United States Department of Labor
Employees' Compensation Appeals Board

R.C., Appellant	)	
and	)	**Docket No. 09-2217**
	)	**Issued: September 8, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Hartford, CT, 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 September 4, 2009 appellant filed a timely appeal of an August 24, 2009 decision of the Office of Workers' Compensation Programs affirming an April 30, 2009 schedule award decision. 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 is entitled to greater than 11 percent impairment of the right lower extremity for which he received a schedule award.

FACTUAL HISTORY

On January 31, 1994 appellant, then a 44-year-old mail handler, filed a traumatic injury claim alleging that on January 18, 1994 he dislocated his right knee after slipping on ice in the performance of duty. He stopped work on January 18, 1994 and returned to restricted duty on

February 3, 1994. The Office accepted appellant's claim for right knee dislocation and authorized arthroscopic surgery.[1]

Initial reports from Dr. Michael Kruger, an orthopedic surgeon, diagnosed patella subluxation secondary to violent contracture of quadriceps in a fall and quadriceps atrophy. He recommended physical therapy. On July 21, 1994 Dr. Kruger performed an arthroscopic lateral synovectomy on appellant's right knee. In a January 16, 1995 report, he opined that appellant had reached maximum medical improvement and that there would be little improvement with further therapy. Dr. Kruger noted that appellant's leg muscle had reached its maximum point since his preexisting knee injury and surgery.

In a May 17, 1995 report, Dr. Kruger diagnosed lumbar sprain and mechanical back symptoms. He noted that appellant had preexisting back symptoms that had bothered him since using crutches following surgery. Dr. Kruger determined that appellant's right knee had reached maximum medical improvement, and that based on the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) appellant had eight percent impairment of the right knee.[2]

Appellant filed a schedule award claim for his right knee on March 21, 2008. He submitted a March 13, 2008 report from Dr. Steven Selden, a Board-certified orthopedic surgeon, whose examination revealed well-healed surgical scars for both knees, satisfactory gait, difficulty with full extension of the knees and slight patellofemoral crepitus. Dr. Selden indicated that appellant's patellae were very loose. There was no gross varus or valgus instability and no appreciable effusions. He opined that Dr. Kruger's assignment of eight percent right knee impairment was accurate and remained in effect.

In a December 15, 2008 report, Dr. George Cohen, an Office medical adviser, reviewed Dr. Selden's March 13, 2008 report and opined that it was not possible to determine appellant's impairment based on the record. Dr. Cohen requested a report with measurements of motions of each knee as there appeared to be impairment for pain and loss of motion. He suggested that such a report could be requested from Dr. Selden. In December 18, 2008 letter, the Office requested that Dr. Selden provide a rationalized medical opinion regarding appellant's impairment rating using applicable figures and tables of the fifth edition of the A.M.A., *Guides*.

A December 29, 2008 statement from Dr. Selden disagreed with the Office's statement that his March 13, 2008 report was inadequate because it did not record appellant's knee range of motion. He noted that Dr. Kruger performed surgery on appellant's right knee in July 1994 and assessed eight percent impairment. Dr. Selden reiterated that the rating was appropriate. He noted that the A.M.A., *Guides* were used but that it was not entirely reliable to completely and adequately address the permanency of appellant's condition.

[1] The Office also accepted a recurrence of disability claim beginning March 8, 1994.

[2] Appellant filed a traumatic injury claim for his left knee on May 20, 1995. This was developed as case number xxxxxx740 and was combined with the present case. The Office accepted the claim for left knee strain and awarded him a schedule award of seven percent impairment of the left lower extremity. There are no issues regarding this claim presently before the Board.

On January 7, 2009 appellant asked that the Office help him find another physician due to Dr. Selden's refusal to provide a report in accordance to the A.M.A., *Guides*.

On January 16, 2009 the Office referred appellant to Dr. Thomas Stevens, a Board-certified orthopedic surgeon, for a referee evaluation to resolve the conflict in medical opinion between Dr. Selden, appellant's treating physician, and Dr. Cohen, an Office medical adviser.

In a February 2, 2009 report, Dr. Stevens provided a detailed summary of appellant's history of injury and treatment received. Upon examination he measured 44 centimeters for appellant's left knee circumference and 41.5 centimeters for appellant's right knee and noted some atrophy of the right distal thigh as compared to the left thigh. Dr. Stevens found that both patellae appeared to have excessive laxity and increased medial to lateral translation. He also found no effusion in either knee and no medial or lateral instability. Dr. Stevens noted gross deformity of the right knee consistent with early arthritis and some stiffness in both hips with right worse than left. Extension strength of the right lower leg when sitting was 3.5 of 5 with patella femoral crepitation and discomfort. Appellant's neurovascular examination was within normal limits. Dr. Stevens measured appellant's right leg flexion to 130 degrees in the supine position with full extension. X-rays of both knees with weight bearing upright and sunrise views taken during examination revealed marked tilting of the right patella and an area of arthritic change was present on the sunrise view of the right patella. Dr. Stevens noted bipartite patella, arthritic changes under the right patellar joint and degenerative changes of the lower lumbar spine. He indicated that appellant had reached maximum medical improvement. Dr. Stevens opined that based on the x-rays and atrophy with gross deformity that appellant had 10 percent right knee impairment based on the changes that had developed since Dr. Kruger last evaluated him.

On February 13, 2009 the Office requested that Dr. Stevens provide page numbers, tables and figures of the A.M.A., *Guides* that he used to support his impairment findings.

In a February 18, 2009 report, Dr. David Krohn, a Board-certified internist and an Office medical adviser, reviewed Dr. Stevens' findings dated February 2, 2009. He determined that based on Table 17-6 on page 530 of the A.M.A., *Guides*, appellant's right thigh atrophy corresponded to 11 percent impairment. Dr. Krohn also determined that, based on Table 17-33 on page 546 of the A.M.A., *Guides*, appellant had seven percent impairment for patellar subluxation with residual instability. He combined 11 percent right thigh atrophy impairment with 7 percent patellar subluxation impairment to derive 17 percent right lower extremity impairment based on the Combined Values Chart on page 604 of the A.M.A., *Guides*. Dr. Krohn noted that appellant reached maximum medical improvement for his right knee on May 17, 2005 when Dr. Kruger indicated no further intervention was necessary. He disagreed with Dr. Stevens' opinion as Dr. Stevens claimed that appellant's knee impairment was due to range of motion, but the medical adviser found no impairment based on flexion and extension measurements in his report. Dr. Krohn also noted that Dr. Stevens did not specifically indicate a further basis upon which he established his impairment ratings. He further noted that Dr. Stevens claimed the right knee impairment rating was based on x-rays, atrophy and deformity findings but the medical adviser found an insufficient basis from x-ray reports of the knees to claim impairment for joint space loss.

In a February 23, 2009 supplemental report, Dr. Stevens opined that based on Chapter 17 of the fifth edition of the A.M.A., *Guides*, appellant had 10 percent permanent impairment of each knee. He found that appellant's right knee had atrophy, weakness and arthritis as well as 2.5 centimeter atrophy of the right quadriceps 10 centimeters above the patella. Dr. Stevens indicated that Table 17-6 gave him 3 to 4 percent whole person impairment that converted to 8 to 13 percent impairment of the right leg. He noted that, based on his evaluation and the A.M.A., *Guides*, appellant had 10 percent permanent impairment of the right leg.

On February 24, 2009 the Office asked that Dr. Krohn review Dr. Stevens' February 23, 2009 report and indicate whether he agreed with Dr. Stevens and to explain any differences he had with Dr. Stevens. In a February 24, 2009 report, Dr. Krohn opined that Dr. Stevens' description of arthritic changes on the sunrise view of appellant's right patella had no basis within the A.M.A., *Guides* upon which to assign a schedule award for such a nonspecific description of arthritis. He noted that Table 17-31 on page 544 of the A.M.A., *Guides* was very specific regarding schedule award findings for arthritis on x-rays of the lower extremities. Dr. Krohn opined that appellant did not fulfill the requirements for such impairment. He agreed with Dr. Stevens that 2.5 centimeters atrophy of the right thigh was ratable. Dr. Krohn advised that this corresponded to 11 percent impairment of the right leg in a range of potential impairments from 8 to 13 percent.

In an April 20, 2009 report, Dr. Barry Levine, a Board certified internist and an Office medical adviser[3] noted that Dr. Stevens evaluated appellant on February 2, 2009 with findings of 44 centimeters of the left thigh and 41.5 right thigh circumference, 3.5 of 5 right extension strength and 130 degrees right flexion. He opined that, based on right quadriceps atrophy, appellant had 10 percent right lower extremity impairment according to Table 17.6 on page 530 of the A.M.A., *Guides*. Dr. Levine also noted that appellant reached maximum medical improvement on February 2, 2009.

In an April 30, 2009 decision, the Office issued appellant a schedule award for 11 percent permanent impairment of the right lower extremity. It paid appellant compensation for 31.68 weeks from May 17 to December 24, 2005.[4]

Appellant requested a review of the written record on May 18, 2009. In a statement of the same date, he noted that his former representative informed him that the Office had discretion regarding "minimum and maximum time of payment for disability awards." Appellant asserted that he should be compensated "somewhere in the middle or maximum due to the amount of pain" he suffered daily. He also asserted that the minimum amount he received was not fair.

In an August 24, 2009 decision, an Office hearing representative affirmed the April 30, 2009 decision finding that the Office medical adviser properly determined appellant's impairment rating as 11 percent right lower extremity impairment.

[3] On April 17, 2009 the Office requested that the Office medical adviser evaluate Dr. Stevens' February 18 and 23, 2009 reports regarding impairment.

[4] On June 11, 2009 the Office adjusted appellant's schedule award compensation to reflect payment rate at the augmented 75 percent rate as he had a dependent.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[5] and its implementing regulations 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. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sounds discretion of the Office. For consistent results and to ensure equal justice, the Board has authorized 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 Office for evaluating schedule losses and the Board has concurred in such adoption.[6]

ANALYSIS

Appellant received a schedule award for 11 percent impairment for the right leg due to his accepted right knee dislocation. The Office found that a conflict in medical opinion existed between Dr. Selden, appellant's treating physician, and Dr. Cohen, an Office medical adviser, regarding the impairment rating for appellant's right lower extremity. Section 8123(a) of the Act provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[7] A conflict under section 8123(a) cannot exist unless there is a conflict between an attending physician and an Office physician.[8] The Board finds that the evidence from these physicians was not sufficient to create a conflict in medical opinion. In a December 15, 2008 report, Dr. Cohen did not determine the percentage of appellant's right leg impairment; rather he requested a report with measurements regarding each knee. Additionally, Dr. Selden's March 13, 2008 report is of little probative value as he did not explain how his impairment rating was made in accordance with the A.M.A., *Guides*.[9] Based on the nature of the reports from Drs. Selden and Cohen, there was no medical conflict and the Office improperly designated Dr. Stevens as an impartial medical specialist.

However, the Board finds that, although Dr. Stevens' report is not entitled to the special weight afforded to the opinion of an impartial medical specialist resolving a conflict in medical opinion, his report can still be considered for its own intrinsic value and can still constitute the

[5] 5 U.S.C. §§ 8101-8193. *See* 5 U.S.C. § 8107.

[6] *See* 20 C.F.R. § 10.404; *R.D.*, 59 ECAB ___ (Docket No. 07-379, issued October 2, 2007).

[7] 5 U.S.C. § 8123(a).

[8] *Delphia Y. Jackson*, 55 ECAB 373 (2004).

[9] *See I.F.*, 60 ECAB ___ (Docket No. 08-2321, issued May 21, 2009) (an opinion which is not based upon the standards adopted by the Office and approved by the Board as appropriate for evaluating schedule losses is of diminished probative value in determining the extent of permanent impairment).

weight of the medical evidence.[10] Also, as Dr. Stevens is an Office-referred physician, his examination and opinion constitute a second opinion.[11]

Dr. Stevens' February 2 and 23, 2009 reports constitute the most reliable and probative evidence regarding whether appellant has more than 11 percent impairment of the right leg. These are also the most recent reports from an examining physician that purport to rate impairment under the A.M.A., *Guides.* Dr. Stevens reviewed the medical evidence and provided detailed findings on examination in accordance with the A.M.A., *Guides.* In his February 2, 2009 report, he found right thigh atrophy as appellant's left thigh measured 44 centimeters and his right thigh measured 41.5 centimeters. Examination also revealed normal knee range of motion as appellant had full extension and 130 degrees of flexion. Although Dr. Stevens noted that x-ray findings revealed arthritic changes in the right patellar joint, he calculated 10 percent right knee impairment based on appellant's atrophy. In a February 23, 2009 supplemental report, he explained that he determined 10 percent right knee impairment based on Table 17-6 on page 530 of the A.M.A., *Guides.* Dr. Stevens noted that 2.5 centimeters of right thigh atrophy[12] fell within a range of 8 to 13 percent lower extremity impairment, of which he assigned 10 percent impairment within that range. He noted that this was also the total impairment for appellant's right leg.

In the February 18, 2009 report, Dr. Krohn found that appellant had 11 percent right thigh atrophy impairment based on a 2.5 centimeter difference in circumference, according to Table 17-6 on page 530 of the A.M.A., *Guides*. He also opined that appellant had 7 percent impairment for patellar subluxation with residual instability, citing Table 17-33 on page 546. Using the Combined Values Chart on page 604, he concluded that appellant had 17 percent right leg impairment. However, Dr. Krohn improperly combined these impairments as Table 17-2 on page 526 indicates that atrophy cannot be combined with patellar subluxation, which is a diagnosis-based estimate. With regard to the atrophy finding, his finding is generally consistent with that of Dr. Stevens. Furthermore, in his February 24, 2009 report, based on a review of Dr. Stevens' February 23, 2009 report, Dr. Krohn opined that appellant had 11 percent right leg impairment based on atrophy. Similarly, Dr. Levin, another Office medical adviser, opined in an April 20, 2009 report that appellant had 10 percent right leg impairment based on atrophy. Neither Office medical adviser set forth any basis, pursuant to a proper application of the A.M.A., *Guides,* to support any greater impairment of the right leg. The Board finds that any error in the discrepancy of the impairment rating due to thigh atrophy between Dr. Stevens and Dr. Krohn is harmless as the discrepancy involves a range within Table 17-6 and appellant received the benefit of an award for 11 percent impairment instead of 10 percent.

[10] *See Cleopatra McDougal-Saddler*, 47 ECAB 480 (1996); *see also Rosa Whitfield Swain*, 38 ECAB 368 (1987).

[11] *See Pierre W. Peterson*, 39 ECAB 955 (1988) (where the Board found that the opinion of a physician improperly designated as an impartial specialist constituted a second opinion and was entitled to the same weight as the other reports of record).

[12] Dr. Stevens determined appellant's right thigh atrophy by subtracting 44 centimeters of left thigh circumference by 41.5 centimeters of right thigh circumference to derive 2.5 centimeters as the difference in circumference, in accordance with Table 17-6.

For these reasons, the Board finds that the weight of the medical evidence rests with Dr. Stevens whose opinion and findings support that appellant has no greater permanent impairment of the right leg than that for which he has received a schedule award.

On appeal, appellant asserts that 30 weeks of schedule award compensation is insufficient as he has daily pain and suffering. However, he was actually awarded 31.68 weeks of compensation. Moreover, this award was properly calculated by multiplying 288 weeks of compensation for total, or 100 percent, right leg loss by 11 percent permanent impairment of the right lower extremity.[13] Additionally, the Board has held that factors such as limitations on daily activities are not considered in the calculation of a schedule award.[14]

CONCLUSION

The Board finds that appellant has no more than 11 percent impairment of the right lower extremity for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decisions dated August 24 and April 30, 2009 are affirmed, as modified.

Issued: September 8, 2010
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

[13] *See* 20 C.F.R. § 10.404; *see also* 5 U.S.C. § 8107(c)(2).

[14] *E.L.*, 59 ECAB ___ (Docket No. 07-2421, issued March 10, 2008).