United States Department of Labor
Employees' Compensation Appeals Board

TIMOTHY J. TUCCIARONE, Appellant	)	
and	)	**Docket No. 06-1005**
	)	**Issued: July 14, 2006**
DEPARTMENT OF HOMELAND SECURITY, BUREAU OF CUSTOMS & IMMIGRATION, Chula Vista, CA, Employer	)	

Appearances:
Timothy J. Tucciarone, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On March 30, 2006 appellant filed a timely appeal from the February 22, 2006 merit decision of the Office of Workers' Compensation Programs which granted a schedule award for permanent impairment. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the schedule award.

ISSUE

The issue is whether appellant has more than a two percent impairment of his right lower extremity.

FACTUAL HISTORY

On December 13, 2002 appellant, a 32-year-old border patrol agent (trainee), sustained an injury in the performance of duty during physical training exercises at the Border Patrol Academy in Charleston, South Carolina. The Office accepted his claim for a torn anterior cruciate ligament (ACL) in his right knee and authorized surgery.

On February 20, 2003 appellant underwent ACL reconstruction and a partial medial meniscectomy. On December 18, 2003 Dr. Michael P. Kimball, his orthopedic surgeon, reported that appellant was permanent and stationary:

> "On exam[ination] [appellant] has healed portal sites and incision sites. There is no redness, warmth, erythrema or effusion. There is no patellar femoral crepitation. [Appellant's] range of motion is 0 [to] 135 degrees, which is normal. He has no joint line tenderness either medially or laterally. [Appellant] has a negative Lachman. No posterior sag. He has a negative pivot shift. There is no varus or valgus instability at 0 [to] 30 degrees of knee motion. Thigh circumferences are 20 inches on the right and 19¾ inches of the left. [Appellant's] calf circumferences are equal at to 16 inches bilaterally."

Dr. Kimball released appellant from further active care.

On May 9, 2005 Dr. Kimball rated appellant's permanent impairment:

> "As you will recall, this patient had an ACL tear with reconstruction and also a partial medial meniscectomy. Presently, he has no ACL instability and 0 to] 135 degrees of motion, which is normal, along with 0 [to] 30 degrees of varus and valgus, again for no instability. This means [appellant] has no whole person impairment for range of motion. As he had a partial medial meniscectomy from Table 17-33, page 546, he would have a one percent whole person impairment for this surgical procedure having been performed. Manual muscle testing showed [appellant] to have 5/5 in all lower extremity muscle groups with active movement against gravity with full resistance, from Table 17-7, page 531. He has no atrophy from Table 17-6, page 530, to his right thigh or calf. As such, it is my medical opinion that the only whole person impairment would be one percent for the surgical procedure as previously mentioned."

On May 26, 2005 appellant filed a claim for a schedule award.

The Office referred appellant, together with the medical record and a statement of accepted facts, to Dr. Thomas J. Sabourin, a Board-certified orthopedic surgeon, for a second opinion. He examined appellant on January 9, 2006. Dr. Sabourin recorded flexion of the right knee from 0 to 130 degrees and extension to minus 5 degrees. All other findings were normal. The only residual of the injury, Dr. Sabourin explained, was loss of motion: "The claimant has a slight decrease in range of motion in both flexion and extension when measured by myself using goniometer."

On February 2, 2006 Dr. Arthur S. Harris, an Office orthopedic consultant, reviewed appellant's file and reported a two percent impairment of the right lower extremity due to a partial medial meniscectomy. He explained that appellant had no residual instability from his ACL reconstruction and, therefore, had no additional impairment. Dr. Harris added that the date of maximum medical improvement was December 18, 2003, the date his treating physician, Dr. Kimball, reported a permanent and stationary status.

In a decision dated February 22, 2006, the Office issued a schedule award for a two percent impairment of appellant's right lower extremity.

On appeal, appellant questions whether he should receive compensation for loss of range of motion and pain. He also requests an explanation of the period of the schedule award.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[1] authorizes the payment of schedule awards for the loss or loss of use, of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[2]

ANALYSIS

Under Table 17-33, page 546, of the A.M.A., *Guides*, a partial meniscectomy, either medial or lateral, represents a two percent impairment of the lower extremity. This is what the Office awarded. Additional compensation could be awarded under this table for cruciate laxity, but both Dr. Kimball, the attending physician and Dr. Sabourin, the Office referral physician, found no ACL instability on examination. So no further compensation may be awarded for a diagnosis-based estimate of impairment under Table 17-33.

In addition to diagnosis-based estimates, impairment ratings may be assigned on the basis of findings on physical examination. Thus, lower extremity impairment can be evaluated by assessing the range of motion of its joints, recognizing that pain and motivation may affect the measurements.[3]

Dr. Sabourin recorded flexion of the right knee from 0 to 130 degrees and extension to minus 5 degrees. He stated: "The claimant has a slight decrease in range of motion in both flexion and extension when measured by myself using goniometer." Under Table 17-10, page 537, of the A.M.A., *Guides*, knee flexion of 110 degrees or more represents no impairment of the lower extremity. The slight decrease in flexion reported by Dr. Sabourin, therefore, entitles appellant to no compensation. Flexion contracture of 5 degrees, however, represents a mild impairment of the lower extremity, to which Table 17-10 assigns an impairment estimate of 10 percent. Contracture is a permanent shortening, as of a muscle or tendon, producing a loss of motion, deformity or distortion.[4] If appellant's surgery has left him without full extension, if he can extend his lower leg only to within 5 degrees of neutral because of a permanent shortening of

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001 the Office began using the A.M.A., *Guides* (5th ed. 2001). FECA Bulletin No. 01-05 (issued January 29, 2001).

[3] A.M.A., *Guides* 533.

[4] *Id*. at 600.

his reconstructed ACL, he may have a 10 percent impairment of his right lower extremity based on examination criteria.

Table 17-2, page 526, of the A.M.A., *Guides* offers a guide to the appropriate combination of evaluation methods. The Cross-Usage Chart indicates that diagnosis-based estimates and range of motion estimates should not be combined. The A.M.A., *Guides* states the following:

> "It is the responsibility of the evaluating physician to explain in writing 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.
>
> "Typically, one method will adequately characterize the impairment and its impact on the ability to perform ADL [activities of daily living]. In some cases, however, more than one method needs to be used to accurately assess all features of the impairment. When more than one rating method is used, the individual ratings are combined using the Combined Values Chart (page 604).
>
> "Avoid combining methods that rate the same condition. Selecting the optimal approach or combining several methods requires judgment and experience. A careful examination and review of supporting material is essential to produce accurate and consistent results. If more than one method can be used, the method that provides the higher rating should be adopted."[5]

Because appellant may have a higher impairment rating using examination criteria than the two percent diagnostic estimate he received for a partial meniscectomy, the Board will set aside the Office's February 22, 2006 schedule award decision and remand the case for further development. The Office should ask Dr. Harris, the consulting orthopedic surgeon, to clarify whether extension to minus 5 degrees represents a 10 percent impairment of the lower extremity due to flexion contracture and if so whether the higher rating from examination criteria should be adopted in appellant's case. After such further development of the evidence as may be necessary, the Office shall issue an appropriate final decision on appellant's claim for a schedule award.

As for appellant's question about the period of the schedule award, section 8107 of the Act authorizes the payment of 288 weeks' compensation for the total loss of a leg, as with amputation at the hip.[6] Partial losses are compensated proportionately.[7] So a two percent

[5] *Id*. at 526-27; *see id*. at 548: "The evaluating physician must determine whether diagnostic or examination criteria better describe the impairment of a specific individual. The evaluator should, in general, use only one approach for each anatomic part. There are, however, a few instances in which elements from both diagnostic and examination approaches will apply to a specific situation (see [Table] 17-2)."

[6] 5 U.S.C. § 8107(c)(2). The Act does not authorize compensation for impairments to the "whole person."

[7] *Id*. § 8107(c)(19).

impairment of his right lower extremity would entitle him to two percent of 288 weeks' compensation or 5.76 weeks' compensation. The period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the injury. Maximum medical improvement means that the physical condition of the injured member of the body has stabilized and will not improve further. The question of when the employee reaches maximum medical improvement is a factual one that depends upon the medical findings in the record. The determination of such date is to be made in each case upon the basis of the medical evidence in that case.[8] The attending physician, Dr. Kimball, reported on December 18, 2003 that appellant was permanent and stationary; he released him on that date from further active care. Dr. Harris reviewed the record for the Office and determined that December 18, 2003 was thus, the date of maximum medical improvement. The period of appellant's schedule award -- the number of weeks of compensation to which he is entitled for impairment of his right lower extremity -- therefore begins on December 18, 2003.[9]

CONCLUSION

The Board finds that this case is not in posture for decision. Further development of the medical evidence is warranted. The report of the Office referral physician indicates that appellant may have more than a two percent impairment of his right lower extremity based on examination criteria.

[8] *See generally Marie J. Born*, 27 ECAB 623 (1976), *reaff'd* 28 ECAB 89 (1976).

[9] A subsequent date may be chosen to start the award, however, if the date of maximum medical improvement falls within a period of compensable disability such that converting disability payments into a schedule award would be disadvantageous to the claimant. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.0808.7.a(1) (November 1998).

ORDER

IT IS HEREBY ORDERED THAT the February 22, 2006 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: July 14, 2006
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board