U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of CARLOS CANDELARIO and U.S. POSTAL SERVICE,
POST OFFICE, Santa Clarita, CA

Docket No. 03-178; Submitted on the Record;
Issued May 16, 2003

DECISION and ORDER

Before COLLEEN DUFFY KIKO, DAVID S. GERSON,
MICHAEL E. GROOM

The issue is whether appellant has greater than a nine percent impairment of the right lower extremity and a four percent impairment of the left lower extremity.

On February 6, 1999 appellant, then a 40-year-old mail carrier, filed a traumatic injury claim alleging that he injured his right knee in an employment-related motor vehicle accident. The Office of Workers' Compensation Programs accepted his claim for thoracolumbar strain, aggravation of preexisting spondylolisthesis at L4-5 and right knee strain with arthroscopic surgery.[1] Appellant received compensation for the appropriate periods of wage loss.

On March 31, 2001 appellant requested a schedule award.

In a report dated April 16, 2001, Dr. Scott Baden, a Board-certified orthopedic surgeon and appellant's treating physician, noted his history of injury and treatment and conducted a physical examination. He conducted several tests that were negative and stated they included the: Lasègue's sign; contralateral SLR; Patrick's test, Gaenslen's test; Babinski's and ankle clonus. Dr. Baden noted that motor testing revealed no motor weakness in either lower extremity and sensation testing in the lower extremities revealed no impairment. Regarding motor testing, he noted no weakness in either extremities and the sensation in the lower extremities was not impaired. He conducted that vascular testing indicating posterior tibial and dorsalist pedis pulses were also present, the deep tendon reflexes for knee and ankle jerks was positive three and they were equal and reactive. Dr. Baden noted that, regarding the right knee, appellant ambulated with an abnormal gait, with a limp on the right, there were healed arthroscopic portals on the right knee, a five centimeter incision on the anteromedial aspect of the right knee, with no evidence of swelling, heat inflammation, synovial thickening or effusion and medial joint line tenderness. He found a three positive patellar crepitation, the apprehension

[1] The record reflects that appellant filed a subsequent claim on January 15, 2000 alleging that he was lifting a tub of flats when he felt a snap in his back in the performance of his job duties.

test was negative with lateral stressing of the patella and no ligamentous laxity, the patella grind test was positive, the quadriceps, hamstrings and popliteal space were normal and sensation was intact with no trophic changes and no evidence of atrophy.

Regarding range of motion, for flexion, Dr. Baden indicated that appellant had 135 degrees on the right and left and for extension 180 degrees on the right and left. Dr. Baden indicated that appellant stood on his heals with difficulty and with pain. He indicated that appellant stood on his toes without difficulty or pain and squatted, kneeled and stooped without difficulty and with pain, although he stood on the right and left foot without difficulty or pain. Regarding leg length, he indicated the umbilicus was 42½ on the right and left and the crest was 42¼ on the right and left. Dr. Baden found the circumference of the thighs to be 19 inches on the right and left, the calves were 15 inches on the right and left and the ankles were 14 inches on the right and left. He found that the objective factors of disability for the right knee were; multiple healed arthroscopic portals and a healed five centimeter incision on the anteromedialaspect of the right knee, an abnormal gait with a limp present on the right, medial joint line tenderness, plus three patellar crepitation, positive patella grind test, standing on the heels with difficulty and pain, squatting, kneeling and stooping with difficulty and pain.[2] Dr. Baden stated the subjective factors of disability were intermittent slight to moderate discomfort increasing to moderate discomfort with repetitive kneeling, stopping, squatting, ascending and descending staircases and stepladders. He diagnosed: residuals for a chronic thoracolumbosacral strain; Grade I spondylolisthesis, L4-5, lumbar spine; degenerative disc disease, lumbar spine, L5-S1; status postarthrotomy with patellar chondroplasty of the right knee; status postoperative arthroscopy, right knee, with resection of medial snyonvial plica, subtotal synovectomy and patelloplasty, June 22, 1999; status postrepeat operative arthroscopy, right knee, with partial synovectomy, patelloplasty, June 30, 2000; and residual patellofemoral chondromalacia, right knee. Dr. Baden indicated that appellant's condition was permanent and stationary. He provided a work restriction regarding the lumbar spine of no heavy lifting, repeated bending or stooping. Regarding the right knee, Dr. Baden stated no repetitive kneeling, stooping, squatting, ascending or descending staircases or stepladders. He added that all of the restrictions were "prophylactic." Dr. Baden did not provide an impairment rating.

By letter dated May 24, 2001, the Office advised appellant that he was being referred for an examination to determine whether he sustained an impairment due to his work injury.

In an August 16, 2001 report, Dr. William C. Boeck, a Board-certified orthopedic surgeon and second opinion impartial physician, conducted a physical examination comprised of vital signs, stance and gait, flexion and extension, circumferential measurements and diagnosed right knee strain, status post arthroscopy. Dr. Boeck noted that appellant had pain in the category of uncomfortable, localized in the patellar tendon and to the joint line medially and laterally. He indicated that the pain interfered with daily activity to the extent it interfered with the amount of time appellant could walk and stand on his feet, there was no sensory loss and there was a one centimeter difference in the circumference of the right thigh compared with the left, but no weakness was apparent in the examination. Dr. Boeck added that there were

[2] Dr. Baden also noted the magnetic resonance imaging findings from April 5, 1999, March 17 and March 28, 2000.

arthroscopic scars over the right knee with a short vertical incision medial to the patella. He conducted that motion examinations of the lower extremities by goniometer and found: for the knee flexion was 125 degrees on the right and 140 degrees on the left, with normal being 135. Dr. Boeck did not provide any figures for the extension. The circumferential measurement of the leg lengths was 98 centimeters, the thigh was 46 centimeters on the right and 47 on the left and the calf was 39.5 centimeters on the right and left at the widest portion. Dr. Boeck indicated his examination of the lower extremities revealed a complaint of pain at the limits of flexion of the right knee, with no effusion, no increased warmth, no swelling about the right knee and some tenderness to palpation over the patellar tendon at the junction of the patella, negative McMurray tests and no ligamentous laxity. He did not provide an estimate of the percentage of loss of strength.

In a September 26, 2001 report, Dr. Leonard A. Simpson, a Board-certified orthopedic surgeon and Office medical adviser, reviewed the record, including the reports of Dr. Baden dated April 16, 2001 and Dr. Boeck dated August 16, 2001. He noted that appellant had right knee pain that may interfere with activity, which would be graded a maximal Grade III using the grading scheme found in Table 16-10 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. Dr. Simpson opined that this would be a 60 percent grade of a maximal 7 percent (femoral nerve), equivalent to a 4.2 percent or rounded off to 4 percent impairment for pain factors. He stated that the range of motion was documented at 0/0 through 120/135, which would equate to a 0 percent impairment as per Table 17-10. Dr. Simpson indicated that the thigh atrophy of one centimeter would be rated three percent impairment as per Table 17-6. He then indicated that a value for loss of function due to muscle atrophy could not be combined with a value for limitation of motion (which in this particular case was zero percent), or a value for peripheral nerve injury (pain and/or altered sensation), as per Table 17-2. Dr. Simpson indicated that totaled a four percent impairment of the right lower extremity or leg.

The Office medical adviser also used a second method of calculating the award based on the presence of patellofemoral pain, the operative findings, coupled with the clinical findings of crepitation and/or tenderness. He stated that there was no roentgenographic documentation of narrowing of the patellofemoral joint and the pathology described would equate to that set forth in the footnote attached to Table 17-31, or a five percent impairment. The Office medical adviser advised the second method arrived at a higher award and should be adopted, for a five percent impairment of the right lower extremity or leg. He recommended March 7, 2001 as the date of maximum medical improvement, which corresponded to the date of evaluation by the primary treating physician.

The Office medical adviser noted that he was not asked to calculate any award for the permanent functional loss of the lower extremities due to the accepted back strain, which is a "thoracolumbar strain" and aggravation of preexisting spondylolisthesis. However, if he were to calculate an award for the permanent functional loss of the lower extremities as a result of the accepted back condition, he opined that the records described lower back pain and bilateral lower extremity radicular-type symptoms. The Office medical adviser explained that with pathology at L4-5, one would select the L5 nerve root which is assessed at a maximal five percent impairment for loss of function due to sensory deficit and/or pain (Table 15-18). The Office medical adviser indicated that one would grade the pain a maximal Grade II, which would

prevent some activities, or an 80 percent of 5 percent, for a 4 percent impairment of each lower extremity or leg. He noted that the records did not describe any atrophy or weakness secondary to the back condition and they did not describe any loss of peripheral joint range of motion secondary to the back condition. Thus, he opined, if one were to calculate an award for the permanent functional loss of each lower extremity due to the back condition, there would be a four percent impairment of each lower extremity. The Office medical adviser explained that this would be combined with the five percent impairment for the right knee pathology to arrive at a nine percent impairment of the right lower extremity, and a four percent impairment of the left lower extremity. He again indicated that the date of maximum medical improvement would be March 7, 2001.

On October 18, 2001 the Office granted appellant a schedule award for a nine percent impairment of the right lower extremity and a four percent impairment of the left lower extremity. The award covered a period of 37.40 weeks from March 7 to November 24, 2001.[3]

The Board finds that appellant has no greater than a nine percent impairment of the right lower extremity and a four percent impairment of the left lower extremity

The schedule award provisions of the Federal Employees' Compensation Act[4] and its implementing regulation[5] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. 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.[6]

In the instant case, appellant's attending physician, Dr. Baden and the Office second opinion impartial physician, Dr. Boeck, provided detailed reports, which included objective measurements but did not provide analysis under the A.M.A., *Guides.*

Dr. Simpson, the Office medical adviser, relied upon Drs. Baden's and Boeck's objective and subjective findings to assess the degree of permanent impairment of appellant's left and right lower extremities. Dr. Simpson properly applied the A.M.A., *Guides*[7] to calculate a nine percent impairment of the right lower extremity and a four percent impairment of the left lower extremity.

[3] The record reflects that the Office rendered a decision on October 23, 2001 regarding appellant's wage-earning capacity; however, he is not appealing that decision.

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404 (1999).

[6] A.M.A., *Guides* (5th ed. 2001).

[7] A.M.A., *Guides* (5th ed. 2000).

The Board finds that the reports of Drs. Baden and Boeck did not comform with the instructions found in the A.M.A., *Guides.* The Office medical adviser thus applied the relevant standards of the A.M.A., *Guides* to the findings of Drs. Baden and Boeck in order to determine that appellant had a nine percent impairment of the right lower extremity and a four percent impairment of the left lower extremity. It is appellant's burden to submit sufficient evidence to establish his claim.[8] Drs. Baden and Boeck did not provide any impairment ratings and there is, therefore, no medical evidence establishing that appellant has greater than a nine percent impairment of the right lower extremity and a four percent impairment of the left lower extremity.

The medical evidence does not establish entitlement to any greater award.

On appeal, appellant alleged that he should be given an impairment rating for his back. However, neither the Act nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back,[9] no claimant is entitled to such an award.[10]

The October 18, 2001 decision of the Office of Workers' Compensation Programs is affirmed.

Dated, Washington, DC
May 16, 2003

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member

[8] *See Annette M. Dent*, 44 ECAB 403 (1993).

[9] The Act itself specifically excludes the back from the definition of "organ." 5 U.S.C. § 8101(19).

[10] *E.g., Timothy J. McGuire*, 34 ECAB 189 (1982).