United States Department of Labor
Employees' Compensation Appeals Board

P.D., Appellant	)	
and	)	**Docket No. 09-544**
	)	**Issued: October 16, 2009**
DEPARTMENT OF VETERANS AFFAIRS, MANCHESTER VETERANS HOSPITAL, Manchester, NH, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 19, 2008 appellant timely appealed an October 8, 2008 merit decision of the Office of Workers' Compensation Programs denying modification of his schedule award. Pursuant to 20 C.F.R. §§ 501.2 and 501.3, the Board has jurisdiction over the merits of this claim.

ISSUE

The issue is whether appellant has more than 38 percent impairment to his right lower extremity, for which he received a schedule award.

FACTUAL HISTORY

This is the second appeal in this case. By decision dated July 5, 2007,[1] the Board found that the Office properly denied appellant compensation for leave buyback for March 31, 2005

[1] Docket No. 07-152 (issued July 5, 2007).

and intermittent dates from August 28, 2005 to January 3, 2006. However, the Board remanded the case to the Office for a determination of the appropriate amount of time that should be allowed for appellant's April 13, 2005 medical appointment. The facts and the law of the previous Board decision are incorporated herein by reference.

On July 30, 1999 appellant claimed a schedule award. On October 14, 1999 the Office awarded him a schedule award for a 17 percent permanent impairment of the right leg with the date of maximum medical improvement of December 1998. On August 18, 2005 it issued appellant a schedule award for 25 percent impairment of his right leg. As appellant was previously paid a schedule award for 17 percent right leg impairment, he received an additional 8 percent impairment. The award covered the period August 6, 2005 to January 14, 2006.

On February 7, 2006 appellant claimed an additional schedule award. In a March 24, 2006 report, Dr. H. James Forbes, a Board-certified orthopedic surgeon, opined that appellant was at maximum medical improvement on January 1, 2005. He advised two factors affected appellant's permanent impairment: laxity secondary to his torn cruciate ligament and the secondary degenerative arthritis, which attributed to his loss of joint space on standing x-ray. Dr. Forbes opined that appellant's impairment was based on both his laxity and loss of joint space. Under Table 17-33 of the fifth edition of the American Medical Associations, *Guides to the Evaluation of Permanent Impairment*, (hereinafter A.M.A., *Guides*), he found cruciate and collateral ligament laxity of moderate severity to be 10 percent whole person impairment or 25 percent lower extremity impairment. Under Table 17-31 of the A.M.A., *Guides*, Dr. Forbes found that appellant had three percent whole person impairment or seven percent lower extremity impairment based on mild joint space narrowing. Using the Combined Values Chart, Dr. Forbes found that appellant had 13 percent whole person impairment.[2]

In a May 5, 2006 report, an Office medical adviser reviewed Dr. Forbes' reports of record. He indicated that Dr. Forbes, in his January 31, 2006 report, measured joint space in the medial compartment as 2 millimeter (mm). Under Table 17-31, page 544 of the A.M.A., *Guides*, Dr. Forbes found 2 mm joint space in the medial compartment equated to 20 percent lower extremity impairment. He advised that under the fifth edition of the A.M.A., *Guides*, an x-ray measurement of the joint space supersedes range of motion or physical findings. Thus, the Office medical adviser opined that the impairment rating had to be adjusted for degenerative arthritis or 20 percent lower extremity rating, rather than the previously approved 25 percent impairment due to the physical finding of laxity. He further noted that Dr. Forbes incorrectly assigned a seven percent impairment, which according to Table 17-33, is for a joint space of three mm. The Office medical adviser advised that there appeared to be inconsistencies in Dr. Forbes evaluation and recommended that appellant undergo a second opinion evaluation, including repeat x-rays, to accurately determine an impairment.

In a June 22, 2006 report, Dr. Douglas M. Goumas, a Board-certified orthopedic surgeon and Office referral physician, reviewed the medical record and presented his examination findings. Under Table 17-33, page 546 of the A.M.A., *Guides*, he noted that appellant had moderate instability of the cruciate ligament which would result in 7 percent whole person

[2] Under the Combined Values Chart, the 25 percent leg impairment for ligament laxity combined with 7 percent leg impairment for joint space narrowing yields 30 percent impairment. *See* A.M.A., *Guides* 604.

impairment or 17 percent lower extremity impairment. Dr. Goumas stated that there was no evidence of instability of the medical cruciate ligament. In a July 18, 2006 report, he advised that appellant was at maximum medical improvement when he evaluated him on June 22, 2006. Dr. Goumas advised repeat x-rays were needed to adequately determine joint space as he only had x-rays from approximately one year prior. In an August 24, 2006 report, he noted reviewing August 24, 2006 x-rays and advised that there was no evidence of any changes. Thus, Dr. Goumas stated that there was no change in his rating of June 22, 2006.

On June 6, 2007 an Office medical adviser noted that the accepted condition was a sprain to the knee and while a knee strain would involve the medial collateral ligament, it would not involve the anterior cruciate ligament, which was an intra-articular structure not affected by a knee sprain. Under Table 17-33, page 546 of the A.M.A., *Guides*, the Office medical adviser opined that there was seven percent leg impairment based on mild laxity of the medial collateral ligament. On September 18, 2007 the Office requested another opinion from an Office medical adviser. In a September 24, 2007 response, a different Office medical adviser concluded that seven percent impairment of the right leg was appropriate as the preexisting degenerative arthritis and anterior cruciate ligament laxity should not be considered in the schedule award.

The Office found a conflict in medical opinion between Dr. Forbes, appellant's treating physician, and the Office medical advisers, with regard to whether appellant's anterior cruciate ligament laxity should be included in the schedule award and whether appellant had more than seven percent permanent impairment of the right leg.

The Office referred appellant, along the medical evidence of file, a statement of accepted facts and questions, to Dr. Gary P. Francke, a Board-certified orthopedic surgeon, for an independent medical evaluation. In an October 31, 2007 report, Dr. Francke noted the history of injury and his review of the medical record. He presented his examination as well as x-ray findings. Dr. Francke advised that right knee x-rays showed moderate to severe narrowing of the medial compartment of the right knee secondary to arthritic change. Appellant had no atrophy and strength was normal. Under Table 17-31, page 544 of the A.M.A., *Guides*, Dr. Francke opined that appellant had a 25 percent impairment of the lower extremity. He advised that the second area of impairment was his anterior cruciate ligament laxity, which is cruciate of collateral ligament laxity and was of a moderate laxity, which accounts for 17 percent impairment. Using the Combined Values Chart, Dr. Francke opined that appellant has 38 percent impairment of the right lower extremity. In a November 14, 2007 supplemental report, Dr. Francke opined that appellant reached maximum medical improvement on June 1, 1999.

In a November 29, 2007 report, a different Office medical adviser reviewed Dr. Francke's examination findings and opined maximum medical improvement was reached on June 1, 1999 and appellant had 38 percent impairment of the right lower extremity. Under Table 17-31, page 544 of the A.M.A., *Guides*, he found 25 percent for cartilage interval of one mm. Under Table 17-33, page 546, he found 17 percent impairment for moderate cruciate or collateral ligament laxity. Using the Combined Values Chart, page 604, he found 25 percent impairment for arthritis with 17 percent impairment for ligament laxity which resulted in 38 percent impairment of the right lower extremity.

By decision dated January 29, 2008, the Office issued appellant a schedule award for 38 percent impairment of the right lower extremity. As appellant was previously paid a schedule award for 25 percent right lower extremity impairment, he received an additional 13 percent impairment covering the period January 20 to October 8, 2008.

On April 4, 2008 appellant requested reconsideration. He stated that he did not dispute the 25 percent impairment for arthritis or the 17 percent impairment for ligament laxity. However, appellant disputes the method that was used to arrive at the 38 percent impairment for the right lower extremity. He argued that the whole person impairment rating for arthritis (10 percent) and the whole person impairment rating for ligament laxity (7 percent) should have been combined (16 percent) and then converted to a lower extremity impairment rating under Table 17-3, page 527 of the A.M.A, *Guides,* which would result in 41 percent impairment rating instead of 38 percent impairment rating awarded. In support of appellant's argument, he submitted copies of various sections of the A.M.A., *Guides*.

In a May 8, 2008 decision, the Office denied modification of its January 29, 2008 decision.

On July 12, 2008 appellant requested reconsideration. He argued that he did not request that his impairment be calculated in whole person impairment for the payment of the schedule award. Appellant stated that the A.M.A., *Guides* allow for converting lower extremity impairment ratings to whole person impairment ratings for the purpose of combining impairment ratings. He also contended that the A.M.A., *Guides* allow the total combined impairment to be converted to a lower extremity impairment rating for the purpose of awarding a schedule award. Appellant argued that, since the A.M.A., *Guides* specifically state that, the method providing the greater of the two impairment estimates be used, in his case, the Office should have used whole person impairments, combined them and then convert that rating to lower extremity rating as it would result in a higher lower extremity award. He referenced sections of the A.M.A., *Guides.*

By decision dated October 8, 2008, the Office denied modification of its prior decision.

LEGAL PRECEDENT

The schedule award provisions of the Federal Employees' Compensation Act[3] and the implementing regulations[4] 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 A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[5]

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Id.; see Billy B. Scoles*, 57 ECAB 258 (2005).

Schedule awards under the Act are limited to specific members or functions of the body as enumerated under section 8107 and the federal regulations.[6] It is well established that schedule awards are not payable for whole person impairment.[7]

Section 8123(a) of the Act provides, in pertinent part: 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.[8] 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.[9]

ANALYSIS

The Office determined that a conflict arose between appellant's physician, Dr. Forbes, appellant's treating physician, who found right leg impairment totaling 30 percent, including impairment for anterior cruciate ligament laxity, and the Office medical advisers, who found that appellant had no more than seven percent impairment and did not include impairment for anterior cruciate ligament laxity.

The Office referred appellant to Dr. Francke for an impartial medical examination. The Board finds that the report of Dr. Francke, the impartial medical specialist selected to resolve the conflict in the medical opinion evidence, is sufficiently well rationalized and based on a proper factual and medical background. Therefore, it is entitled to special weight. Dr. Francke noted findings on examination and upon review of diagnostic testing. Under Table 17-31, page 544 of the A.M.A., *Guides*, he opined that appellant had a 25 percent impairment of the lower extremity for moderate to severe narrowing of the medial compartment of the right knee secondary to arthritic change. He also found impairment based on appellant's anterior cruciate ligament laxity, which he deemed to be moderate in nature and for which he attributed 17 percent impairment. Using the Combined Values Chart, he opined that appellant has 38 percent impairment of the right lower extremity.

An Office medical adviser, in a November 29, 2007 report, reviewed Dr. Francke's examination findings and applied the A.M.A., *Guides* to such findings. He concurred with Dr. Francke that appellant had 38 percent impairment of the right lower extremity. Under Table 17-31, page 544 of the A.M.A., *Guides*, the Office medical adviser found 25 percent impairment for cartilage interval of one mm. Under Table 17-33, page 546, he found 17 percent impairment for moderate cruciate or collateral ligament laxity. Using the Combined Values Chart, page 604,

[6] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[7] *See Robert Romano*, 53 ECAB 649 (2002); *John Yera*, 48 ECAB 243 (1996).

[8] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207, 210 (1993).

[9] *See Roger Dingess*, 47 ECAB 123, 126 (1995); *Juanita H. Christoph*, 40 ECAB 354, 360 (1988); *Nathaniel Milton*, 37 ECAB 712, 723-24 (1986).

he found 25 percent impairment for arthritis with 17 percent impairment for ligament laxity resulted in 38 percent impairment of the right lower extremity.

The Board finds that the Office properly relied upon Dr. Francke's reports in finding that appellant has 38 percent impairment of the right lower extremity. There is no probative medical evidence of record establishing that appellant has more than 38 percent impairment of the right lower extremity.

On appeal, appellant submitted documents from the record and from the A.M.A., *Guides* in support of his contention that, had the Office utilized the whole person impairment ratings for each of his impairments and combined them, it would have resulted in a greater schedule award when the whole person impairment was converted into a lower extremity rating. He argued that such a method of calculation would yield 41 percent impairment as opposed to the 38 percent impairment found.[10]

Appellant's contention is without merit. As noted, it is well established that schedule awards are not payable for whole person impairment.[11] As such, there would be no reason to convert impairment of the leg into whole person impairment. While the A.M.A., *Guides* provide rating systems for both individual body members and whole person impairment, the Act and its regulations defines impairment to specific members and functions of the body.[12] Office procedures specifically provide that percentages of impairment are determined in accordance with the part of the body affected and not in terms of the whole person.[13] There is no basis in the Act, Board precedent or Office regulations for initially rating impairment on the basis of whole person impairment before converting its impairment of an individual scheduled member.

CONCLUSION

The Board finds that appellant has not established that he sustained more than 38 percent permanent impairment of his right lower extremity, for which he received a schedule award.

[10] Appellant argued that the 10 percent whole person rating for arthritis should have been combined with the 7 percent whole person rating for ligament laxity to arrive at a combined whole person rating of 16 percent. The 16 percent whole person rating, when converted into a lower extremity rating under Table 17-3, page 527 of the A.M.A., *Guides*, would result in 41 percent impairment.

[11] *Supra* note 7.

[12] *Supra* note 6.

[13] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003).

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated October 8, 2008 is affirmed.

Issued: October 16, 2009
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

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