United States Department of Labor
Employees' Compensation Appeals Board

PARISH T. SIM'KEN, Appellant	)	
and	)	**Docket No. 04-2258**
	)	**Issued: March 17, 2006**
DEPARTMENT OF THE NAVY, NORFOLK NAVAL SHIPYARD, Portsmouth, VA, Employer	)	

Appearances:
Parish T. Sim'Ken, 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 September 15, 2004 appellant filed a timely appeal from the June 10, 2004 merit decision of the Office of Workers' Compensation Programs, granting him a schedule award for 20 percent permanent impairment of the left lower extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this schedule award case.

ISSUE

The issue is whether appellant has established that he has more than a 20 percent impairment for which he received a schedule award.

FACTUAL HISTORY

This is the second appeal in this case. In a February 25, 2000 decision, the Board affirmed the Office's February 21 and December 4, 1996 decisions which found that appellant

did not have more than a 17 percent permanent impairment of the left lower extremity.[1] The Board accorded special weight to the November 8, 1996 report of Dr. Bernard A. Lublin, a Board-certified orthopedic surgeon and impartial medical specialist, who found that appellant did not have any additional impairment of the left lower extremity. The facts of the case, as set forth in the Board's decision, are incorporated herein by reference.[2]

On June 27, 2003 appellant filed a claim (Form CA-7) for an additional schedule award for his left lower extremity. By letter dated July 10, 2003, the Office requested that Dr. Sidney S. Loxley, an attending Board-certified orthopedic surgeon, provide an impairment rating based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*).

In a July 30, 2003 medical report, Dr. Loxley reviewed the history of appellant's employment-related left knee injury, which included arthroscopic surgery with severe chondromalacia and a torn medial meniscus. He stated that a magnetic resonance imaging scan showed a popliteal cyst and laxity of the lateral collateral ligaments which were caused by the accepted work injury. Dr. Loxley reported constant, moderate pain. He diagnosed complex regional pain and found that it constituted a 10 percent impairment of the left lower extremity. Dr. Loxley reported flexion of 45 degrees, extension of negative 10 degrees, varus of 10 degrees laxity and valgus of 0 degrees. He stated that ankylosis was not applicable. Dr. Loxley opined that appellant had severe chondromalacia. Utilizing the A.M.A., *Guides* 537, 540, Tables 17-10, 17-20 and 17-23, he found that 45 degrees of flexion and negative 10 degrees of extension constituted a 20 percent impairment, appellant's meniscectomy constituted a 2 percent impairment as a diagnosis-based estimate and chondromalacia constituted a 7 percent impairment, totaling a 28 percent impairment of the left lower extremity.[3] Dr. Loxley also found that appellant had a 17 percent impairment for mild gait derangement based on the A.M.A., *Guides* 529, Table 17-5. He calculated a 55 percent impairment of the left knee by combining the 28 percent impairment due to loss of range of motion and a meniscectomy, the 17 percent impairment for gait derangement and the 10 percent impairment for complex regional pain. Dr. Loxley concluded that appellant reached maximum medical improvement on June 19, 2000.

[1] Appellant also received a schedule award for permanent impairment of the right lower extremity. In a decision dated October 25, 1989, the Office granted him a schedule award for a 35 percent permanent impairment of the right lower extremity for the period August 28, 1989 through August 31, 1991. On April 29, 1993 the Office granted appellant an additional schedule award for a 7 percent permanent impairment of the right lower extremity, totaling a 42 percent impairment of the right lower extremity for the period April 8 through August 27, 1993. By decision dated June 6, 2003, the Office granted him an additional schedule award for a 38 percent impairment of the right lower extremity, totaling an 80 percent impairment of the right lower extremity for the period June 19, 2000 through July 25, 2002.

[2] Docket No. 97-1238 (issued February 25, 2000). Appellant, a 33-year-old truck driver, filed a traumatic injury claim alleging that on May 13, 1986 he hurt his right knee when he stepped into a hole. The Office accepted his claim for right knee sprain, right knee post-traumatic chondromalacia and permanent residuals, consequential left knee pain secondary to the May 13, 1986 employment injury and lateral patellar stabilizing knee sleeves for both knees.

[3] The Board notes that the calculation of Dr. Loxley's impairment ratings totaled 29 percent impairment rather than 28 percent impairment of the left lower extremity.

On October 6, 2003 an Office medical adviser reviewed Dr. Loxley's July 30, 2003 report. He found that appellant's severe chondromalacia with a one millimeter interval constituted a 10 percent impairment based on the A.M.A., *Guides* 544, Table 17-31. The Office medical adviser further found that appellant's partial medial meniscectomy was a two percent impairment based on the A.M.A., *Guides* 546, Table 17-33, his mild lateral collateral ligament laxity constituted a seven percent permanent impairment according to the A.M.A., *Guides* 546, Table 17-33 and his reflex sympathetic dystrophy or complex regional pain syndrome merited a five percent permanent impairment according to the A.M.A., *Guides* 575-90. Utilizing the A.M.A., *Guides* 537, Table 17-10, the Office medical adviser determined that flexion of 45 degrees constituted a 35 percent permanent impairment and extension of minus 10 degrees constituted a 20 percent permanent impairment. Based on the Combined Values Chart of the A.M.A., *Guides*, the Office medical adviser concluded that appellant had a 59 percent permanent impairment of the left lower extremity. He further concluded that appellant reached maximum medical improvement on July 30, 2003, the date of Dr. Loxley's medical evaluation.

The Office set up payment for an additional schedule award for a 42 percent impairment of the left lower extremity, based on the 59 percent impairment calculated by the Office medical adviser less the 17 percent impairment previously awarded. However, the Office subsequently deleted this payment, finding that appellant was not entitled to an additional schedule award based on the Board's February 15, 2000 decision. The Office determined that further development of the medical evidence was appropriate.

By letter dated January 21, 2004, the Office referred appellant, together with the case record and a statement of accepted facts, to Dr. Edward W. Gold, a Board-certified orthopedic surgeon, for a second opinion medical examination.

In a February 9, 2004 report, Dr. Gold reviewed the history of appellant's employment-related right and left knee injuries and medical treatment. Examination of the left knee revealed flexion of 5 to 60 degrees, no soft tissue swelling or effusion, no tenderness at the patella and tenderness at the medial retinaculum and popliteal area. Dr. Gold stated that there was no laxity or pain due to varus or valgus stress to both knees and the Lachman's test was negative. There was no hyperextension at the knees and sensation, motor function, pedal pulses and circulation were normal. An x-ray examination of both knees demonstrated some irregularities on the undersurface of the patella on the right knee. Dr. Gold stated that otherwise, there was no joint space narrowing or any significant degenerative change evident in either knee. He diagnosed chronic patellafemoral pain/chondromalacia of the right knee, status post arthroscopic surgery of the right knee and chronic pain in the left knee. Dr. Gold stated that appellant continued to experience problems with his right knee and that he did not respond well to treatment, including surgery. He also stated that appellant had developed discomfort in his left knee. In response to questions posed by the Office, Dr. Gold stated that there was no peripheral nerve damage. He noted that his range of motion findings were as described and stated that there was no varus or valgus deformity. Dr. Gold related that there was no evidence of post-traumatic arthritis in either knee. Based on the A.M.A., *Guides* 537, Table 17-10, he found that appellant had a 25 percent impairment of each knee. Dr. Gold concluded that appellant reached maximum medical improvement on December 5, 2000, the date of his last disability assessment.

On March 18, 2004 a second Office medical adviser reviewed Dr. Gold's report. He noted Dr. Gold's finding that flexion was from 5 to 60 degrees and stated that there was no other basis for an impairment rating. The Office medical adviser further stated that Dr. Gold's 25 percent impairment rating was clearly inconsistent with the A.M.A., *Guides* 537, Table 17-10. Utilizing this table, the Office medical adviser found that appellant had a 20 percent impairment of the left lower extremity. He concluded that appellant reached maximum medical improvement on February 9, 2004, the date of Dr. Gold's evaluation.

By decision dated June 10, 2004, the Office granted appellant an additional schedule award for 3 percent impairment of the left lower extremity for a total award of 20 percent permanent impairment.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[4] and its implementing regulation[5] sets forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[6] However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[7]

The A.M.A., *Guides*, Chapter 17, provides multiple grading schemes and procedures for determining the impairment of a lower extremity due to gait derangement,[8] muscle atrophy,[9] muscle weakness,[10] arthritis,[11] nerve deficits[12] and other specific pathologies. The A.M.A., *Guides* also provides impairment ratings of the lower extremities for diagnosis-based estimates, including specific disorders of the knee, such as a torn meniscus or meniscectomy.[13]

---

[4] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[5] 20 C.F.R. § 10.404 (1999).

[6] 5 U.S.C. § 8107(c)(19).

[7] 20 C.F.R. § 10.404 (1999); *see also Joseph Lawrence, Jr.*, 53 ECAB 331 (2002); *Tommy R. Martin*, 56 ECAB ___ (Docket No. 03-1491, issued January 21, 2005).

[8] A.M.A., *Guides* 529, Table 17-5.

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

[10] *Id.* at 532, Table 17-8.

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

[12] *Id.* at 552, Table 17-37.

[13] *Id.* at 545-48, Table 17-33.

FECA Bulletin No. 01-05 provides that in making an impairment rating for the lower extremities, different evaluation methods cannot be used in combination.[14] Before finalizing any physical impairment calculation, the Office medical adviser is to verify the appropriateness of the combination of evaluation methods with that listed in Table 17-2, the cross-usage chart.[15] The FECA Bulletin No. 01-05 also provides that "the preferred method for determining impairment secondary to all complex regional pain syndromes is that described on pages 495-497 [of the A.M.A., *Guides*]."

ANALYSIS

The Board's February 25, 2000 decision found that appellant did not have more than a 17 percent impairment of the left lower extremity. The Office subsequently referred appellant to Dr. Gold for a second opinion medical examination. Under 5 U.S.C. § 8123 the Office has authority to order examination of an injured employee as frequently and at the times and places as may be reasonably required.[16] As the Office has the authority to refer appellant to Dr. Gold for another second opinion medical examination under its procedures, the Board finds that the referral was proper.

In a February 9, 2004 medical report, Dr. Gold provided his findings on physical and x-ray examination which provided, among other things, flexion of 5 to 60 degrees and no varus or valgus deformity. The Board notes that he did not provide any extension measurements. Dr. Gold diagnosed chronic patellofemoral pain/chondromalacia of the right knee, status post arthroscopic surgery of the right knee and chronic pain in the left knee. Utilizing the A.M.A., *Guides* 537, Table 17-10, he determined that appellant has a 25 percent impairment of the left knee which constitutes a severe impairment. In accordance with this table, flexion less than 60 degrees represents an impairment of up to 35 percent of the lower extremity. The Board finds that Dr. Gold properly utilized the tables in the A.M.A., *Guides* in determining appellant's impairment of the left lower extremity as he found flexion of 5 to 60 degrees.

A second Office medical adviser reviewed Dr. Gold's report and noted that the range of motion finding of 5 to 60 degrees of flexion was the only basis for his 25 percent impairment estimate and stated that it was inconsistent with the A.M.A., *Guides* 537, Table 17-10. Based on this table, the Office medical adviser determined that appellant had a 20 percent impairment of the left lower extremity, which constitutes a moderate impairment. In accordance with this table, flexion greater than 60 degrees but less than 80 degrees represents a 20 percent impairment of the lower extremity. As appellant has 5 to 60 degrees of flexion, the Office medical adviser's impairment rating is not supported by the A.M.A., *Guides*.

Similarly, Dr. Loxley's finding that appellant has a 55 percent impairment of the left lower extremity and the initial Office medical adviser's finding that appellant has a 59 percent

[14] See FECA Bulletin No. 01-05 (issued January 29, 2001).

[15] *Id.*

[16] *See* 5 U.S.C. § 8123(a); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Second Opinion Examinations*, Chapter 3.500.3 (March 1994).

impairment of the left lower extremity are not supported by the A.M.A., *Guides*. Dr. Loxley found a combined 28 percent impairment due to loss of range of motion, a meniscectomy which is a diagnosis-based estimate and chondromalacia, with 17 percent impairment due to gait derangement and the 10 percent impairment due to complex regional pain. Table 17-2 of the A.M.A., *Guides*, the cross-usage chart, precludes combining range of motion, chondromalacia and gait derangement in assessing impairment.[17] Further, it is not clear how Dr. Loxely rated appellant's complex regional pain which should be calculated in accordance with FECA Bulletin No. 01-05.[18]

In finding that appellant had a 59 percent impairment of the left lower extremity, the first Office medical adviser also combined impairment ratings precluded by Table 17-2 of the A.M.A., *Guides*. As noted above, the 10 percent impairment rating for chondromalacia cannot be combined with the 35 and 20 percent impairments due to loss of range of motion and the 2 percent impairment for appellant's meniscectomy.

CONCLUSION

The Board finds that appellant has a 25 percent permanent impairment of the left lower extremity, based on the report of Dr. Gold.

[17] A.M.A., *Guides* 526, Table 17-2.

[18] *See supra* note 14.

ORDER

IT IS HEREBY ORDERED THAT the June 10, 2004 decision of the Office of Workers' Compensation Programs is affirmed as modified.

Issued: March 17, 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