United States Department of Labor
Employees' Compensation Appeals Board

SCOTT D. HOSKINS, Appellant	)	
	)	**Docket No. 04-200**
and	)	**Issued: May 4, 2004**
DEPARTMENT OF THE NAVY, NAVAL AVIATION DEPOT, Cherry Point, NC Employer	)	

Appearances:
Scott D. Hoskins, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
MICHAEL E. GROOM, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On October 27, 2003 appellant filed a timely appeal from a September 10, 2003 Office of Workers' Compensation Programs' schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award issue in this case.

ISSUE

The issue is whether appellant has more than a 20 percent permanent impairment of the left lower extremity.

FACTUAL HISTORY

On February 28, 2002 appellant, then a 39-year-old instrument mechanic, filed a traumatic injury claim alleging that on February 22, 2002 he was pushing an electric cart which overturned and he sustained a broken kneecap. On March 25, 2002 the Office accepted a left tibial plateau fracture and arthroscopy with left knee fixation, which was performed on February 22, 2002 when appellant stopped working. He returned to limited duty on May 20, 2002 and full duty on June 17, 2002.

Appellant submitted various medical records from Dr. Donald S. Bright, a Board-certified orthopedic surgeon, dated March 6 to September 10, 2002. He diagnosed a comminuted displaced lateral tibial plateau fracture, which was sustained at work. He performed an arthroscopically assisted open reduction and internal fixation with bone grafting on February 22, 2002 and diagnosed displaced depressed lateral tibial plateau. The physician indicated that appellant was progressing satisfactorily following surgery. Evaluation of a magnetic resonance imaging (MRI) scan of the left knee dated June 6, 2002 was limited due to the screws in the lateral tibial plateau. The MRI scan revealed no abnormality in the medical meniscus, medial joint compartment or patella femoral joint. In an operative report dated September 10, 2002, Dr. Bright noted that he removed the screws and washer from the proximal tibia.

On January 16, 2003 appellant filed a claim for a schedule award. He submitted a report from Dr. Bright, dated January 8, 2003, which noted that appellant underwent an open reduction, internal fixation of a severe fracture of the tibial plateau and experienced persistent valgus deformity, limp and pain. The physician reviewed a functional capacity evaluation (FCE) dated December 10, 2002 and advised that appellant was qualified for a light-duty position with occasional lifting of up to 15 pounds. Dr. Bright noted that appellant was at a steady state and disability was at 50 percent based on the intra-articular damage, the need for a bone graft and the valgus deformity. The FCE dated December 10, 2002 noted range of motion of the left knee of 125 flexion and –15 for extension and advised that appellant could return to work light duty with occasional lifting of 15 pounds and frequent lifting of 8 pounds.

The medical record was referred to an Office medical adviser who, in a report dated February 26, 2003, determined that appellant sustained a 20 percent impairment of the left lower extremity. The Office medical adviser noted that the date of maximum medical improvement was December 10, 2002. He advised that in accordance with the fifth edition of the of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,*[1] (A.M.A., *Guides*) appellant sustained a 20 percent impairment of the left lower extremity for a flexion contracture, based on range of motion figures of 125 flexion and –15 extension.[2]

In a report dated March 3, 2003, Dr. Bright provided restrictions for appellant's return to work.

In a letter dated April 3, 2003, the Office requested that Dr. Bright provide a permanent impairment rating for the left lower extremity in accordance with the A.M.A., *Guides.*

In a report dated May 21, 2003, Dr. Bright provided findings under the A.M.A., *Guides* and concluded that appellant had a 15 to 30 percent impairment of the whole person due to gait derangement, antalgic limp with shortened stance and use of a cane;[3] atrophy of the unilateral leg muscle, loss of muscle mass;[4] knee flexion was a Grade 1 to 2 for a 10 percent impairment of the

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

[2] *Id.* at Table 17-10, page 537.

[3] *Supra* note 1 at Table 17-2, 17-3, 17-5, pages 526-29.

[4] *Supra* note 1 at Table 17-6, page 530.

whole person; severe valgus for an impairment rating of 16 to 20 percent of the whole person;[5] and severe collapse of the valgus with no remaining articular cartilage for an impairment of 20 percent of the whole person.[6] He noted a final disability of 50 to 60 percent of the foot or 20 to 30 percent of the whole person.[7]

In a decision dated September 10, 2003, the Office granted appellant a schedule award for 20 percent permanent impairment of the left lower extremity. The period of the schedule award was from December 10, 2002 to January 17, 2004.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[8] and its implementing regulation[9] 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 regulation as the appropriate standard for evaluating schedule losses.

ANALYSIS

Dr. Bright found a 50 to 60 percent permanent impairment of the left foot and a 20 to 30 percent impairment of the whole person and while the physician indicated whole person findings, the A.M.A., *Guides* provides a whole person to lower extremity conversion table.[10] In a May 21, 2003 report, Dr. Bright noted a 15 to 30 percent whole person impairment rating for gait derangement, antalgic limp with shortened stance, with use of cane.[11] Utilizing Table 17-3 of the A.M.A., *Guides* these figures convert into a 12 percent permanent impairment of the lower extremity. He determined that atrophy of the unilateral leg muscle, loss of muscle mass;[12] and knee flexion was a Grade 1 to 2 for a 10 percent impairment of the whole person[13] or 25 percent permanent impairment of the left foot. Dr. Bright noted severe valgus for an impairment rating

[5] *Supra* note 1 at Table 17-10, page 537.

[6] *Supra* note 1 at Table 17-31, page 544.

[7] The Office found that the weight of the medical evidence rested with the Office medical adviser.

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404 (1999).

[10] *Supra* note 1 at Table 17-3, page 527.

[11] *Supra* note 1 at Table 17-2, 17-3, 17-5, page 526, 527.

[12] *Supra* note 1 at Table 17-6, page 530.

[13] *Supra* note 1 at Table 17-8, page 532.

of 16 to 20 percent of the whole person or 35 percent of the lower extremity.[14] Dr. Bright also indicated that appellant sustained a severe collapse of the valgus with no remaining articular cartilage for an impairment of 20 percent of the whole person or 50 percent impairment of the lower extremity.[15] However, the A.M.A., *Guides*, Table 17-2, provides that if the gait derangement analysis is used then the evaluator cannot also use the arthritis analysis or the impairment rating generated from loss of muscle atrophy, muscle strength or range of motion ankylosis. The evaluator must choose the method or combination of methods that gives the most clinically accurate impairment rating.

The Board notes that, although Office medical adviser found a 20 percent impairment of the left lower extremity, the record reveals that he was not provided with the May 21, 2003 report of Dr. Bright. Therefore, the medical adviser did not consider all the medical evidence in reaching his opinion. For example, the Office medical adviser did not have the opportunity to review Dr. Bright's specific findings with regard to gait derangement, muscle atrophy, muscle strength problems, valgus, range of motion findings and loss of articular cartilage. Dr. Bright's findings provided for an additional impairment rating greater than the 20 percent granted by the Office medical adviser. In view of the disparity in the evaluations of the Office medical adviser and Dr. Bright and the failure of the Office to forward Dr. Bright's May 21, 2003 report to the Office medical adviser for review, the Office should refer the matter to an Office medical adviser to determine whether appellant has any additional ratable impairment in the left lower extremity.[16]

Proceedings under the Act are not adversary in nature nor is the Office a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[17] Accordingly, once the Office undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.

[14] *Supra* note 1 at Table 17-10, page 537.

[15] *Supra* note 1 at Table 17-31, page 544.

[16] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

[17] *John W. Butler*, 39 ECAB 852 (1988).

CONCLUSION

Therefore, the Board finds that the case must be remanded to the Office for referral of the matter to an Office medical adviser, consistent with Office procedures, to determine whether appellant sustained any additional permanent impairment of left lower extremity in accordance with the A.M.A., *Guides*. Following this and any other further development as deemed necessary, the Office shall issue an appropriate merit decision on appellant's schedule award claim.

ORDER

IT IS HEREBY ORDERED THAT the September 10, 2003 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development in accordance with this decision of the Board.

Issued: May 4, 2004
Washington, DC

Colleen Duffy Kiko
Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member