United States Department of Labor
Employees' Compensation Appeals Board

D.K., Appellant	)	
	)	**Docket No. 06-724**
and	)	**Issued: September 5, 2006**
DEPARTMENT OF THE NAVY, PHILADELPHIA NAVAL SHIPYARD, Newtowne Square, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
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 February 6, 2006 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit decision dated October 6, 2005, which denied appellant's claim for an additional schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than a 17 percent permanent impairment of the left leg for which he received a schedule award.

FACTUAL HISTORY

On October 28, 1994 appellant, then a 34-year-old pipefitter, filed a traumatic injury claim alleging that on October 27, 1994 he sustained a contusion to his left knee when he bumped his leg against a boiler while installing a funnel. The Office accepted appellant's claim

for left knee contusion and post-traumatic chondromalacia and authorized left knee arthroscopy and a lateral retinacular release.

Appellant came under the treatment of Dr. E. James Kohl, a Board-certified orthopedic surgeon. In reports dated October 10 and 14, 1994, Dr. Kohl noted that appellant sustained a left knee injury at work and a subsequent staff infection. In an operative report dated November 15, 1994, he performed a debridement of the left infrapatellar bursa and diagnosed abscess of the left infrapatellar bursa. In reports dated November 21, 1994 to January 30, 1995, Dr. Kohl stated that appellant was progressing well and could return to work without restrictions and would need no further orthopedic treatment. An x-ray of the left knee dated October 29, 1994, revealed no evidence of an acute fracture or dislocation.

On June 6, 1995 appellant filed a claim for a schedule award. He submitted a report from Dr. David J. Weiss, an osteopath, dated May 2, 1995. Dr. Weiss noted appellant's history and diagnosed status post-traumatic infrapatellar bursa infection/abscess of the left knee, status post incision and drainage of the left infrapatellar bursa, post-traumatic patellofemoral arthralgia of the left knee and chondromalacia. He opined that in accordance with the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[1] (A.M.A., *Guides*) appellant had 17 percent permanent impairment of the left leg. Dr. Weiss listed a 5 percent impairment of the left knee for patellar grating and crepitance[2] and 12 percent impairment for quadriceps muscle weakness.[3]

The Office referred the case record to an Office medical adviser. In a report dated July 6, 1995, the medical adviser concurred with Dr. Weiss' impairment rating.

In a decision dated July 17, 1995, the Office granted appellant a schedule award for 17 percent permanent impairment of the left leg.

Appellant came under the treatment of Dr. Curt D. Miller, a Board-certified orthopedic surgeon, who treated appellant on April 18, 1997 for persistent patellofemoral syndrome. In a report dated August 28, 1997, Dr. Miller performed arthroscopic evaluation and debridement of the patella and diagnosed articular flap of the patella, Grade 2. On February 16, 1998 he advised that appellant had reached maximum medical improvement and was released to work on December 26, 1997; however, he did not return because of pain. In a report dated October 5, 1998, Dr. Miller noted appellant's complaint of persistent pain in his left knee despite conservative treatment. He opined that appellant experienced lateral tilting of the kneecap and

[1] A.M.A., *Guides* (4th ed. 1993).

[2] *Id.* at 83, Table 62.

[3] *Id.* at 77, Table 38-39.

lateral facet pressure consistent with arthritis of the lateral facet of the kneecap. A magnetic resonance imaging (MRI) scan of the left knee dated August 17, 1998 revealed no abnormalities.[4]

In an operative report dated January 16, 2001, Dr. Miller performed a modified Elmslie patella realignment of the left knee and diagnosed lateral patella facet syndrome with subluxation of the patella and Grade 2 articular change of the lateral facet patella. In reports dated January 29 to May 3, 2001, he noted that appellant was progressing well postoperatively and recommended physical therapy. On May 3, 2001 Dr. Miller returned appellant to full duty with a restriction on climbing towers.

On February 24, 2002 appellant filed a schedule award claim. He submitted a December 10, 2001 report from Dr. Nicholas Diamond, an osteopath, who stated that appellant reached maximum medical improvement on November 1, 2001. Dr. Diamond diagnosed post-traumatic left knee patellar subluxation, status post modifier Elmslie Trillat patella realignment of the left knee, left knee patellar bursitis, post-traumatic left chondromalacia patella and post-traumatic patellofemoral degenerative joint disease of the left knee. He noted that, in accordance with the A.M.A., *Guides* fifth edition,[5] appellant had a 27 percent impairment of the left lower extremity. Dr. Diamond noted left thigh atrophy measuring 42 centimeters (cm) on the right versus 40 cm on the left, for an impairment rating of 13 percent;[6] left calf atrophy measuring 39 cm on the right versus 37 cm on the left, for an impairment rating of 13 percent;[7] and pain-related impairment of 3 percent.[8]

The case record was referred to an Office medical adviser who, in a report dated February 14, 2002, recommended a second opinion referral. He noted that the surgery on the patella should not result in permanent muscle atrophy as described by Dr. Diamond.

On September 4, 2002 the Office referred appellant to Dr. Anthony W. Salem, a Board-certified orthopedic surgeon, for an evaluation of the extent of permanent impairment in accordance with the A.M.A, *Guides.*[9] In a report dated September 24, 2002, Dr. Salem noted a normal motor examination of the left knee with excellent alignment, stability and strength. He diagnosed bilateral patellofemoral chondromalacia, which was not secondary to the work injury, rather from years of bending, climbing and squatting as a pipefitter. Dr. Salem advised that the

[4] After further development of appellant's claim, in a decision dated March 10, 1999, the Office terminated appellant's compensation benefits on the grounds that the second opinion physician opined that appellant did not have residuals of his work-related condition. In a decision dated August 24, 2000, the Office vacated the March 10, 1999 decision and reinstated appellant's compensation benefits and expanded appellant's claim to include post-traumatic chondromalacia of the patella and authorized lateral retinalcular release surgery.

[5] A.M.A., *Guides* (5th ed. 2001).

[6] *Id*. at 530, Table 17-6.

[7] *Id.*

[8] *Id*. at 574, Figure 18-1.

[9] *See supra* note 5.

patella surgery contributed to appellant's muscle atrophy. He opined that appellant did not have a 17 percent permanent impairment of the left leg and experienced no permanent functional loss of his left leg.

In a December 16, 2002 report, the Office medical adviser recommended that the case be referred to an impartial medical examiner to resolve a conflict of opinion between Dr. Diamond and Dr. Salem as to the degree of muscle weakness and impairment of the left leg.

On May 21, 2003 the Office found a medical conflict between Dr. Diamond, appellant's physician, who found a 27 percent permanent impairment of the left lower extremity and Dr. Salem, an Office referral physician, who determined that appellant did not have any permanent impairment of the left lower extremity.

The Office referred appellant to Dr. Stanley R. Askin, a Board-certified orthopedic surgeon. In a June 11, 2003 report, Dr. Askin noted examining appellant and reviewing his medical records. He noted a history of appellant's work-related injury. He diagnosed chondromalacia patellae, status post surgery. Dr. Askin noted findings upon physical examination on the left side of the thigh measuring 40.5 cm on the right and 40 cm on the left, there was no functional deficit of the left quadriceps or hamstrings, there was no effusion present, no visual or palpable synovitis of the left knee, no instability on the lateral collateral, medial collateral, anterior cruciate or posterior cruciate ligament, there was no rotary instability and range of motion on the right of 140 degrees and 100 degrees on the left. He noted that the fifth edition of the A.M.A., *Guides*[10] did not specifically rate chondromalacia patellae. However, Dr. Askin indicated that there was a comparable diagnosis of patellar fracture, displaced with nonunion. He opined that the A.M.A., *Guides* provide 17 percent leg impairment for a patellar fracture, displaced with nonunion[11] and he believed appellant's condition was less serious than this condition. Dr. Askin indicated that there was no objective foundation for Dr. Diamond's opinion and specifically noted that there was no muscle atrophy present as reported. He opined that there was no objective evidence to support an increase in the impairment rating.

In a decision dated December 29, 2003, the Office denied appellant's claim for additional schedule award. The Office found that the weight of the medical evidence rested with Dr. Askin, the referee physician, who opined that appellant sustained no more than a 17 percent permanent impairment of the left leg which was previously granted.

By a letter dated January 5, 2004, appellant requested an oral hearing before an Office hearing representative. The hearing was held on July 12, 2005.

In a decision dated October 6, 2005, the hearing representative affirmed the December 29, 2003 decision.

[10] *Id.*

[11] *See id.* at 546, Table 17-33.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[12] and its implementing regulation[13] sets 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 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 A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[14]

ANALYSIS

On appeal, appellant contends that he is entitled to an additional schedule award for permanent impairment of the left leg. The Office accepted his claim for a contusion and post-traumatic chondromalacia of the left knee and authorized left knee arthroscopy and a lateral retinacular release. He received a schedule award on July 12, 1995 for percent impairment of the left lower extremity. The Office found that a conflict existed in the medical evidence between appellant's attending physician, Dr. Diamond and an Office referral physician, Dr. Salem, concerning whether he had additional permanent impairment of the left lower extremity. Consequently, the Office referred appellant to Dr. Askin to resolve the conflict.

Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.[15]

The Board finds that the opinion of Dr. Askin is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight. His report establishes that appellant has no more than a 17 percent impairment of the left leg.

Dr. Askin reviewed appellant's history, reported findings and noted an essentially normal physical examination. He diagnosed chondromalacia patellae and status post surgery of the same. He noted findings upon physical examination with regard to the left knee of the thigh measuring 40.5 cm on the right and 40 cm on the left which he noted as "insignificant," no functional deficit of the left quadriceps or hamstrings, there was no effusion or synovitis, no instability on the lateral collateral, medial collateral, anterior cruciate or posterior cruciate ligament, no rotary instability and range of motion on the right of 140 degrees and 100 degrees on the left. Dr. Askin noted that the fifth edition A.M.A., *Guides* does not specifically rate chondromalacia patellae; however, he indicated that a comparable diagnosis was that of a patellar fracture, displaced with nonunion. He indicated that appellant's condition was less

[12] 5 U.S.C. § 8107.

[13] 20 C.F.R. § 10.404 (1999).

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

[15] *Aubrey Belnavis*, 37 ECAB 206 (1985). *See* 5 U.S.C. § 8123(a).

serious than this and stated that the A.M.A., *Guides* provided a 17 percent lower extremity impairment for a patellar fracture, displaced with nonunion.[16] Dr. Askin found no other basis on which to rate appellant's impairment and opined that there was no objective foundation for Dr. Diamond's rating of 27 percent impairment of the left leg. He concluded that there was no objective evidence to support an increase in impairment greater than the 17 percent impairment previously granted.

The Board finds that Dr. Askin properly determined that there was no basis under the A.M.A., *Guides* for an award greater than the 17 percent impairment previously granted. This evaluation conforms to the A.M.A., *Guides* and establishes that appellant has no more than a 17 percent of the left leg.

On appeal, appellant asserts that Dr. Askin's report is not consistent with the factual circumstances of his case, noting that Dr. Askin provided an impairment rating for 17 percent impairment for the left lower extremity for a patella fracture that was displaced with nonunion; however, appellant was never diagnosed with this condition. The Board notes that Dr. Askin indicated that appellant's condition was essentially a painful kneecap or chondromalacia and the A.M.A., *Guides* do not specifically provide a rating for chondromalacia patellae. He noted that a comparable diagnoses was a patellar fracture, displaced and nonunion which offered a 17 percent permanent impairment rating. He opined that appellant's condition was less serious than this condition and, therefore, appellant had to no greater than the 17 percent impairment previously awarded. Appellant further asserted that Dr. Askin noted range of motion for the left knee measured 100 degrees, which would provide a 10 percent impairment of the lower left extremity;[17] however, he failed to offer additional impairment for this loss. The Board notes that 17.2j, Diagnosis Based Estimates, of the A.M.A., *Guides*[18] provides that some impairment estimates are assigned more appropriately on the basis of diagnosis than on the findings upon physical examination. The A.M.A., *Guides* provides that the evaluating physician must determine whether the diagnostic or examination criteria best describe the impairment of a specific individual, but should in general only use one approach for each anatomic part. In this instance, Dr. Askin stated that his condition, though not as severe, was analogous to a patellar fracture, displaced and nonunion. The A.M.A., *Guides,* provide that impairment derived from a diagnosis based estimate should not be combined with that derived from loss of range of motion.[19] Dr. Askin properly indicated that, at most, appellant would be entitled to a greater impairment rating of 17 percent under the diagnostic based estimate method while, using lost range of motion, would only establish a 10 percent impairment.

[16] A.M.A., *Guides* 546, Table 17-33.

[17] *See id.* at 537, Table 17-10.

[18] *See id.* at 545-49, 17.2j Diagnosis-Based Estimates (5th ed. 2001).

[19] *See id.* at 526, Table 17-2.

CONCLUSION

The Board finds that appellant is not entitled to an additional impairment rating for his leg.

ORDER

IT IS HEREBY ORDERED THAT the October 6, 2005 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 5, 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