U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of STEPHEN D. HARPER and DEPARTMENT OF THE NAVY, MARINE CORPS BASE, Camp Pendleton, Calif.

Docket No. 96-2602; Submitted on the Record;
Issued September 9, 1998

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON,
A. PETER KANJORSKI

The issue is whether appellant has more than a 25 percent permanent impairment in each lower extremity for which he received a schedule award.

The Board has reviewed the case record and concludes that appellant has no more than a 25 percent permanent impairment in each lower extremity.

In the present case, the Office of Workers' Compensation Programs accepted that appellant sustained a right knee strain and torn medial meniscus' bilaterally with arthroscopies/meniscectomies as a result of an injury appellant sustained in the course of his federal employment on December 11, 1989. On August 2, 1996 the Office granted appellant a schedule award for a 25 percent impairment to each lower extremity.

In support of the request for a schedule award, the Office received a November 20, 1995 report from Dr. Satish S. Kadaba, appellant's treating physician and a Board-certified orthopedic surgeon. Dr. Kadaba indicated that he performed a right knee arthroscopy with partial medial meniscectomy as well as debridement. He also stated that a partial medial meniscectomy on the right was repeated and that he performed an arthroscopy of the left knee with a partial medial meniscectomy and debridement. Dr. Kadaba indicated that appellant suffered bilateral knee pain which prevented him from doing his regular work and normal activities. He stated that there was no sensory loss. He stated that appellant had a lack of 5 degrees of extension on both sides, but that flexion was 130 degrees. He indicated that the ankylosis would be 5 degrees loss of extension. Dr. Kadaba noted bilateral quadriceps weakness and continuous crepitation in both knees. He also found evidence of patellofemoral pathology. Furthermore, Dr. Kadaba stated that x-ray evidence revealed joint narrowing, but it remained unclear whether this was due to his injury because he also found evidence of degenerative spurs. Dr. Kadaba calculated that the loss of flexion and extension on each knee was 8 percent. He combined this with a joint ankylosis in each knee to find a 48 percent impairment in each lower extremity. He concluded that the partial

medial meniscectomy in each knee caused a 20 percent impairment. Dr. Kadaba totaled these impairments to find that there was a 76 percent impairment in each lower extremity.

The schedule award provision of the Act[1] and its implementing regulations[2], set forth that schedule awards are payable for permanent impairment of specified body members, functions, or organs. However, neither the Act nor the regulations specify the manner in which the percentage of impairment is to be determined. For consistent results and to ensure equal justice for all claimants, the Office has adopted the American Medical Association's, *Guides to the Evaluation of Permanent Impairment* as a standard for determining the percentage of impairment.[3]

In obtaining medical evidence for schedule award purposes, the Office must obtain an evaluation by an attending physician which includes a detailed description of the impairment including, where applicable, the loss in degrees of motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment. The description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[4] If the attending physician has provided a detailed description of the impairment, but has not properly evaluated the impairment pursuant to the A.M.A., *Guides*, the Office may request that the Office medical adviser review the case record and determine the degree of appellant's impairment utilizing the description provided by the attending physician and the A.M.A., *Guides*.[5]

Following receipt of Dr. Kadaba's report, the Office requested that its medical adviser apply the A.M.A., *Guides* to the measurements of impairment provided by the treating physician. The Office medical adviser thereafter evaluated appellant's impairment in a report dated April 8, 1996. The Office medical adviser noted that Dr. Kadaba's description of bilateral knee pain inhibiting normal activities constituted a class 4 description of sensory loss or pain pursuant to Table 20, page 151 of the A.M.A., *Guides* which yielded an 80 percent impairment. Pursuant to this same table, the medical adviser multiplied the 80 percent impairment by the 7 percent, the lower extremity impairment percentage for femoral nerve dysesthesia found at Table 68, page 89, to establish that appellant had a 5.6 percent impairment of each lower extremity due to pain. The medical adviser then properly rounded this figure up to 6 percent to determine the amount of impairment in each lower extremity due to pain. The medical adviser further found that Dr. Kadaba's finding of flexion of 130 degrees in each knee failed to constitute any impairment pursuant to Table 41, page 78, but that the mild five degree loss of extension constituted a 10 percent impairment of each lower extremity. After noting that Dr. Kadaba failed to quantitate his finding of bilateral quadriceps weakness, the medical adviser properly utilized the Combined Values Chart of the A.M.A., *Guides* to determine that appellant had a 15 percent permanent

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.304.

[3] *Leisa D. Vassar*, 40 ECAB 1287 (1989).

[4] *Joseph D. Lee*, 42 ECAB 172 (1990).

[5] *Paul R. Evans, Jr.*, 44 ECAB 646 (1993).

impairment of each lower extremity. The medical adviser requested that Dr. Kadaba provide additional evidence regarding the quadriceps weakness and joint narrowing which could increase the percentage of impairment for schedule award purposes.[6]

On May 31, 1996 Dr. Kadaba responded that there was moderate bilateral quadricep weakness with the right knee worse than the left. Based on x-rays, he found that there was narrowing of the medial, lateral, and patellofemoral compartments. He stated that the cartilage narrowing in the medial join line was down to four millimeters and that the cartilage narrowing at the patellofemoral joint was three millimeters. He indicated that there was degenerative spurs underneath the patella and along the medial joint of both knees.

The Office medical adviser reviewed Dr. Kadaba's clarifying report on July 25, 1996. The medical adviser properly found that pursuant to Table 62, page 83 of the A.M.A., *Guides* both the narrowing of the medial joint space to four millimeters and the narrowing of the patellofemoral joint to three were insufficient to establish additional impairment. The Office medical adviser, however, found that Dr. Kadaba's description of moderate quadriceps atrophy constituted an 11 percent impairment pursuant to Table 37, page 77 of the Guides. The medical adviser, therefore, properly utilized the Combined Values Chart to establish a 25 percent impairment of both lower extremities based on his finding of this additional 11 percent impairment combined with his previous impairment findings of a 10 percent impairment for loss of extension and a six percent impairment for pain.

As the medical adviser properly utilized the descriptions of appellant's impairments provided by Dr. Kadaba and the A.M.A., *Guides* to evaluate appellant's impairment, and there is no other medical evidence of record that appellant has more than a 25 percent impairment of each lower extremity, the Office properly granted appellant a schedule award of 25 percent impairment for each lower extremity.

[6] The medical adviser further found that appellant could not receive a greater award based on his partial meniscectomies which, according to Table 64, page 85 of the *Guides*, constituted a two percent impairment, and his crepitation with patellofemoral pathology, which according to Table 62 footnote constituted a five percent impairment. The medical adviser noted that the combined value of these impairments was 7 percent which was less than the previously established impairment rating of 15 percent. Moreover, the adviser properly noted that the impairment rating obtained pursuant to Tables 62 and 64 of the *Guides* could not be added with the other values obtained in Tables 20, 41, and 68; *see* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3 (October 1995).

The decision of the Office of Workers' Compensation Programs dated August 2, 1996 is affirmed.

Dated, Washington, D.C.
September 9, 1998

George E. Rivers
Member

David S. Gerson
Member

A. Peter Kanjorski
Alternate Member