United States Department of Labor
Employees' Compensation Appeals Board

LAURA HEYEN, Appellant	)	
and	)	**Docket No. 05-1766**
	)	**Issued: February 15, 2006**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Milwaukee, WI, Employer	)	

Appearances:
Laura Heyen, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On August 24, 2005 appellant filed a timely appeal from an Office of Workers' Compensation Programs' schedule award decision dated July 22, 2005. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant has more than a six percent impairment of her right lower extremity and more than a six percent impairment of her left lower extremity for which she received a schedule award.

FACTUAL HISTORY

On July 12, 1991 appellant, then a 35-year-old nursing assistant, filed a traumatic injury claim alleging that she twisted her left knee while moving a bed.[1] She stopped work on

[1] Appellant has several preexisting conditions including: a Bakers cyst and a 1988 arthroscopy due to an injury in 1987. She also has asthma and osteoarthritis.

July 12, 1991.[2] The Office subsequently accepted appellant's claim for: contusion to the left knee, left knee strain, internal derangement and medial compartment-cartilage injury with left knee arthroscopy on November 27, 1991 and arthroscopic-debridement and lateral retinacular release on March 15, 1993. It also accepted right knee internal derangement with permanent aggravation of preexisting patellofemoral chondromalacia and medial compartment, arthroscopy on October 6, 1995. Surgery was performed for a maquet tibial turbercle of the left knee on May 17, 1996, right knee retinacular release with removal of screws on September 13, 1996 and a right knee arthroscopic lateral release on October 8, 1997.[3] The Office also authorized a patellar tendon elevation surgery of the right knee on January 25, 1999 and a left knee arthroscopy with removal of a screw on August 17, 1999. Appellant received appropriate compensation benefits. She resigned on April 7, 2000.[4]

On August 31, 2002 appellant requested a schedule award.

By letter dated September 18, 2002, the Office requested that Dr. Patrick Cummings, a Board-certified orthopedic surgeon and treating physician, provide an impairment rating.[5]

By letter dated October 22, 2003, the Office referred appellant for an examination, together with a statement of accepted facts, a set of questions and the medical record, to Dr. Karl B. Scheidt, a Board-certified orthopedic surgeon.

In a December 5, 2003 report, Dr. Scheidt utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001) (hereinafter A.M.A., *Guides*). He noted appellant's history of injury and treatment, including her prior injuries, preexisting conditions and diagnostic findings. Dr. Scheidt conducted a physical examination of both knees. He advised that the knees were tender about the patella, with a positive patellofemoral grind test and well-healed anterior incisions, with prominence in the tibial tubercle. Dr. Scheidt determined that appellant had prominence in the tibial tubercle, that her range of motion was 0 to 145 degrees and both knees were stable with regard to the anterior/posterior drawer and varus/valgus stress and lachman's examinations. Regarding the left knee, he indicated that she was minimally tender over the medial and lateral joints bilaterally, with no significant effusions and no significant *pes planus*. Dr. Scheidt indicated that appellant had a full range of motion of the hips and negative straight leg raising signs. He indicated that her lower extremity strength was 5/5 of all groups and she was able to heel toe walk with no appreciable limp on ambulation. Dr. Scheidt explained that appellant's current difficulties were related to her right and left

[2] The record also reflects that appellant has several accepted claims. They include a left knee injury on December 12, 1988 and November 23, 1991. Appellant also sustained an injury to both knees on September 14, 1995. The Office doubled all of these cases into one active claim, No. 10-405252.

[3] Appellant returned to part-time light duty on March 30, 1998. She stopped work on or about January 26, 1999. Appellant again returned to limited duty on January 20, 2000.

[4] The record reflects that appellant subsequently began working in the private industry for a marketing research firm in a sit down marketing position for six hours a day.

[5] The Office previously requested on May 22, 2000, that Dr. Cummings provide an impairment rating. However, it does not appear that he responded to the request.

patellofemoral articulation. Based upon the slight loss of flexion to both knees, with flexion of 145 degrees as opposed to normal flexion of 150 degrees, she would be entitled to an impairment of 1 percent based on loss of motion. He allowed an impairment of seven percent due to arthritis of the patellofemoral joint for each knee, which was inclusive of the pain at the level. Dr. Scheidt concluded that appellant had eight percent impairment to each lower extremity and had reached maximum medical improvement on August 10, 2000.

On March 23, 2004 the Office requested that an Office medical adviser review the impairment rating provided by Dr. Scheidt.

In a March 28, 2004 report, the Office medical adviser utilized the A.M.A., *Guides* and noted appellant's history of injury and treatment, including Dr. Scheidt's December 5, 2003 report. He explained that arthritis, pain and diagnosis based estimates could not be combined with gait derangement, muscle atrophy, muscle strength or range of motion/ankylosis under the Cross-Usage Chart at Table 17-2.[6] The Office medical adviser determined that appellant was entitled to a one percent bilateral lower extremity impairment for Grade 3 pain in the distribution of the saphenous nerve to her bilateral knees and referred to Tables 16-10[7] and 17-37.[8] He determined that appellant was entitled to a five percent bilateral lower extremity impairment for bilateral patellar arthritis secondary to a history of direct trauma with complaints of patellofemoral pain and crepitation with greater than 2 millimeters of cartilage space remaining as demonstrated by x-ray.[9] The Office medical adviser referred to the Combined Values Chart[10] and determined that appellant had six percent impairment to both lower extremities and had reached maximum medical improvement on August 10, 2000.

By decision dated April 8, 2004, the Office granted appellant a schedule award for a 6 percent impairment of each leg or a total of 34.56 weeks of compensation.

In a September 27, 2004 report, Dr. Cummings conducted a physical examination, noted that appellant related a concern regarding her impairment ratings and determined that her knees continued to be problematic. He diagnosed bilateral osteoarthritis of the patellofemoral joints.

In a February 7, 2005 report, Dr. Cummings reviewed the impairment assessments provided by Dr. Scheidt and the Office medical adviser. He related that appellant had requested an impairment rating. Dr. Scheidt noted that she continued to have an antalgic gait pattern on the left and synovitis of both knees with crepitus on active extension in both knees. Dr. Cummings opined that he did not "think that there is an effusion in either knee and [appellant] has full extension." He repeated his previous diagnosis of bilateral osteoarthritis of the knees involving the patellofemoral joint.

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[6] A.M.A., *Guides* 526, Table 17-2.

[7] *Id.* at 482, Table 16-10.

[8] *Id.* at 552, Table 17-37.

[9] *Id.* at 544, Table 17-31.

[10] *Id.* at 604.

Appellant requested reconsideration on February 28, 2005 and submitted a February 10, 2005 report in which Dr. Cummings indicated that her diagnosis was consistent with arthritis in the patellofemoral joint of her right and left knees and opined that her symptoms were permanent. He provided a permanent assessment of impairment and loss of function of eight percent in her right knee and eight percent in her left knee. Dr. Cummings also indicated that appellant would require additional surgery in the future due to the progression of her arthritis in the patellofemoral joint.

On April 8, 2005 the Office requested that the Office medical adviser provide an opinion with respect to whether appellant was entitled to an increased schedule award.

In an April 11, 2005 report, the Office medical adviser indicated that he reviewed Dr. Cummings' reports. He explained that there was no new objective data upon which an additional award could be determined. The Office medical adviser agreed with the previous award of six percent to the lower extremities. He noted that the five percent appellant received was based upon residual patellofemoral arthritis pursuant to Table 17-31[11] and that the two primary compartments in the knee (medial and lateral) were essentially normal. The Office medical adviser explained that appellant had only manifested degenerative changes in the patellofemoral compartment. He opined that there was no objective evidence to support additional impairment and that the date of maximum medical improvement remained August 10, 2000.

In a July 22, 2005 decision, the Office denied modification of the April 8, 2004 decision.

LEGAL PRECEDENT

The schedule award provisions of the Federal Employees' Compensation Act[12] and its implementing regulation[13] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of specified members or functions of the body. However, the Act does not specify the manner in which the percentage of loss shall be 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* (A.M.A., *Guides*) has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[14]

FECA Bulletin No. 01-05 provides that in making an impairment rating for the lower extremities, different evaluation methods cannot be used in combination. Before finalizing any

[11] *See supra* note 9.

[12] 5 U.S.C. § 8107.

[13] 20 C.F.R. § 10.404.

[14] *Id. See Jacqueline S. Harris*, 54 ECAB 139 (2002).

physical impairment calculation, the Office medical adviser is to verify the appropriateness of the combination of evaluation methods with that listed in Table 17-2, the Cross-Usage Chart.[15]

ANALYSIS

In support of her claim for a schedule award, the Office requested that appellant's treating physician provide an impairment rating. In a report dated February 10, 2005, Dr. Cummings opined that she had an eight percent impairment to both the right and left knees.[16] However, he did not provide an explanation as to how he arrived at his rating. Board precedent is well settled that when an attending physician's report gives an estimate of impairment but does not address how the estimate is based upon the A.M.A., *Guides*, the Office is correct to follow the advice of its medical adviser or consultant where he or she has properly applied the A.M.A., *Guides*.[17]

The Office based its six percent schedule awards on the opinions of Dr. Scheidt and the Office medical adviser. In a December 5, 2003, report, Dr. Scheidt utilized the A.M.A., *Guides* and stated his findings. He noted that, regarding appellant's range of motion, she had bilateral flexion of 145 degrees. Dr. Scheidt explained that she was entitled to an impairment of one percent based on loss of motion. He also determined that appellant would be entitled to an impairment of seven percent due to the arthritis of the patellofemoral joint for each knee which was inclusive of the pain at the level and concluded that appellant was entitled to eight percent of each lower extremity and reached maximum medical improvement on August 10, 2000. Although he utilized the A.M.A., *Guides*, Dr. Scheidt did not provide a percentage of impairment.

The Office medical adviser utilized the findings of Dr. Scheidt and applied the A.M.A., *Guides*. He properly noted that arthritis, pain and diagnosis based estimates could not be combined with gait derangement, muscle atrophy, muscle strength or range of motion/ankylosis under the Cross Usage Chart at Table 17-2.[18] The A.M.A., *Guides*, exclude a combination of impairments for loss of muscle strength and loss of range of motion in evaluating lower extremity impairments.[19] Dr. Scheidt referred to Tables 16-10[20] and 17-37[21] and determined that appellant was entitled to a one percent bilateral lower extremity impairment for a Grade 3 of pain

[15] *Philip A. Norulak*, 55 ECAB ___ (Docket No. 04-817, issued September 3, 2004). *See* FECA Bulletin No. 01-05 (issued January 29, 2001).

[16] The Board notes that while Dr. Cummings submitted several other reports, he did not provide any opinion regarding an impairment rating.

[17] *See Ronald J. Pavlik*, 33 ECAB 1596 (1982); *Robert R. Snow*, 33 ECAB 656 (1982); *Quincy E. Malone*, 31 ECAB 846 (1980).

[18] *Supra* note 6 at 526, Table 17-2.

[19] *Vanessa Young*, 55 ECAB ____ (Docket No. 04-562, issued June 22, 2004).

[20] *Supra* note 6 at 482, Table 16-10.

[21] *Supra* note 6 at 552, Table 17-37.

in the distribution of the saphenous nerve to her bilateral knees. The Board notes that pursuant to Table 16-10,[22] a Grade 3 classification for pain would warrant a 26 to 60 percent sensory deficit. According to Table 17-37, this 60 percent when multiplied by the 2 percent maximum impairment, for sensory nerve deficits, to the femoral nerve resulted in bilateral lower extremity impairment ratings of 1.2 percent (60 percent x 2 percent = 1.2 percent). This number was rounded to the nearest whole number of one percent.[23] Dr. Scheidt also determined that appellant was entitled to a five percent bilateral lower extremity impairment for bilateral patellar arthritis secondary to a history of direct trauma with complaints of patellofemoral pain and crepitation with greater than two millimeters of cartilage space remaining as demonstrated by x-ray.[24] The Office medical adviser subsequently referred to the Combined Values Chart[25] and determined that appellant was entitled to an award of six percent of the bilateral lower extremities and that she reached maximum medical improvement on August 10, 2000.

The Board finds that the Office medical adviser properly applied the A.M.A., *Guides* to the medical evidence of record and that there is no other medical evidence of record supporting any greater impairment pursuant to the A.M.A., *Guides*.

CONCLUSION

The Board finds that appellant does not have more than a six percent impairment of her right lower extremity and more than a six percent impairment of her left lower extremity for which she received a schedule award.

[22] *Supra* note 6 at 482, Table 16-10.

[23] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.4b(2)(b) (September 1994).

[24] *Supra* note 6 at 544, Table 17-31.

[25] *Supra* note 6 at 604.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 22, 2005 is affirmed.

Issued: February 16, 2006
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board