U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of PHILIP R. BRUECK and DEPARTMENT OF INTERIOR, NATIONAL PARK SERVICE, Triangle, Va.

Docket No. 97-2487; Submitted on the Record;
Issued June 14, 1999

DECISION and ORDER

Before GEORGE E. RIVERS, WILLIE T.C. THOMAS, A. PETER KANJORSKI

The issue is whether appellant has greater than a nine percent permanent loss of use of his left leg.

This case has previously been on appeal before the Board. In its December 6, 1996 decision,[1] the Board found that the Office of Workers' Compensation Programs medical adviser properly assigned a two percent impairment rating for appellant's partial medial meniscus tear. However, the Board further found that the Office medical adviser inappropriately rated appellant's ligament laxity without providing any explanation or any reference to the examining physician's findings. The Board therefore remanded the case for the examining physician (or another examining physician) to address whether appellant's ligament laxity is mild or moderate. The Board noted that no additional percentage of impairment need be assigned for pain. The Board further stated that in its determination of the percentage of permanent impairment of appellant's left leg, the Office should also take into account his preexisting impairment to the left ankle,[2] even though appellant's injury was not accepted for an ankle condition. The facts and circumstances of the case as set out in the Board's December 6, 1996 decision are incorporated herein by reference.

Following the Board's decision, appellant was examined by Dr. David R. Heiner, a Board-certified orthopedic surgeon. In an April 4, 1997 report, Dr. Heiner noted the results of his examination. He stated that he agreed with Dr. John W. Johnson's determination that maximum medical improvement was reached on October 22, 1993. Using the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), Dr. Heiner stated that based on Table 24, page 3-85, there was a 1 percent whole person impairment or a 2 percent lower extremity impairment for the partial medial meniscus tear. It

[1] Docket No. 95-1760.

[2] Appellant has a congential condition of the left foot.

would allow for the collateral and cruciate injury moderate, a 7 percent whole person, or 17 percent lower extremity impairment. For the foot and ankle, table 64, page 3-86, would allow for a vascular necrosis of the talus a 6 percent whole person or 15 percent lower extremity. Utilizing these diagnosis, Dr. Heiner added up the whole person impairments to equate to a 14 percent whole person or a 34 percent lower extremity impairment.

An Office medical adviser reviewed Dr. Heiner's report on May 2, 1997 and stated that appellant had a nine percent impairment rating to the left lower extremity. The rating was seven percent for mild laxity to the knee due to the cruciate ligament and two percent for meniscal tear. He further indicated that limb atrophy is due to the club foot. All symptoms and signs related to foot and ankle are also due to the club foot. In a June 11, 1997 report, the Office medical adviser provided a discussion on Dr. Heiner's recommended 34 percent impairment rating. The Office medical adviser stated that Dr. Heiner rated appellant for collateral ligament injury, but there was no injury to this ligament. Also, the Office medical adviser stated, "He provides a 21 percent permanent impairment for a vascular necrosis of the talus. This is an abnormality of the foot. Note: There was *no injury* to the foot." In conclusion, the Office medical adviser indicated that Dr. Heiner provided ratings for abnormalities not related to the injury of October 20, 1992.

By decision dated June 15, 1997, the Office, after performing a merit review, denied modification of its prior decision. Thus, the Office denied the claim for an additional schedule award above the nine percent previously received as the medical evidence did not support an additional award.

The Board finds that further development of the evidence is needed on the issue of the extent of permanent impairment of appellant's left leg.

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulation,[4] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of specified 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 Office, and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[5]

In this case, Dr. Heiner, the new examining physician, recommended a permanent impairment rating of 34 percent of the left lower extremity. Dr. Heiner used the A.M.A., *Guides* to rate appellant's permanent impairment and indicated how he applied the A.M.A., *Guides*. He further took into account all impairments to appellant's leg in determining appellant's schedule award.

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.304.

[5] *Quincy E. Malone*, 31 ECAB 846 (1980).

The Office medical adviser properly assigned a two percent impairment for appellant's partial medial meniscus tear. This is the percentage provided by Table 64 of the A.M.A., *Guides* for a partial medial or lateral meniscectomy. With regard to appellant's ligament laxity, Table 64 of the A.M.A., *Guides* provides for a 7 percent impairment for "mild" laxity and for a 17 percent impairment for "moderate" laxity. Dr. Heiner opined that appellant's "collateral and cruciate injury [was] moderate" and assigned a 17 percent impairment. The Office medical adviser opined that appellant had a seven percent impairment for mild laxity to the knee due to cruciate ligament and stated that there was no injury to the collateral ligament. In light of the fact that there is a discrepancy between Dr. Heiner and the Office medical adviser as to whether appellant's ligament laxity is mild or moderate and what role, if any, the collateral ligament played in this determination, the case will be remanded to the Office to obtain a supplemental report from Dr. Heiner addressing this question. On remand Dr. Heiner should also address the question of whether appellant's situation is one of those "instances in which elements from both diagnostic and examination approaches will apply to a specific situation."[6]

The Board also notes that the Office medical adviser failed to follow the Board's directive pertaining to appellant's preexisting impairment to the left ankle in making his determination of the percentage of permanent impairment of appellant's left leg. Dr. Heiner provided a 21 percent permanent impairment for a vascular necrosis of the talus, which the Office medical adviser discounted stating that there was no injury to the foot. It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[7] When two or more impairments are involved the values are combined using the Combined Values Chart to ascertain the impairment to the extremity, based on the principle that each impairment acts not on the whole part but on the portion that remains after the preceding impairment has acted.[8] The Act does not provide for a schedule award for an impairment of the knee, but rather of the leg.[9] All impairments of the leg should be considered in determining appellant's entitlement to a schedule award.

The decision of the Office of Workers' Compensation Programs dated June 15, 1997 is set aside and the case remanded to the Office for further action consistent with this decision of the Board.

Dated, Washington, D.C.
June 14, 1999

[6] Chapter 3.2i of the A.M.A., *Guides* notes that evaluating physicians "in general, should decide which estimate best describes the situation and should use only one approach for each anatomic part," but the language from Chapter 3.2i quoted above and the language of Chapter 3.2 stating that "In some instances, a combination of two or three methods is required" allows the evaluating physician discretion to use more than one method where appropriate. Chapter 3.2 states, "Selecting the optimal approach or combining several methods requires judgment and experience."

[7] *See Dale B. Larson*, 41 ECAB 481 (1990); *Pedro M. DeLeon, Jr.*, 35 ECAB 487 (1983).

[8] *See Joseph L. Hibbard*, 34 ECAB 1416 (1983).

[9] 5 U.S.C. § 8107.

George E. Rivers
Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member