

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

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In the Matter of LEIGH J. KISSANE and DEPARTMENT OF THE TREASURY,  
U.S. SECRET SERVICE, Miami, FL

*Docket No. 03-562; Submitted on the Record;  
Issued April 22, 2003*

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DECISION and ORDER

Before DAVID S. GERSON, MICHAEL E. GROOM,  
A. PETER KANJORSKI

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

The Office of Workers' Compensation Programs accepted that on September 22, 2000 appellant, then a 29-year-old special agent, sustained internal derangement of his left knee while performing physical training that date. He did not stop work.

On May 24, 2001 appellant underwent left knee arthroscopic surgery for patellar tendinitis/chronic prepatellar bursitis and an intra-articular prepatellar bursectomy was performed by Dr. Alfred A. DeSimone, a Board-certified orthopedic surgeon. On June 15, 2001 Dr. DeSimone noted that appellant was healing well, with scant residual prepatellar effusion, 115 degrees of flexion and full extension, and mild global tenderness.

On July 20, 2001 Dr. DeSimone noted that appellant had close to full flexion, full extension and mild quadriceps atrophy, and that he complained of tenderness over the distal pole patella and tenderness over the lateral patellar tendon. Dr. DeSimone noted that the date of maximum medical improvement was July 20, 2001, that appellant had 135 degrees of retained active flexion and 0 degrees of retained extension and that there was additional impairment due to weakness, atrophy, pain or discomfort. Dr. DeSimone found that appellant had a left lower extremity impairment of eight percent.

On August 22, 2001 Dr. DeSimone noted that appellant had mild trochlear tenderness, mild prepatellar tenderness, focal posterolateral joint line tenderness, positive effusion, vague medial tenderness, mild restriction of flexion and close to full extension. A magnetic resonance imaging (MRI) scan was recommended.

A September 4, 2001 MRI scan was reported as demonstrating a suspected small tear in the posterior horn of the medial meniscus and small joint effusion and mild subcutaneous edema in the prepatellar and infrapatellar regions.

On September 21, 2001 Dr. DeSimone noted that appellant had some quadriceps atrophy and restriction of flexion and opined that, in accordance with the A.M.A., *Guides*, appellant had an eight percent impairment of his left lower extremity. No formal weakness was noted.

On October 22, 2001 the Office referred appellant's record to an Office medical adviser to evaluate appellant's permanent impairment. On October 24, 2001 Dr. Harry L. Collins, Jr., opined that Dr. DeSimone did not provide physical findings to support an eight percent permanent impairment, particularly measurements of any atrophy and range of motion.

On October 24, 2001 appellant claimed that, as he was walking down stairs, his left knee buckled due to atrophy on his left quadriceps. Appellant claimed that this was attributable to residual weakness and noted that he was placed on restricted duty.

By letter dated December 17, 2001, the Office requested that Dr. DeSimone provide the requested measurements to support his impairment award.

By report dated April 12, 2002, Dr. DeSimone indicated that appellant had 120 degrees of knee flexion with mild restriction of extension. He noted that appellant's quadriceps atrophy was one centimeter side to side difference, left less than right and again opined that appellant had an eight percent permanent impairment.

On June 20, 2002 another Office medical adviser, Dr. Charles, opined that, in accordance with the A.M.A., *Guides*, atrophy of 1 centimeter was a 3 percent impairment under Table 17-6, and flexion of 120 degrees was a 0 percent impairment in accordance with Table 17-10. The medical adviser found a total permanent impairment of the left lower extremity of 3 percent.

On July 2, 2002 the Office granted appellant a schedule award for a three percent permanent impairment of his left lower extremity for the period September 21 to November 20, 2001 for a total of 8.64 weeks of compensation. The Office found that the opinion of the Office medical adviser constituted the weight of the medical evidence as appellant's treating physician, Dr. DeSimone, based his impairment rating on the Florida Impairment Guidelines instead of the A.M.A., *Guides*, and the medical adviser properly applied the A.M.A., *Guides* to appellant's range of motion restriction and atrophy measurements.

On September 9, 2002 the Office received an undated letter from appellant's representative, noting that Dr. DeSimone had reconsidered his impairment rating. In support he submitted a July 31, 2002 report from Dr. DeSimone, who stated as follows:

“Upon review of [appellant's] medical records and all of his previous notes according to the Fifth Edition of the A.M.A., *Guidelines* (sic), I will base my impairment on muscle atrophy, (Table 17-6), muscle weakness (17-8) and restriction of motion (17-10). With regard to muscle atrophy, I will allow for a five percent lower extremity impairment based on a one centimeter side to side difference. With regard to muscle weakness, despite no formal weakness, he did present with clinical weakness when compared to his other lower extremity. I will allow for 6 percent lower extremity impairment based on Table 17-8, as his strength was comparatively a Grade IV according to my recollection. Lastly, at the time of final assessment his flexion was with 120 degrees of flexion, as he was

with restriction of flexion based on knee motion evaluation. Using Table 17-10, I will provide for an additional 4 percent lower extremity using a derivation of mild restriction to motion based on this chart.

“With review of the above criteria, I will allow for a corrected lower extremity impairment based on the fifth edition A.M.A., *Guidelines* lower extremity section. This totals 15 percent lower extremity impairment which converts to a 6 percent whole person impairment based on the above criteria. This is a corrected impairment by request. This impairment stands and will be changed from his initial previous impairment on September 21, 2001....”

On October 10, 2002 the Office requested that the Office medical adviser provide an opinion as to whether Dr. DeSimone’s July 31, 2002 letter changed his estimate of appellant’s impairment. On October 17, 2002 the medical adviser replied that Dr. DeSimone “does not indicate any l[oss] o[f] m[otion], instability, weakness or [illegible] on which to base any additional [impairment] for the left knee.” On October 31, 2002 the medical adviser reiterated that Dr. DeSimone’s July 31, 2002 letter was read and “did not indicate any reason for [an] increased rating.”

By decision dated November 6, 2002, the Office denied modification of the July 2, 2002 award, finding that the evidence submitted in support was insufficient to warrant modification. The Office found that the opinion of the Office medical adviser constituted the weight of the medical opinion evidence.

The Board finds that this case is not in posture for decision due to a conflict in medical opinion evidence.

The schedule award provisions of the Federal Employees’ Compensation Act<sup>1</sup> and its implementing regulation<sup>2</sup> 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 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.<sup>3</sup>

In this case, on September 21, 2001 appellant’s treating physician, Dr. DeSimone, referred to the A.M.A., *Guides* and determined that he had an eight percent impairment of his left lower extremity due to residual atrophy and diminished flexion. Following the Office’s finding that he did not provide physical findings in terms of measurements to support an eight percent impairment, Dr. DeSimone responded that appellant had 120 degrees of knee flexion with mild

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<sup>1</sup> 5 U.S.C. §§ 8101-8193.

<sup>2</sup> 20 C.F.R. § 10.404 (1999).

<sup>3</sup> *Id.*

restriction of extension and 1 centimeter of quadriceps atrophy on the left, but then referred to the Florida Impairment Guidelines to determine that appellant had an eight percent impairment.

The Office medical adviser utilized Dr. DeSimone's clinical measurements and applied the A.M.A., *Guides* to determine that atrophy of 1 centimeter was a 3 percent impairment under Table 17-6, and flexion of 120 degrees was a 0 percent impairment with Table 17-10, which yielded a total permanent impairment of 3 percent of appellant's left lower extremity. The Office medical adviser, however, did not explain why he chose the 3 percent impairment, as Table 17-6 allows up to 8 percent impairment of the lower extremity for 1 to 1.9 centimeters of atrophy.

Thereafter, on July 31, 2002 Dr. DeSimone opined that appellant had a 15 percent permanent impairment of his left lower extremity, based his rating on the Fifth Edition of the A.M.A., *Guides*. He based his impairment rating for muscle atrophy on Table 17-6, for muscle weakness on Table 17-8 and for restriction of motion on Table 17-10. Dr. DeSimone allowed for a 5 percent lower extremity impairment for atrophy based on a 1 centimeter side to side difference, a 6 percent lower extremity impairment for clinical muscle weakness based on Table 17-8 with strength noted as a Grade IV, and an additional 4 percent lower extremity impairment for flexion of 120 degrees using Table 17-10.

The Act, at 5 U.S.C. § 8123(a), in pertinent part, provides: "If there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."

The Board finds there is a conflict in medical opinion evidence between Dr. DeSimone and the Office medical adviser as to the degree of appellant's permanent impairment according to the A.M.A., *Guides*. The Office medical adviser found that appellant had a three percent permanent impairment. Dr. DeSimone opined that appellant had a 15 percent permanent impairment, according to the A.M.A., *Guides*, based on atrophy, weakness and losses in range of motion. The case will be remanded to the Office for preparation of a statement of accepted facts, questions to be addressed, and referral of appellant to an appropriate medical specialist for a medical opinion as to appellant's extent of permanent impairment.

The decisions of the Office of Workers' Compensation Programs dated November 6 and July 2, 2002 are hereby set aside, and the case is remanded for further development in accordance with this decision and order of the Board.

Dated, Washington, DC  
April 22, 2003

David S. Gerson  
Alternate Member

Michael E. Groom  
Alternate Member

A. Peter Kanjorski  
Alternate Member