U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JOHN T. DOULETTE and DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION HEALTH CARE SYSTEM, West Haven, CT

Docket No. 02-2087; Submitted on the Record;
Issued January 28, 2003

DECISION and ORDER

Before COLLEEN DUFFY KIKO, DAVID S. GERSON,
MICHAEL E. GROOM

The issue is whether appellant has more than a three percent permanent impairment of the right leg.

On January 25, 1992 appellant, then a 32-year-old security officer, assisted in restraining a patient, which included lifting the patient, placing him on a bed and restraining all limbs. He subsequently developed lower back pain. He stopped working on January 26, 1992 and returned to work on January 28, 1992. In a February 24, 1992 report, Dr. Ruben Kier, a Board-certified radiologist, indicated that a computerized tomography (CT) scan of the lower spine showed a herniated L5-S1 disc. The Office of Workers' Compensation Programs accepted appellant's claim for a back strain.

On February 15, 1994 appellant filed a claim for a recurrence of disability due to back pain. He attributed his condition to driving for a prolonged period in an employing establishment vehicle with a broken front seat which was supported by a concrete block. Appellant subsequently submitted the claim as a claim for a new injury. The Office accepted appellant's claim for lumbar paraspinal muscle strain.

On February 27, 1997 appellant filed a claim for degenerative disc disease and L5-S1 disc herniation. He noted that he been found unfit for his job and had been placed on light duty. He contended that the Office had not accepted his claim for a herniated L5-S1 disc. He submitted a February 13, 1997 report from Dr. Robert McLean, a Board-certified rhuematologist, who stated that appellant had intermittent back pain since the 1994 incident. He indicated that appellant was suffering from ongoing chronic back discomfort with intermittent radiculopathic symptoms likely due to a herniated L5-S1 disc. He related appellant's back condition to his employment injuries. In a July 9, 1997 decision, the Office denied appellant's claim on the grounds that the evidence of record failed to establish that appellant's herniated disc was causally related to factors of his employment.

Appellant requested a hearing before an Office hearing representative, which was conducted on March 19, 1998. In a May 29, 1998 decision, the Office hearing representative found that Dr. McLean's report was sufficient to require further development of the medical record. He remanded the case for referral of appellant to an appropriate specialist for an examination and opinion on whether appellant's herniated L5-S1 disc was causally related to the employment injuries. The Office referred appellant to Dr. Enzo Sella, a Board-certified orthopedic surgeon, who, in an August 14, 1998 report, concluded that appellant's herniated disc was causally related to his January 25, 1992 employment injury. The Office accepted appellant's claim for a herniated L5-S1 disc.

Appellant submitted a May 9, 1997 report from Dr. Patrick Ruwe, a Board-certified orthopedic surgeon, who stated that appellant was descending stairs in October 1996 while doing his laundry when he had an acute back spasm that caused him to miss a step. He fell and twisted his right knee. Dr. Ruwe reported that appellant had pain anteriorly and laterally in the right knee since that time. He noted that a magnetic resonance imaging (MRI) scan of the right knee performed in January 1997 showed Grade II changes in the posterior horn of the medial meniscus, which was a known variant. Dr. Rowe stated that appellant had patellofemoral syndrome and iliotibial band syndrome in the right knee. He related appellant's right knee condition to the fall which appellant attributed to the back spasm.

In a May 28, 1998 report, Dr. Joseph Ayoub, an internist, reviewed appellant's medical history. Dr. Ayoub related that, in July 1997, appellant was descending the stairs at his home when he had a back spasm that caused him to miss a step and fall down the stairs. Appellant twisted his right knee in the fall. Dr. Ayoub indicated that a magnetic resonance imaging (MRI) scan of the right knee performed in January 1998 showed Grade II changes in the posterior horn of the medial meniscus. He noted that the diagnosis was patellofemoral syndrome. Dr. Ayoub reported that appellant had limitation of motion in the back and right shoulder. He noted that appellant had difficulty performing the tandem and heel-toe walk due to his right knee pain. Dr. Ayoub indicated that appellant's motor system was three out of four in the right leg. He diagnosed lower back pain syndrome, sprain of the right shoulder with impingement, fracture of the fifth metacarpal, tendinitis of the left ankle, patellofemoral syndrome of the right knee, cervical sprain and depression.

In an April 18, 1999 memorandum, an Office medical adviser stated that there was no evidence to show that the back spasm reported by appellant occurred as he alleged, caused him to miss a step or that, if the back spasm did occur, that it was related to appellant's employment injuries. He concluded that, since appellant was able to return to work after his employment-related back injuries, it could not reasonably be claimed that the back spasm, occurring two and a half years later, was causally related to either employment injury.

The Office referred appellant to Dr. David Brown, a Board-certified orthopedic surgeon, for an examination. In a June 18, 1999 report, Dr. Brown reviewed appellant's medical history and noted the history of a fall in October 1996 due to a reported back spasm, resulting in a twisted right knee. He stated that appellant currently complained of intermittent back and right leg pain. Dr. Brown indicated that appellant had no clear referred pain pattern on the right with a negative sciatic tension sign. He reported that appellant complained of numbness along the lateral border of the foot extending to the dorsum. Dr. Brown commented that appellant's

muscle strength was normal. He noted some snapping and tenderness over the iliotibial band as the knee flexed and extended. Dr. Brown found no ligamentous laxity or instability of the knee. He concluded appellant did not have a permanent impairment of the right knee or the right leg apart from the accepted previous disability rating of the lumbar spine. In an August 30, 1999 note, he stated that appellant had a five percent permanent impairment of the lumbar spine with an unoperated stable documented pain and rigidity with radiculopathy.

The Office medical adviser reviewed Dr. Brown's report. In a September 23, 1999 memorandum, Dr. Brown stated that the maximum lower extremity impairment due to pain or sensory deficit of the S1 nerve root was five percent. He graded appellant's pain as 60 percent for pain or decreased sensation which interfered with activity. Dr. Brown multiplied the 60 percent for pain by the 5 percent for maximum impairment of the S1 nerve root sensory function and concluded that appellant had a 3 percent permanent impairment of the right leg.

In an October 6, 1999 decision, the Office issued a schedule award for a three percent permanent impairment of the right leg.

Appellant requested a hearing before an Office hearing representative, which was conducted on February 25, 2000. He submitted a February 14, 2000 report from Dr. Gary N. Grippo, a podiatrist, who stated that appellant had chronic foot problems, which included achilles tendinitis and recurring inflamed bursitis, with mechanically-induced calluses on both feet. Dr. Grippo indicated that appellant's antalgic gait was the result of previous injuries which were at least contributory to appellant's current foot problems. In a May 19, 2000 decision, the Office hearing representative stated that the Office had properly concluded that appellant's right knee condition was not causally related to appellant's employment injuries or preexisted the employment injuries. She found that appellant had not established that he was entitled to a schedule award greater than the three percent previously awarded.

In a May 31, 2000 letter, appellant's attorney requested reconsideration. He submitted a July 19, 1999 report from Dr. Brown, who stated that Dr. Ruwe's findings regarding the right knee were consistent with a twisting stress that occurred while appellant was having a back spasm. Dr. Brown indicated that appellant had a 10 percent permanent impairment of the right knee based on Dr. Ruwe's examination.

The Office requested from Dr. Ruwe a clarification of the cause of appellant's right knee condition. In a July 31, 2000 report, Dr. Ruwe repeated appellant's history of the right knee injury after falling down stairs due to a back spasm. He stated that appellant on examination had tenderness along the iliotibial band and along the lateral facet of the patella. Dr. Ruwe diagnosed patellofemoral syndrome and iliotibial band syndrome which had arisen as a result of appellant's fall which appellant attributed to the back spasm. He noted that there was no evidence at the time of his examination of any significant preexisting knee condition. Dr. Ruwe stated that appellant's knee injury was the direct result of appellant's L5-S1 herniated disc which caused the back spasm that lead to appellant's fall.

The Office asked the Office medical adviser to again review appellant's right leg condition. In an August 2, 2000 memorandum, he stated that appellant's right knee condition was not related to his employment injuries and commented that it was speculation to relate

appellant's knee condition to his herniated disc. The Office informed the Office medical adviser that it had accepted that the right knee condition was causally related to appellant's employment injuries so the issue did not exist. The Office asked the medical adviser to address the permanent impairment of the right leg. In a September 3, 2000 memorandum, the medical adviser stated that Dr. Ruwe's reports did not show any loss of motion, atrophy, pain or neurologic compromise of the right knee. He concluded that there was no basis on which to increase appellant's schedule award for the right leg.

In a September 22, 2000 report, Dr. John C. Kagan, a Board-certified orthopedic surgeon, stated that appellant had crepitus in the right knee with patellar compression, tenderness on palpation over the lateral patellar facet and over the iliotibial band insertion near the fibular head. He concurred that appellant had a 10 percent permanent impairment of the right knee. He noted appellant had a range of motion from 2 degrees to 120 degrees comfortably.

In an October 17, 2000 memorandum, the Office medical adviser stated that Dr. Kagan did not indicate on what basis he concluded appellant had a 10 percent permanent impairment of the right leg. Dr. Kagan noted that appellant had no permanent impairment due to loss of motion and a permanent impairment for crepitus. He stated that the tenderness reported in the right knee was sufficient for the three percent permanent impairment of the leg previously assigned.

The Office requested from Dr. Kagan a clarification of his opinion. In a September 22, 2000 addendum, Dr. Kagan noted that, in reviewing Drs. Ruwe and Brown's reports, a 10 percent permanent impairment was present.

In a January 3, 2001 merit decision, the Office denied appellant's request for modification of its prior decision.

In a January 8, 2001 letter appellant requested reconsideration. In a February 1, 2001 decision, the Office denied appellant's request for reconsideration on the grounds that evidence submitted and arguments made were repetitive or immaterial and were therefore insufficient to warrant review of the prior decision.

Appellant appealed to the Board. In a February 22, 2002 order, the Board remanded the case because the Office had not submitted the complete case record on appeal.[1] In an April 3, 2002 decision, the Office denied appellant's request for modification of the prior decision.

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

The schedule award provisions of the Federal Employees' Compensation Act[2] and its implementing regulation[3] 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. However, the Act does not specify the manner in which the percentage of loss shall be

[1] Docket No. 01-862 (Order Remanding Case issued February 22, 2002).

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.

Dr. Brown, in his June 18, 1999 report, stated that appellant had numbness along the dorsum of the foot. He subsequently concluded that appellant had a five percent permanent impairment of the lumbar spine due to sensory loss along the S1 nerve root. Dr. Brown stated that appellant had no permanent impairment due to the right knee. The Office medical adviser found that the sensory loss equaled a three percent permanent impairment of the foot. In his July 19, 1999 report, however, Dr. Brown stated that appellant had a 10 percent permanent impairment of the right knee as described by Dr. Ruwe. The Office accepted appellant's right knee condition as a consequential injury arising from his employment injuries. Dr. Brown's reports therefore gave reports which led to differing findings on the extent of the permanent impairment of appellant's right leg. His differing opinions on whether appellant had a permanent impairment of the right leg due to the knee condition calls into question the conclusion that appellant has only a three percent permanent impairment of the right leg.

The Office medical adviser reviewed Dr. Kagan's findings. He stated that appellant had no permanent impairment due to crepitation or loss of motion. He indicated that the tenderness of the right knee was sufficient to reach appellant's three percent permanent impairment previously awarded. However, the three percent permanent impairment was based on loss of sensation along the S1 nerve root arising from appellant's herniated L5-S1 disc. Appellant's right knee condition was due to a subsequent, consequential injury and therefore would be in addition to the initial three percent permanent impairment initially awarded. Dr. Kagan's report therefore would show that appellant is entitled to a greater schedule award. The reports of Drs. Brown and Kagan are not sufficiently well rationalized to establish that appellant is entitled to a greater schedule award. However they are sufficient to raise questions that require further development of the medical evidence.[4]

The case will therefore be remanded for referral of appellant to an appropriate medical specialist for an examination. The specialist should be requested to describe the findings involving appellant's right leg and then give a rating of the permanent impairment of appellant's right leg in accordance with the A.M.A., *Guides*. After further development as it may find necessary, the Office should issue a *de novo* decision.

[4] *John J. Carlone*, 41 ECAB 354 (1989).

The decision of the Office of Workers' Compensation Programs dated April 3, 2002 is hereby set aside and the case remanded for further action as set forth in this decision.

Dated, Washington, DC
January 28, 2003

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member