United States Department of Labor
Employees' Compensation Appeals Board

KEVIN CHARBONEAU, Appellant	)	
and	)	**Docket No. 05-153**
	)	**Issued: March 25, 2005**
DEPARTMENT OF HEALTH & HUMAN SERVICES, INDIAN HEALTH SERVICES, Oklahoma City, OK, Employer	)	

Appearances:
Kevin Charboneau, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
WILLIE T.C. THOMAS, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On October 18, 2004 appellant filed a timely appeal of a September 24, 2004 decision of the Office of Workers' Compensation Programs, awarding appellant a schedule award for a 16 percent permanent impairment to his right leg. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than a 16 percent permanent impairment to his right leg, for which he received a schedule award on September 24, 2004.

FACTUAL HISTORY

On May 4, 2003 appellant, then a 38-year-old registered nurse, filed a traumatic injury claim (Form CA-1) alleging that on May 2, 2003 he sustained a right knee injury when he twisted his knee while walking up stairs in the performance of duty. The Office accepted the claim for internal derangement of the right knee. Appellant underwent right knee surgery on

July 2, 2003. The surgery was performed by Dr. Christopher Deloache, an osteopath, who described the procedure as a right knee arthroscopy, partial medial meniscectomy, lateral meniscus meniscoplasty and drilling chondroplasty.

In a report dated December 2, 2003, Dr. Deloache opined that appellant had a 22 percent impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001). He identified Tables 17.5, 17.6, 17.10, 17.31 and 17.33 of the A.M.A., *Guides*, without explaining how these tables were applied. An Office medical adviser stated in a January 14, 2004 report that Dr. Deloache needed to clarify his opinion with respect to the degree of permanent impairment.

In a report dated February 9, 2004, Dr. Harold Battenfield, an osteopath, opined that appellant had a 15 percent impairment to his right knee based on the A.M.A., *Guides*. He did not provide additional explanation. An Office medical adviser again indicated in a March 10, 2004 report that additional evidence was required to determine the degree of permanent impairment. Dr. Battenfield submitted a March 29, 2004 report again stating that appellant had a 15 percent permanent impairment to the right knee from the May 2, 2003 injury. He stated that appellant prior injury from 1984 and the impairment rating did not include this injury. Dr. Battenfield did not identify specific tables or explain how the 15 percent impairment rating was calculated. An Office medical adviser recommended in an April 12, 2004 report that appellant be referred for a second opinion evaluation.

The Office referred appellant and her medical records to Dr. William Smith, an orthopedic surgeon, for a second opinion evaluation. In a report dated July 20, 2004, Dr. Smith provided a history and results on examination. He reported right knee range of motion of 5 to 130 degrees, quadriceps atrophy, and stated that radiographs revealed minimal medial compartment narrowing. Dr. Smith opined that appellant had chronic right knee pain secondary to post-traumatic osteoarthritis, and he would assign a 22 percent permanent impairment to the right leg. He stated that his opinion was based on Table 17-6 (13 percent), Table 17-31 (7 percent) and Table 17-33 (2 percent).

In a report dated August 30, 2004, an Office medial adviser reviewed Dr. Smith's report and opined that under Table 17-33 appellant would have a 10 percent impairment for a partial medial and lateral meniscectomy. The medical adviser also found a 7 percent impairment under Table 17-31 for arthritis, based on a cartilage interval of one millimeter. Combining the 10 and 7 percent, the medical adviser opined that appellant had a 16 percent permanent impairment to the right lower extremity. He noted that no consideration was given for muscle atrophy, because this would be contrary to the cross usage chart (Table 17-2) in the A.M.A., *Guides.* The medical adviser opined that the date of maximum medical improvement was July 7, 2004, the date of Dr. Smith's examination.

By decision dated September 24, 2004, the Office issued a schedule award for a 16 percent impairment to the right leg. The period of the award was 46.08 weeks commencing July 7, 2004.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[1] Neither the Act nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[2]

ANALYSIS

On appeal, appellant noted that Dr. Smith, the second opinion referral physician, had opined that the degree of permanent impairment under the A.M.A., *Guides* was 22 percent. He argued that the Office had erroneously given more weight to the Office medical adviser, who had not examined appellant. A schedule award, however, must be based on a proper application of the relevant tables and figures of the A.M.A., *Guides.* Office procedures indicate that an Office medical adviser should review the medical evidence and provide an opinion as to the degree of permanent impairment based on the findings of the examining physician.[3]

In this case, Dr. Smith calculated appellant's permanent impairment by attempting to use three different tables: Table 17-33,[4] which provides diagnosis-based estimates of impairment to the lower extremities, Table 17-31,[5] a table providing impairments for arthritis based on cartilage intervals, and Table 17-6,[6] for impairments due to unilateral leg muscle atrophy. Dr. Smith had opined that under Table 17-33 appellant had a two percent lower extremity impairment for a partial or lateral meniscectomy. The Office medical adviser found a greater impairment under Table 17-33, opining that appellant had a 10 percent impairment to the right leg based on a partial medial and lateral meniscectomy.

Both Dr. Smith and the Office medical adviser concluded that appellant had a seven percent impairment to the right lower extremity under Table 17-31 for arthritis. Dr. Smith had noted that radiographs revealed minimal medical compartment narrowing on the right, and under Table 17-31 a cartilage interval reduction of one millimeter from the normal four millimeters is a seven percent lower extremity impairment.

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[1] 5 U.S.C. § 8107. This section enumerates specific members or functions of the body for which a schedule award is payable and the maximum number of weeks of compensation to be paid; additional members of the body are found at 20 C.F.R. § 10.404(a).

[2] *A. George Lampo*, 45 ECAB 441 (1994).

[3] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

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

[5] *Id.* at 544, Table 17-31.

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

Dr. Smith found that appellant had a 13 percent impairment to the right lower extremity due to muscle atrophy under Table 17-6. The combining of different methods of assessing permanent impairment must be made in light of the principles of assessment set forth in the A.M.A., *Guides*, and in particular the cross-usage chart at Table 17-2.[7] This chart recognizes that certain methods of assessment cannot be combined because the methods are not mutually exclusive. Table 17-2 clearly indicates that an impairment for muscle atrophy cannot be combined with either an arthritis impairment or a diagnosis-based impairment. The only combination permitted among the three evaluation methods identified in this case are the diagnosis-based estimate and the arthritis impairment. In other words, the 10 percent impairment under Table 17-33 may be combined with the arthritis impairment of 7 percent under Table 17-31, but no other combination is permitted under the cross-usage chart.[8]

Using the Combined Values Chart, the 10 percent and the 7 percent combine for a 16 percent permanent impairment to the right lower extremity.[9] The Board finds that the Office medical adviser appropriately applied the relevant tables, while Dr. Smith did not consider the cross-usage chart. Accordingly, the probative medical evidence of record does not establish more than a 16 percent permanent impairment to the lower extremity in this case.

CONCLUSION

The Board finds that the Office properly concluded that the weight of the medical evidence regarding the degree of permanent impairment to the right leg was represented by the Office medical adviser's report. The medical evidence does not establish more than a 16 percent permanent impairment to the right leg.

[7] *Id.* at 526, Table 17-2. There are 13 methods that can be used to assess the lower extremities, including anatomic methods such as muscle atrophy, arthritis and peripheral nerve injuries, functional methods such as range of motion, and diagnosis based methods. *See id.* at 525.

[8] The Board notes that Dr. Smith reported 5 to 130 degrees of right knee range of motion. Under Table 17-10, page 537, flexion contracture of 5 degrees would be a 10 percent lower extremity impairment; however, range of motion impairments cannot be combined with muscle atrophy, arthritis or diagnosis-based methods. Therefore, even if a range of motion impairment were to be considered based on Dr. Smith's findings, it would not result in greater than a 16 percent leg impairment in this case.

[9] A.M.A., *Guides* at 604, Combined Values Chart.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 24, 2004 is affirmed.

Issued: March 25, 2005
Washington, DC

Alec J. Koromilas
Chairman

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member