U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JOHN BELLMER and U.S. POSTAL SERVICE,
POST OFFICE, Lynn, MA

Docket No. 02-1492; Submitted on the Record;
Issued April 3, 2003

DECISION and ORDER

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

The issue is whether appellant sustained greater than a 21 percent impairment to his right lower extremity, for which he received a schedule award.

Appellant filed multiple claims, alleging injuries to his right knee. Initially, he alleges that, on July 10, 1978, while delivering mail, a dog broke his chain and began chasing him, causing him to fall onto his right kneecap. The Office of Workers' Compensation Programs accepted appellant's claim for fractured right patella. He returned to work on September 10, 1978.

On July 25, 1980 appellant sustained an injury to his right knee after jumping onto a car to avoid being bitten by a dog; the Office accepted appellant's claim for internal derangement of the right knee. Arthroscopic surgery was completed on July 31, 1980 and he returned to work on October 14, 1980. On May 7, 1981 the Office issued a schedule award based on a 14 percent permanent loss of use of the right leg.

On November 10, 1981 appellant filed a claim alleging that he sustained an injury to his right knee on November 9, 1981. This claim was accepted on December 1, 1981 for strain right knee and internal derangement right knee. Appellant returned to work on November 30, 1981.

On May 22, 1997 appellant filed a claim for a supplemental schedule award.

In a medical report dated October 7, 1997, Dr. John J. Walsh, appellant's treating Board-certified surgeon, noted that appellant had multiple surgical procedures on his left knee and recent symptoms of his right knee. He noted:

> "Standing AP x-rays of the right knee were obtained, revealing a half millimeter joint space. The normal joint space for the knee as noted in the (fourth [edition of the] American Medical Association (A.M.A.), *Guides to Evaluation of Permanent Impairment* is 4 millimeter. Consistent with [T]able 62, page 3/88, [appellant]

has a 15 percent loss of function of the whole person and a 37.5 percent loss of function of the lower extremity. I would anticipate that he may require eventual definitive surgery in the form of a total joint arthroplasty, depending on his symptoms and his age.

By letter dated January 14, 1998, the Office asked Dr. Walsh for a determination of appellant's impairment rating for schedule award purposes. On February 24, 1998 Dr. Walsh answered questions propounded by the Office by indicating that appellant had reached maximum medical improvement "two[to] three years ago." He noted that appellant had retained active flexion of 100 degrees. Dr. Walsh further noted that there was an additional impairment of function due to weakness, atrophy, pain or discomfort estimated at 7 percent of the lower extremity and he recommended an impairment rating of 37.5 percent of the right lower extremity.

On April 21, 1998 the Office medical adviser reviewed appellant's record and concluded that there was insufficient information upon which to authorize an additional schedule award and recommended that he be referred for simultaneous standing AP films of both knees. In a report dated June 19, 1998, the Office medical adviser reviewed the bilateral standing x-rays of both knees and indicated that there was no objective information contained in the medical record by which to authorize an additional impairment for the right knee. He noted that the recent knee x-rays showed no significant change from the prior bilateral knee films. The Office medical adviser stated that it was likely that appellant's current discomfort results not from an intrinsic knee abnormality, but rather from bilateral lumbar radiculopathy. He indicated that even should appellant's discomfort derive from degenerative change in both knees, such degenerative change is symmetric and thus likely resulting from wear and tear of events of living and not from any particular job-related injury. The Office medical adviser further noted:

"[T]he degree of degenerative change is mild enough not to qualify by the 4th ed., [of the] A.M.A., *Guides*, page 3/83 Table 62 for loss of cartilage interval, described by Dr. Walsh in his letter of October 7, 1997.

In a medical report dated October 14, 1998, Dr. Robert Shapiro, a Board-certified orthopedic surgeon, noted appellant's history, reviewed the medical reports, examined him and found that he had: (1) degenerative post-traumatic and postoperative arthritis of left knee; (2) degenerative post-traumatic and postoperative arthritis of right knee; (3) status post-traumatic injuries to low back, specified herniated lumbar disc, right L5-S1 with secondary right lower limb radiculopathy and arachnoiditis, postoperative. He opined that appellant was permanently and totally disabled. In an addendum, Dr. Shapiro indicated that he was not comfortable with the A.M.A., *Guides:*

"For example, they offer various percents of loss of function according to limitation of motion. In [appellant's] case, I would find no loss of function in the knees; *i.e.*, unless I take into consideration the pathology and expected symptoms, leading me to close to 100 percent loss of function. A spine limited totally in mobility might elicit an estimation of 30[to] 40 percent [loss of function], when we know that the anticipated pain leads one to close to 100 percent. I prefer to

estimate my own figures and I have always realized that no two physicians agree on any particular figure."

By letter dated October 20, 1998, the Office referred appellant to Dr. James S. Hewson, a Board-certified orthopedic surgeon. In a medical report dated November 10, 1998, he noted:

"The left knee shows a range of motion of 0 to 105 degrees. [Appellant] has a two and one-half inch medial scar in the left knee from previous meniscectomy. He has a +one Lachman test on the left and there is no knee joint effusion. There is slight grating underneath the patella on the right and left knees. There is ridging noted at the femoral condyles on both knees medial and lateral femoral condyles.

"Diagnosis: This is significant osteoarthritis of both knees and the left knee had a previous existing arthritic change. The right knee problems are causally related to the incidents starting July 10, 1978 and including incidences of July 25, 1980 and November 9, 1981. These incidences are cumulative and it is impossible to differentiate between them in terms of impairment of the right knee.

"In my opinion, the right knee is impaired 15 percent by virtue of loss of range of motion, loss of cartilage, pain and previous meniscectomy. I find no evidence of additional impairment due to the right knee problems. [Appellant] is impaired by other factors such as the left knee and his back also, but primarily the right knee according to the 4th and 5th [ed. of the] A.M.A., *Guides* rates at 15 percent impairment of the right knee. According to the note that I have received and the history from [appellant], he has reached a plateau with maximum medical improvement since October 18, 1988."

On February 17, 1999 the Office medical adviser reviewed appellant's case. He stated:

"I have used the [4th ed. Of the] A.M.A., *Guides* to determine the percent[age of] impairment of the right lower extremity.

"Using Table 64, page 85, for patella fracture, undisplaced, healed, there is 7 percent impairment of the right lower extremity. I can find no documented evidence of a meniscectomy at any of the arthroscopies.

"Using Table 41, page 78, for 105 degrees of knee flexion, there is 10 percent impairment of the right lower extremity.

"Using Table 68, page 89, the maximum lower extremity impairment due to knee pain is 9 percent. Using Table 20, Class 4, page 151, there is 80 percent impairment for pain, which may prevent activity. 80 percent of 9 percent results in 7 percent impairment of the right lower extremity due to pain."

"Using the Combined Values Chart, page 322, 7 percent impairment due to patellar fracture combined with 10 percent for abnormal motion results in 16

percent. 16 percent combined with 7 percent due to pain results in 22 percent impairment of the right lower extremity.

"The above impairment could be adjusted if a radiologist reviews the most recent standing knee films and specifically reports on the cartilage intervals in the compartments of the right knee. If Table 62 is used to determine arthritis impairments based on x-ray determined cartilage intervals, there would be no impairment permitted for abnormal motion or for pain. If total knee replacement is performed, the lower extremity impairment could be determined based on outcome."

On March 23, 1999 the Office medical adviser modified his opinion. He noted that he made a mistake by combining impairment for undisplaced, healed patellar fracture with that for pain and abnormal motion. Accordingly, utilizing the Combined Values Chart, he took the 10 percent impairment for abnormal motion and combined it with 7 percent for pain and indicated that this resulted in a 16 percent impairment of the right lower extremity.

On April 20, 1999 the Office issued a schedule award for an additional two percent impairment of the right leg.

By letter dated May 17, 1999, appellant requested a hearing. By decision dated November 17, 1999, the hearing representative remanded for additional development. Specifically, the hearing representative stated that the Office should refer appellant for a second opinion and that this doctor should be requested to address whether the work-related back injuries contributed to the claimant's radiculopathy and if so, to evaluate permanent impairment of the right lower extremity from a combined evaluation of neurological and orthopedic injuries.

By letter dated January 13, 2000, the Office referred appellant to Dr. Hyman Glick, a Board-certified orthopedic surgeon, and Dr. Brian Mercer, a Board-certified neurologist. In a report dated January 28, 2000, Drs. Glick and Mercer reviewed appellant's medical and work history, conducted a physical examination and concluded that appellant had: (1) lumbosacral degenerative disc/spine disease; status post L5-S1 disc herniation with discectomy (1984), aggravation of preexisting degenerative lumbosacral disc/spine disease; (2) degenerative and post-traumatic arthritis of the right knee; and (3) degenerative and post-traumatic arthritis of the left knee. The panel noted:

"From a neurologic viewpoint, the right lower extremity impairment, due to the L5 and S1 sensory radiculopathy, based upon Table 83, page 130, would be a 5 percent impairment for the L5 sensory/pain radiculopathy and a 5 percent impairment of a right S1 sensory/pain radiculopathy causing a total 10 percent lower extremity impairment due to the radiculopathy. Using this model, additional impairments related to the lumbosacral loss of motion would also be applied. From the neurologic perspective, the DRE categorization is more appropriate since the range of motion measurements were of questionable validity."

* * *

"Based upon the history, medical records and examination, [appellant] suffers from degenerative and post-traumatic arthritis of the right knee of a mild to moderate nature. This diagnosis is causally related to the 1978 injury, which was aggravated by the injuries of 1980 and 1981. [Appellant] has reached a medical end result with respect to this diagnosis. Because of his diagnoses, he has a permanent disability. Based upon the [4th ed. of the] A.M.A., *Guides* [appellant] has a 15 percent right lower extremity impairment related to his right knee condition.

In response to questions propounded by the Office, Drs. Glick and Mercer responded:

"The work injury of 1983 with aggravation of the injury in 1988 contributed to the right L5 and S1 radiculopathy. The 1983 injury with a disc herniation requiring surgery would hasten the degenerative process of the lumbosacral spine. The increased symptoms reported in 1988 are consistent with a permanent aggravation with the 1988 injury. As noted in the neurologic report, solely evaluating the right lower extremity for impairment related to the L5 and S1 sensory pain radiculopathy is consistent with a 10 percent right lower extremity permanent impairment. Combining this 10 percent right lower extremity permanent impairment for the radiculopathy with the 15 percent right lower extremity impairment related to his degenerative and post-traumatic right knee condition, [appellant] has a total impairment of the right lower extremity of 24 percent (using combined values table)."

On May 9, 2000 the Office medical adviser reviewed the panel examination of January 28, 2000. He noted that he agreed with the panel that the right lower extremity pain is from lumbosacral radiculopathy involving the L5 and S1 nerve roots. The Office medical adviser then stated:

"I used the [4th ed. of the] A.M.A., *Guides* to determine the percent impairment of the right lower extremity.

"Using Table 83, page 130, the maximum lower extremity impairment for loss of function due to sensory deficit or pain is 5 percent for involvement of the L5 nerve root and 5 percent for involvement of the S1 nerve root.

"Table 11, Grade 3, page 48 allows 60 percent for pain, which interferes with activity. 60 percent of 5 percent results in 3 percent impairment of the right lower extremity due to involvement of L5 and 3 percent for S1. These are combined using the [C]ombined Values Chart, page 322 and result in 6 percent impairment of the right lower extremity due to lumbosacral radiculopathy.

"[The Federal Employees' Compensation Act's] regulations do not permit impairment for lumbar pain except insofar as the lower extremities may be involved.

"It has been previously determined that there is 16 percent impairment of the right lower extremity due to the separate right knee condition. Using the Combined

Values Chart, 16 percent impairment due to the right knee combined with 6 percent due to radiculopathy results in 21 percent impairment of the right lower extremity."

The Office medical adviser further noted that the date for maximum medical improvement for the right lower extremity due to the knee condition and the radiculopathy from the back condition was October 1990, based on the panel's opinion.

On May 19, 2000 the Office determined that appellant suffered from a 21 percent impairment of the right lower extremity. As appellant had already been paid based on a 16 percent impairment, the Office found him entitled to an additional 5 percent impairment.

By letter dated December 14, 2000, appellant requested reconsideration.

By decision dated January 9, 2002, the Office denied modification of the May 19, 2000 decision and noted that the additional five percent schedule award for impairment of the right lower extremity will be paid.

The Board finds that appellant has no more than a 21 percent impairment to his right lower extremity, for which he received a schedule award.

The schedule award provisions of the Act[1] and its implementing regulation,[2] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use of specified members, functions or organs of the body. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage loss of use.[3] 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 regulation as the appropriate standard for evaluating schedule losses.[4]

Pursuant to the Office's May 7, 1981 and April 20, 1999 decisions, appellant had already received an award based on a 16 percent impairment of the right lower extremity when he asked for a larger award.[5] The hearing representative, in the decision dated November 17, 1999, remanded the case for referral of appellant to a second opinion physician who would determine whether his work-related back injuries contributed to his radiculopathy and if so, to evaluate permanent impairment of the right lower extremity from a combined evaluation of neurological and orthopedic injuries. Pursuant to the hearing representative's instructions, appellant was

[1] 5 U.S.C. § 8107

[2] 20 C.F.R. § 10.404 (1999).

[3] 5 U.S.C. § 8107(c)(19).

[4] *See* 20 C.F.R. § 10.606(b)(2).

[5] The 16 percent impairment due to the right knee was properly determined by the Office medical adviser in his March 23, 1999 report and was the basis for the additional award made by the Office in its April 20, 1999 decision.

referred to Drs. Glick and Mercer, who indicated that appellant had a 15 percent right lower extremity impairment related to his right knee condition. With regard to appellant's radiculopathy, Drs. Glick and Mercer found that this was work related. Evaluating the right lower extremity for impairment related to the L5 and S1 sensory pain radiculopathy, Drs. Glick and Mercer, applying Table 83 of A.M.A., *Guides*, gave 5 percent impairment for the L5 sensory/pain radiculopathy and 5 percent for the S1 sensory pain radiculopathy for a total of 10 percent lower extremity impairment due to radiculopathy. However, in finding 10 percent impairment, Drs. Glick and Mercer neglected to finish applying the A.M.A., *Guides*. Pursuant to the A.M.A., *Guides*, the evaluator should follow the procedures described in Table 11 and 12,[6] which, briefly stated, that the sensory or motor impairment percent for the impaired nerve root is multiplied by a percent from Tables 11 or 12, that represents the degree of sensory or motor impairment.[7] The Office medical adviser, utilizing the findings of Drs. Glick and Mercer, completed the equation. He noted that Table 11, Grade 3, allows 60 percent for pain, which interferes with activity. The Office medical adviser properly noted that, 60 percent of 5 percent results in 3 percent impairments of the right lower extremity for L5 and 3 percent for S1. Using the Combined Values Chart, the Office medical adviser properly determined that appellant had a six percent impairment of the right lower extremity due to lumbosacral radiculopathy. Then the Office medical adviser noted that appellant had already received a schedule award for 16 percent impairment of the right knee (which is greater than the 15 percent that Drs. Glick and Mercer found). He, used the Combined Values Chart, took the 16 percent impairment due to the right knee and combined it with the 6 percent due to radiculopathy and found that appellant had sustained a 21 percent impairment to his right lower extremity for schedule award purposes. The Board finds that the Office medical adviser properly applied the A.M.A., *Guides*. Furthermore, other than appellant's allegation that he disagreed with the Office's conclusion, he has offered no additional medical evidence to support modification of the Office's May 19, 2000 decision.

[6] A.M.A., *Guides*, Table 11, page 48.

[7] A.M.A., *Guides*, page 130.

The decision of the Office of Workers' Compensation Programs dated January 9, 2002 is hereby affirmed.

Dated, Washington, DC
April 3, 2003

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member