U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of THOMAS L. IVERSON and DEPARTMENT OF THE TREASURY, CUSTOMS SERVICE, CANINE ENFORCEMENT PROGRAM, San Diego, CA

Docket No. 98-446; Submitted on the Record;
Issued August 5, 1999

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issues are: (1) whether appellant has more than a seven percent permanent impairment of his right lower extremity for which he received a schedule award; and (2) whether the Office of Workers' Compensation Programs abused its discretion by refusing to reopen appellant's claim for consideration of the merits on September 5, 1997.

The Board has duly reviewed the case on appeal and finds that it is not in posture for a decision.

Appellant filed a claim on April 16, 1996 alleging that he injured his right knee on April 15, 1996 in the performance of duty. The Office accepted appellant's claim for right knee meniscus tear and arthroscopy on May 3, 1996. Appellant requested a schedule award on September 1, 1996. By decision dated January 30, 1997, the Office granted appellant a schedule award for a seven percent permanent impairment of his right lower extremity. Appellant requested reconsideration on July 9, 1997 and the Office declined to reopen appellant's claim for consideration of the merits on September 5, 1997.

Under section 8107 of the Federal Employees' Compensation Act[1] and section 10.304 of the implementing federal regulations,[2] schedule awards are payable for permanent impairment of specified body members, functions or organs. However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants the Office adopted the American Medical

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R § 10.304.

Association, *Guides to the Evaluation of Permanent Impairments*,[3] as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[4]

In support of his claim for a schedule award, appellant submitted a report dated August 26, 1996 from his attending physician, Dr. Thomas W. Harris, an orthopedic surgeon. Dr. Harris noted appellant's continued complaints of knee pain due to damage to the weight bearing surface of the knee joint, as well as osteochondral damage to the patellofemoral joint. He stated appellant required medication for moderate knee pain after activity. Dr. Harris performed a physical examination and found that appellant walked with an antalgic gait to the right knee. He found medial and lateral joint line crepitus and tenderness along the medial and lateral joint line. Dr. Harris noted trace effusion to the right knee. He also found 0.5 centimeter (cm) loss of the right major quadriceps. Dr. Harris noted that appellant's May 16, 1996 surgery resulted in the diagnoses of a complex tear of the posterior horn of the medial meniscus, as well as, Grade II and Grade III chondromalacia of the medial femoral condyle and lateral femoral condyle intracondylar area. He stated that appellant underwent a partial medial meniscectomy and synovectomy. Dr. Harris found that appellant had reached maximum medical improvement.

Dr. Harris applied the A.M.A., *Guides*, to his findings and concluded that appellant had a two percent impairment due to a partial meniscectomy.[5] He found a full range of motion and strength. Dr. Harris noted appellant's pain, crepitus and effusion, the need to take narcotics and appellant's subjective right knee stiffness with activity. He concluded that these impairments, as well as the loss to the articular knee joint surface at the medical and lateral femoral condyles, warranted an impairment of 22 percent of the right lower extremity. Dr. Harris noted that the A.M.A., *Guides*, required radiographic evidence of decreased cartilage intervals, but stated that at the time of appellant's operative procedure appellant had a Grade II-III osteochondral defect of the weight bearing surface of the medial and lateral femoral condyles on direct visualization. He concluded, "In my opinion, this is rated at a 2 to 3 millimeter (mm) loss of the weight bearing surface of the medial and lateral femoral condyles with a remaining 1.0 to 1.5 mm interval. This is my basis for making my opinion." In accordance with that A.M.A., *Guides*, a cartilage interval of between 1 and 1.5 mm would be between 25 and 20 percent impairment of the lower extremity.[6]

The Office medical adviser reviewed Dr. Harris' report on October 7, 1996. He recommended rating appellant's right knee in accordance with Tables 62 and 64 of the A.M.A., *Guides*,[7] as Dr. Harris had. He noted that a partial menisectomy was a two percent impairment.[8] The Office medical adviser then stated that with some crepitus, but no roentgenographic

[3] A.M.A., *Guides*, (4th ed. 1993).

[4] *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[5] A.M.A., *Guides*, 85, Table 64.

[6] A.M.A., *Guides*, 83, Table 62.

[7] A.M.A., *Guides*, 83, Table 62; 85, Table 64.

[8] *Id.* at 85, Table 64.

evidence of narrowing appellant should be assigned a five percent impairment.[9] He concluded that appellant had seven percent impairment of his right lower extremity.

The Office medical adviser noted that Dr. Harris recommended impairment of 22 percent, but stated in the absence of roentgenographic narrowing and actual joint space narrowing on x-ray or direct vision, that it would be more applicable to utilize the footnote at the bottom of Table 62 allowing for the 5 percent impairment for crepitation on physical examination but without joint space narrowing on roentgenograph. He further noted that when utilizing the diagnosis-based estimates no additional value for loss of function due to pain, atrophy or loss of motion should be combined.

In this case, the Office credited the Office medical adviser's determination that appellant had five percent permanent impairment of the right lower extremity due to loss of cartilage intervals over Dr. Harris' finding that appellant had 20 percent impairment. Dr. Harris based his impairment rating of 20 percent on 1.5 mm of cartilage remaining in accordance with Table 62 which he observed on direct visualization when performing appellant's arthroscopy. The Board finds that Dr. Harris' impairment rating of 20 percent is insufficient to establish entitlement to a schedule award inasmuch as his rating for impairment due to arthritis based on Table 62 of the A.M.A., *Guides*, is not documented as supported by a "sunrise view" x-ray.[10] The Board, however, finds that the Office medical adviser's determination that appellant has a five percent permanent impairment of the right lower extremity is insufficient to establish a schedule award for the same reason, as the Office medical adviser used the findings and medical report of Dr. Harris and did not review nor request x-rays in order to determine the degree of appellant's permanent impairment.[11] The Board therefore finds that the case must be remanded to the Office for further development, a medical opinion that is consistent with the A.M.A., *Guides,* and an appropriate decision.[12]

[9] A.M.A., *Guides*, 83, Table 62. "In a patient with a history of direct trauma, a complaint of patellofemoral pain, and crepitation on physical examination, but without joint space narrowing on roentgenographs, a … five percent lower extremity impairment is given."

[10] Federal (FECA) Bulletin No. 96-17 (September 1996).

[11] *John M. Gonzales,* 48 ECAB ___ (Docket No. 95-397, issued February 25, 1997).

[12] Due to the disposition of this issue, it is not necessary for the Board to address whether the Office abused its discretion by refusing to reopen appellant's claim for consideration of the merits on September 5, 1997.

The decision of the Office of Workers' Compensation Programs dated January 30, 1997 is hereby set aside, and the case is remanded for further development consistent with this opinion.

Dated, Washington, D.C.
August 5, 1999

David S. Gerson
Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member