

February 16, 2001 decision denying appellant's request for reconsideration.¹ In a May 25, 2004 decision, the Board affirmed an April 1, 2003 Office decision, finding that appellant had a six percent impairment of the right lower extremity.² The Board, however, set aside a September 30, 2003 decision, which denied appellant's request for reconsideration and remanded the case for further merit review of his claim. The factual history of the case is set forth in the Board's prior decisions and incorporated herein by reference.³

On August 10, 2004 Dr. Leonard A. Simpson, an Office medical adviser, reviewed the medical evidence and again determined that appellant had a six percent impairment of the right lower extremity. This estimate was based on the footnote to Table 17-31 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), which allows five percent impairment for patellofemoral pain. In addition, the Office medical adviser allowed an additional one percent impairment for pain under Chapter 18. He noted that Dr. John Kayvanfar, an attending orthopedic surgeon, allowed a 24 percent impairment rating based on Table 18-7 of the A.M.A., *Guides*, at page 584. He noted that section 18.5 of the A.M.A., *Guides* provides an additional impairment of up to three percent if an individual has a pain-related impairment that increases the burden of illness slightly. The Office medical adviser concluded that Dr. Kayvanfar's report did not alter his previous recommendation of one percent impairment for pain under that Chapter.

By decision dated September 22, 2004, the Office denied modification of the prior schedule award decision. The Office found the evidence of record insufficient to establish that appellant had more than a six percent impairment of the right lower extremity.

On December 2, 2004 appellant requested reconsideration. He submitted an October 7, 2004 report from Dr. Kayvanfar, who again rated appellant's right knee impairment as 24 percent. He noted that appellant experienced pain continuously and stated that, based on the A.M.A., *Guides* 584, Table 18.7, that appellant's pain score was between 25 and 42, which constituted a moderate impairment. Dr. Kayvanfar also stated that appellant had difficulty in maintaining the standing position and could not walk without assistance. He referred to "Table 15.5", indicating that appellant's gait and movement disorder met the criteria allowing a Class 3, or 20 to 30 percent impairment of the whole body.⁴ He provided an impairment rating for lower extremity muscle weakness based on the A.M.A., *Guides* 532, Table 17.8. Dr. Kayvanfar found

¹ Docket No. 01-1211, issued February 6, 2002.

² Docket No. 04-280, issued May 25, 2004.

³ On July 28, 1998 appellant, a 43-year-old facility inspection specialist, filed a traumatic injury claim alleging that on July 16, 1998 he hurt his left knee while in the performance of his work duties. On September 16, 1998 the Office accepted appellant's claim for left knee strain and authorized arthroscopic surgery, which was performed on October 24, 1998 by Dr. Thomas L. Smith, an orthopedic surgeon. By decision dated November 23, 1999, the Office granted a schedule award for a 15 percent permanent impairment of the left knee. The Office received information indicating that he experienced pain and discomfort in his right knee. On August 23, 2002 the Office expanded the acceptance of appellant's claim to include chondromalacia of the right knee based on the opinion of Dr. William C. Boeck, Jr., a Board-certified orthopedic surgeon and Office referral physician.

⁴ The Board notes that Table 15-5 at page 392 provides criteria for rating whole man impairment due to cervical disorders.

that appellant had a Grade 3 impairment and allowed 17 percent impairment to the lower extremity.⁵ He next cited to Table 17-10 at page 537, to find eight percent whole man impairment due to “motion.”⁶ He also cited to Table 17-37, at page 552, to state that appellant had impairment due to nerve deficit of a moderate degree. Dr. Kayvanfar concluded that appellant had a total 24 percent impairment of the right lower extremity.

On January 14, 2005 Dr. Simpson reviewed Dr. Kayvanfar’s October 7, 2004 report and concluded that the medical evidence did not establish greater than the six percent impairment previously determined. He stated that appellant had five percent impairment based on Table 17-31, page 544, which rates impairment due to arthritis of the knee and allows up to seven percent impairment of the lower extremity. He also allowed one percent impairment for pain, for a six percent total impairment of the right lower extremity. He stated that the various impairment values as cited in Dr. Kayvanfar’s report could not be combined based on Table 17-2 of the A.M.A., *Guides* at page 526. The Office medical adviser further noted that Dr. Kayvanfar’s reports did not provide specific descriptions of appellant’s impairment to identify the 17 percent impairment allowed for muscle weakness; the range of motion of the knee to support the 18 percent impairment based on Table 17-10; or indicate the nerve deficit or the actual motor weakness.

By decision dated February 3, 2005, the Office denied modification of the September 22, 2004 decision. The Office found that the medical evidence did not establish that appellant had more than a six percent impairment of the right lower extremity.

In an April 19, 2005 letter, appellant requested reconsideration of the Office’s schedule award pertaining to his left knee. He submitted a January 6, 2005 report from Dr. Kayvanfar, who stated that he had evaluated appellant’s left knee impairment and found total impairment of 28 to 30 percent impairment. In making this impairment rating, the physician addressed various Tables of the A.M.A., *Guides* at pages 532, 584, 552, 540.

On April 29, 2005 Dr. Simpson stated that he reviewed Dr. Kayvanfar’s January 6, 2005 report and found that the medical evidence would support a 12 percent impairment of the right lower extremity based on Grade 4 motor weakness involving knee flexion and knee extension under Table 17-8 at page 532. He noted that the other impairment values addressed by Dr. Kayvanfar could not be combined under Table 17-2.

On May 18, 2005 the Office requested that Dr. Simpson clarify his impairment rating, as Dr. Kayvanfar’s January 6, 2005 only addressed permanent impairment to appellant’s left lower extremity and not to the right lower extremity. On May 30, 2005 the medical adviser stated that he would recommend the prior rating of six percent to the right lower extremity if Dr. Kayvanfar’s January 6, 2005 report referred only to the left knee. He suggested that the Office contact Dr. Kayvanfar to determine which lower extremity he was referring to in this report.

⁵ Table 17-8, at page 532, provides lower extremity impairment of 17 percent for Grade 3 knee impairment for muscle weakness.

⁶ Table 17-10, at page 537 provides impairment ratings for loss of motion to the knee.

By letter dated June 10, 2005, the Office requested that Dr. Kayvanfar clarify whether the January 6, 2005 report pertained to appellant's left or right knee. On June 15, 2005 appellant advised the Office that Dr. Kayvanfar's January 6, 2005 report pertained to his left knee and that he wanted reconsideration of the impairment rating regarding his left knee.

In a June 29, 2005 decision, the Office denied appellant's request for reconsideration. The Office found that the evidence submitted by appellant pertaining to his left knee impairment was irrelevant to the issue of the impairment to his right knee.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act⁷ and its implementing regulation⁸ sets forth the number of weeks of compensation to be paid for permanent loss or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.⁹ However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.¹⁰

With regard to the lower extremity, the A.M.A., *Guides* provide protocols for rating the extent of permanent impairment at Chapter 17. Section 17-2 notes that after identifying all the potentially impairing conditions and recording the correct ratings, the medical evaluator should select the clinically most appropriate method of rating impairment. The Cross-Usage Chart at page 526 states which methods and impairment ratings may be combined with one another.

ANALYSIS -- ISSUE 1

The Office accepted that appellant sustained chondromalacia of the right knee as work related and granted a schedule award for a five percent impairment of the right knee. This impairment rating was based on the footnote to Table 17-31 pertaining to patellofemoral pain and crepitation on physical examination without joint space narrowing on x-rays. Appellant sought reconsideration of this impairment rating and the Office medical adviser allowed an additional one percent impairment for pain under Chapter 18.

Appellant again requested an additional schedule award for his right lower extremity and submitted the July 3, 2003 report of Dr. Kayvanfar, who reported range of motion from 0 degrees to 120 degrees with slight muscle atrophy and decreased muscle strength in the hamstring compared to the quadriceps. He also reported that appellant walked with a wide based

⁷ 5 U.S.C. § 8107(c).

⁸ 20 C.F.R. § 10.404.

⁹ 5 U.S.C. § 8107(c)(19).

¹⁰ 20 C.F.R. § 10.404; *see also Joseph Lawrence, Jr.*, 53 ECAB 331 (2002); *Tommy R. Martin*, 56 ECAB ____ (Docket No. 03-1491, issued January 21, 2005).

gait and found crepitation with range of motion of the knee and ambulation. Dr. Kayvanfar stated that appellant was unable to use stairs independently, stoop, squat, bend, use ladders, jump or walk long distances. Appellant's knee popped, grinded and was constantly tingling. His pain level was 7/10. Citing to Table 17.1 at page 525, Dr. Kayvanfar found that appellant had thigh atrophy. He also listed range of motion impairment under Table 17-10, page 537; muscle weakness under Table 17-8, page 532; and a Class 2 moderate pain disorder based on Table 18.3 at page 575 of the A.M.A., *Guides* 575. Citing to Table 18.4, at page 576, he stated that appellant had a D5 impairment associated with pain. Appellant also had a +5 pain behavior based on Table 18.5 at page 580. Lastly, Dr. Kayvanfar listed that appellant's pain-related impairment score was 25 to 42 under Table 18.7 at page 584 and concluded that appellant's total impairment to the right lower extremity was 24 percent. In an October 7, 2004 report, Dr. Kayvanfar essentially repeated these findings and repeated his conclusion that appellant had a total 24 percent impairment of the right lower extremity.

Dr. Simpson reviewed the additional reports of Dr. Kayvanfar and found that appellant did not have more than six percent impairment of the right lower extremity, citing again to the footnote of Table 17-31 on page 544 of the A.M.A., *Guides* for chondromalacia and allowing one percent additional impairment under Chapter 18 for pain.

The Board finds that the case is not in posture for decision. As noted by the Office medical adviser, Dr. Kayvanfar provided a total impairment rating for appellant's right knee, which does not conform to the A.M.A., *Guides*. Dr. Kayvanfar based his impairment rating by combining various findings pertaining to atrophy, loss of range of motion, muscle weakness and pain. However, he did not acknowledge the Cross-Usage Chart at Table 17-2 or explain why he combined these various methods for rating impairment. Moreover, he cited to Chapter 18 to rate impairment due to pain. Pursuant to FECA Bulletin No. 01-05, incorporated in the Office's procedure manual at Chapter 3.700, medical examiners "should not use this chapter to rate pain[-]related impairment for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the [A.M.A.,] *Guides*."¹¹ In this regard, Dr. Simpson allowed an impairment rating of five percent for patellofemoral pain under the footnote to Table 17-31 and an additional one percent for pain under Chapter 18. However, the medical adviser did not provide any explanation as to why he utilized Chapter 18 in combination with Chapter 17 in light of the Office's established procedures or otherwise explain why the rating under the footnote to Table 17-31 would not be adequate to rate appellant's right knee pain. Moreover, while noting the Cross-Usage Chart's preclusion of combining methods of rating lower extremity impairment, Dr. Simpson did not address which method of impairment addressed by Dr. Kayvanfar was clinically most appropriate or favorable to appellant. For example, the 17 percent impairment rating Dr. Kayvanfar allowed for muscle weakness of the right knee under Table 17-8 would be greater than the 6 percent estimate the medical adviser allowed for pain. The only medical report of the medical adviser addressing this aspect of the claim was related to medical evidence from the attending physician pertaining to the left lower extremity. For this reason the case will be remanded to the Office for further development of the medical evidence and a reasoned medical opinion on the extent of permanent impairment to

¹¹ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.4 (June 2003).

appellant's right lower extremity.¹² The Office should secure a medical opinion which provides a full description of the impairment(s) to appellant's right lower extremity under Chapter 17 and a discussion of which method of rating impairment is most appropriate under the Cross-Usage Chart.

CONCLUSION

The Board finds that the case requires further development on the nature and extent of impairment to appellant's right lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the June 29 and February 3, 2005 decisions of the Office of Workers' Compensation Programs be set aside. The case is remanded to the Office for further action in conformance with this decision.

Issued: February 2, 2006
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

¹² In light of the Board's disposition of the first issue, the denial of reconsideration is rendered moot.