United States Department of Labor
Employees' Compensation Appeals Board

T.S., Appellant	)	
and	)	**Docket No. 12-1953**
	)	**Issued: March 14, 2013**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Bay Pines, FL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 24, 2012 appellant filed a timely appeal from the August 23, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[2]

ISSUE

The issue is whether appellant has more than a 24 percent impairment of her left lower extremity, for which she received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

[2] Appellant requested an oral argument. The Clerk of the Board mailed a letter to appellant to confirm a continuing desire for an oral argument in Washington, DC. No written confirmation was received; thus the Board will decide the appeal on the record.

FACTUAL HISTORY

On April 17, 2007 appellant, a 56-year-old housekeeping aide, sustained a traumatic injury in the performance of duty when she slipped on a wet floor and fell. OWCP accepted her claim for a closed fracture of the left patella, a torn left medial meniscus and loose body. Appellant underwent an open reduction and internal fixation in 2007, a patella tendon repair in 2008 and a total patellectomy on September 29, 2008. On March 23, 2010 she underwent a left partial medial meniscectomy and synovectomy.

Appellant claimed a schedule award. Dr. Vladimir A. Alexander, her Board-certified orthopedic surgeon, evaluated her left lower extremity under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009). Applying Table 16-3, page 510, he found that appellant had a 22 percent default impairment rating as a result of her total patellectomy, which is classified as a moderate problem. As appellant's functional history[3] and clinical studies[4] were also moderate, the default impairment rating required no adjustment.

An OWCP medical adviser reviewed Dr. Alexander's evaluation and confirmed a 22 percent impairment of the left lower extremity resulting from appellant's total patellectomy. He noted, however, that appellant also had a two percent impairment as a result of her partial medial meniscectomy, according to Table 16-3, page 509. As this represented a separate structure, the medical adviser found it appropriate to combine both impairments for a total impairment of 24 percent.

On August 23, 2012 OWCP issued a schedule award for a 24 percent impairment of appellant's left lower extremity.

LEGAL PRECEDENT

FECA sets forth the number of weeks of compensation payable for permanent impairment from loss, or loss of use, of scheduled members or functions of the body. It does not, however, specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.[5]

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. OWCP has adopted the A.M.A., *Guides* as the appropriate

[3] A.M.A., *Guides* 516 (6th ed. 2009) (Table 16-6, Functional History Adjustment).

[4] *Id*. at 519 (Table 16-8, Clinical Studies Adjustment).

[5] *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

standard for evaluating schedule losses.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7]

ANALYSIS

Diagnosis-based impairment is the primary method of evaluating the lower extremity. Impairment is determined first by identifying the relevant diagnosis, then by selecting the class of the impairment: no objective problem, mild problem, moderate problem, severe problem, very severe problem approaching total function loss. This will provide a default impairment rating, which may be adjusted slightly based on grade modifiers or nonkey factors, such as functional history, physical examination and clinical studies.[8]

Table 16-3 of the A.M.A., *Guides* provides the default impairment ratings for diagnoses of the knee. For a diagnosis of total patellectomy, the default impairment is 22 percent of the lower extremity. This is classified as a moderate problem. Because Dr. Alexander, the attending orthopedic surgeon, also classified appellant's functional history and clinical studies as moderate, there is no adjustment. The default rating stands.[9]

A question arises whether OWCP may rate appellant's impairment on the basis of multiple diagnoses, as OWCP's medical adviser recommended. The A.M.A., *Guides* explains that in most cases, only one diagnosis in a region, such as the knee, will be appropriate. If a patient has two significant diagnoses, the examiner should use the diagnosis with the highest impairment rating in that region that is causally related for the impairment calculation.[10]

The A.M.A., *Guides* adds that selecting the optimal diagnosis requires judgment and experience. If more than one diagnosis in a region, such as a knee, can be used, the one that provides the most clinically accurate and causally-related impairment rating should be used. This will generally be the more specific diagnosis. Typically, one diagnosis will adequately characterize the impairment and its impact on activities of daily living.[11]

Accordingly, it appears that Dr. Alexander properly followed the protocols of the A.M.A., *Guides* when he selected the diagnosis of patellectomy over meniscectomy. OWCP's medical adviser reasoned that the two should be combined because they represented different structures, but the A.M.A., *Guides* does not discuss separate structures, it discusses regions. The knee is defined as the region from the mid femur to the mid tibia, including all the bone,

[6] 20 C.F.R. § 10.404.

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010).

[8] A.M.A., *Guides* 497.

[9] Dr. Alexander did not use the grade modifier for physical examination because he already used appellant's physical examination to define the class of impairment for the diagnosis of patellectomy. *Id*. at 515-16.

[10] *Id*. at 497.

[11] *Id*. at 499.

joint, ligamentous and soft tissue structures encompassing the joint.[12] Thus, appellant's patella and meniscus are both considered to be the knee. In most cases, only one diagnosis in a region, such as the knee, will be appropriate.

The Board finds that appellant has no more than the 24 percent awarded for the impairment of her left lower extremity. On that basis, the Board will affirm the August 23, 2012 schedule award.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has no more than a 24 percent impairment of her left lower extremity, for which she received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the August 23, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 14, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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

[12] *Id*. at 500.