U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of RONALD E. COMBS and DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Leavenworth, KS

Docket No. 02-1674; Submitted on the Record;
Issued March 21, 2003

DECISION and ORDER

Before DAVID S. GERSON, MICHAEL E. GROOM,
A. PETER KANJORSKI

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

Appellant, a 50-year-old firefighter, filed a notice of traumatic injury on May 3, 2000 alleging that on March 25, 2000 he sprained his right knee in the performance of duty. The Office of Workers' Compensation Programs accepted appellant's claim for a right knee medial and lateral meniscus tear. The Office authorized right knee arthroscopy, which appellant's physician recommended. Appellant declined to pursue surgical treatment.[1] Appellant requested a schedule award and by decision dated December 18, 2001, the Office granted appellant a schedule award for three percent impairment of his right lower extremity. In a decision dated March 21, 2002, the Office denied modification of the December 18, 2001 decision.

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

The schedule award provisions of the Federal Employees' Compensation Act[2] and its implementing 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 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 American Medical Association, *Guides to the*

[1] In a prior claim, number 11-0070700, the Office accepted that on February 11, 1985 appellant suffered a right knee contusion, which was expanded to include a medial parapatellar plica and lateral shelf plica. Appellant underwent an arthrogram on May 14, 1985 and a right knee arthroscopy on May 29, 1985.

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

Evaluation of Permanent Impairment (A.M.A., *Guides*)[4] has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.

In a report dated August 13, 2001, Dr. John A. Gillen II, a Board-certified orthopedic surgeon and appellant's treating physician, advised that appellant's magnetic resonance imaging (MRI) scan revealed a complex posterior horn tear of his medial meniscus and the lateral meniscus also appeared to have a tear in the posterior horn. Appellant was noted not to have any further treatment for this injury. Examination findings revealed a range of motion from 0 to 130 degrees of flexion. Appellant was stable to varus and valgus stress at 0 to 30 degrees, Lachman's test was negative, anterior drawer test was negative and his patella tracked well. Appellant was noted to have medial and lateral joint line mild tenderness. The medial joint line tenderness was moderate with palpation of the posterior medial joint line during the McMurray's test. Dr. Gillen stated that appellant would likely benefit from surgical repair versus debridement of the meniscus tears. He advised, however, that, as appellant was approximately 15 months out from his injury, he might be developing some degenerative joint changes around the areas of the meniscus tear.

In a report dated November 15, 2001, Dr. M. George Varghese, Board-certified in physical medicine and rehabilitation and an Office referral physician, examined appellant and provided an impairment rating. Dr. Varghese noted that appellant's 1985 arthrogram revealed a small tear of the lateral meniscus in the central portion along the inferior surface and appellant's May 29, 1985 arthroscopic surgery revealed findings of medial parapatellar plica and lateral shelf plica, which were shaved. He further noted that the tear in the lateral meniscus was found not to be large enough for a resection at that time. Appellant stated that he had pain for several months following his surgery in 1985, but was pain free up until his injury in March 2000. Examination of the right knee revealed no edema, erythema or effusion. There was no warmth to palpation over the knee, no pain was noted with patellar compression and appellant had minimal pain with palpation over the lateral joint space; with no pain on palpation over the medial joint space. Appellant did have crepitus with range of motion. There was no medial or lateral laxity with valgus and varus strain of the right knee. Drawer's test, Lockman's test, McMurray's, Appley's compression and distraction tests were all negative. Range of motion was full with 0 to 130 degrees of flexion. Examination of the right thigh was 1 centimeter smaller. On examination of the left knee for comparison, there was no edema, erythema or effusion or warmth to palpation. There was no pain with patellar compression. Appellant had no pain over the medial or lateral joint spaces. He did have some crepitus with range of motion. He had no medial or lateral laxity with valgus and varus strain. Drawer's test, Lockman's test, McMurray's, Appley's compression and distraction tests were all negative. Range of motion was also full. Neuromuscular examination revealed motor strength testing at 5/5 in the lower extremities with hip flexion, knee flexion, knee extension, dorsiflexion and plantar flexion. Deep tendon reflexes were +2 and symmetrical at the knee and Achilles. Sensation was intact. Examination of the right ankle and right hip were normal. Dr. Varghese noted that the MRI scan revealed posterior horn tears of the medial and lateral meniscus. Anterior cruciate ligament and posterior cruciate ligament appeared intact, as did the collateral ligaments.

[4] A.M.A., *Guides*, (5th ed. 2001).

Dr. Varghese opined that appellant had right knee pain with internal derangement, specifically medial and lateral posterior horn meniscal tears. He opined that appellant had reached maximum medical improvement and provided the following impairment rating based on the fifth edition A.M.A., *Guides*. With regard to the diagnosis of internal derangement with medial and lateral posterior horn meniscal tears based on MRI scan findings, Dr. Varghese attributed a 10 percent impairment rating according to Table 17-33. For range of motion, he stated that, with a range of motion being 0-130 degree with flexion, there would be no impairment rating according to Table 17-10. For strength, Dr. Varghese stated that appellant had 5/5 strength in his right lower extremity, or no impairment rating under Tables 17-7 and 17-8. For pain, he noted that appellant did experience right knee discomfort, which did not interfere with his activities. Dr. Varghese stated that appellant's complaints of pain were taking into consideration with regard to the impairment rating regarding internal derangement. For atrophy, he stated that as appellant had a 1 centimeter difference in thigh girth in the right compared to the left, which was ratable under Table 17-6. Dr. Varghese stated, however, that, under Table 17-2, this measurement could not be used in conjunction with the diagnosis of internal derangement. Accordingly, he opined that appellant had a 10 percent total impairment rating for his right knee pain with internal derangements, specifically the medial and lateral posterior horn meniscal tears.

The Office medical adviser reviewed the medical evidence of record on November 28, 2001. He noted that Dr. Varghese discussed range of motion; chronic pain and sensory deficit; and chronic weakness. He chose, however, to offer a rating in terms of the lateral and medial menisces, which appellant did not permit operative intervention on. The Office medical adviser noted that Table 17-33, upon which Dr. Varghese based his 10 percent rating on, is to be used for partial lateral and medial meniscectomies, not for tears, which had not been surgically treated or arthroscopically validated to have been actually present.[5] Thus, he opined that the rating for meniscal tears, as shown by MRI scan but not confirmed or treated by arthroscopic operative intervention, could not be accepted. The Office medical adviser further opined that Dr. Varghese's approach to the rating process would give appellant an unwarranted advantage in that, if the rating were offered for atrophy, which was verified by measurements, the lower extremity rating would be considerably less. Utilizing Table 17-6, the Office medical adviser found that the one centimeter of thigh atrophy represented three percent impairment of the lower extremity.[6] Although the atrophy rating from 1 centimeter to 1.9 centimeter yield a 3 to 8 percent impairment rage for the lower extremity, appellant was given an impairment rating of 3 percent for his right lower extremity as he had exactly 1 centimeter of atrophy.

The Board notes that, although the Office medical adviser properly applied the fifth edition of the A.M.A., *Guides* to the findings and explained the basic for his rating of appellant's impairment, he did not address appellant's preexisting right knee injury. The record reflects, appellant had a prior employment-related right knee injury in 1985, which included an arthroscopy on May 29, 1985. In evaluating appellant's knee condition following the March 25, 2000 injury, for which appellant declined further surgery, the Office medical adviser did not

[5] A.M.A., *Guides*, 546, Table 17-33.

[6] *Id.* at 530, Table 17-6.

discuss excluding appellant's preexisting knee injury from the rating. It is well established that in determining the amount of a schedule award, preexisting impairments are to be included.[7] In addition, Dr. Varghese, the referral physician, indicated that appellant had right knee pain with internal derangement. The Office medical adviser did not fully address this aspect of appellant's knee impairment when providing his impairment rating. Accordingly, further development is needed on these issues.

In a November 21, 2001 report, Dr. Gillen reiterated his examination findings of August 13, 2001. He opined that appellant's injury would not get better with conservative treatment. Dr. Gillen noted that studies indicate that patients with degenerative meniscus tears tend to progress more rapidly toward degenerative arthritis of the knee, possibly accelerating the need for a total knee arthroplasty prematurely. Without utilizing the A.M.A., *Guides* as a basis for his opinion, Dr. Gillen opined that his best estimate of appellant's lower extremity impairment was 20 to 25 percent, with a whole person impairment of 10 percent.[8] Dr. Gillen noted that with surgical treatment of this injury, appellant might not develop any significant degenerative arthritis and his whole person impairment would be 4 percent, with 10 percent lower extremity impairment for partial medial and lateral meniscectomies. The Board notes Dr. Gillen did not support his impairment ratings in accordance with the protocols of the A.M.A., *Guides*, his opinion is of diminished probative value.

As further development is required to determine whether appellant has established that he has more than three percent permanent impairment of his right lower extremity, the case will be remanded for further development in confomace with this decision.

[7] *See Dale B. Larson*, 41 ECAB 481 (1990).

[8] The Board notes that the Act does not provide for schedule awards for impairment to the person as whole, but instead only to the listed scheduled members. 5 U.S.C. § 8107. Therefore, appellant would not be entitled to a schedule award for impairment to the whole person.

The March 21, 2002 and December 18, 2001 decisions of the Office of Workers' Compensation Programs are hereby remanded for further development.

Dated, Washington, DC
March 21, 2003

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member