# United States Department of Labor
# Employees' Compensation Appeals Board

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| **R.C., Appellant** | ) | |
| **and** | ) | **Docket No. 08-1055** |
| | ) | **Issued: September 17, 2008** |
| **DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF INVESTIGATION, Houston, TX, Employer** | ) | |

*Appearances:*
*Appellant, pro se*
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

### ***JURISDICTION***

On February 26, 2008 appellant filed a timely appeal from the November 28, 2007 merit decision of the Office of Workers' Compensation Programs, which awarded schedule compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

### ***ISSUE***

The issue is whether appellant has more than a 10 percent permanent impairment of his right lower extremity.

### ***FACTUAL HISTORY***

On May 5, 1991 appellant, then a 39-year-old special agent, sustained an injury in the performance of duty when he unexpectedly stepped off a curb while jogging and twisted his right knee. The Office accepted his claim for right knee strain.

A June 28, 1991 magnetic resonance imaging scan revealed a complex tear of the anterior horn of the right lateral meniscus and an associated oblique tear in conjunction with degenerative changes in the posterior horn of the lateral meniscus. Findings were compatible with an osteochondral fracture or bone bruise involving the subcondral margin of the lateral femoral condyle. A linear zone of high signal near the posterior horn of the medial meniscus most likely represented a zone of intrameniscal degeneration as opposed to a tear. The Office authorized surgical intervention.

On December 12, 1991 following surgery,[1] Dr. Eddie T. Matsu, the attending orthopedic surgeon, reported that appellant had a 20 percent impairment of the right lower extremity due to arthritis of the knee and an additional 20 percent impairment due to crepitation of a moderate nature. He stated this translated into a 24 percent impairment of the whole person.

On June 8, 2006 appellant filed a claim for a schedule award.

On October 6, 2006 Dr. Jeffrey L. Tedder, an orthopedic surgeon and Office referral physician, examined appellant and found 105 degrees of right knee flexion, crepitus and medial and lateral joint line tenderness. X-rays showed moderate to focally severe degenerative joint disease. Dr. Tedder reported that appellant had a 16 percent impairment of the right lower extremity due to loss of flexion "and I will give him 20 percent for chondromalacia of his right knee."

After an Office medical adviser reported problems with Dr. Tedder's rating, the Office referred appellant to Dr. William Dinenberg, an orthopedic surgeon, for evaluation. On October 9, 2007 appellant told Dr. Dinenberg that he was diagnosed with bone-on-bone arthritis in 2004 and that a knee replacement was recommended. Dr. Dinenberg reported range of motion from 5 to 105 degrees, crepitation and medial and lateral joint line tenderness. He diagnosed degenerative right knee status post arthroscopic meniscectomy. Dr. Dinenberg found a 10 percent impairment of the right lower extremity due to loss of range of motion, a 10 percent impairment due to meniscectomy and an additional 2 percent impairment for pain.

An Office medical adviser reviewed Dr. Dinenberg's findings and reported that appellant had a 10 percent impairment due to decreased flexion. He explained that a rating for decreased motion may not be combined with diagnosis-based estimates of impairment.

On November 28, 2007 the Office issued a schedule award for a 10 percent permanent impairment of appellant's right lower extremity. On appeal, appellant argues that this award is insufficient.

## ***LEGAL PRECEDENT***

Section 8107 of the Federal Employees' Compensation Act[2] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body.

[1] The operative report is not in the record.

[2] 5 U.S.C. § 8107.

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*.[3]

## ***ANALYSIS***

The 1991 impairment rating given by Dr. Matsu, the attending orthopedic surgeon, is not helpful in determining the permanent impairment of appellant's right lower extremity. Dr. Matsu reported 20 percent impairment due to knee arthritis and 20 percent due to crepitation, but he did not explain how he arrived at these numbers and he made no reference to the applicable tables and pages in the A.M.A., *Guides*. This makes it impossible to review whether he properly evaluated appellant's impairment. Also, he reported a total impairment of 24 percent of the whole person. The Act does not authorize the payment of schedule awards for the permanent impairment of the "whole person."[4] Payment is authorized only for the permanent impairment of specified members, organs or functions of the body.[5]

Dr. Tedder, a second opinion orthopedic surgeon, found 105 degrees of right knee flexion. According to Table 17-10, page 537 of the A.M.A., *Guides*, knee flexion less than 110 degrees represents a lower extremity impairment of 10 percent. Dr. Tedder gave appellant 20 percent rating for chondromalacia but did so without explanation. Impairment ratings for arthritis are based on roentgenographically determined cartilage intervals at the knee and patellofemoral joints, which Dr. Tedder did not report.[6] Moreover, impairment ratings for range of motion and arthritis may not be combined.[7] So appellant may not receive both.

Although appellant told Dr. Dinenberg, the most recent second opinion physician, that he was diagnosed with bone-on-bone arthritis in 2004 and that a knee replacement was recommended, Dr. Dinenberg took no x-rays to evaluate impairment due to loss of cartilage intervals. He reported range of motion from 5 to 105 degrees. As noted earlier, flexion less than 110 degrees represents a 10 percent lower extremity impairment. But a flexion contracture of five degrees -- where the joint is drawn into flexion and there is a fixed resistance to passive

[3] 20 C.F.R. § 10.404 (1999).

[4] *Ernest P. Govednick*, 27 ECAB 77 (1975).

[5] Section 8107(c)(2) of the Act provides 288 weeks of compensation for the total loss of a leg, as with amputation at the hip.

[6] A.M.A., *Guides* 544 (Table 17-31). The A.M.A., *Guides* explains that for most individuals roentgenographic grading is a more objective and valid method for assigning impairment estimates than physical findings, such a range of motion or joint crepitation. Crepitation, the A.M.A., *Guides* adds, is an inconstant finding that depends on such factors as forces on joint surfaces and synovial fluid viscosity.

[7] *Id*. at 526 (Table 17-2, Guide to the Appropriate Combination of Evaluation Methods).

extension -- also represents 10 percent lower extremity impairment. Appellant's impairment due to loss of knee motion therefore appears to be 20 percent.[8]

Dr. Dinenberg also found 10 percent impairment due to meniscectomy. Table 17-33, page 546 of the A.M.A., *Guides*, shows that a partial medial and lateral meniscectomy, together, represents a 10 percent lower extremity impairment. But this impairment may not be combined with impairment for range of motion.[9]

Impairment due to meniscectomy may be combined with impairment due to arthritis,[10] but again, Dr. Dinenberg did not evaluate impairment due to arthritis. Instead, he gave an additional two percent for pain-related impairment. Discussing the difficulties associated with integrating pain-related impairment into an impairment rating system, the A.M.A., *Guides* states:

> "Finally, at a practical level, a chapter of the [A.M.A.,] *Guides* devoted to pain-related impairment should not be redundant of or inconsistent with principles impairment rating described in other chapters. The [A.M.A.,] *Guides'* impairment ratings currently include allowances for the pain that individuals typically experience when they suffer from various injuries or diseases, as articulated in Chapter 1 of the [A.M.A.,] *Guides*: 'Physicians recognize the local and distant pain that commonly accompanies many disorders. Impairment ratings in the [A.M.A.,] *Guides* already have accounted for pain. For example, when a cervical spine disorder produces radiating pain down the arm, the arm pain, which is commonly seen, has been accounted for in the cervical spine impairment rating' (p. 10). Thus, if an examining physician determines that an individual has pain-related impairment, he or she will have the additional task of deciding whether or not that impairment has already been adequately incorporated into the rating the person has received on the basis of other chapters of the [A.M.A.,] *Guides*."[11]

Without a sound explanation for incorporating pain-related impairment,[12] Dr. Dinenberg has not supported a two percent increase in appellant's rating.

The Board finds that this case is not in posture for decision. The Office issued a schedule award for a 10 percent impairment of the right lower extremity due to loss of knee flexion, but Dr. Dinenberg also appeared to report a flexion contracture. As impairment due to meniscectomy may be combined with impairment due to arthritis, the Office should further develop the evidence to evaluate roentgenographically determined cartilage intervals. After comparing the impairment due to loss of knee motion with the combined impairment due to

[8] The A.M.A., *Guides* explains that range-of-motion restrictions in multiple directions do increase the impairment, so one adds the range-of-motion impairments for a single joint to determine the total joint range-of-motion impairments. *Id*. at 533.

[9] *Id*. at 526 (Table 17-2).

[10] *Id*.

[11] *Id*. at 570.

[12] *See id*. ("[w]hen [t]his [c]hapter [s]hould [b]e [u]sed to [e]valuate [p]ain-[r]elated [i]mpairment").

meniscectomy and arthritis, the Office shall issue a schedule award based on the method or combination of methods that gives, in the evaluating physician's opinion, the most clinically accurate impairment rating.[13] The Board will set aside the Office's November 28, 2007 decision and remand the case for further development and an appropriate final decision on appellant's entitlement to a schedule award.

## ***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 November 28, 2007 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded for further action consistent with this opinion.

Issued: September 17, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[13] *See id*. at 526.