



## **FACTUAL HISTORY**

On October 20, 1987 appellant, then a 41-year-old rigger, sustained employment-related injuries when he fell into a barrier trough of a ship. The claim was accepted for cervical strain/sprain, bilateral knee contusions, contusions to the left elbow and buttock and left lateral epicondylitis. Appellant worked a few days in December 1987 but stopped work and underwent arthroscopic surgery of the right knee on May 26, 1989.<sup>2</sup> By decision dated January 31, 1997, the Office terminated appellant's compensation benefits, effective February 2, 1997, based on the opinion of Dr. Leonard Klinghoffer, a Board-certified orthopedic surgeon, who opined that appellant's condition was not due to the employment injury. On January 29, 1998 an Office hearing representative affirmed the January 31, 1997 decision. In an October 14, 1998 decision, the Office denied modification of the prior decisions.

By letter dated August 18, 1999, appellant's attorney requested a schedule award and submitted a June 30, 1999 report from Dr. Nicholas Diamond, an osteopath, who provided examination findings and diagnosed post-traumatic right knee chondral fracture of the medial femoral condyle and posterior horn of the medial meniscus, Grade 4 post-traumatic right knee chondromalacia patella, post-traumatic right knee tenosynovitis, status post right knee arthroscopy, unresolved chronic cervical spine strain and sprain, unresolved chronic left knee strain and sprain and unresolved chronic left elbow strain and sprain. Dr. Diamond found that under the fourth edition of the A.M.A., *Guides*, appellant had 31 percent right lower extremity impairment and 16 percent left lower extremity impairment. On October 7, 2003 an Office medical adviser reviewed the medical reports of record and stated that maximum medical improvement was reached on September 3, 1996. He opined that since appellant sustained direct trauma to both knees on October 20, 1987 with complaints of pain and crepitation on physical examination. Under Table 17-31 of the fifth edition of the A.M.A., *Guides*, appellant had five percent impairment to each lower extremity.

By decision dated October 21, 2003, appellant was granted a schedule award for a five percent permanent impairment of each lower extremity.

On October 24, 2003 appellant, through his attorney, requested a hearing, which was held on June 22, 2004. In an October 18, 2004 decision, an Office hearing representative determined that a conflict in medical opinion arose between Drs. Diamond and Klinghoffer. The case was remanded for referral to an impartial specialist regarding the extent permanent impairment as a result of the accepted work injury.

On November 15, 2004 appellant was referred to Dr. Randall N. Smith, a Board-certified orthopedic surgeon. In a November 30, 2004 report, Dr. Smith reviewed the medical record, history of injury and appellant's complaints. He provided physical examination findings and advised that, under the fifth edition of the A.M.A., *Guides*, there were no objective evidence of impairment beyond the crepitus and subjective complaints of pain which constituted a five percent loss in each knee. On January 2, 2005 an Office medical adviser reviewed Dr. Smith's

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<sup>2</sup> By decision dated January 23, 1995, an overpayment in compensation in the amount of \$5,057.26 was waived.

report and agreed with his determination that appellant had a five percent impairment of each lower extremity.

In a January 10, 2005 decision, the Office denied appellant's claim for an additional schedule award.

On January 12, 2005 appellant, through his attorney, requested a hearing that was held on November 17, 2005. By decision dated February 16, 2006, an Office hearing representative remanded the case to the Office to obtain a supplemental opinion from Dr. Smith in accordance with the A.M.A., *Guides*. Dr. Smith was to address whether appellant had an impairment of the left upper extremity and whether x-rays demonstrated joint space narrowing of the lower extremities.

As Dr. Smith, he was unable to clarify his opinion, on July 19, 2006, the Office referred appellant to Dr. Joseph A. Jelen, Jr., a Board-certified orthopedic surgeon, for an impartial evaluation. In an August 15, 2006 report, Dr. Jelen reviewed the medical record, the history of injury and appellant's complaints. He listed findings on physical examination and diagnosed resolved cervical strain and bilateral knee contusions with cartilage injury on the right, treated arthroscopically and stable. Dr. Jelen advised that, under Chapter 16 of the A.M.A., *Guides*, appellant had no impairment of either upper extremity or the cervical spine. Regarding the lower extremities, he advised that, under Table 17-6, appellant had a mild calf circumference decrease on the left and a moderate thigh circumference decrease for 5 percent calf impairment and 10 percent thigh impairment. Dr. Jelen found no limited motion of the knee and, under Table 18-7, rated 10 percent impairment for pain. He added the impairments, finding a 25 percent impairment which, when converted under Table 17-3, yielded a 10 percent whole person impairment.<sup>3</sup> On September 5, 2006 an Office medical adviser reviewed the medical record. He opined that the atrophy of the muscles of appellant's left lower extremity was related to a hip condition which was not employment related and, any pain rating had previously been accounted for in the five percent impairment awarded in accordance with Table 17-31.

By decision dated September 12, 2006, the Office denied appellant's claim for a left upper extremity schedule award and for an additional schedule award for his lower extremities.

On September 19, 2006 appellant, through his attorney, requested a hearing. In a December 6, 2006 decision, an Office hearing representative remanded the case to the Office to obtain a supplemental report from Dr. Jelen to clarify his rating for atrophy to appellant's left leg.

In a January 15, 2007 report, Dr. Jelen advised that under Table 18-7 of the A.M.A., *Guides*, appellant had a 25 percent impairment to each lower extremity due to pain and that the majority of his weakness was due to pain. In a February 7, 2007 report, an Office medical adviser reviewed Dr. Jelen's report. He advised that appellant's knee pain was properly addressed in Chapter 17 of the A.M.A., *Guides* and, pursuant to Office procedures, a pain-related impairment of each lower extremity could not exceed three percent.

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<sup>3</sup> Dr. Jelen also noted appellant's complaint of right elbow pain and also diagnosed right elbow tendinitis. A right upper extremity condition, however, was not accepted as employment related.

By decision dated February 16, 2007, the Office denied appellant's claim for an additional schedule award. In a May 3, 2007 decision, an Office hearing representative again remanded the case, finding that Dr. Jelen's supplemental report was not rationalized and did not conform to the A.M.A., *Guides*. Therefore, another impartial medical evaluation was required. The Office was also to reissue a denial of the upper extremity claim.

On June 12, 2007 the Office referred appellant to Dr. Andrew J. Collier, Jr., a Board-certified orthopedic surgeon, for an impartial evaluation. In a July 11, 2007 report, Dr. Collier reviewed the medical record and statement of accepted facts. He noted appellant's report that he had hit his right elbow, not his left elbow, in the fall on October 20, 1987. Dr. Collier reported appellant's complaints of pain at the base of the neck but no radiation, weakness, numbness or paresthesias. Appellant also noted bilateral knee pain and swelling. Neurological examination of both upper extremities was intact to sensory, motor and deep tendon reflexes with good grip strength bilaterally. Examination of both elbows demonstrated minimal tenderness on the right and no tenderness on the left with good range of motion. Examination of both knees demonstrated no synovitis, effusion, erythema or warmth and minimal patellofemoral crepitus with negative inhibition and grind and no ligamentous laxity. Lachman's drawer and McMurray's tests were negative. Dr. Collier noted that appellant had a nonemployment-related contusion on the mid portion of the left tibia. He was aware that appellant's right elbow condition had not been accepted and reported that appellant had no symptoms in his left elbow. Dr. Collier advised that the accepted left elbow condition and cervical spine strain/sprain had resolved. Regarding the knees, he noted that appellant had reached maximum medical improvement and had no significant post-traumatic arthritis. There was no restriction to range of motion from 0 to 140 degrees or evidence of decreased strength, atrophy, ankylosis or sensory changes. Under the fifth edition of the A.M.A., *Guides*, appellant had no impairment of his cervical spine. As to his knees, he had no impairment for range of motion and no deformity of varus or valgus. Dr. Collier stated that the only applicable rating would be for post-traumatic chondromalacia patellae with residuals or a seven percent impairment of each lower extremity. In an attached work capacity evaluation, he advised that appellant could work four hours a day with restrictions on his physical activity. On July 27, 2007 an Office medical adviser agreed with Dr. Collier's conclusion that appellant had a seven percent impairment of each lower extremity, based on Table 17-31 of the A.M.A., *Guides*.

By decision dated August 16, 2007, appellant was granted a schedule award for an additional two percent impairment of each lower extremity. The Office also found that appellant was not entitled to a schedule award for the left upper extremity.

On August 22, 2007 appellant, through his attorney, requested a hearing that was held on December 11, 2007. Counsel contended that Dr. Collier's report was insufficient to carry the weight of the medical evidence because he relied on an incorrect history in stating that appellant fell on his right elbow when left elbow epicondylitis was an accepted condition. He noted that Dr. Collier did not provide range of motion measurements for the knees, elbows or wrists and should have x-rayed appellant's knees to determine the loss of joint space. Counsel noted that Dr. Collier did not reference the A.M.A., *Guides* in rating appellant's impairment.

In a February 15, 2008 decision, an Office hearing representative affirmed the August 16, 2007 decision.

## LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act<sup>4</sup> and section 10.404 of the implementing federal regulations,<sup>5</sup> schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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*<sup>6</sup> has been adopted by the Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.<sup>7</sup>

Although the A.M.A., *Guides* include guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under the Act for injury to the spine.<sup>8</sup> In 1960, amendments to the Act modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Therefore, as the schedule award provisions of the Act include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.<sup>9</sup> Impairment should not be considered permanent until the clinical findings indicate that the medical condition is static and well stabilized<sup>10</sup> and schedule awards for permanent impairment of the whole person are not authorized under the Act.<sup>11</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 shall appoint a third physician who shall make an examination.<sup>12</sup> When the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.<sup>13</sup> Office procedures indicate that referral to an Office medical adviser is appropriate when a detailed description of the impairment from the attending physician is

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<sup>4</sup> 5 U.S.C. § 8107.

<sup>5</sup> 20 C.F.R. § 10.404.

<sup>6</sup> A.M.A., *Guides*, *supra* note 2.

<sup>7</sup> See *Joseph Lawrence, Jr.*, *supra* note 2; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

<sup>8</sup> *Pamela J. Darling*, 49 ECAB 286 (1998).

<sup>9</sup> *Thomas J. Engelhart*, 50 ECAB 319 (1999).

<sup>10</sup> *Patricia J. Penney-Guzman*, 55 ECAB 757 (2004).

<sup>11</sup> *D.J.*, 59 ECAB \_\_\_\_ (Docket No. 08-725, issued July 9, 2008).

<sup>12</sup> 5 U.S.C. § 8123(a); see *Geraldine Foster*, 54 ECAB 435 (2003).

<sup>13</sup> *Manuel Gill*, 52 ECAB 282 (2001).

obtained. Where a medical conflict is present, to properly resolve the conflict, it is the impartial medical specialist who should provide a reasoned opinion as to a permanent impairment to a scheduled member of the body in accordance with the A.M.A., *Guides*. An Office medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.<sup>14</sup>

### ANALYSIS

The Board notes appellant's contention that Dr. Collier relied on an incorrect history of injury without basis. Dr. Collier reported that appellant stated he had hit his right elbow on October 20, 2007. However, appellant's claim form and statement regarding the injury, the statement of accepted facts and contemporaneous medical evidence describe a left upper extremity injury.<sup>15</sup> This is contradictory to appellant's report to Dr. Collier, 20 years later, that a left elbow contusion and left lateral epicondylitis were accepted as employment related. In his July 11, 2007 report, Dr. Collier advised that appellant had no left elbow impairment and there is no contemporaneous medical evidence to establish that appellant has any left upper extremity impairment. He found that appellant would not be entitled to a schedule award for his left upper extremity.

The Board also finds that Dr. Collier provided a reasoned impartial opinion that is sufficient to establish that appellant is not entitled to an additional schedule award for his bilateral knee condition. Dr. Collier noted a review of the medical record and provided findings on examination. He applied the fifth edition of the A.M.A., *Guides* to find, appellant had no impairment based on range of motion and no deformity of varus or valgus. He concluded that the only applicable rating would be for post-traumatic chondromalacia patellae with residuals, or a seven percent impairment of each lower extremity. Dr. Collier provided thorough findings on evaluation and rationale for his determination that appellant has seven percent impairment to each lower extremity under the A.M.A., *Guides*. The Board finds that his report is entitled to the special weight accorded an impartial examiner and therefore constitutes the weight of the medical evidence.<sup>16</sup> Appellant therefore did not establish that he is entitled to greater than the seven percent impairment of each lower extremity previously awarded.<sup>17</sup>

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<sup>14</sup> *Thomas J. Fragale*, 55 ECAB 619 (2004).

<sup>15</sup> In reports dated November 12 and 13, 1987 respectively, Drs. Apollo M. Arenas and Henry E. David reported that appellant hit his left elbow when he fell.

<sup>16</sup> *See Sharyn D. Bannick*, 54 ECAB 537 (2003).

<sup>17</sup> The Board notes that, while Table 17-31 provides that in an individual with a history of direct trauma, a complaint of patellofemoral pain and crepitation on physical examination but without joint space narrowing on x-rays, a five percent lower extremity impairment is given. A.M.A., *Guides*, *supra* note 2 at 544. In this case, there is no x-ray evidence of record to demonstrate joint space narrowing that would increase the initial award of five percent for each lower extremity. The record therefore establishes that appellant is entitled to a five percent impairment of each lower extremity.

**CONCLUSION**

The Board finds that appellant has no more than a seven percent impairment to each lower extremity for which he received schedule awards.

**ORDER**

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated February 15, 2008 be affirmed.

Issued: April 10, 2009  
Washington, DC

David S. Gerson, Judge  
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge  
Employees' Compensation Appeals Board