United States Department of Labor
Employees' Compensation Appeals Board

J.M., Appellant	)	
	)	**Docket No. 07-928**
and	)	**Issued: August 8, 2007**
	)	
DEPARTMENT OF THE ARMY, NATIONAL GUARD, Fort Irvin, CA, 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 February 21, 2007 appellant filed a timely appeal from a January 26, 2007 decision of the Office of Workers' Compensation Programs adjudicating his schedule award claim. 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 two percent permanent impairment of his right lower extremity.

FACTUAL HISTORY

On December 14, 2004 appellant, then a 46-year-old materials handler, filed a traumatic injury claim alleging that on December 13, 2004 he twisted his right knee while using a treadmill during physical training. The Office accepted his claim for a right knee strain. On

May 23, 2005 appellant underwent right knee arthroscopy with synovectomy.[1] He was released to full-duty work on November 4, 2005. On September 14, 2006 appellant filed a claim for a schedule award.

On November 15, 2006 the Office referred appellant to Dr. Rajeswari Kumar, a Board-certified physiatrist, for an examination and impairment rating of his right lower extremity. On December 19, 2006 Dr. Kumar provided a history of appellant's condition and findings on physical examination. She diagnosed osteoarthritis of the right knee. Dr. Kumar stated that the circumference of appellant's right and left thighs was 50 centimeters (cm) as measured, 10 cm above the patella. Appellant's right calf measured 42 cm and his left calf measured 41 cm. Dr. Kumar stated:

> "[Appellant] returned to his regular job in February 2005. Since then he has noticed increased swelling in the right knee and reports that he has been followed by [his] doctor twice a month and he has been receiving medications. [Appellant] denies any further workup. He reports that he was issued a brace, which he wears at work. [Appellant] reports that the pain is throbbing and aggravated with standing, walking 20 to 25 minutes and bending. He reports that getting up after prolonged sitting causes severe pain. [Appellant] notices intermittent swelling of the knee."
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> * * *
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> "[Appellant's] gait is antalgic and he favors the right lower extremity. He is able to walk without any assistive device. [Appellant] could not walk on heels and toes because of the right knee pain.
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> "Examination of the right knee … there is no significant deformity. There is no obvious atrophy of the quadriceps [muscle]. There is no joint effusion noted. [Appellant] complains of pain throughout the range of motion.
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> "[Appellant] has pain on varus and valgus stress, but McMurray and Lachman tests were negative. He has tenderness in the medial and lateral joint line.
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> "[Appellant] has negative drawer sign. Patellar compression test is positive. He has also tenderness in the patellafemoral joint. Quadriceps [muscle] strength is 5/5."
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> "Range of motion: ... [e]xtension: …. 0 [degrees] …. [f]lexion: 120 [degrees]….
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> "[Appellant] had arthroscopic surgery on the right knee on [May 23, 2005]. He had conservative treatment prior to that and he did not improve with the

[1] Synovectomy is the excision of a synovial membrane, as of that [membrane] lining the capsule of the knee joint, performed in treatment of rheumatoid arthritis of the knee or of the synovial sheath of a tendon. *See* DORLAND'S *Illustrated Medical Dictionary* (27th ed. 1988), 1648.

conservative treatment and even after the surgery, [appellant] reports that he had pain relief for a few days and he noted gradually worsening pain. Currently, [appellant's] pain is constant and it is aggravated with prolonged walking, prolonged sitting, kneeling or climbing stairs.[2]

> "On physical exam[ination], [appellant's] gait is antalgic. His range of motion of the right knee is restricted. There is no definite evidence of meniscus involvement, but he has no ligamentous laxity. [Appellant] has tenderness in the medial and lateral joint line and at the patellafemoral joint ….
>
> "At this point, it appears that [appellant] has not received maximum benefit from the treatment. He would benefit by a repeat MRI [magnetic resonance imaging] [scan] and probably will benefit by cortisone injection and/or Synvisc injection. [Appellant] will also benefit by a short course of physical therapy ….
>
> "Functional limitation is due to the limited range of motion of the right knee and medial and lateral joint tenderness. [Appellant] can stand and walk a total of four hours per day and can … occasionally [climb] stairs. He probably needs to change his position frequently if he is sitting for a long time."

Dr. Kumar did not provide an impairment rating.

On January 6, 2007 Dr. Arthur S. Harris, a Board-certified orthopedic surgeon and an Office medical director,[3] found that appellant had a 2 percent impairment of the right lower extremity for Grade 4 pain or sensory deficit (25 percent) that was forgotten with activity, according to Table 16-10 at page 482 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,*[4] multiplied by 7 percent for dysesthesia in the distribution of the femoral nerve, according to Table 17-37 at page 552 (25 percent multiplied by 7 percent equals 1.75 percent, rounded to 2 percent). He indicated that the date of maximum medical improvement (MMI) was December 19, 2006, the date of Dr. Kumar's examination.

[2] Dr. Kumar described the intensity of appellant's pain as "distressing" and indicated that it interfered with daily activity.

[3] *See* Federal (FECA) Procedural Manual, Part 2 -- Claims, *Schedule Award 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).

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

On January 26, 2007 the Office granted appellant a schedule award for 5.76 weeks of compensation[5] from January 4 to February 13, 2007, based on a two percent impairment of the right lower extremity.[6]

LEGAL PRECEDENT

The schedule award provision of the Act[7] and its implementing regulation[8] 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.[9]

The A.M.A., *Guides* provides for three separate methods for calculating the lower extremity permanent impairment of an individual: anatomic, functional and diagnosis based.[10] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[11] The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligament us instability, bursitis and various surgical procedures, including joint replacements and meniscectomy.[12] The functional method is used for conditions when anatomic changes are difficult to categorize or when functional implications have been documented and includes range of motion, gait derangement and muscle strength.[13] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[14] When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of

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[5] The Federal Employees' Compensation Act provides for 288 weeks of compensation for 100 percent loss or loss of use, of a lower extremity. 5 U.S.C. § 8107(c)(2). Multiplying 288 weeks by 2 percent equals 5.76 weeks of compensation.

[6] Subsequent to the January 26, 2007 Office decision, appellant submitted additional evidence. The Board's jurisdiction is limited to the evidence that was before the Office at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c). The Board may not consider this evidence for the first time on appeal.

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id.*

[10] A.M.A., *Guides,* 525.

[11] *Id.*

[12] *Id.*

[13] *Id*. at 525, Table 17-1.

[14] *Id*. at 548, 555.

methods that gives the most clinically accurate impairment rating.[15] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[16]

Although the claimant has the burden of establishing entitlement to compensation, the Office shares responsibility in the development of the evidence.[17]

ANALYSIS

The Board finds that this case is not in posture for a decision. Further development of the medical evidence is necessary to determine whether appellant has more than a two percent impairment of his right lower extremity.

It is well established that the period covered by the schedule award commences on the date that the employee reaches MMI from the residuals of the accepted employment injury.[18] The Board has explained that MMI means that the physical condition of the injured member of the body has stabilized and will not improve further.[19] This determination of whether MMI has been reached is based on the probative medical evidence of record.[20] Dr. Kumar opined that appellant had not reached a point of MMI from his treatment and would benefit from a repeat MRI scan and cortisone or Synvisc injections, followed by physical therapy. Therefore, based on Dr. Kumar's medical opinion, determination of an impairment rating was not appropriate at the time of his examination of appellant on December 19, 2006. The Board notes that Dr. Kumar did not provide an impairment rating in his report. Dr. Harris calculated a two percent impairment of appellant's right lower extremity based on the findings in Dr. Kumar's report. However, even if appellant had reached MMI, the impairment rating of Dr. Harris is not consistent with Dr. Kumar's report.

Dr. Kumar described appellant's right knee pain as constant and severe. She indicated that appellant's pain was aggravated by standing, walking more than 25 minutes, kneeling, climbing stairs, bending and prolonged sitting. Appellant also experienced pain throughout the range of motion testing. This description of his pain is not consistent with a Grade 4 classification from Table 16-10 at page 482 of the A.M.A., *Guides,* as determined by Dr. Harris. Grade 4 is described as "[d]istorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations or pain that is forgotten during activity." Appellant had constant and severe pain, not minimal pain and his pain was aggravated by certain activities, not forgotten during activity. The Board finds that the Grade 4 classification selected by Dr. Harris is not appropriate given the description of appellant's pain in Dr. Kumar's report.

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[15] *Id*. at 526.

[16] *Id*. at 527, 555.

[17] *Willie James Clark*, 39 ECAB 1311 (1988).

[18] *Mark A. Holloway,* 55 ECAB 321 (2004).

[19] *Id.*

[20] *Id.*

Regarding range of motion, there is no impairment for appellant's 0 degrees of extension (flexion contracture) of his right knee or 120 degrees of flexion as measured by Dr. Kumar, according to Table 17-10 at page 536 of the A.M.A., *Guides.* However, Dr. Kumar stated that the range of motion of appellant's right knee was restricted and that he had functional limitation due to his limited range of motion. Impairment due to decreased range of motion can be combined with impairment due to peripheral nerve injury causing motor or sensory deficit according to Table 17-2, the cross-usage chart, at page 526 of the A.M.A., *Guides.* Aside from the measurements for flexion and extension, Dr. Kumar did not provide any other range of motion measurements, such as varus or valgus measurements or internal or external rotation measurements. He did not explain the specific nature of appellant's limited range of motion. Dr. Harris' impairment rating for appellant was incomplete as it did not address appellant's range of motion deficit in his right knee.

Due to these deficiencies, the reports of Dr. Kumar and Dr. Harris are not sufficient to establish appellant's impairment of his right lower extremity. Further development of the medical evidence is necessary.

CONCLUSION

The Board finds that this case is not in posture for a decision. On remand, the Office should refer appellant to an appropriate medical specialist for an examination and evaluation of his right lower extremity impairment, causally related to his December 14, 2004 employment-related right knee strain. The specialist should determine whether appellant has reached MMI. If so, the specialist should provide an opinion of appellant's right lower extremity impairment with correct application of the applicable sections of the A.M.A., *Guides*, fifth edition. After such further development as it deems necessary, the Office should issue an appropriate decision on appellant's schedule award claim.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated January 26, 2007 is set aside and the case is remanded for further development consistent with this decision.

Issued: August 8, 2007
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