United States Department of Labor
Employees' Compensation Appeals Board

B.W., Appellant	)	
and	)	**Docket No. 06-1045**
	)	**Issued: November 17, 2006**
DEPARTMENT OF DEFENSE, DEFENSE FINANCING & ACCOUNTING SERVICE, Fort Belvoir, VA, Employer	)	

Appearances:
Appellant, 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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 31, 2006 appellant filed a timely appeal from a December 28, 2005 merit decision of the Office of Workers' Compensation Programs granting him a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant has more than a 22 percent impairment of the right lower extremity for which he received a schedule award.

FACTUAL HISTORY

On November 22, 2000 appellant, then a 51-year-old chief information officer, filed a claim for a traumatic injury occurring on that date when he slipped and fell on ice twisting his right knee. He stopped work on November 22, 2000 and returned to work on

November 28, 2000. The Office accepted appellant's claim for low back strain, a right knee contusion and a right medial meniscus tear.[1]

On January 14, 2004 Dr. Wylie D. Lowery, Jr., a Board-certified orthopedic surgeon, performed an arthroscopy of appellant's right knee with arthroscopic chondroplasty of the patellofemoral joint and medial femoral condyle. In the operative report, he provided:

> "[Appellant] had an intact medial and lateral meniscus. The articular cartilage showed [a] [G]rade 4 lesion involving the medial facet of the patella, [G]rade 3 and 4 involving the femoral groove and [G]rade 3 involving the medial femoral condyle. It was consistent with a direct blow since the rest of the articular cartilage was within normal limits, [G]rade 0 and 1 involving the lateral femoral condyle and medial and lateral tibial pateau."

In a report dated January 11, 2005, Dr. Lowery found that appellant had reached maximum medical improvement subsequent to his surgery. He opined that any impairment determination should be "based on the known chondral lesion" which Dr. Lowery attributed to appellant's work injury.

By letter dated April 29, 2005, the Office requested that Dr. Lowery evaluate the extent of appellant's impairment of the right knee in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*).

In a report dated May 17, 2005, Dr. Lowery related:

> "[Appellant] is having continued difficulty with squatting, kneeling, stooping, climbing, prolonged standing and walking, which is consistent with his known cartilage injuries. His mid calf and mid thigh circumferences are symmetric at 45 and 57 respectively. There is no evidence of any ankylosis and no sensory changes are noted. [Appellant] has a mild effusion today. He has full extension, [and] flexion to 130 degrees."

Dr. Lowery further stated:

> "In reviewing [appellant's] x-rays of the patellofemoral joint from January 11, 2005, on the medial side he has some bone spurs and findings consistent with decreased cartilaginous interval of two millimeter. This is a whole person impairment of 8 percent [and a] lower extremity impairment of 20 percent. In addition he does have an antalgic gain for an additional seven percent whole person impairment."

[1] By decision dated February 19, 2002, the Office found that appellant had not established a recurrence of disability in August 2001. In a decision dated September 24, 2003, an Office hearing representative set aside the February 19, 2002 decision and remanded the case for his referral for a second opinion examination. On December 11, 2003 the Office expanded its acceptance of the claim to include a right medial meniscus tear. In a decision dated September 17, 2004, it denied appellant's claim for compensation from January 11 to February 7, 2004.

Dr. Lowery concluded that appellant had an 11 percent whole person impairment or a 30 percent lower extremity impairment. He indicated that he based his determination on Tables 17-5 and 17-31 of the A.M.A., *Guides*.

An Office medical adviser reviewed the medical evidence on August 26, 2005. He noted that the January 14, 2004 operative report revealed no medial meniscal tear and that the procedure performed was "an arthroscopic chondroplasty of the patellofemoral joint and the medial femoral condyle." The Office medical adviser opined that the A.M.A., *Guides* did not provide a rating for a chondroplasty. He noted that Dr. Lowery's May 17, 2005 impairment rating was for arthritis which was not an accepted condition. The Office medical adviser further indicated that an impairment for an antalgic gait was "a stand alone whole person impairment rating" which was not accepted by the Office.

On October 12, 2005 the Office referred appellant to Dr. Kevin F. Hanley, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a report dated October 27, 2005, he discussed his history of injury and treatment, including a partial medial meniscectomy and chondroplasty on January 14, 2004. On physical examination, Dr. Hanley listed findings of mild knee crepitus with motion, mild loss of motion, tenderness along the medial joint and a small effusion. He diagnosed degenerative arthritis of the right knee which Dr. Hanley found aggravated by appellant's employment injury in 2000. Dr. Hanley opined that appellant had a 20 percent impairment of the lower extremity due to his loss of 2 millimeter of cartilage interval according to Table 17-31 on pages 544. He further found that he had an additional 2 percent impairment due to his partial medial meniscectomy according to Table 17-33 on page 546, for a total impairment of 22 percent. Dr. Hanley noted that the impairment due to appellant's gait disorder could not be combined with any other ratings.

An Office medical adviser reviewed Dr. Hanley's report on December 8, 2005 and concurred with his findings. He opined that appellant had a 20 percent impairment of the right lower extremity due to a loss of 2 millimeter of cartilage interval[2] and an additional 2 percent impairment for his partial medial meniscectomy.[3] The Office medical adviser combined these impairment determinations to find a 22 percent impairment of the right lower extremity. He concluded that the date of maximum medical improvement was October 27, 2005.

By decision dated December 28, 2005, the Office granted appellant a schedule award for a 22 percent impairment of the right lower extremity. The period of the award ran for 53.26 weeks from October 27, 2005 to January 13, 2007.[4]

[2] A.M.A., *Guides* 544, Table 17-31.

[3] *Id*. at 546, Table 17-33.

[4] The amount of compensation for total loss of use, of the lower extremity is 288 weeks. *See* 5 U.S.C. § 8107. Appellant is entitled to 63.26 weeks of compensation for a 22 percent impairment of the lower extremity. The Office's indication that he is entitled to 53.26 weeks appears to be a typographical error as the period of the award properly runs for 63.26 weeks.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,[5] and its implementing federal regulation,[6] sets 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 for all claimants, the Office has adopted the A.M.A., *Guides* (5th ed. 2001) as the uniform standard applicable to all claimants.[7] Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001.[8]

Chapter 17 of the A.M.A., *Guides*[9] provides multiple grading schemes and procedure for determining the impairment of a lower extremity due to gait derangement,[10] muscle atrophy,[11] muscle weakness,[12] arthritis,[13] nerve deficits[14] and other specific pathologies.

ANALYSIS

The Office accepted appellant's claim for low back strain, a right knee contusion and a right medial meniscus tear. He underwent an arthroscopic chondroplasty of the patellofemoral joint and medial femoral condyle on January 14, 2004. Dr. Lowery indicated in his operative report that appellant's lateral and medial meniscus were intact, but that the articular cartilage had lesions of the medial facet of the patella, the femoral groove and the medial femoral condyle "consistent with a direct blow…." In a report dated January 11, 2005, he asserted that appellant had reached maximum medical improvement and opined that an impairment determination should be based on his chondral lesion, which resulted from his employment injury. At the request of the Office, Dr. Lowery provided an impairment evaluation on May 17, 2005. He noted appellant's continued problems with extended walking and standing. Dr. Lowery found no ankylosis or sensory changes, full extension and flexion to 130 degrees. He indicated that x-rays obtained on January 11, 2005 of the patellofemoral joint on the medial side of the right knee showed a loss of 2 millimeter of cartilaginous interval which constituted a 20 percent lower

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] 20 C.F.R. § 10.404(a).

[8] *See* FECA Bulletin No. 01-5, issued January 29, 2001.

[9] A.M.A., *Guides* 523-61, Chapter 17, The Lower Extremities.

[10] *Id*. at 529, Table 17-5.

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

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

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

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

extremity impairment or 8 percent whole person impairment. Dr. Lowery further added an additional seven percent whole person impairment for gait derangement. The Act, however, does not provide for impairment for the whole person.[15] Additionally, the A.M.A., *Guides* precludes the use of gait derangement to calculate an impairment if a more specific method is available to assess the impairment.[16] Further, the A.M.A., *Guides* indicate that the impairment percentages of Table 17-5 for gait derangement "stand alone and are not combined with any other impairment evaluation method."[17]

An Office medical adviser reviewed Dr. Lowery's report and noted that he provided an impairment rating for loss of cartilage interval or arthritis, but that arthritis was not an accepted condition. He further noted that gait abnormalities were based on whole person impairments which were not recognized by the Act.

The Office referred appellant to Dr. Hanley for a second opinion evaluation. In a report dated October 27, 2005, Dr. Hanley noted that appellant had undergone a partial medial meniscectomy and chondroplasty on January 14, 2004. He diagnosed degenerative arthritis which he found was aggravated by appellant's employment injury. On examination, Dr. Hanley found mild knee crepitus and loss of range of motion, tenderness of the medial joint and mild effusion. He opined that appellant had a 20 percent impairment of the lower extremity due to his loss of 2 millimeter of cartilage interval according to Table 17-31 on pages 544 and an additional 2 percent impairment due to his partial medial meniscectomy according to Table 17-33 on page 548, which he combined to find a total right lower extremity impairment of 22 percent. Dr. Hanley advised that he could not combine an impairment due to gait derangement with his other ratings.

An Office medical adviser reviewed Dr. Hanley's report on December 8, 2005 and concurred with his conclusions. The Office medical adviser properly determined that an x-ray finding of a 2 millimeter loss of cartilage interval constituted a 20 percent lower extremity impairment.[18] He further found that appellant had a two percent impairment due to a partial medial meniscectomy. The Board notes, however, that the January 14, 2004 operative report from Dr. Lowery found that the medial and lateral meniscus were intact and the report does not indicate that a meniscectomy was performed. Appellant is thus, not entitled to an additional award for a partial medial meniscectomy. Consequently, he has not established that he has more than a 22 percent impairment of the right lower extremity for which he received a schedule award.

On appeal, appellant argues that he is entitled to a greater schedule award. As discussed, however, the evidence shows that he has no more than a 22 percent right lower extremity impairment. Appellant also argued that his back condition was not considered by the Office.

[15] *Robert Romano*, 53 ECAB 649 (2002).

[16] A.M.A., *Guides* 529.

[17] *Id*.

[18] *Id*. at 544, Table 17-31. It appears, based on the Office's issuance of the schedule award that it accepted that appellant sustained an aggravation of degenerative arthritis due to his employment injury.

The Act, however, specifically excludes the back as an organ and, therefore, the back does not come under the provisions for payment of a schedule award.[19]

CONCLUSION

The Board finds that appellant has no more than a 22 percent impairment of the right lower extremity for which he received a schedule award.[20]

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated December 28, 2005 is affirmed.

Issued: November 17, 2006
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

[19] *Francesco C. Veneziani*, 48 ECAB 572 (1997). A schedule award is payable for a permanent impairment of the extremities that is due to a work-related back condition; *see Denise D. Cason*, 48 ECAB 530 (1997).

[20] Appellant submitted new evidence with his appeal to the Board; however, the Board's jurisdiction is limited to a review of the evidence that was in the case record before the Office at the time of its final decision. *See* 20 C.F.R. § 501.2(c).