U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of PETER C. VORUM and DEPARTMENT OF THE AIR FORCE, WRIGHT-PATTERSON AIR FORCE BASE, Dayton, OH

Docket No. 03-1817; Submitted on the Record;
Issued September 16, 2003

DECISION and ORDER

Before ALEC J. KOROMILAS, DAVID S. GERSON, WILLIE T.C. THOMAS

The issue is whether appellant has more than a ten percent impairment of the right lower extremity and more than a nine percent impairment of the right long (second) finger, for which he received a schedule award.

On September 13, 1995 appellant, then a 45-year-old materials research engineer, sustained a traumatic injury when he fell while swinging from a rope during an employment-sponsored training exercise. Appellant's claim was initially denied; however, on December 6, 1999 the Office of Workers' Compensation Programs accepted the claim for right knee anterior cruciate ligament tear (resolved), right medial meniscus tear, left proximal interphalangeal (PIP) joint strain of the long finger (resolved) and right PIP joint strain of the long finger.[1] The Office subsequently expanded the claim to include sacrum and pelvis sprains and lumbosacral strain as additional accepted conditions. On January 24, 2002 the Office granted appellant a schedule award for a ten percent impairment of the right leg and a nine percent impairment of the left long (second) finger.[2] The award covered a period of 33.9 weeks and appellant received a payment of $26,026.73.

In a decision dated April 24, 2002, an Office hearing representative set aside the January 24, 2002 schedule award and remanded the claim for further development. The hearing representative noted that the Office had misidentified the finger that was permanently impaired. While the medical evidence indicated an impairment of appellant's right long finger, the Office erroneously identified appellant's left long finger as the impaired finger. Additionally, the hearing representative stated that it was not entirely clear how the Office determined the number

[1] Additionally, the Office retroactively authorized arthroscopic surgery for a right knee meniscectomy performed by Dr. Brian J. Ceccarelli, an osteopath, on September 19, 1996.

[2] The Office based its determination on the August 26, 2001 report of its medical adviser.

of weeks of compensation appellant was entitled to.[3] Lastly, the hearing representative stated that the Office medical adviser did not clearly explain the basis for his August 26, 2001 impairment rating. The hearing representative instructed the Office to obtain additional medical information from appellant's treating physician, Dr. Martin Fritzhand and then refer the additional information to the Office medical adviser for review.

On remand, the Office received a May 14, 2001 report from Dr. Fritzhand wherein he stated that appellant had a five percent impairment of his right upper extremity as a result of his injury involving the right long finger. Additionally, Dr. Fritzhand determined that appellant had a 40 percent impairment of his right lower extremity. Another Office medical adviser, Dr. Rajesh Bazaz, reviewed Dr. Fritzhand's report and determined that appellant had an eight percent impairment of the finger, which represented a two percent upper extremity impairment.[4] Additionally, the Office medical adviser calculated a two percent right lower extremity impairment.

By decision dated June 27, 2002, the Office found that appellant was not entitled to an additional schedule award. The Office explained that the recent medical evidence revealed that appellant's impairment was less than what he had previously been awarded and, therefore, he was not entitled to an additional schedule award.

Appellant requested a hearing, which was held on March 25, 2003. In a decision dated June 17, 2003, the Office hearing representative affirmed the June 27, 2002 decision denying an additional schedule award.

The Board finds that appellant failed to establish that he has more than a ten percent impairment of the right lower extremity and more than a nine percent impairment of the right long (second) finger.

Section 8107 of the Federal Employees' Compensation Act sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[5] The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the appropriate

[3] The Office awarded compensation for a combined 33.9 weeks. The hearing representative noted that, pursuant to 5 U.S.C. § 8107(c)(2), a 10 percent loss of use of a leg entitled appellant to 28.8 weeks of compensation. And a 9 percent loss of use of the second finger entitled appellant to an additional 2.7 weeks of compensation in accordance with 5 U.S.C. § 8107(c)(9). The combined award should have amounted to 31.5 weeks of compensation; not 33.9 weeks as the Office determined.

[4] Again, the Office medical adviser improperly identified appellant's impaired finger as the left long finger.

[5] 5 U.S.C. § 8107.

standard for evaluating schedule losses.[6] Effective February 1, 2001, schedule awards are determined in accordance with the A.M.A., *Guides* (fifth edition 2001).[7]

Dr. Fritzhand submitted two impairment ratings, both dated May 14, 2001. The initial May 14, 2001 report included an impairment rating under the fourth edition of the A.M.A., *Guides* (1993). Dr. Fritzhand's second May 14, 2001 report included the same history and physical examination findings as set forth in his initial report. However, this later report differs to the extent that Dr. Fritzhand rated appellant's impairment in accordance with the A.M.A., *Guides* (fifth edition 2001).

Dr. Fritzhand's initial report was reviewed by one Office medical adviser and his second May 14, 2001 report, which referenced the A.M.A., *Guides* (fifth edition 2001), was reviewed by another Office medical adviser, Dr. Bazaz. Although the medical information presented was essentially the same, the two Office medical advisers reached differing conclusions regarding the extent of appellant's permanent impairment. The first Office medical adviser, relying on Dr. Fritzhand's May 14, 2001 range-of-motion measurements, determined that appellant had a ten percent impairment of the right lower extremity and a nine percent impairment of the long (second) finger.[8] Dr. Bazaz, the second Office medical adviser, whose report is undated, similarly relied on Dr. Fritzhand's range-of-motion measurements and found that appellant's impairment to his long (second) finger was only eight percent,[9] which converted to a two percent upper extremity impairment. Regarding appellant's right lower extremity, the second Office medical adviser determined that appellant had only a two percent impairment.

The difference between the first and second Office medical adviser's calculation of appellant's lower extremity impairment was that the latter relied on the diagnosis-based estimates under Table 17-33 rather than appellant's reported loss of knee flexion under Table 17-10. The application of differing rating methods resulted in an eight percent decline in appellant's right lower extremity impairment rating. According to Table 17-2 at page 526 of the A.M.A., *Guides* (fifth edition 2001), the two rating methods are mutually exclusive. Thus, appellant cannot be rated based upon a combination of impairments under Table 17-33 and Table 17-10. The first Office medical adviser correctly noted in his August 26, 2001 report that appellant's reported knee flexion of 90 degrees represented a 10 percent lower extremity impairment under Table 17-10. The second Office medical adviser also correctly determined that appellant's September 19, 1996 partial medial meniscectomy of the right knee represented a two percent lower extremity impairment under Table 17-33. However, while he noted that

[6] 20 C.F.R. § 10.404 (1999).

[7] FECA Bulletin No. 01-05 (issued January 29, 2001).

[8] The long (2nd) finger impairment rating was based on Figure 16-23 at page 463 of the A.M.A., *Guides* (5th ed. 2001). Dr. Fritzhand reported flexion to 90 degrees and extension to 5 degrees. Under Figure 16-23, 90 degrees of flexion represents a 6 percent impairment and a loss of 5 degrees of extension falls between 0 and 3 percent impairment. It appears that the Office medical adviser gave appellant a 3 percent impairment, which under Figure 16-23 is equivalent to a loss of 10 degrees of extension.

[9] The second Office medical adviser similarly rated appellant's loss of flexion at six percent. However, unlike the first Office medical adviser, Dr. Bazaz gave appellant only a two percent impairment for the loss of five degrees of extension under Figure 16-23.

range-of-motion impairments could not be combined with diagnosis-based impairment estimates, the second Office medical adviser provided no justification for relying upon the diagnosis-based estimates instead of loss of range of motion under Table 17-10.[10]

The second Office medical adviser erred in determining that appellant could not be rated for his reported right knee patellofemoral chondromalacia. He explained that no x-ray evidence of joint space narrowing had been provided. Table 17-31 at page 544 of the A.M.A., *Guides* (fifth edition 2001) provides for a five percent lower extremity impairment for an individual with a "history of direct trauma, a complaint of patellofemoral pain and crepitation on physical examination, but without joint space narrowing on x-ray…." The history and physical findings necessary to support an impairment rating for arthritis are clearly demonstrated in the record; particularly Dr. Fritzhand's May 14, 2001 report and Dr. Ceccarelli's September 19, 1996 operative report. Thus, the absence of x-ray evidence of joint space narrowing does not preclude a rating for arthritis under Table 17-31.

While appellant's additional 5 percent impairment for arthritis under Table 17-31 may be combined with Dr. Bazaz's 2 percent impairment rating under the diagnosis-based estimates at Table 17-33, the 5 percent arthritis impairment cannot be combined with appellant's previously awarded 10 percent impairment for loss of knee flexion under Table 17-10.[11] Consequently, an additional five percent impairment for arthritis would not increase appellant's overall impairment rating above what he has already received for his right lower extremity.[12]

The record reveals that appellant's right anterior cruciate ligament (ACL) was surgically repaired in September 19, 1996 and Dr. Fritzhand noted in his May 14, 2001 report that there was no evidence of laxity. Therefore, there is no medical evidence demonstrating a permanent impairment associated with appellant's accepted ACL tear. Dr. Fritzhand also noted that appellant experienced constant sharp to dull low back pain with occasional radiation to the right hip and down the posterolateral aspect of the leg. On physical examination, Dr. Fritzhand reported that appellant's range of motion of the hips with the knees flexed was diminished to 90 degrees bilaterally. With respect to appellant's loss of hip flexion, the second Office medical adviser noted Dr. Fritzhand's measurements, but explained that its relevance to appellant's lower extremity injury was unclear. Dr. Fritzhand failed to explain the relationship between appellant's hip condition and his accepted injury. While appellant accepted conditions included sacrum and pelvis sprains and lumbosacral strain and Dr. Fritzhand reported symptoms of low back pain with occasional radiation to the right hip, the doctor did not clearly explain how appellant's bilateral loss of range of motion in the hips was related to either the accepted low back and pelvic strains or appellant's right knee injury.

[10] Dr. Bazaz stated that the most accurate assessment of appellant's right knee was based on arthroscopic evaluation. However, he did not explain why the September 19, 1996 arthroscopic evaluation provided a more accurate assessment than presumably Dr. Fritzhand's more recent May 14, 2001 physical examination findings.

[11] *See* Table 17-2 at page 526, A.M.A., *Guides* (5th ed. 2001).

[12] Under the Combined Values Chart, page 604 of the A.M.A., *Guides* (5th ed. 2001), a five percent impairment for arthritis of the patellofemoral joint (Table 17-31) combined with a two percent impairment for a partial medial meniscectomy (Table 17-33) would result in an overall lower extremity impairment of seven percent.

Dr. Fritzhand referenced Tables 17-9, 17-10, 17-33 and 17-37 as the basis for his 40 percent impairment rating, but he did not otherwise explain how he applied those particular tables to reach his overall impairment rating of 40 percent of the right lower extremity. His upper extremity impairment rating of five percent was similarly vague.[13] As Dr. Fritzhand did not specifically correlate his findings with the A.M.A., *Guides* (fifth edition 2001), his May 14, 2001 impairment rating is insufficient to establish the extent of appellant's permanent impairment.[14] Accordingly, appellant has failed to establish that he has more than a ten percent impairment of the right lower extremity and more than a nine percent impairment of the right long (second) finger.

The June 17, 2003 decision of the Office of Workers' Compensation Programs is hereby affirmed.

Dated, Washington, DC
September 16, 2003

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

[13] Dr. Fritzhand merely noted that he relied on Figure 16-23 and Tables 16-1, 16-2, 16-3, 16-18 and 16-29 in determining appellant's right upper extremity impairment.

[14] *Lela M. Shaw*, 51 ECAB 372 (2000).