United States Department of Labor
Employees' Compensation Appeals Board

C.J., Appellant	)	
and	)	**Docket No. 08-2429**
	)	**Issued: August 3, 2009**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION NORTHERN CALIFORNIA HEALTH CARE SYSTEM, Mather, CA, 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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 10, 2008 appellant filed a timely appeal of the Office of Workers' Compensation Programs' July 22, 2008 schedule award decision.[1] 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 the evidence establishes that appellant has more than a 12 percent permanent partial impairment of the right lower extremity.

[1] The Board notes that on August 25, 2008 the Office terminated appellant's compensation benefits, finding that her actual earnings as an information technology specialist, which met or exceeded her wages of the job she held when injured, fairly and reasonably represented her wage-earning capacity. Appellant has not contested its August 25, 2008 decision in this appeal. Therefore, the Board will not address the wage-earning capacity issue.

FACTUAL HISTORY

On April 10, 2007 appellant, a 40-year-old systems analyst, filed a traumatic injury claim alleging that she injured her right knee when she slipped on a ramp at work. The Office accepted her claim for a right knee sprain and medial meniscus tear. On August 6, 2007 appellant underwent arthroscopic surgery involving an excision of a right medial plica.

Appellant was treated by Dr. Jeffry A. Metheny, a Board-certified orthopedic surgeon. On April 9, 2008 Dr. Metheny opined that appellant was able to work full time with restrictions, which precluded kneeling, crawling or lifting more than 25 pounds.

The Office referred appellant, together with the medical record and statement of accepted facts, to Dr. Aubrey A. Swartz, a Board-certified orthopedic surgeon, for a second opinion examination and an opinion as to whether appellant continued to suffer residuals from her work-related injury and, if so, whether she was disabled as a result of those residuals. It also requested an opinion as to whether appellant was permanently impaired as a result of her accepted injury and, if so, the degree of impairment under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2]

In a May 21, 2008 report, Dr. Swartz reviewed the history of appellant's accepted injury and diagnosed chondromalacia patella. He stated that she was status post contusion and strain, anteromedial right knee, with injury to the medial plica. Dr. Swartz noted that appellant had undergone arthroscopic surgery on April 9, 2007 and had returned to light duty on October 1, 2007. He related appellant's complaints of right knee pain, with stabbing radiation to the popliteal region, as well as numbness in the right lower extremity down to the right ankle.

Examination of the right knee revealed 2 to 4+ laxity (mild), tenderness medially, and pain with McMurray maneuver. Range of motion was 0 to 155 degrees in the knees bilaterally. Dr. Swartz found a click in the patella of the right knee, with extension and crepitus. Circumferential measurements of the thighs and calves were as follows: right thigh -- 48 centimeter (cm), left thigh -- 48.5 cm, right calf -- 36 cm., left calf -- 35.7 cm. Girth of the right knee joint was 36.5 cm and girth of the left knee joint was 35.7 cm. Appellant was able to squat only to approximately 60 to 70 percent. Dr. Swartz opined that her preexisting patellar chondromalacia was probably aggravated by the plica syndrome, which likely caused some enhancement of the chondromalacia process in the patella.

In a form report dated June 6, 2008, Dr. Swartz indicated that the intensity of appellant's right knee pain was "uncomfortable" and interfered with daily activities, such as climbing, crawling or lifting. He stated that the knee pathology caused atrophy of the right thigh (.5 cm.), and that post-traumatic irregularity or arthritis affected the patellar cartilage.

The Office forwarded Dr. Swartz' reports, together with the entire medical file and statement of accepted facts, to the Office medical adviser for review and a calculation of the degree of appellant's permanent impairment under the A.M.A., *Guides* and an opinion as to the date of maximum medical improvement. In a July 12, 2008 report, after reviewing his objective

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

findings and considering the various options available for assessment under the A.M.A., *Guides*, the Office medical adviser concluded that appellant had a 12 percent permanent impairment of her right lower extremity. The Office medical adviser also opined that the date of maximum medical improvement was May 21, 2008, the date of Dr. Swartz' examination.

Using an anatomic assessment method, the Office medical adviser referred to Tables 15-15 and 16-10. Under Table 16-10 at page 482, he determined that appellant had a Grade 3 classification for sensory deficit for pain and/or altered sensation that may interfere with activity in the distribution of the femoral nerve, which corresponded to a 60 percent sensory deficit. Applying the 60 percent deficit to the maximum five percent impairment allowed (for branches of the femoral nerve), the Office medical adviser concluded that appellant had a four percent impairment for pain factors.[3] He found no ratable impairment based on range of motion measurements (155 degrees), thigh atrophy of 0.5 cm., or quadriceps function of 5/5. Therefore, under this method of assessment, appellant would be entitled to a four percent permanent partial impairment for the right lower extremity.

Using a diagnosis-based estimate, the Office medical adviser referred to Tables 17-33 and 17-31. Based on Dr. Swartz' description of 2 to 4+ anterior/posterior laxity (mild) in the right knee, he assessed seven percent impairment under Table 17-33 at page 546. Pursuant to Table 17-31 at page 544, he determined that appellant had an additional five percent impairment for the finding of chondromalacia patella, with some crepitus, without documentation of roentgenographic narrowing. Dr. Swartz combined the 7 percent impairment for laxity with the 5 percent impairment for patellofemoral pain and crepitation, for a total impairment of 12 percent. He recommended that appellant be awarded the greater award under the diagnosis-based method. Accordingly, Dr. Swartz opined that appellant had a 12 percent permanent partial impairment of the right lower extremity. The Office medical adviser also opined that the date of maximum medical improvement was May 21, 2008, the date of Dr. Swartz' examination.

By decision dated July 22, 2008, the Office granted appellant a schedule award for a 12 percent impairment of her right lower extremity. The period of the award ran from May 21 to July 5, 2008. The Office found that the date of maximum medical improvement was May 21, 2008.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[4] and its implementing regulations[5] 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

[3] The Board notes that the Office medical adviser's calculations are incorrect. Applying his Grade 3 classification (60 percent) to a 5 percent maximum would result in 3 percent impairment for pain. It would appear that the Office medical adviser intended to use a seven percent maximum impairment for branches of the femoral nerve under Table 17-37 at page 552 of the A.M.A., *Guides*. Applying his calculations to a seven percent maximum would result in four percent impairment for pain.

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

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* as the uniform standard applicable to all claimants.[6] 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.[7]

The fifth edition of 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.[8] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[9] The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligamentous instability, bursitis and various surgical procedures, including joint replacements and meniscectomies.[10] 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.[11] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[12] When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.[13] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[14]

The A.M.A., *Guides* provides that any chapter devoted to pain-related impairment should not be redundant of, or inconsistent with, principles of 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*. Impairment ratings provided in the A.M.A., *Guides* have already accounted for pain.[15]

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[6] *Id.* at § 10.404(a).

[7] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Award*s, Chapter 3.700, Exhibit 4 (June 2003).

[8] A.M.A., *Guides* at 525.

[9] *Id.*

[10] *Id.*

[11] *Id.*

[12] *Id.* at 548.

[13] *Id.* at 526.

[14] *Id*. at 555.

[15] *Id.* at 570.

ANALYSIS

The Board finds that appellant has not established that she has more than 12 percent impairment of the right lower extremity. Therefore, the Board will affirm the Office's July 22, 2008 decision.

In his May 21, 2008 second opinion report, Dr. Swartz reviewed the history of appellant's accepted injury and diagnosed chondromalacia patella. He stated that appellant was status post concussion and strain, anteromedial right knee, with injury to the medial plica. Dr. Swartz noted that appellant had undergone arthroscopic surgery on April 9, 2007. He related appellant's complaints of right knee pain, with stabbing radiation to the popliteal region, as well as numbness in the right lower extremity down to the right ankle. Examination of the right knee revealed mild laxity (2 to 4+), tenderness medially, and pain with McMurray maneuver. Range of motion was 0 to 155 degrees in the knees bilaterally. Dr. Swartz found a click in the patella of the right knee, with extension and crepitus. Circumferential measurements of the thighs and calves were as follows: right thigh -- 48 cm, left thigh -- 48.5 cm, right calf -- 36 cm, left calf -- 35.7 cm. Girth of the right knee joint was 36.5 cm and girth of the left knee joint was 35.7 cm. Appellant was able to squat only to approximately 60 to 70 percent. Dr. Swartz opined that her preexisting patellar chondromalacia was probably aggravated by the plica syndrome, which likely caused some enhancement of the chondromalacia process in the patella. On June 6, 2008 he stated that the intensity of appellant's right knee pain was "uncomfortable" and interfered with daily activities, such as climbing, crawling or lifting. Dr. Swartz opined that the knee pathology caused atrophy of the right thigh (.5 cm), and that post-traumatic irregularity, or arthritis affected the patellar cartilage. He did not provide an opinion as to the degree of appellant's permanent impairment based on the A.M.A., *Guides*.

The Office appropriately routed the case file to the Office medical adviser for review.[16] As Dr. Swartz failed to provide an impairment rating, the Office medical adviser properly applied the A.M.A., *Guides* to his examination findings and concluded that appellant had a 12 percent impairment of the right lower extremity.[17] Using an anatomic assessment method, he referred to Tables 15-15 and 16-10.[18] Under Table 16-10 at page 482, the Office medical adviser determined that appellant had a Grade 3 classification for sensory deficit for pain and/or altered sensation that may interfere with activity in the distribution of the femoral nerve, which corresponded to a 60 percent sensory deficit. Applying the 60 percent deficit to the maximum 5

[16] *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 Office medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

[17] Pursuant to Office procedures, when the case appears to be in posture for schedule award determination, the Office will ask the Office medical adviser to evaluate cases. The Office medical adviser is responsible for reviewing the file, particularly the medical report on which the award is to be based, and then calculating the award. Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Award*s, Chapter 3.700.3(a) (June 2003). *See also John L. McClenic*, 48 ECAB 552 (1997); *Lena P. Huntley*, 46 ECAB 643 (1997).

[18] Section 17.2l of the A.M.A., *Guides* provides that partial sensory and motor deficits should be rated as in the upper extremity under Tables 16-10 and 16-11. A.M.A., *Guides* at 550.

percent impairment allowed (for branches of the femoral nerve), he concluded that appellant had a 4 percent impairment for pain factors.[19] The Office medical adviser found no ratable impairment based on range of motion measurements (155 degrees), thigh atrophy of 0.5 cm, or quadriceps function of 5/5. Therefore, under this method of assessment, he determined appellant would be entitled to a four percent permanent partial impairment for the right lower extremity.

The Office medical adviser, then, appropriately analyzed the degree of appellant's permanent impairment under a diagnosis-based estimate,[20] to Tables 17-33 and Table 17-31. Based on Dr. Swartz' description of 2 to 4+ anterior/posterior laxity (mild) in the right knee, he assessed seven percent impairment under Table 17-33 at page 546. Pursuant to Table 17-31 at page 544, he determined that appellant had an additional five percent impairment for the finding of chondromalacia patella, with some crepitus, without documentation of roentgenographic narrowing.[21] He correctly combined the 7 percent impairment for laxity with the 5 percent impairment for patellofemoral pain and crepitation, for a total impairment of 12 percent.[22]

The A.M.A., *Guides* provides that, if more than one rating method can be used, the method that provides the higher rating should be adopted.[23] Therefore, the Office medical adviser properly recommended that the diagnosis-based method be adopted, which resulted in a 12 percent impairment rating.[24]

The Board finds that the Office medical adviser based his opinion on a proper review of the record and appropriately applied the A.M.A., *Guides* in finding that appellant had a 12 percent impairment of the right lower extremity. There is no other probative medical evidence of record to establish that appellant has more than a 12 percent impairment of her right lower extremity. Therefore, appellant has not established entitlement to a schedule award for more than a 12 percent impairment of her right lower extremity.

The Office medical adviser found that appellant reached maximum medical improvement on May 21, 2008, the date of Dr. Swartz' examination. It is well established that the period of a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the accepted employment injury. The determination of

[19] *See supra* note 3.

[20] A.M.A., *Guides* 526, 555.

[21] Appellant met the requirements of the last footnote of Table 17-31, in that she had a history of direct trauma to her right knee, complaints of patellofemoral pain and crepitation on physical examination. A.M.A., *Guides* 544, Table 17-31.

[22] *Id*. at 526, Table 17-2.

[23] A.M.A., *Guides* 527. Section 17.2 of the A.M.A., *Guides* provides that functional impairments are chosen for conditions when anatomic changes are difficult to categorize or when functional implications have been documented and are assessed last. *Id.* at 525. A functional assessment was not indicated in this case.

[24] The Board notes that the Office medical adviser correctly did not include a separate rating for pain in his analysis under the diagnosis-based estimate. *See L.H.*, 58 ECAB ___ (Docket No. 06-1691, issued June 18, 2007) (the impairment ratings in the body organ system chapters of the A.M.A., *Guides* make allowance for any accompanying pain). *See also T.H.*, 58 ECAB ___ (Docket No. 06-1500, issued January 31, 2007).

whether maximum medical improvement has been reached is based on the probative medical evidence of record and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by the Office.[25] The Board finds that the Office correctly determined that the date of maximum medical improvement was May 21, 2008.

CONCLUSION

The Board finds that appellant failed to establish that she has more than a 12 percent impairment of the right lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the July 22, 2008 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 3, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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