U.S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of GUADALUPE J. MAURICIO and DEPARTMENT OF JUSTICE, IMMIGRATION & NATURALIZATION SERVICE, U.S. BORDER PATROL STATION, Falfurrias, Tex.

Docket No. 96-1915; Submitted on the Record;
Issued June 22, 1998

DECISION and ORDER

Before WILLIE T.C. THOMAS, BRADLEY T. KNOTT,
A. PETER KANJORSKI

The issue is whether appellant has more than a nine percent permanent impairment of the left lower extremity, for which he received a schedule award.

Appellant, a border patrol agent, injured his left knee while in the performance of duty on February 19, 1993, when his partner accidentally fell on the knee during self-defense maneuvers. A magnetic resonance imaging (MRI) scan report dated March 5, 1993 stated that there was a "through and through complete tear" vertically in the posterior horn of the left medial meniscus and a questionable anterior cruciate ligament tear, with increased signal seen in the anterior cruciate superiorly, suggesting tear or synovial edema. The Office of Workers' Compensation Programs accepted his claim for torn medial meniscus.

Appellant again injured his left knee while in the performance of duty on March 7, 1994, when he fell from a barbed wire fence while tracking a group of aliens. An operative report dated March 14, 1994 stated that appellant had a torn lateral meniscus in the left knee, chondromalacia of the lateral femoral condyle, and an old tear of the anterior cruciate ligament, which was healed but had laxity. A partial left lateral meniscectomy was performed. The Office accepted his claim for internal derangement of the left knee and chondromalacia.[1]

On December 13, 1994 appellant filed a claim for a schedule award. On November 17, 1994 Dr. William E. Swan, Jr., a Board-certified orthopedic surgeon and appellant's attending physician, reported that appellant had a tear of the lateral meniscus, representing a two percent impairment for the leg; an old tear of the anterior cruciate ligament, representing a seven percent impairment for the leg; and chondromalacia of the condyle, representing a seven percent impairment to the leg. Stating that he based these functional impairments on the American

[1] The operative report of March 14, 1994 stated that the medial meniscus (which the Office accepted appellant tore on February 19, 1993) was intact, with the medial joint compartment intact and with no wear.

Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.), Dr. Swan gave a total impairment rating for the leg of 16 percent.

On June 8, 1995 the Office provided Dr. Swan with the guidelines for evaluating the permanent impairment of a lower extremity and asked that he show how he arrived at his figures using the applicable tables in the A.M.A., *Guides*.

On December 4, 1995 Dr. Swan reported that he had performed new calculations. He stated that appellant had a total arc of flexion of 109 degrees that went from minus 4 to 113, representing a 10 percent impairment to the lower extremity. He stated that appellant also had chondromalacia of the lateral femoral condyle, representing a seven percent impairment to the lower extremity. In addition, he stated, appellant had a tear of the lateral meniscus, representing a two percent impairment to the lower extremity. Dr. Swan determined that appellant had an overall functional impairment of the left lower extremity of 19 percent.[2]

An Office medical adviser reviewed the medical evidence and, based on Dr. Swan's December 4, 1995 clinical findings, determined that appellant had a nine percent permanent impairment of the left lower extremity. The medical adviser determined that appellant had a two percent impairment due to the partial meniscectomy, from page 85 of the A.M.A., *Guides*, and a seven percent impairment due to chondromalacia, from page 84, though he noted that chondromalacia is not given a specific impairment estimate in the 4th edition of the A.M.A., *Guides*. As for the range of motion, however, the medical adviser reported that flexion contracture of 4 degrees and flexion of 113 degrees warranted no impairment rating based on Table 41, page 78, of the A.M.A., *Guides*.

On March 28, 1996 the Office issued a schedule award for a nine percent permanent impairment of the left lower extremity.

Appellant argues on appeal that the schedule award should be based on Dr. Swan's first-hand evaluation of a 19 percent impairment, as he was the physician who saw appellant on a regular basis, who performed the surgery, and who was able to verify appellant's progress through direct contact during office visits. In this case, the Office medical adviser did not question Dr. Swan's clinical findings, only whether these findings supported a 10 percent impairment for restricted range of motion according to Table 41, page 78, of the A.M.A., *Guides*.

The Board finds that Dr. Swan's December 4, 1994 clinical findings do not support more than a 9-percent permanent impairment of the left lower extremity.

[2] Dr. Swan did not include an estimate for the laxity of the anterior cruciate ligament, as he had in his November 17, 1994 report. Although the MRI obtained two weeks after appellant's February 19, 1993 employment injury showed an increased signal in the left anterior cruciate superiorly, suggesting tear or synovial edema, and although the operative report of March 14, 1994 confirmed an old tear that had healed with laxity, the Office did not accept that appellant sustained a torn anterior cruciate as a result of the incident that occurred on February 19, 1993.

Section 8107 of the Federal Employees' Compensation Act[3] and section 10.304 of the implementing federal regulations[4] authorize the payment of schedule awards for the loss or permanent impairment of specified members, functions or organs of the body. But neither the Act nor the regulations specify how the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office has adopted the A.M.A. *Guides, to the Evaluation of Permanent Impairment* as the standard for determining the percentage of impairment, and the Board has concurred in such adoption.[5]

The 4th edition of the A.M.A., *Guides*, at page 84, provides that some impairment estimates are assigned more appropriately on the basis of a diagnosis than on the basis of findings on physical examination. For most diagnosis-based estimates, the ranges of impairment are broad, and the estimate will depend on the clinical manifestations. The evaluating physician must determine whether diagnostic or examination criteria best describe the impairment of a specific patient. The physician, in general, should decide which estimate best describes the situation and should use only one approach for each anatomic part.[6] There may be instances in which elements from both diagnostic and examination approaches will apply to a specific situation. The diagnosis-based estimates in Table 64 include expected muscle weakness or atrophy. When there is an impairment not usually associated with the diagnosis or an impairment to a different organ system, these estimates should be combined with the diagnosis-based estimates using the Combined Values Chart on page 322.

There is no dispute in this case concerning the impairment rating given for the partial meniscectomy. Table 64, page 85, of the A.M.A., *Guides* provides that a partial lateral meniscectomy represents a two percent impairment of the lower extremity, which Dr. Swan reported and the Office accepted.

Neither is there a dispute concerning the impairment rating given for the chondromalacia of the lateral femoral condyle. The Office medical adviser correctly noted, however, that the 4th edition of the A.M.A., *Guides* specifies no diagnosis-based estimate for this condition. The revised 3rd edition of the A.M.A., *Guides* included a range of impairment for arthritis and chondromalacia of the knee at Table 40, page 68, but these conditions are no longer included in the corresponding table appearing in the 4th edition. Table 62, page 83, of the 4th edition does provide estimates for arthritis impairment based on Roentgenographically determined cartilage intervals, including the cartilage interval of the knee. Although this section of the A.M.A., *Guides* does not expressly include chondromalacia, it makes clear that the impairments addressed are those related to joint surface degeneration and thinning of the articular cartilage, which arguably include chondromalacia of the lateral or exterior femoral condyle. Dr. Swan did not explain how he estimated the impairment for chondromalacia at seven percent, which is

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.304.

[5] *See, e.g., Leisa D. Vassar*, 40 ECAB 1287 (1989).

[6] For instance, a patient with a femoral neck fracture with nonunion, who requires one crutch, should be rated either for the use of the crutch or for the nonunion plus the range of motion restriction, whichever is greater.

indicative of a 3 millimeter cartilage interval according to Table 62, page 83, and there is no evidence in the record that he took an x-ray of appellant's knee in the neutral position with appellant standing. Nonetheless, the Office accepted Dr. Swan's estimate for this condition, and on appeal appellant supports his physician's opinion. The Board therefore finds no compelling reason to disturb an estimate to which both parties agree.

The Office medical adviser correctly observed that the only difference between his rating and the one given by Dr. Swan was the inclusion by Dr. Swan of a 10-percent impairment for restricted motion. The Board finds that the Office properly excluded this impairment. First, as explained above, diagnosis-based estimates and examination-based estimates are generally not to be used together. In this case, any impairment based on restricted range of motion would not represent an impairment to a different organ system. Second, even if appellant could receive a rating from both diagnosis-based and examination-based estimates, the reported flexion contracture of 4 degrees and flexion of 113 degrees represent no impairment of the knee according to Table 41, page 78.

As the two percent impairment due to the partial lateral meniscectomy and the seven percent impairment due to chondromalacia combine for a total of 9 percent, using the Combined Values Chart on page 322, the Board will affirm the Office's March 28, 1996 decision awarding schedule compensation for a nine percent permanent impairment of the left lower extremity.

The March 28, 1996 decision of the Office of Workers' Compensation Programs is affirmed.

Dated, Washington, D.C.
June 22, 1998

Willie T.C. Thomas
Alternate Member

Bradley T. Knott
Alternate Member

A. Peter Kanjorski
Alternate Member