



On April 25, 2003 appellant filed a claim for a schedule award.

In a January 27, 2003 report, Dr. David Weiss, an osteopathic specialist in orthopedics, provided a history of appellant's left lower extremity condition and findings on physical examination. He diagnosed post-traumatic internal derangement with a medial meniscus tear, post-traumatic chondromalacia of the patella, post-traumatic osteoarthritis and noted that he had undergone surgery. Dr. Weiss indicated that appellant had occasional left knee pain, stiffness, swelling, weakness and a locking sensation and had restrictions in his daily activities. He stated:

“Examination of the left knee reveals well[-]healed portal arthroscopy scars. There is noted to be a suprapatellar effusion.... Patellar apprehension and inhibition signs are negative.... There is tenderness noted along the medial joint line and the medial joint space. Joint crepitus is noted in both the medial and lateral joint compartments.... Range of motion is 0-90/140 degrees. Patellafemoral compression produces crepitus, but no pain. Valgus and varus stress testing produces firm end points. The Lachman and draw sign are both negative....

“Muscle strength testing reveals the quadriceps [G]graded 4/5 and gastrocnemius [G]graded 5/5....

“Gastrocnemius circumferential measurements [calf] are 44.5 [centimeters] on the right versus 47 [centimeters] on the left. The quadriceps circumferential measurements [thigh], at 10 [centimeters] above the patella, are 61.5 [centimeters] on the right versus 60 [centimeters] on the left.”

Dr. Weiss calculated a 35 percent impairment of appellant's left lower extremity, based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,<sup>1</sup> which included 10 percent for decreased flexion, based on Table 17-10 at page 537, 13 percent each for left thigh and left calf atrophy, based on Table 17-6 at page 530<sup>2</sup> and 3 percent for pain-related impairment, based on Figure 18-1 at page 574 of Chapter 18.

After reviewing the report of Dr. Weiss, an Office medical adviser noted that atrophy and range of motion impairment values could not be combined in an impairment rating according to

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<sup>1</sup> A.M.A., *Guides* (5<sup>th</sup> ed. 2001).

<sup>2</sup> The Board notes that the 1.5 centimeter difference between appellant's left and right thighs would equal a maximum impairment of 8 percent according to Table 17-6, not 13 percent. He also indicated that his left calf was larger than his right which would not support a finding of impairment due to atrophy based on Table 17-6. See A.M.A., *Guides* 530, Table 17-6.

Table 17-2 at page 526 of the A.M.A., *Guides*. He indicated that appellant had a 10 percent impairment of the left knee due to decreased flexion, based on Table 17-10 at page 537.<sup>3</sup>

Due to the conflict in the medical opinion evidence between Dr. Weiss and the Office medical adviser, the Office referred appellant, together with a statement of accepted facts, a list of questions and the case file, to Dr. John H. de Jong, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a report dated September 17, 2003, Dr. de Jong provided a history of appellant's condition, course of treatment, a summary of the medical records and findings on physical examination. He noted that appellant had preexisting left knee osteoarthritis which was aggravated by the October 18, 2001 employment injury. Dr. de Jong indicated that appellant had left knee numbness after extensive walking, occasional weakness and difficulty negotiating stairs. Appellant also experienced occasional pain and weakness at night. Dr. de Jong diagnosed internal derangement of the left knee and a tear of the medial meniscus due to the October 18, 2001 employment injury and preexisting osteoarthritic changes of the left knee, "not factually accepted to be related to the accident of [October 18, 2001]." Dr. de Jong stated:

"[M]easurements of [appellant's] knees were equal bilaterally at 49 [centimeters]. Measurements of his lower legs ... revealed a 44 [centimeter] circumference of his left lower leg, while the ... right was 41.5 [centimeters]. ([Appellant] had informed us that intermittently his left leg will swell up.) [W]e measured a .5 [centimeter] atrophy of his left thigh in comparison to the right.

"Range of motion was also carefully and repeatedly examined. At full extension of [appellant's] left knee, he appeared to lack approximately 5 [degrees] of full extension.... Flexion range of motion of the left knee was to 90 [degrees]...."

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"Strength in his quadriceps and hamstring musculature was examined by having [him] move his left knee into flexion and extension against resistance while sitting on the examining table. We noted essentially no difference between his left knee and right, which appeared to indicate that he had been able to attain full recovery of strength.

"Deep tendon reflexes revealed the patellar reflexes to be at the trace level, while Achilles reflexes were 1+. Sensory examination was performed with a small brush and failed to reveal any evidence of sensory abnormalities of [appellant's] left leg.

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<sup>3</sup> Dr. Weiss calculated a three percent impairment due to pain based on Table 18-1 in Chapter 18. The Office's procedure manual provides that Chapter 18 should not be used to rate pain-related impairment for any condition that can be adequately rated on the basis of the impairment rating systems given in other chapters of the A.M.A., *Guides*. See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003); see also A.M.A., *Guides* 570-72.

“[Appellant] was asked to perform a deep knee bend and was able to do so to 50 percent of a full squatting maneuver with both legs at the same level of bending at the knee.”

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“[P]er [the] A.M.A., *Guides*, [5<sup>th</sup> ed.], there are various methods of [impairment] assessment. This can be on an anatomic, functional or diagnosis-based method. The diagnosis-based estimates are used to evaluate impairments, including joint replacements and meniscectomies (see page 525). This being the case, I decided that a diagnosis-based estimate with regard to [appellant’s] left knee was the appropriate method to use. I then went to page 546, Table 17-33, which lists the impairment estimates for certain lower extremity impairments. In the table to the right on page 546, in the middle, you will see listed medial or lateral partial meniscectomy, causing a lower extremity impairment of two [percent], while total meniscectomy was listed to cause a seven [percent] impairment. From [the June 3, 2002] operative report, we noted ... a partial medial meniscectomy of the left knee. Therefore, the lower extremity impairment on the basis of the medial meniscectomy, as per preferred methods from the [A.M.A., *Guides*, 5<sup>th</sup> ed.] would be two [percent] of the left leg.

“With regard to the differences between the figures I arrived at and those of Dr. Weiss, I can only state that my figures were arrived at by using the [A.M.A., *Guides*], which statedly prefer a diagnosis-based estimate to evaluate impairments such as meniscectomies (again see page 525). Dr. Weiss used a different method, which was based on range of motion deficit, thigh and calf atrophy and pain-related impairment.”

In an October 1, 2003 memorandum, an Office medical adviser noted that Dr. de Jong had calculated a two percent impairment of appellant’s left lower extremity based on Table 17-33 at page 546 of the A.M.A., *Guides*. He stated:

“I did not find any difference between my calculation [and] Dr. de Jong’s. He explained how his exam[ination] was different from that of Dr. Weiss, who used ROM [range of motion] values [and] loss of strength. I realized Dr. Weiss’ exam[ination] was [January 27, 2003] [and] Dr. de Jong’s exam[ination] was [September 17, 2003,] [nine] months later. Either [appellant] improved markedly in [nine] months or one of the exam[inations] is inaccurate. Dr. de Jong’s of course was an [independent medical examination [and] I am sure that is why I was asked to review his report.”

By decision dated October 30, 2003, the Office granted appellant a schedule award for 5.67 weeks based on a 2 percent impairment of the left lower extremity for the period September 4 to October 14, 2002.

Appellant requested a hearing that was held on June 22, 2004. His attorney argued that Dr. de Jong should have based his impairment rating on the functional method which provided a

greater impairment than the diagnosis-based method and he failed to consider appellant's preexisting left knee arthritis in his impairment rating.

By decision dated November 5, 2004, an Office hearing representative affirmed the October 30, 2003 decision.

### **LEGAL PRECEDENT**

Section 8107 of the Federal Employees' Compensation Act<sup>4</sup> authorizes the payment of schedule awards for the loss or loss of use, of specified members, organs or functions of the body. Such loss or loss of use, is known as "permanent impairment." 20 C.F.R. § 10.404 sets forth the number of weeks of compensation payable to employees sustaining 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.

The A.M.A., *Guides* provides for three separate methods for calculating the impairment of an individual: anatomic, functional and diagnosis based.<sup>5</sup> The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.<sup>6</sup> The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligamentous instability, bursitis and various surgical procedures, including joint replacements and meniscectomies.<sup>7</sup> In certain situations, diagnosis-based estimates are combined with other methods of assessment.<sup>8</sup> The functional method is used for conditions when anatomic changes are difficult to categorize or when functional implications have been documented and includes range of motion, gait derangement and muscle strength.<sup>9</sup> The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.<sup>10</sup> When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that

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<sup>4</sup> 5 U.S.C. § 8107.

<sup>5</sup> A.M.A., *Guides* 525.

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

<sup>8</sup> The A.M.A., *Guides* specifically excludes combining diagnosis-based estimates with range of motion deficits due to ankylosis. A.M.A., *Guides* 526 Table 17-2.

<sup>9</sup> *Id.* at 525, Table 17-1.

<sup>10</sup> *Id.* at 548, 555.

gives the most clinically accurate impairment rating.<sup>11</sup> If more than one method can be used, the method that provides the higher impairment rating should be adopted.<sup>12</sup>

Section 8123(a) of the Act provides that if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary of Labor shall appoint a third physician who shall make an examination.<sup>13</sup> Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.<sup>14</sup>

### ANALYSIS

Due to the conflict in the medical opinion evidence between Dr. Weiss and the Office medical adviser as to the permanent impairment of appellant's left lower extremity, the Office referred appellant to Dr. de Jong, a Board-certified orthopedic surgeon, for an independent medical examination.

The Board finds that the impairment rating of Dr. de Jong is not sufficient to resolve the conflict in the medical opinion evidence between Dr. Weiss and the Office medical adviser due to several deficiencies.

Dr. de Jong diagnosed internal derangement of appellant's left knee and a tear of the medial meniscus and preexisting osteoarthritic changes of the left knee, "not factually accepted to be related to the accident of [October 18, 2001]." It is well established that in determining entitlement to a schedule award, preexisting impairment to the schedule member is to be included.<sup>15</sup> Dr. de Jong noted that appellant's preexisting left knee arthritis was aggravated by his employment injury but did not opine as to whether there was any impairment as a consequence of both the preexisting condition and the employment injury.

Dr. de Jong found that appellant's left calf had a 44 centimeter circumference as compared to 41.5 centimeters on the right and noted that he sometimes had left leg swelling. The A.M.A., *Guides* provides that in evaluating muscle atrophy, neither limb should have swelling or varicosities that would invalidate the measurements.<sup>16</sup> As appellant was experiencing left calf swelling when Dr. de Jong examined him, the left calf measurement was not valid. Consequently, whether or not he had left calf atrophy is unknown.

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<sup>11</sup> *Id.* at 526.

<sup>12</sup> *Id.* at 527, 555.

<sup>13</sup> 5 U.S.C. § 8123(a); *see also* *Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

<sup>14</sup> *See Roger Dingess*, 47 ECAB 123 (1995); *Glenn C. Chasteen*, 42 ECAB 493 (1991).

<sup>15</sup> *Michael C. Milner*, 53 ECAB 446 (2002); *Lela M. Shaw*, 51 ECAB 372 (2000).

<sup>16</sup> A.M.A., *Guides* 530, 17.2d

Dr. de Jong stated that he selected the diagnosis-based method of calculating impairment because this method included joint replacements and meniscectomies according to page 525 of the A.M.A., *Guides*. He calculated a two percent impairment of appellant's left lower extremity based on Table 17-33 at page 546 his partial meniscectomy. However, an impairment rating can also be based on the functional method which includes impairment for loss of range of motion. Dr. de Jong noted in his report that appellant had a 5 degree loss of extension of his left knee and his flexion range of motion was 90 degrees. According to Table 17-10 at page 537, his decreased extension (flexion contracture) equals a 10 percent impairment of the lower extremity and his decreased flexion also equals a 10 percent impairment. Thus, an impairment evaluation based on loss of range of motion would be greater than an impairment noting based on the partial meniscectomy. As noted above, if more than one impairment method can be used, the method that provides the higher impairment rating should be adopted. For this reason, the record should be remanded to the Office to seek clarification of Dr. de Jong's medical opinion.<sup>17</sup>

### **CONCLUSION**

The Board finds that this case is not in posture for a decision and will be remanded for further development of the medical evidence. After such further development as the Office deems necessary, it should issue an appropriate decision

### **ORDER**

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated October 5, 2004 is set aside and the case remanded for further action consistent with this decision of the Board.

Issued: November 7, 2005  
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

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<sup>17</sup> See *Richael O'Brien*, 53 ECAB 234 (2001) (the Office has the responsibility to obtain a supplemental report from an impartial medical specialist to correct any defects in the original report).