United States Department of Labor
Employees' Compensation Appeals Board

J.R., Appellant	)	
	)	**Docket No. 08-1948**
and	)	**Issued: February 6, 2009**
	)	
DEPARTMENT OF THE ARMY, FORT CARSON CO, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 7, 2008 appellant filed a timely appeal of the April 1, 2008 merit decision of the Office of Workers' Compensation Programs which found that he had a 20 percent impairment of the right leg. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than a 20 percent impairment of the right lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On December 14, 2006 appellant, then a 66-year-old contract specialist, slipped on ice and fell in the employing establishment parking lot and injured his right knee and thigh. His claim was accepted for an aggravation of a torn lateral meniscus of the right knee, effusion of the right knee and contusion of the right thigh. The Office authorized arthroscopic surgery. Appropriate compensation benefits were paid.

On December 12, 2006 appellant was treated by Dr. Kenneth A. Stone, a Board-certified family practitioner, who diagnosed preexisting severe degenerative joint disease of the right knee and contusion of the right thigh. Dr. Stone returned appellant to work limited duty four hours per day. On December 19, 2006 he diagnosed internal derangement of the right knee with effusion, aggravation of degenerative joint disease and improved right thigh contusion. A magnetic resonance imaging (MRI) scan of the right knee dated December 20, 2006, revealed extensor mechanism strain, lateral meniscus complex horizontal tear, partial meniscectomy change of the medial meniscus, joint effusion and severe osteoarthritis. An MRI scan of the right femur revealed a right dorsal mid-thigh hematoma.

Appellant came under the treatment of Dr. Ronald O. Royce, an osteopath, who, in reports dated December 18, 2006 to May 21, 2007, noted the history of injury and diagnosed right leg pain with right knee effusion. Dr. Royce stated that appellant's history was significant for three prior right knee arthroscopies. He noted that appellant continued to have right knee pain and recommended surgery. In an operative report dated May 17, 2007, Dr. Royce performed arthroscopy of the right knee with chondroplasty and debridement of the patellofemoral joint, lateral tibiofemoral joint, medial tibiofemoral joint and partial lateral and medial meniscectomies. He diagnosed patellofemoral chondromalacia, femoral trochlear groove chondromalacia, lateral femoral condyle chondromalacia, lateral tibial plateau chondromalacia, medical femoral condyle chondromalacia, medial tibial plateau chondromalacia and chronic complex degenerative tearing to medial and lateral meniscus. In reports dated July 6 to October 31, 2007, Dr. Royce found that appellant was progressing well postoperatively and reached maximum medical improvement on October 3, 2007. Dr. Stone also provided updates concerning appellant's treatment for lateral meniscus tear of the right knee and accompanying effusion.

On November 14, 2007 appellant filed a claim for a schedule award. On October 29, 2007 Dr. Royce found that appellant sustained 28 percent impairment of the right lower extremity.

In a memorandum dated December 11, 2007, the Office referred the medical record to an Office's medical adviser for evaluation of the extent of permanent partial impairment to under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[1] (A.M.A., *Guides*). The Office medical adviser determined that appellant had reached maximum medical improvement on October 3, 2007. He was unable to decipher Dr. Royce's impairment rating as the physician did not cite to the A.M.A., *Guides.* The medical adviser recommended that the Office request that Dr. Royce provide an impairment rating in accordance with the A.M.A., *Guides* and fully document his calculations.

In a letter dated January 4, 2008, the Office requested that Dr. Royce evaluate the extent of impairment to appellant's right knee in accordance with the A.M.A., *Guides*. In a letter dated February 1, 2008, Dr. Royce noted incorrectly using the third edition of the A.M.A., *Guides* in

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

previously calculating appellant's impairment. He opined that appellant had a loss of extension of eight degrees for a 10 percent impairment of the lower extremity.[2]

On February 6, 2008 the Office referred appellant for a second opinion to Dr. Hendrick J. Arnold, a Board-certified orthopedic surgeon, for evaluation. In a report dated March 12, 2008, Dr. Arnold noted findings upon physical examination of a well-healed scar on the right knee, stable varus and valgus testing, noticeable atrophy of the right thigh, tenderness at the lateral joint line and medial joint line and smooth reciprocating gait with equal stance. He noted range of motion of the right knee of extension of 10 degrees and flexion of 110 degrees. Dr. Arnold diagnosed degenerative joint disease of the right knee in three compartments, prior partial medial and lateral meniscectomy and a resolved contusion of the right thigh. He opined that appellant had a 20 percent impairment of the right lower extremity for flexion contracture of 10 degrees.[3] Appellant had medial and lateral partial meniscectomies which would provide 10 percent impairment.[4] Dr. Arnold further noted that Table 17-31 of the A.M.A., *Guides* provides impairment based on x-ray cartilage intervals; however, no data was provided for him to calculate impairment based on x-ray findings. Moreover, he noted that, pursuant to Table 17-2, page 526, of the A.M.A., *Guides*, the evaluator was prohibited from combining range of motion impairment with diagnostic based estimates and range of motion findings with arthritis impairment. Therefore, the greatest impairment for loss of range of motion was 20 percent permanent impairment of the right leg.

Dr. Arnold's report and the case record were referred to the Office's medical adviser. On March 29, 2008 the Office medical adviser concurred with Dr. Arnold that appellant sustained a 20 percent impairment of the right leg in accordance with the A.M.A., *Guides*. He noted that flexion contracture measured 10 degrees for 20 percent impairment and pursuant to the A.M.A., *Guides* the evaluator was prohibited from combining range of motion impairment with diagnostic based estimates.[5]

In a decision dated April 1, 2008, the Office granted appellant a schedule award for 20 percent permanent impairment of the right lower extremity. The period of the award was from October 3, 2007 to November 9, 2008.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[6] and its implementing regulations[7] 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

[2] *Id*. at 537, Table 17-10.

[3] *Id.*

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

[5] *See supra* note 2.

[6] 5 U.S.C. § 8107.

[7] 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 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 regulations as the appropriate standard for evaluating schedule losses.

Office procedures provide that in making an impairment rating for the lower extremities different evaluation methods cannot be used in combination. For example, arthritis impairments obtained from Table 17-31 cannot be combined with impairment determinations based on gait derangement (Table 17-5); muscle atrophy (Table 17-6); muscle strength (Tables 17-7 and 17-8) or range of motion loss (section 17.2f). Before finalizing any physical impairment calculation, the Office medical adviser is to verify the appropriateness of the combination of evaluation methods with that listed in Table 17-2, the cross-usage chart.[8]

ANALYSIS

On appeal, appellant contends that he has more than 20 percent impairment of the right leg. The Office accepted his claim for aggravation of a torn lateral meniscus, effusion of the right knee and contusion of the right thigh and arthroscopic surgery was authorized and performed on May 17, 2007.

The Office referred appellant to Dr. Arnold for an impairment evaluation. In an March 12, 2008 report, Dr. Arnold noted findings upon physical examination of the right knee of extension of 10 degrees and flexion of 110 degrees. He diagnosed degenerative joint disease of the right knee in three compartments, prior partial medial and lateral meniscectomy and a resolved contusion of the right thigh. Dr. Arnold opined that appellant had a 20 percent permanent impairment of the right lower extremity for flexion contracture of 10 degrees.[9] He noted that appellant had medial and lateral partial meniscectomies which represented 10 percent impairment of the lower extremity.[10] However, Dr. Arnold noted that, pursuant to Table 17-2, page 526, of the A.M.A., *Guides*, the evaluator is prohibited from combining range of motion impairment with diagnostic-based estimates. Dr. Arnold determined that appellant reached maximum medical improvement on October 3, 2007.

The Board finds that the opinion of Dr. Arnold establishes that appellant sustained 20 percent permanent impairment of the right lower extremity.

The Board has carefully reviewed the reports of Dr. Royce, who opined that appellant had loss of extension of eight degrees for 10 percent impairment.[11] Although this calculation conforms with the A.M.A., *Guides*, the impairment rating provided by Dr. Arnold, the second

[8] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 Exhibit 4**.** Use of the Fifth Edition of the A.M.A., *Guides* (June 2003); *see also* Table 17-2, page 526, (5th ed. 2001) (A.M.A., *Guides*).

[9] *See supra* note 2.

[10] *See supra* note 4.

[11] *See supra* note 2.

opinion physician, based upon his findings for flexion contracture of 10 degrees, provides a greater impairment of 20 percent.

The Office medical adviser concurred with Dr. Arnold that appellant sustained a 20 percent impairment of the right lower extremity under in accordance with the A.M.A., *Guides*. He noted that flexion contracture measured 10 degrees for 20 percent impairment.[12] The medical adviser noted that no consideration was given for arthritis and diagnosed-based estimates in addition to the loss of range of motion because this was contrary to the cross-usage chart of Table 17-2, page 526.

There is no other medical evidence of record explaining how, pursuant to the fifth edition of the A.M.A., *Guides*, appellant has more than a 20 percent impairment of the right lower extremity.

CONCLUSION

The Board finds that appellant has no more than a 20 percent permanent impairment of the right lower extremity, for which he received a schedule award.[13]

ORDER

IT IS HEREBY ORDERED THAT the April 1, 2008 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 6, 2009
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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

[12] *Id.*

[13] With his request for an appeal, appellant submitted additional medical evidence. However, the Board may not consider new evidence on appeal; *see* 20 C.F.R. § 501.2(c). The Board notes that this decision does not preclude appellant from filing a reconsideration request with the Office and submitting this evidence in support of his request.