United States Department of Labor
Employees' Compensation Appeals Board

L.G., Appellant	)	
	)	**Docket No. 07-90**
and	)	**Issued: May 16, 2007**
	)	
U.S. SENATE, STATE OFFICE, Columbia, SC, Employer	)	

Appearances:
Eric G. Dawson, MD, for the appellant
No appearance, for the Director

Oral Argument May 2, 2007

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 11, 2006 appellant, through her representative, filed a timely appeal from the July 14, 2006 merit decision of the Office of Workers' Compensation Programs, which denied an additional schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the schedule award issue.

ISSUE

The issue is whether appellant has more than a two percent permanent impairment of her right lower extremity, for which she received a schedule award.

FACTUAL HISTORY

On September 8, 1992 appellant, then a 31-year-old senate aide, sustained an injury in the performance of duty: "The stairs apparently had a foreign object on them. Claimant stepped on the foreign object and fell." The Office accepted her claim for right knee sprain and osteochondritis dissecans.

Appellant underwent surgery on May 27, 1993 and May 31, 1994, the latter for removal of the osteochondritic lesion and a partial medial meniscectomy. On June 3, 1996 she filed a claim for a schedule award. An Office medical adviser reviewed the record on December 30, 1996 and reported a two percent impairment of the right lower extremity due to the partial meniscectomy. He found no documentation of any other factors that would result in impairment.

On February 5, 1997 another Office medical adviser suggested further development of the evidence:

> "We need to look at the clinical evidence very carefully. I reviewed the op[erative] report and I looked at the 'Xeroxed' copy of the intra-operative arthroscopy photo[graph]. The real issue here is osteochondritis dissecans, not a minor medial meniscus tear. The osteochondritic lesion in the right knee (articular surfaces) will contribute to the gradual decline of the claimant's right knee function over time, through the development of progressive arthritis.
>
> "The most appropriate action at this juncture would be to persuade the attending doctor (orthopedist) to examine Table 62, fourth edition, [the American Medical Association, *Guides to the Evaluation of Permanent Impairment*] and review the instructions for '3.02g [a]rthritis.' Standard x-rays (roentgenographs) of the claimant's right knee with the patient standing should reveal a significant loss of cartilage interval within the knee. Let's get this measurement and then arrive at the correct permanent partial impairment which addresses the 'heart' of the real diagnosis and its consequences."

The Office referred appellant to several orthopedic surgeons. Dr. Robert A. Smith examined appellant on September 30, 1997. He reported that x-rays from October 1996 showed an irregularity of the joint surface of the medial femoral condyle but a well-maintained joint space. Dr. Kevin E. McGovern reported on July 17, 2002 that x-rays showed an irregularity and a small cyst in the medial femoral condyle and some osteophyte formation. Dr. Havinder S. Pabla reported on September 12, 2003 that x-rays of the right knee (anterior-posterior, lateral, tunnel and sunrise views) showed "normal" preservation of the medial and lateral joint space. There was no evidence of soft-tissue calcification or intra-articular loose body.

On August 19, 2004 Dr. Eric G. Dawson, appellant's attending orthopedic surgeon, reported that x-rays were taken on August 3, 2004: "I will direct the viewer to the sunrise view which demonstrates medial patellofemoral joint loss where she has only two mm [millimeters] space for the cartilage well less than the 4 to 5 anticipated." He noted that this represented a 10 percent impairment of the lower extremity under Table 17-31 of the A.M.A., *Guides* 544 (5th ed. 2001). Using the same table, he reported a seven percent impairment of the lower extremity for the measurement of the medial femoral-tibial joint line. Dr. Dawson noted significant degenerative changes and reported that appellant reached maximum medical improvement that date.

On December 29, 2004 an Office medical adviser reported that appellant's partial medial meniscectomy was the only basis for rating impairment: "The simple removal of the osteochondrotic lesion is in and of itself not a basis for an impairment rating in referencing the

fifth [e]dition of the A.M.A., *Guide*[*s*]." The medical adviser noted no evidence of any post-traumatic arthritis having developed over the years. He also found that appellant reached maximum medical improvement on May 31, 1995, one year after her most recent surgery.

On January 27, 2005 the Office issued a schedule award for a two percent permanent impairment of appellant's right lower extremity.

Dr. Dawson submitted a follow-up report on April 7, 2005. He reviewed a magnetic resonance imaging (MRI) scan of appellant's knee, as well as the radiologist's report. The knee (medial femoral-tibial) joint showed cartilage intervals of two mm and even less in various areas. The patellofemoral gap was also in the two mm range. Using Table 17-31, page 544, of the A.M.A., *Guides*, Dr. Dawson determined that appellant had a 12 percent impairment of the whole person. To this he added one percent for the partial meniscectomy and two percent for an undisplaced supracondylar fracture, both from Table 17-33, page 546. On June 23, 2005 Dr. Dawson stated that osteochondritis dissecans was a chronic and degenerative phenomenon.

On May 30, 2006 an Office medical adviser reported that osteochondritis dissecans can be a progressive degenerative process leading to frank osteoarthritis, but examinations in 2002 and 2003 were benign and radiographic studies in 2003 were negative for loss of joint interval. The medical adviser found no evidence for an impairment rating. He stated that appellant reached maximum medical improvement on May 31, 1995.

In a decision dated July 14, 2006, the Office reviewed the merits of appellant's claim and denied modification of its January 27, 2005 schedule award. The Office found that the opinion of the Office medical advisers constituted the weight of the medical evidence. The Office found that Dr. Dawson did not properly apply the A.M.A., *Guides*, as he used whole person impairments and did not base his rating on an accurate and current set of standing radiographs. The Office stated:

> "Since it appears that your accepted work injury may be worsening, based on the ongoing reports we have received from Dr. Dawson, you should consider filing for an additional schedule award once you have an accurate and current set of standing radiographs needed to measure the degree of osteoarthritis, as outlined in Table 17-31, page 544 of the A.M.A., *Guides*."

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body.[1] Such loss or loss of use is known as permanent impairment. The Office evaluates the

[1] 5 U.S.C. § 8107. The Act provides 288 weeks' compensation for the total loss of a leg. *Id*. at § 8107(c)(2). Partial losses are proportionate. *Id*. at § 8107(c)(19).

degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[2]

ANALYSIS

The A.M.A., *Guides* provides that the best roentgenographic indicator of disease stage and impairment for a person with arthritis is the cartilage interval or joint space:

> "The hallmark of all types of arthritis is thinning of the articular cartilage; this correlates well with disease progression.
>
> "The need for joint replacement or major reconstruction usually corresponds with complete loss of the articular surface (joint space). The impairment estimates in a person with arthritis (Table 17-31) are based on standard x-rays taken with the individual standing, if possible. The ideal film-to-camera distance is 90 [centimeters] (36 in) and the beam should be at the level of and parallel to the joint surface. The estimate for the patellofemoral joint is based on a 'sunrise view' taken at 40 degrees flexion or on a true lateral view.
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> "In the case of the knee, the joint must be in the neutral flexion-extension position (0 degrees) to evaluate the x-rays."[3]

Findings from the physicians who obtained x-rays appear inconsistent. Dr. Pabla, the Office referral orthopedic surgeon, reported on September 12, 2003 that x-rays of the right knee (anterior-posterior, lateral, tunnel and sunrise views) showed "normal" preservation of the medial and lateral joint space. Less than a year later, Dr. Dawson, the attending orthopedic surgeon, reported that x-rays obtained on August 3, 2004 showed a two mm medial patellofemoral interval (sunrise view) and a three mm medial femoral-tibial interval.[4] In neither case did the physician make clear that the x-rays strictly conformed to the requirements of the A.M.A., *Guides*. With no x-rays submitted to the record and no report from the radiologists, an Office medical adviser cannot independently review the intervals reported or, indeed, whether any post-traumatic arthritis has developed over the years.

The Board finds, however, that further development of the medical evidence is warranted. Appellant has submitted medical evidence supporting an additional impairment due to injury-related arthritis in the femoral-tibial and patellofemoral joints. The Office medical advisers have twice recommended obtaining appropriate x-rays to determine the impairment under the A.M.A., *Guides*. The Board shall, therefore, set aside the Office's July 14, 2006 decision and remand the case for further development. The Office shall determine whether appellant currently has arthritis causally related to her accepted employment injury and if so,

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[2] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001 the Office began using the A.M.A., *Guides* (5th ed. 2001).

[3] A.M.A., *Guides* 544.

[4] The seven percent impairment Dr. Dawson reported corresponds to a three mm interval at the femoral-tibial joint under Table 17-31. He reported a two mm interval in 2005 based apparently on an MRI scan.

shall determine whether she currently has impairment due to that arthritis according to the protocols set out in the A.M.A., *Guides*. The Office shall determine whether appellant is entitled to an additional rating for the supracondylar fracture Dr. Dawson reported and shall obtain medical rationale for the date of maximum medical improvement. After such further development as may be necessary, the Office shall issue an appropriate final decision.

CONCLUSION

The Board finds that this case is not in posture for decision. Further development of the medical evidence is warranted.

ORDER

IT IS HEREBY ORDERED THAT the July 14, 2006 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: May 16, 2007
Washington, DC

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

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

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