U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of PAUL M. WILDE and DEPARTMENT OF THE ARMY,
MUNSON ARMY HEALTH CENTER, FORT LEAVENWORTH, KS

Docket No. 02-868; Submitted on the Record;
Issued July 26, 2002

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether appellant has greater than a seven percent permanent impairment of his right lower extremity for which he has received a schedule award.

The Office of Workers' Compensation Programs accepted that on December 10, 1999 appellant, then a 58-year-old physician's assistant, sustained a right knee strain and a torn medial meniscus from rotating his knee inward while rolling on an examination stool. He did not stop work.

On December 26, 2000 Dr. William O. Hopkins, a Board-certified orthopedic surgeon, evaluated appellant for an impairment rating. Dr. Hopkins rated appellant as having a medial meniscectomy with degenerative medial compartment changes and opined that a medial meniscectomy would be a seven percent disability of the knee or a three percent whole person disability. He opined that the degenerative changes would add an additional 30 percent loss of function in the knee. Dr. Hopkins opined that this would translate to an additional 12 percent whole person impairment added to the previous total, which would give him a 37 percent impairment in the knee with a whole person impairment of 15 percent.

On May 25, 2001 the Office medical adviser, Dr. Zimmerman, opined that Dr. Hopkins' impairment rating was not in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, fifth edition, that he did not provide enough information from which one could extrapolate a rating from the A.M.A., *Guides* and that he had not established the date of maximum medical improvement.[1]

[1] According to FECA Bulletin No. 01-05, issued January 29, 2001, all claims examiners and district medical advisers were to begin using the fifth edition of the A.M.A., *Guides* effective February 1, 2001.

In an attending physician's report dated July 17, 2001, Dr. Marc Chu, a Board-certified primary care practitioner, indicated that appellant had constant right lower extremity pain and walked with a limp.

By report dated July 19, 2001, Dr. Hopkins noted that appellant had some atrophy of his right quadriceps and had complete right knee extension, complete flexion, a well-tracking patella, excellent collateral ligament stability and good cruciate ligament stability without pain. Dr. Hopkins noted that appellant had right joint line tenderness over the medial aspect of the knee and that compression of his medial meniscus with extension and rotation caused rather acute pain and a palpable crepitation at the medial and anteromedial margin of his right knee. Dr. Hopkins opined that appellant had reached maximum medical improvement in December 2000 and he referred to the A.M.A., *Guides*, fourth edition, Table 64, page 3-85 in opining that appellant had a 3 percent disability in regards to his medial meniscus tear[2] and an additional 30 percent loss of function due to degenerative changes, which resulted in a total of a 37 percent loss of function of his right lower extremity.

On September 26, 2001 Dr. Zimmerman reviewed the A.M.A., *Guides*, fifth edition, Chapter 17 and noted that chronic pain and/or sensory deficit and chronic weakness may be considered using Table 17-37, page 552 in conjunction with instructions on page 550, section 17.21 "Peripheral Nerve Injuries" and if necessary also Chapter 18.

On September 21, 2001 appellant was referred for a second opinion evaluation, to Dr. George Varghese, a Board-certified physical medicine and rehabilitation specialist of professorial rank.

On September 24, 2001 Dr. Zimmerman noted that Dr. Hopkins' 37 percent impairment rating was not validated by examination findings as it was stated that appellant had no loss of motion. He noted that if Table 64 were used from the fourth edition of the A.M.A., *Guides*, an impairment rating of 2 percent of the lower extremity due to a meniscal tear could be extrapolated, however, Dr. Hopkins offered no explanation as to how he arrived at a 30 percent impairment rating for arthritis in the knee using the fourth edition of the A.M.A., *Guides*. Dr. Zimmerman concluded that Dr. Hopkins' rating could not be accepted for schedule award purposes.

By report dated October 23, 2001, Dr. Varghese reviewed appellant's history and complaints of pain, noted his findings upon physical examination, including mild medial bony swelling consistent with osteoarthritis of the knee, no effusion, no inflammatory changes, range of motion at 130 degrees with normal quadriceps and hamstring strength, 1.5 centimeters of atrophy in the circumference of the right lower extremity quadriceps, normal reflexes and normal sensory function. Dr. Varghese opined that appellant had reached maximum medical improvement and that he had some residual arthritic knee pain and some mild gait abnormalities as well as the quadriceps atrophy. He applied the A.M.A., *Guides*, fifth edition and considered range of motion using Figure 17-10, no rating was given; muscle strength, no loss was detected; muscle atrophy, as per Table 17-6 this was rated as mild and he assigned the rating of 7 for the extremity; gait derangement, no specific gait derangement was detected and no rating was given;

[2] This was the whole person impairment.

diagnosis-based estimates for a medial meniscal tear treated conservatively was rated at 2 percent; however, as per Table 17-2 a rating for muscle atrophy cannot be combined with a rating for the meniscal tear; and arthritis, which cannot be combined with a rating for muscle atrophy according to Table 17-2. Dr. Varghese concluded that appellant had a permanent impairment rating of seven percent of his right knee.

On November 5, 2001 Dr. Zimmerman opined that Dr. Varghese needed to provide the range of motion in extension as measured by a goniometer as it was conceivable that this range of motion could impact the impairment rating.

By report dated November 19, 2001, Dr. Varghese used the goniometer and measured 130 degrees of flexion and 0 degrees of extension. He noted that as per Table 17-10, no rating was given for appellant's range of motion.

Thereafter Dr. Zimmerman reviewed Dr. Varghese's addendum and concluded that appellant had no greater than a seven percent permanent impairment of his right lower extremity.

On December 20, 2001 appellant was granted a schedule award for a seven percent permanent impairment of his right lower extremity for the period October 19, 2001 to March 9, 2002 for a total of 20.16 weeks of compensation.

The Board finds that appellant has no greater than a seven percent permanent impairment of his right lower extremity, for which he has received a schedule award.

The Federal Employees' Compensation Act[3] provides compensation for both disability and physical impairment. "Disability" means the incapacity of an employee, because of an employment injury, to earn the wages the employee was receiving at the time of injury.[4] In such cases, the Act compensates an employee for loss of wage-earning capacity. In cases of physical impairment, the Act, under section 8107(a), compensates an employee, pursuant to a compensation schedule, for the permanent loss of use of certain specified members of the body, regardless of the employee's ability to earn wages.[5] As a claimant seeking compensation under the Act has the burden of establishing the essential elements of his or her claim by the weight of the reliable, probative and substantial evidence, it is thus, the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of his or her employment injury entitling him or her to a schedule award.[6]

The schedule award provision of the Act and its implementing regulation[7] 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

[3] 5 U.S.C. §§ 8101-8193.

[4] *Frazier V. Nichol*, 37 ECAB 528 (1986); *Elden H. Tietze*, 2 ECAB 38 (1948); 20 C.F.R. § 10.5(17).

[5] 5 U.S.C. § 8107(a); *see Yolanda Librera (Michael Librera)*, 37 ECAB 388 (1986).

[6] *See Raymond E. Gwynn*, 35 ECAB 247 (1983).

[7] 20 C.F.R. § 10.404 (1999).

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.

The A.M.A., *Guides* standards for evaluating the impairment of extremities are based primarily on loss of range of motion.[8] However, all factors that prevent a limb from functioning normally, including pain or discomfort, should be considered, together with loss of motion, in evaluating the degree of permanent impairment.[9] The A.M.A., *Guides* Chapter 17[10] provides multiple grading schemes and procedures for determining the impairment of a lower extremity due to gait derangement,[11] muscle atrophy,[12] muscle weakness,[13] arthritis,[14] nerve deficits[15] and other specific pathologies. The A.M.A., *Guides* also provides impairment ratings of the lower extremities for diagnosis-based estimates, including specific disorders of the knee, such as torn meniscus or meniscectomy.[16] The evaluator should, in general, use only one approach for each anatomic part, however, there are certain exceptions in which elements from both diagnostic and examination approaches will apply.

In his December 26, 2000 report, Dr. Hopkins used the fourth edition of the A.M.A., *Guides*,[17] specifically the Diagnosis-Based Estimates Table 64, rated appellant as having a medial meniscectomy with degenerative medial compartment changes and opined that a medial meniscectomy would be a seven percent disability of the knee or a three percent whole person disability. He opined that the degenerative changes would add an additional 30 percent loss of function in the knee and opined that this would translate to an additional 12 percent whole person impairment which, when added to the previous total, would give him a 37 percent impairment in the knee with a whole person impairment of 15 percent.

The Board notes, however, that Dr. Hopkins did not explain where the 30 percent loss of function due to degenerative changes came from or how it was determined with respect to the

[8] *See William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

[9] *See Paul A. Toms*, 28 ECAB 403 (1987).

[10] American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed.) (2001), Chapter 17, *The Lower Extremities*, pp.523-61.

[11] *Id*. at Table 17-5, p.529.

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

[13] *Id*. at Table 17-8, p.532.

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

[15] *Id*. at Table17-37, p.552.

[16] *Id*. at Chapter 17.2j, Table 17-33, page 545-48.

[17] This edition was appropriate for a rating at that time.

A.M.A., *Guides*, fourth edition, particularly since use of the diagnosis-based estimates Table 64, page 3-85 for a final impairment rating generally precluded addition of impairment ratings from other tables. Further, the Board notes that a schedule award is not payable under section 8107(a) of the Act for an impairment of the whole person.[18] Therefore, this report from Dr. Hopkins is insufficient to determine appellant's impairment rating for schedule award purposes.

In a subsequent July 19, 2001 report, Dr. Hopkins continued to use the fourth edition of the A.M.A., *Guides* and specifically Table 64, page 3-85 regarding diagnosis-based estimates, to rate appellant for a medial meniscal tear. However, he also noted that appellant had right quadriceps atrophy, right joint line tenderness over the medial aspect of the knee and acute pain and palpable crepitation at the medial and anteromedial margin of the right knee with compression of the medial meniscus upon extension and rotation. No rating was given for these considerations, but Dr. Hopkins again rating appellant with a 30 percent loss of function due to degenerative changes, despite the finding of no losses in range of motion, without explaining what table or figure he was applying in addition to the diagnostic-based estimates table, to reach a total impairment rating of 37 percent loss of the right lower extremity. As Dr. Hopkins again failed to explain how he arrived at appellant's proposed impairment rating, it cannot be considered to be derived from proper application of the A.M.A., *Guides* and, therefore, cannot constitute the weight of the medical opinion evidence of record. Dr. Hopkins did, however, determine the date of maximum medical improvement as being December 2000.

After receiving Dr. Hopkins' follow-up report, the Office medical adviser, Dr. Zimmerman, indicated that at that point in time the fifth edition of the A.M.A., *Guides*, Chapter 17, should be used for determination of an impairment rating including ratings for chronic pain, sensory deficit and weakness.

After referral for a second opinion specialist impairment rating determination, by report dated October 23, 2001, Dr. Varghese provided objective examination results, opined that appellant had reached maximum medical improvement and correctly applied the fifth edition of the A.M.A., *Guides*, to determine that in accordance with Table 17-6 appellant had mild right quadriceps atrophy rated at 7 percent and in accordance with the diagnosis-based estimates Table 17-33 appellant was rated at 2 percent for his meniscal tear, but that, in accordance with Table 17-2 the atrophy rating could not be combined with the diagnosis-based estimate, such that appellant should be rated at the greater impairment rating.[19] Therefore, Dr. Varghese found that appellant was appropriately rated at a seven percent permanent impairment of his right lower extremity.

As Dr. Varghese's reports were based upon a complete and accurate factual and medical background, contained a complete and detailed description of appellant's impairments and properly applied the fifth edition of the A.M.A., *Guides*, they are entitled to great weight. Because neither of Dr. Hopkins' reports was complete or properly cited to and applied the

[18] *See Gordon G. McNeill*, 42 ECAB 140 (1990).

[19] Dr. Varghese found that no ratings were warranted for range of motion, loss of strength, specific gait derangement, pain or arthritis, as the former were not detected at ratable levels and the arthritis impairment was not combinable with the muscle atrophy rating according to the A.M.A., *Guides*, Table 17-2.

A.M.A., *Guides*, they are of insufficient probative value to create a conflict with the properly based reports of Dr. Varghese. Therefore, the weight of the medical evidence of record establishes that appellant has no greater than a seven percent permanent impairment of his right lower extremity, for which he has received a schedule award.

Accordingly, the decision of the Office of Workers' Compensation Programs dated December 20, 2001 is hereby affirmed.

Dated, Washington, DC
July 26, 2002

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member