United States Department of Labor
Employees' Compensation Appeals Board

A.S., Appellant	)	
and	)	**Docket Nos. 08-1483 & 09-87**
	)	**Issued: December 10, 2008**
U.S. POSTAL SERVICE, POST OFFICE, Princeton, NJ, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On April 25, 2008 appellant filed a timely appeal of a March 8, 2008 decision of an Office of Workers' Compensation Programs' hearing representative who denied his claim for disability. On August 5, 2008 he timely appealed the Office's July 28, 2008 schedule award decision. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over these issues.

ISSUES

The issues are: (1) whether appellant established that he was disabled for the period October 24, 2006 to January 3, 2007, causally related to his employment-related conditions; and (2) whether appellant has more than 37 percent permanent impairment of his right leg, for which he received a schedule award.

FACTUAL HISTORY

On July 25, 2006 appellant, then a 50-year-old city carrier, sustained injury to his right knee when he stepped in a hole on a lawn while in the performance of duty. He stopped work

and did not return. The Office accepted the claim for sprain of the right knee. On September 3, 2006 Dr. Peter C. Vitanzo, a Board-certified orthopedic surgeon, diagnosed degenerative joint disease and opined that appellant could not return to work. In an October 20, 2006 report, Dr. Peter S. Sharkey, a Board-certified orthopedic surgeon, diagnosed degenerative arthritis of the right knee.

On October 23, 2006 Dr. Vitanzo repeated his diagnosis and indicated that appellant's knee would be injected with medication. He noted that, in relation to work, appellant was "capable of minimal activities." On November 6, 2006 Dr. Vitanzo indicated that appellant had modified restrictions. In a January 22, 2007 report, he indicated that he never told appellant that he needed "to be out of work and I made it very clear to him that he is capable of doing modified work."

In January 2007, appellant filed CA-7 forms claiming compensation for the period October 7, 2006 to January 20, 2007. On January 23, 2007 he indicated that he had prior surgery on his right knee in November 2003 to repair his anterior cruciate ligament and had no symptoms or disabilities since the repair. In 1989, appellant had arthroscopic surgery to clean out the patella. He addressed various past times, which included golf, bicycling and kayaking.

In a January 26, 2007 report, Dr. Sharkey recommended a total right knee replacement.

By decision dated February 28, 2007, the Office denied appellant's claim for disability from September 9, 2006 to January 20, 2007. It found that the medical evidence of record failed to establish appellant's disability for the claimed period.

In a July 25, 2006 report, Dr. Lance M. Sterman, an emergency room physician, diagnosed sprain to the right knee with possible further ligamentous injury. Dr. Sterman placed appellant off work and indicated that he would undergo an orthopedic evaluation. An August 3, 2006 report from Dr. Paul A. Marchetto, a Board-certified orthopedic surgeon, advised that appellant had degenerative medial compartment scalloping and narrowing. In a January 20, 2007 duty status report, Dr. Vitanzo indicated that appellant had ongoing knee pain but could return to sedentary work beginning October 23, 2006.

Appellant underwent a right total knee replacement on March 7, 2007, which was performed by Dr. Sharkey. In a March 15, 2007 report, Dr. Marchetto stated that he healed appellant on August 3, 2006 and reviewed his history of injury and treatment. He diagnosed degenerative joint disease of the right knee with an acute exacerbation following the injury of July 25, 2006. Dr. Marchetto opined that a permanent anatomical impairment was caused by the July 25, 2006 fall.

On March 19, 2007 appellant requested a hearing. On July 18, 2007 this was changed to a request for a review of the written record. In an April 27, 2007 report, Dr. Sharkey noted that appellant returned evaluation following his right knee surgery. The physical evaluation revealed satisfactory wound healing, relatively pain free motion and active flexion greater than 90 degrees. Dr. Sharkey noted that lateral x-rays revealed satisfactory positioning and alignment of the right knee.

By letter dated July 23, 2007, appellant's representative requested that the Office approve his claims for disability and authorize the right knee replacement procedure.

By decision dated September 14, 2007, the Office hearing representative set aside the February 28, 2007 decision. The Office hearing representative found that additional development of the evidence was warranted with regard to whether appellant's preexisting right knee condition was exacerbated by his July 25, 2006 work injury.

In an October 19, 2007 report, Dr. Sharkey noted that appellant was functioning well after his right total knee arthroplasty. X-rays revealed satisfactory positioning and alignment of the right knee with no definite evidence of loosening.

The Office referred appellant to Dr. Robert Allen Smith, a Board-certified orthopedic surgeon. In a November 8, 2007 report, Dr. Smith reviewed appellant's history of injury and treatment. He conducted a physical examination and noted a well-healed scar and moderate effusion. Appellant had no pain about the knee at rest and only occasional pain when he accidentally twisted his knee. He could walk up and down steps without difficulty or assistance. Dr. Smith provided range of motion measurements which were satisfactory, noting 0 degrees of extension and 120 degrees of flexion. He found no instability about the knee in either the anterior posterior or medial lateral planes and no flexion contracture or extensor lag. Additionally, Dr. Smith indicated that appellant's alignment was three degrees of valgus, which was optimal. He noted that motor strength was satisfactory and there was no atrophy. Dr. Smith opined that appellant sustained a permanent exacerbation of his preexisting degenerative disease due to the July 25, 2006 employment injury. He indicated that the injury also caused persistent symptoms and the eventual total knee replacement, which was medically necessary to treat the exacerbation of his preexisting arthritis related to the July 25, 2006 employment injury. Appellant was found capable of working "at least light duty from September 9, 2006 until the time he had the surgery in March 2007." Dr. Smith advised that it was reasonable for appellant to be off work for two months following a total knee replacement. He advised that appellant returned to work in a regular duty capacity on May 14, 2007.

In a November 30, 2007 decision, the Office accepted that appellant's injury caused a permanent exacerbation of his preexisting right knee arthritis and the need for total knee replacement. However, the Office denied his claim of disability from September 9, 2006 to January 20, 2007, as the medical evidence established that he was capable of working light duty.

On December 1, 2007 appellant's representative requested a hearing, contending that appellant was unable to work without restrictions and that the employing establishment did not make work available within his restrictions.

In a letter dated December 17, 2007, appellant noted that he was capable of modified duty but was never offered such a position until February 4, 2007. He advised that Dr. Lance Sterman completed a July 25, 2006 duty status report and placed him off work.

In an August 31, 2006 report, Dr. Marchetto addressed appellant's complaints of right knee pain and varus deformity. He provided appellant with a knee brace. On October 5, 2006 Dr. Marchetto indicated that the knee brace provided appellant with some relief but he could not

perform extended activities. He recommended that appellant stay off work pending evaluation by Dr. Sharkey.

By decision dated March 7, 2008, the Office hearing representative found that appellant was entitled to compensation for total disability for the period September 9 to October 23, 2006. The hearing representative found that appellant did not establish disability for work from October 24, 2006 to January 3, 2007.

In a letter dated March 19, 2008, Karin Roy, a health and resource management specialist at the employing establishment, provided a copy of a January 20, 2007 duty status report. Dr. Vitanzo advised that appellant could return to work on October 23, 2006. Ms. Roy indicated that the employing establishment was not provided with this information until January 31, 2007. She noted that the employing establishment informed appellant that limited-duty work was available and he returned to work on February 5, 2007.

On June 3, 2008 appellant filed a claim for a schedule award. He submitted a March 27, 2008 report from Dr. Daisy Rodriguez, a Board-certified internist, who reviewed appellant's history of injury and medical treatment, which included a previous anterior cruciate ligament repair in 2003. Dr. Rodriguez stated that appellant had dysesthesia in the right medial knee and numbness from the scar. Regarding sensation, she indicated that appellant had a reduced two-point discrimination at 16 millimeters in the distribution of the odurator and saphenous cutaneous nerves. Dr. Rodriguez indicated that the reduced two-point discrimination spared the femoral cutaneous area but included the entire saphenous area. On physical examination the right knee had a 21 centimeter (cm) long and 2 cm wide atrophic surgical scar and range of motion of the right knee included 0 degrees extension and 135 degrees of flexion. Dr. Rodriguez utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*) (5th ed. 2001) to find that appellant had 37 percent impairment due to the right total knee replacement.[1] She arrived at this percentage by adding 45 points for pain, 25 points for range of motion and 25 points for stability, for a total of 95 points and represented a good result. Dr. Rodriguez also indicated that appellant was entitled to an award based upon injury to the femoral nerve of five percent.[2] She arrived at this percentage by adding a sensory impairment of two percent to the seven percent for dysesthesias for a total of nine percent. Dr. Rodriguez then applied a Grade 3, which would translate to 60 percent of the nerve value. She determined that this would result in five percent impairment to the leg for the femoral nerve. Dr. Rodriguez also indicated that appellant had impairment of 61 percent for skin disfigurement.[3] She combined the impairments and opined that appellant had a total 76 percent right lower extremity impairment.

In a June 28, 2008 report, the Office medical adviser addressed appellant's history, which included two prior surgical procedures to the right knee in 1989 and 2003, which involved an anterior cruciate ligament repair. He noted that both Dr. Sharkey and Dr. Smith did not find any

[1] A.M.A., *Guides* 547, 549, Tables 17-33, 17-35.

[2] *Id*. at 482, 552, Tables 16-10 and 17-37.

[3] *Id*. at 178, Table 8-2.

femoral deficit or skin disfigurement following surgery. The Office medical adviser referred to Table 17-35 for rating knee replacement results.[4] He noted an assessment of 45 points for pain, range of motion of 25 points, flexion contracture of 0, extensor lag of 0, alignment of 0 for a total of 95 points. The Office medical adviser referred to Table 17-33[5] and explained that a "good result" was 85 to 100 points. As appellant's result fell in the good category, he had 37 percent impairment of the right leg. The Office medical adviser opined that appellant reached maximum medical improvement on March 27, 2008.

On July 29, 2008 the Office granted appellant a schedule award for 37 percent impairment of the right lower extremity. The award covered a period of 106.56 weeks from March 27 to August 22, 2008.

LEGAL PRECEDENT -- ISSUE 1

As used in the Federal Employees' Compensation Act, the term "disability" means incapacity, because of an employment injury, to earn the wages the employee was receiving at the time of injury.[6] When the medical evidence establishes that the residuals of an employment injury are such that, from a medical standpoint, they prevent the employee from continuing in her employment, she is entitled to compensation for any loss of wage-earning capacity resulting from such incapacity.[7]

Whether a particular injury causes an employee to be disabled for employment and the duration of that disability are medical issues which must be proved by a preponderance of the reliable, probative and substantial medical evidence.[8] Findings on examination are generally needed to support a physician's opinion that an employee is disabled for work. When a physician's statements regarding an employee's ability to work consist only of repetition of the employee's complaints that she hurt too much to work, without objective findings of disability being shown, the physician has not presented a medical opinion on the issue of disability or a basis for payment of compensation.[9] The Board will not require the Office to pay compensation for disability in the absence of any medical evidence directly addressing the specific dates of disability for which compensation is claimed. To do so would essentially allow employees to self-certify their disability and entitlement to compensation.[10]

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[4] *Id*. at 549.

[5] *Id*. at 546, 547.

[6] *Richard T. DeVito*, 39 ECAB 668 (1988); *Frazier V. Nichol*, 37 ECAB 528 (1986); *Elden H. Tietze*, 2 ECAB 38 (1948); 20 C.F.R. § 10.5(f).

[7] *Bobby W. Hornbuckle*, 38 ECAB 626 (1987).

[8] *See Fereidoon Kharabi*, 52 ECAB 291, 293 (2001); *Edward H. Horton*, 41 ECAB 301, 303 (1989).

[9] *G.T.*, 59 ECAB ___ (Docket No. 07-1345, issued April 11, 2008); *see Huie Lee Goal*, 1 ECAB 180,182 (1948).

[10] *See G.T., supra* note 9; *see Fereidoon Kharabi, supra* note 8.

ANALYSIS -- ISSUE 1

The Office accepted appellant's claim for sprain of the right knee and permanent exacerbation of his preexisting degenerative arthritis which necessitated a total knee replacement. It also accepted his claim for disability for the period September 9 through October 23, 2006. However, the Office found that the medical evidence did not establish that appellant was disabled from October 24, 2006 through January 3, 2007.

Appellant has the burden of establishing by the weight of the substantial, reliable and probative evidence a causal relationship between his claimed total disability for the period October 24, 2006 through January 3, 2007 and the accepted conditions.[11] The reports of his physicians do not provide a rationalized medical opinion finding him disabled for work for the claimed period due to his accepted condition. Therefore, the medical evidence submitted is insufficient to meet appellant's burden of proof.[12]

The relevant reports from appellant's treating physician, Dr. Vitanzo, establish that appellant was released to perform modified duty from October 24, 2006 through January 3, 2007. On October 23, 2006 Dr. Vitanzo opined that appellant was "capable of minimal activities." He continued to treat appellant and advise of modified restrictions. In January 20, 2007 duty status report, Dr. Vitanzo advised that appellant could return to work in a sedentary capacity beginning October 23, 2006. On January 22, 2007 he stated that he "never said he needed to be out of work and I made it very clear to him that he is capable of doing modified work." The reports of Dr. Vitanzo established that appellant was capable of working at modified duty during the period October 24, 2006 to January 3, 2007. Similarly, on November 8, 2007 Dr. Smith opined that appellant could work light duty during this period.

The other reports submitted by appellant did not address the period of claimed disability.

Appellant has not submitted sufficient medical opinion evidence to establish that he was disabled for the period October 24, 2006 to January 3, 2007 as a result of his accepted employment injury. The Board finds that the Office properly denied his claim for wage-loss compensation.

LEGAL PRECEDENT -- ISSUE 2

Section 8107 of the Act[13] 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.[14] 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 for all claimants under

[11] *See Amelia S. Jefferson*, 57 ECAB 183 (2005); *see also Nathaniel Milton*, 37 ECAB 712 (1986); *Joseph M. Whelan*, 20 ECAB 55 (1968) and cases cited therein.

[12] *Alfredo Rodriguez*, 47 ECAB 437 (1996).

[13] 5 U.S.C. §§ 8101-8193.

[14] 5 U.S.C. § 8107.

the law, good administrative practice requires the use of uniform standards applicable to all claimants.[15] The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[16]

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the tables in the A.M.A., *Guides*.[17] However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment.[18]

ANALYSIS -- ISSUE 2

In support of his schedule award claim, appellant submitted a March 27, 2008 report from Dr. Rodriguez. The record also contains a June 28, 2008 report from the Office medical adviser. Both physicians agreed that appellant had 37 percent impairment to the right lower extremity based on his total knee replacement surgery.

The Board notes that Table 17-33, page 547 of the A.M.A., *Guides,* divides impairment following total knee replacement into three categories: good results (37 percent), fair results (50 percent) and poor results (75 percent). Dr. Rodriguez found that appellant had a good result following surgery. The Office medical adviser reviewed the medical record and agreed. Under Table 17-34, the factors used to rate a good result from a total knee replacement include pain, range of motion, stability and alignment. The Board finds that he has a 37 percent impairment of the right lower extremity.

Dr. Rodriguez also indicated that appellant was entitled to an additional award based upon sensory loss to the femoral nerve of five percent.[19] She arrived at this percentage by adding a sensory impairment of two percent to the seven percent for dysesthesias for a total of nine percent. Dr. Rodriguez described the extent of sensory loss as Grade 3 or 60 percent. This resulted in five percent impairment to the lower extremity for femoral nerve sensory loss. As noted, however, Table 17-34[20] is designed to rate the results of knee replacement surgery. Points are assigned for pain, range of motion and stability, with points deducted for flexion contracture, extension lag and alignment. Since pain is a factor already included in the 37 percent assigned for the total knee replacement surgery, appellant would not be entitled to an additional sensory

[15] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[16] 20 C.F.R. § 10.404.

[17] *See William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

[18] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000); *see also Paul A. Toms*, 28 ECAB 403 (1987).

[19] A.M.A., *Guides* 482, 552, Tables 16-10, 17-37.

[20] *Id*. at 548.

loss.[21] The Board also notes that neither the attending surgeon nor the second opinion physician, provided any objective findings pertaining to a femoral nerve deficit.

Additionally, Dr. Rodriguez rated an impairment of 61 percent for skin disfigurement.[22] However, under 5 U.S.C. § 8107(c)(21), a schedule award for disfigurement is limited to the face, head or neck. The Act makes no provision for scarring or disfigurement of any other part of the body. Neither the Office nor the Board has the authority to enlarge the terms of the Act or to make an award of benefits under any terms other than those specified in the statute or regulations.[23] The record establishes that appellant's work-related scars are located on his right knee. The Board finds that appellant is not entitled to an award for scarring or disfigurement of his leg.[24]

The Board finds that appellant had not submitted sufficient evidence to establish that he has more than 37 percent impairment to the right lower extremity.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he was disabled for the period October 24 to January 3, 2007. The Board also finds that appellant has not established that he has more than a 37 percent permanent impairment of his right lower extremity, for which he received a schedule award.

[21] *See id*. at 548 (in discussing diagnosis based estimates, provides that the evaluating physician should generally use only one approach for each anatomic part).

[22] A.M.A., *Guides* 178, Table 8-2.

[23] *See Richard T. DeVito, supra* note 6.

[24] *See William Tipler*, 45 ECAB 185 (1993); *Norma Jean Polen*, 24 ECAB 64 (1972) (finding no award payable for disfigurement of the breast, abdomen, thighs or right arm).

ORDER

IT IS HEREBY ORDERED THAT the July 28 and March 8, 2008 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: December 10, 2008
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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