knee range of motion, and thereafter determine whether appellant's degree of permanent impairment should be evaluated as a diagnosis-based impairment, or as a loss of range of motion impairment. Accordingly, the Board remands this case so that a new physician can conduct an examination and make findings on physical examination with regard to the degree of permanent impairment of appellant's right knee.

CONCLUSION

The Board finds that this case is not in posture for decision.

[12] *Id.* at 543. *See also D.H.*, Docket No. 12-1857 (issued February 26, 2013).

[13] *Id*. at 543.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated January 8, 2015 is set aside and the case remanded for further proceedings consistent with the above opinion.

Issued: January 8, 2016
Washington, DC

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

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

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