United States Department of Labor
Employees' Compensation Appeals Board

J.B., Appellant	)	
and	)	**Docket No. 07-201**
	)	**Issued: March 28, 2007**
U.S. POSTAL SERVICE, MANHATTANVILLE STATION, New York, NY, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 30, 2006 appellant filed a timely appeal from a schedule award decision of the Office of Workers' Compensation Programs dated October 18, 2006. 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 met her burden of proof to establish that she has greater than 10 percent impairment of both lower extremities for which she received a schedule award.

FACTUAL HISTORY

On March 12, 1999 appellant, then a 52-year-old letter carrier, sustained employment-related low back and right hip strains and contusions to both knees when she fell in the course of her federal duties. On May 25, 1999 Dr. Malik Akhtar, an orthopedic surgeon, performed authorized arthroscopic surgery to repair meniscal tears of both knees. Appellant returned to limited duty on September 13, 1999 and continued under Dr. Akhtar's care until his death. In reports dated August 27 and October 22, 2004, Dr. Placido A. Menezes noted the history of

injury, appellant's treatment regimen and diagnosed traumatic arthritis of both knees. X-rays of the right and left knee on January 5, 2005 demonstrated moderate osteoarthritis on the right and mild osteoarthritis on the left. In reports dated January 26 and March 2, 2005, Dr. Douglas E. Padgett advised that appellant's knee arthritis was caused by the 1999 employment injury. He opined that she would need knee replacement surgery in the future. Dr. Padgett provided work limitations. In reports dated May 4 and June 23, 2005, Dr. Steven D. Zaretsky noted the history of injury, diagnosed knee arthritis and advised that, while there was no need for total knee replacements at the present time, her prognosis in that regard was guarded.

On September 19, 2005 appellant filed a schedule award claim. In a July 26, 2005 report, Dr. Norman M. Heyman noted the history of injury, appellant's complaints of knee pain and effusion and his review of certain medical records. He made findings on examination and diagnosed contusion of the right and left knee; postoperation for partial medial and lateral meniscectomy of the right knee, and questionable partial medial and lateral meniscectomy of the left knee; tricompartmental osteoarthrosis of the right knee greater than the left knee. Dr. Heyman advised that in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[1] she had no impairment rating for the tricompartmental osteoarthrosis. Under Table 17-7 of the A.M.A., *Guides*, she had a Grade 4 muscle function bilaterally, which, under Table 17-8, provided a knee impairment of 12 percent for knee flexion and 12 percent for knee extension or a 24 percent impairment of each knee. He then advised that, under Table 17-10, a mild degree of decreased knee range of motion yielded a 10 percent impairment of the right knee, and that under Table 17-33, her right knee meniscectomy entitled her to a 10 percent impairment. Dr. Heyman also found that under Table 17-33 she was entitled to a bilateral 12 percent impairment for articular surface displacement of a patellar fracture more than three millimeters (mm). Dr. Heyman concluded that appellant had a right knee impairment of 46 percent and a left knee impairment of 40 percent.

In reports dated November 3 and December 6, 2005, an Office medical adviser stated that, under Table 17-7 and 17-8, appellant was entitled to a 24 percent impairment for each knee. He noted that, pursuant to Table 17-2, only one method was to be used for evaluating impairment, advising that muscle function and diagnosis-based estimates were not to be used with a strength rating. The Office determined that a conflict in medical evidence was created between the opinions of Dr. Heyman and the Office medical adviser and referred appellant to Dr. Alan R. Miller, Board-certified in orthopedic surgery, for an impartial medical evaluation.[2] In a March 8, 2006 report, Dr. Miller noted the history of injury, appellant's complaints and his review of the medical record. Examination of both knees demonstrated healed arthroscopic scars with no obvious joint effusion. Right knee range of motion was 5 to 105 degrees and left 0 to 120 degrees. Lachman's test and anterior drawer sign were negative bilaterally and no lateral or medial instability was present. Dr. Miller diagnosed right and left knee internal derangement, status post arthroscopy; bilateral knee osteoarthritis, right greater than left and low back pain. He concluded that, based on the A.M.A., *Guides*, using Tables 17-10, 17-7 and 17-33, appellant had a 41 percent impairment of the right knee and a 34 percent impairment on the left.

[1] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

[2] Drs. Menezes, Padgett, Zaretsky and Heyman are also Board-certified in orthopedic surgery.

By report dated April 27, 2006, an Office medical adviser reviewed Dr. Miller's report. He advised that, pursuant to Table 17-10, appellant had a 10 percent right lower extremity impairment, based on knee flexion of 105 degrees and a 10 percent left lower extremity impairment, pursuant to Table 17-33, based on a partial medial and lateral meniscectomy. The Office medical adviser again noted that, under Table 17-2, only one method could be used in rating impairment. On May 16, 2006 the Office requested that Dr. Miller review the Office medical adviser's report and provided a supplementary explanation regarding appellant's impairment rating. In a May 18, 2006 report, Dr. Miller advised that his original report incorrectly calculated the percentage of impairment of appellant's lower extremities. He agreed that Table 17-2 of the A.M.A., *Guides* provides that only one method can be utilized for determining lower extremity impairments and, using Table 17-33 for a diagnosis-based estimate, found that appellant had a 10 percent impairment of the left lower extremity. Dr. Miller determined that, under Table 17-10, her knee range of motion of 5 to 105 degrees on the right yielded a 10 percent impairment of that lower extremity. He concluded that maximum medical improvement had been reached on December 1, 1999. Dr. Zaretsky continued to submit reports in which he noted appellant's complaints of increased right knee pain and that she used a cane. On January 26, 2006 he reported that left knee x-rays were taken.

By decision dated October 18, 2006, the Office granted appellant a schedule award for a 10 percent permanent impairment of both lower extremities, for a total of 57.6 weeks, to run from March 8, 2006 to April 15, 2007.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[3] and section 10.404 of the implementing federal regulation,[4] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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 Office, and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[5] Chapter 17 provides the framework for assessing lower extremity impairments.[6]

Office procedures indicate that referral to an Office medical adviser is appropriate when a detailed description of the impairment from the attending physician is obtained.[7] When a diagnosis-based impairment rating is applied, it is generally not appropriate to calculate

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *See Joseph Lawrence, Jr., supra* note 1; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[6] A.M.A., *Guides*, *supra* note 1 at 523-64.

[7] *Thomas J. Fragale*, 55 ECAB 619 (2004).

additional impairment based on anatomic or functional based methods (such as limitations of strength or range of motion).[8]

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.[9] When the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[10] Office procedures indicate that referral to an Office medical adviser is appropriate when a detailed description of the impairment from a physician is obtained.[11]

ANALYSIS

The Board finds that appellant has no more than a 10 percent upper impairment of both lower extremities. The Office found that a conflict had been created regarding appellant's degree of impairment between the opinions of Dr. Heyman and the Office medical adviser and referred her to Dr. Miller for an impartial evaluation. In his March 8, 2006 report, Dr. Miller noted his physical findings, and in his May 18, 2006 report opined that maximum medical improvement had been reached on December 1, 1999 and utilized Tables 17-33 and 17-10 to determine that appellant had 10 percent impairment of the left and the right lower extremities.

Table 17-2 of the A.M.A., *Guides* describes the types of impairment ratings that cannot be combined, including that muscle strength cannot be combined with a diagnosis-based estimate.[12] An impairment rating for arthritis, as found in Table 17-31 can, however, be combined with a diagnosis-based estimate.[13] Dr. Akhtar's operative report of May 25, 1999 provided that appellant had bilateral partial meniscectomies for medial and lateral tears. In accordance with Table 17-33 appellant would, therefore, be entitled to a 10 percent lower extremity impairment,[14] as found by both the Office medical adviser and Dr. Miller, the referee examiner. Dr. Miller also found that on examination of appellant's right knee, flexion was from 5 to 105 degrees, and in his May 18, 2006 report correctly advised that Table 17-10 provides that knee flexion of less than 110 degrees yields a lower extremity impairment of 10 percent.[15] Appellant had no loss of knee flexion on the left and would therefore not be entitled to a schedule award on that basis. Dr. Miller explained why he assigned separate methods to each

[8] A.M.A., *Guides*, *supra* note 1, section 17.2j at 545; *Derrick C. Miller*, 54 ECAB 266 (2002).

[9] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

[10] *Manuel Gill*, 52 ECAB 282 (2001).

[11] *See Thomas J. Fragale*, *supra* note 7.

[12] A.M.A., *Guides* at 526; *see Derrick C. Miller*, *supra* note 8.

[13] *Id.*

[14] *Id.* at 544.

[15] *Id.* at 537.

extremity. The Board therefore finds that he properly calculated appellant's left lower extremity based on her previous meniscectomy under Table 17-33 and her right lower extremity in accordance with Table 17-10 for loss of knee flexion.

As to cartilage interval narrowing as described in Table 17-31.[16] The record does not support impairment as the January 5, 2005 x-ray report did not describe cartilage intervals. While appellant submitted additional medical evidence from Drs. Menezes, Padgett and Zaretsky, none of these physicians provided an impairment analysis. Before the A.M.A., *Guides*, can be utilized, a description of impairment must be obtained from the claimant's physician. This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[17]

The Board finds that Dr. Miller's impairment evaluation is in accordance with the A.M.A., *Guides.* It is entitled to special weight and appellant has not established that she has greater than a 10 percent impairments to both lower extremities.[18]

CONCLUSION

The Board finds that appellant has no more than a 10 percent impairment of both lower extremities.

[16] *Id*. at 544.

[17] *Vanessa Young*, 55 ECAB 575 (2004).

[18] The Board notes that there is no provision under the act for bilateral leg impairment. The Office may, as an administrative convenience, grant a schedule award containing a single impairment rating representing the addition of left and right leg impairments if it first, as in this case, calculates that two leg impairments separately before deriving such a figure. *See Carl J. Cleary*, 57 ECAB ____ (Docket No. 05-1558, issued May 10, 2006).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated October 18, 2006 be affirmed.

Issued: March 28, 2007
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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