U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of MELINDA B. KENNEDY and U.S. POSTAL SERVICE,
POST OFFICE, Houston, TX

Docket No. 03-1801; Submitted on the Record;
Issued December 4, 2003

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether appellant has established that she is entitled to a greater than two percent impairment of her right lower extremity, for which she received a schedule award.

On January 20, 2000 appellant, a 47-year-old window clerk, filed a traumatic injury claim alleging that she injured her knee, foot and right shoulder when she fell while getting out of a chair. The Office of Workers' Compensation Programs accepted the claim for right shoulder strain, right knee strain and authorized right knee arthroscopic surgery, which was performed on June 8, 2000.[1] On November 14, 2001 appellant filed a claim for a schedule award.

In his April 3, 2002 report, Dr. J. Bruce Moseley, Jr., an attending Board-certified orthopedic surgeon, concluded that appellant had a 20 percent whole person impairment of her right knee based upon "bone-on-bone arthritis on the medial side of her right knee." The physician based his impairment rating upon Table 17-31, page 544 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001).

In a report dated August 26, 2002, Dr. Bernard Z. Albina, a second opinion Board-certified orthopedic surgeon, noted the following physical findings:

> "A range of motion of the right knee showed the presence of extension at 180 degrees and flexion at 60 degrees for an effective range of motion of 120 degrees in the right knee. McMurray's test was negative medially and laterally. Drawer's sign was negative anteriorly and posteriorly. Pulses were present in both lower extremities. Pivot shift and Lachman tests were negative in the right knee. No atrophy was noted in the lower extremity on the right as compared to the left."

[1] The surgery performed was for a partial and lateral meniscectomies.

Based upon the physical findings, the physician concluded that appellant had a five percent for loss of range of motion based upon Table 17-20 and a two percent impairment for the medial meniscectomy based upon Table 17-33 at page 546 for a total impairment of seven percent of the right lower extremity.

On October 9, 2002 the Office medical adviser reviewed Dr. Albina's August 26, 2002 report and concluded that appellant had a two percent impairment of the right lower extremity based upon Table 17-33, page 546 of the A.M.A., *Guides* (5th ed. 2001). He also concluded that appellant was not entitled to a schedule award for her right upper extremity as the accepted condition of right shoulder sprain is not a basis for a permanent impairment as the conditions are self-limiting.

On November 7, 2002 the Office issued appellant a schedule award for a two percent permanent impairment of her right lower extremity.

Appellant requested reconsideration in a letter dated December 6, 2002 and submitted reports by Dr. Moseley in support of her request.

In a November 29, 2000 report, Dr. Moseley reported the following physical findings:

> "[H]er knee has range of motion lacking full 10 degrees of full extension and achieving 110 degrees of flexion. There is no effusion. She has a normal ligament exam[ination]. She has diffuse tenderness. Hyperflexion and a McMurray's test cause diffuse pain. She has moderate patellofemoral crepitation."

Dr. Moseley, in a March 21, 2002 report, noted appellant's range of motion in her right knee has a 10 degree flexion and 110 degree flexion. He stated that appellant also had "severe, bone-on-bone arthritis."

By decision dated February 7, 2003, the Office denied appellant's request for modification.

The Board finds that this case is not in posture for a decision.

The schedule award provisions of the Federal Employees' Compensation Act[2] and its implementing federal regulation[3] 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 loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice requires the use of a single set of tables so that there may be uniform standards applicable to all claimants.

[2] 5 U.S.C. §§ 8101-8193, § 8107.

[3] 20 C.F.R. § 10.404.

In the instant case, the Board notes that the Office medical adviser and Dr. Albina arrived at different impairment ratings using the A.M.A., *Guides*. In reaching his impairment rating of two percent, the Office medical adviser relied on Dr. Albina's report and Table 17-33, page 546. Dr. Albina concluded that appellant had a five percent for loss of range of motion based upon Table 17-20 and a two percent impairment for the partial medial meniscectomy based upon Table 17-33 at page 546 for a total impairment of seven percent of the right lower extremity.

The A.M.A., *Guides* (5th ed. 2001) in determining lower extremity impairment stated the following method of assessment:

> "[13] methods can be used to assess the lower extremities, as listed in Table 17-2. Table 17-1 classifies the 13 methods into three nonmutually exclusive categories to reflect their primary mode of assessment: (1) anatomic; (2) functional; or (3) diagnosis based."

In determining which evaluation method to follow, the A.M.A., *Guides* provide the following instruction:

> "The evaluator's first step is to establish the diagnosis(es) and whether or not the individual has reached MMI [maximum medical improvement]. The next step is to identify each part of the lower extremity that might possibly warrant an impairment rating (pelvis, hip, thigh, etc, down to the toes). Figure 17-10 lists potential methods for each lower extremity part. The evaluator determines whether ROM [range of motion] impairment or other regional impairments are present for each relevant part and records the impairment values in the appropriate locations on the worksheet. The selection of the most specific method(s) and the appropriate combination are later considerations.
>
> "After all potentially impairing conditions have been identified and the correct ratings recorded, the evaluator should select the clinically most appropriate (*i.e.*, (sic) most specific) method(s) and record the estimated impairment for each. The **cross-usage chart** (Table 17-2) indicates, which methods and resulting impairment ratings may be combined. (Emphasis in the original.) It is the responsibility of the evaluating physician to explaining why a particular method(s) to assign the impairment rating was chosen. When uncertain about which method to choose, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating."[4]

In the instant case, the Office medical adviser used Table 17-33 at page 546 to determine appellant's impairment to calculate a two percent impairment of the right lower extremity. Dr. Albina based his impairment rating on both Table 17-33 and Table 17-20 to calculate a seven percent impairment of the right lower extremity. Figure 17-20 at page 561 indicates Tables 17-10 and 17-20 to 17-23 are to be used in calculating impairment of the knee. It further states, "Add impairment % ROM or use largest ankylosis = %" as to how impairment of the knee

[4] A.M.A., *Guides* (5th ed. 2001) at pp. 525-26,

should be calculated. It is unclear from the record as to why the Office medical adviser used a diagnosis-based estimate, Table 17-33, to calculate appellant's impairment while Dr. Albina used both a range of motion, Table 17-20 and a diagnosis-based estimate, Table 17-33, to calculate appellant's impairment. The cross-usage chart[5] instructs the evaluator that range of motion and diagnosis-based estimates are not to be used together to determine an impairment rating. On remand the Office should obtain a medical opinion clarifying why one method, either diagnosis-based estimate or range of motion, was the correct method to be used in determining appellant's impairment. Furthermore, the Office should indicate on the statement of accepted facts that appellant had both a lateral and medial meniscectomy, as shown by the surgical report.

In addition, in calculating a schedule award for a member of the body that sustained an employment-related impairment, preexisting impairments of that member must be included.[6] Consequently, the Office must take into account any of appellant's nonoccupational arthritic impairments of the right knee in calculating her schedule award.[7] Therefore, on remand the Office should indicate on the statement of accepted facts that appellant's arthritic impairment is to be taken into consideration when determining appellant's impairment.

The decisions of the Office of Workers' Compensation Programs dated February 7, 2003 and November 7, 2002 are hereby set aside and the case remanded for further development consistent with the above opinion.

Dated, Washington, DC
December 4, 2003

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member

[5] Figure 17-2 at page 526.

[6] *See Raymond E. Gwynn*, 35 ECAB 247 (1983) (finding that preexisting arthritis had to be considered along with present knee conditions in determining the degree of impairment); *see also Walter R. Malena*, 46 ECAB 983 (1995); *Dale Larson*, 41 ECAB 481 (1990); *Pedro M. DeLeon, Jr.*, 35 ECAB 487 (1983) (finding that an impairment rating for an accepted knee contusion injury must include consideration of preexisting degenerative knee changes).

[7] The fifth edition of the A.M.A., *Guides* provides that arthritic impairments should be based on roentgenographically determined cartilage intervals; *see* A.M.A., *Guides*, 544, Table 17-31.