



surgery on February 28, 2000, April 10 and September 25, 2002. Appropriate compensation benefits were paid. Appellant did not stop work.<sup>1</sup>

Appellant came under the treatment of Dr. Linden Dillin, a Board-certified orthopedist, who noted in reports dated November 30, 1999 and July 11, 2000, that appellant was treated for left knee injury causally related to carrying mail and prolonged walking during his 29-year career as a letter carrier. He diagnosed right lateral talar exostosis and anterolateral impingement. Appellant underwent left knee arthroscopy on February 28, 2000.

On October 29, 2000 appellant filed a claim for a schedule award.

In a letter dated November 13, 2000, the Office requested that Dr. Dillin provide an evaluation as to the extent of permanent impairment of the left lower extremity in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*). Dr. Dillin submitted a report dated January 22, 2002, in accordance with the A.M.A., *Guides* (4<sup>th</sup> ed. 1993)<sup>2</sup> which noted that the date of maximum medical improvement for the left lower extremity was July 1, 2001. He advised that upon physical examination appellant had flexion of 136 degrees for 0 percent impairment<sup>3</sup> and muscle weakness during extension was a Grade 4 with active movement against gravity with some resistance for a 12 percent impairment,<sup>4</sup> for a total impairment of 12 percent permanent impairment of the left leg.

Appellant underwent another left knee arthroscopy on and April 10, 2002.<sup>5</sup>

On August 2, 2002 appellant filed a claim for a schedule award.

In a memorandum dated August 26, 2002, the Office referred Dr. Dillin's reports and the case record to the Office's medical adviser for evaluation as to the extent of permanent impairment of the left lower extremity in accordance with the A.M.A., *Guides*. The Office medical adviser determined that appellant had reached maximum medical improvement on January 22, 2002 with regard to the left knee. He determined that appellant sustained a 12 percent permanent impairment of the left lower extremity, noting that muscle weakness

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<sup>1</sup> The record reflects that appellant filed the following claims for compensation: a claim filed and accepted for left patella tendinitis, master file number 16-0305645; a claim filed on December 5, 1999, the Office accepted left patella tendinitis, file number 16-0345735; a claim filed for an injury sustained on May 12, 1999 the Office accepted a right knee strain, file number 16-329983; a claim filed and accepted for trochanteric bursitis/tendinitis of the right hip, file number 16-0324640; and a claim filed and accepted for an aggravation of preexisting right ankle fibroma, file number 16-0233460. The record further reflects that appellant was granted several schedule awards totaling 27 percent permanent impairment of the right lower extremity.

<sup>2</sup> A.M.A., *Guides* (4<sup>th</sup> ed. 1993).

<sup>3</sup> See A.M.A., *Guides* 78, Table 41 (4<sup>th</sup> ed. 1993); see also A.M.A., *Guides* 537, Table 17-10 (5<sup>th</sup> ed. 2001).

<sup>4</sup> See A.M.A., *Guides* 77, Table 39 (4<sup>th</sup> ed. 1993); see also A.M.A., *Guides* 532, Table 17-8 a (5<sup>th</sup> ed. 2001).

<sup>5</sup> The complete operative reports are not in the case record.

during extension was a Grade 4 with active movement against gravity with some resistance for a 12 percent impairment.<sup>6</sup>

On September 25, 2002 appellant underwent a further left knee synovectomy, medial plicectomy, notch abrasion and chondroplasty of the affected surfaces. Dr. Dillin diagnosed left notch osteophytosis with medial, femoral and trochlear chondral tearing and medial plica. Appellant returned to full-time work on December 3, 2002.

In a letter dated December 17, 2002, the Office requested that Dr. Dillin provide an evaluation as to the extent of permanent impairment of the left lower extremity in accordance with the A.M.A., *Guides*. Dr. A.J. Morris, a specialist in orthopedics and associate of Dr. Dillin, submitted a report dated January 13, 2003, which noted that upon physical examination appellant had flexion of 122 degrees for 0 percent impairment,<sup>7</sup> flexion contracture of 2 degrees for 0 percent impairment,<sup>8</sup> muscle weakness during extension of Grade 4 with active movement against gravity with some resistance for a 12 percent impairment<sup>9</sup> and arthritis of the left knee at 3 millimeter cartilage interval for a 7 percent impairment,<sup>10</sup> for a combined total impairment of 18 percent permanent impairment of the left leg.

On January 22, 2003 appellant filed a claim for a schedule award.

In a decision dated April 25, 2003, the Office granted appellant a schedule award for a 12 percent permanent impairment. Thereafter appellant requested an oral hearing before an Office hearing representative. The hearing was held on October 23, 2003.

In a decision dated January 8, 2004, the hearing representative set aside the Office decision dated April 25, 2003 and remanded the case file for review by the medical adviser. The hearing representative noted that there was additional medical development not considered by the Office prior to issuing its April 25, 2003 decision which was relevant to appellant's request for a schedule award for the left lower extremity including operative reports from the arthroscopic surgery performed on September 25, 2003, a report prepared by Dr. Morris dated January 13, 2003 and the medical evidence in a subsidiary file number 16-0345735.

In a memorandum dated February 4, 2004, the Office referred Dr. Morris' report and the case record to the Office's medical adviser for evaluation as to the extent of permanent impairment of the left lower extremity in accordance with the A.M.A., *Guides*. The Office medical adviser determined that appellant had reached maximum medical improvement on January 8, 2003 with regard to the left knee. He determined that appellant sustained a 12 percent permanent impairment of the left lower extremity.<sup>11</sup> The medical adviser noted that no

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<sup>6</sup> See A.M.A., *Guides* 531-32, Table 17-7, 17-8 (5<sup>th</sup> ed. 2001).

<sup>7</sup> A.M.A., *Guides* (5<sup>th</sup> ed. 2001), *supra* note 3 at 537.

<sup>8</sup> *Id.* at 537.

<sup>9</sup> A.M.A., *Guides* (5<sup>th</sup> ed. 2001), *supra* note 4 at 532.

<sup>10</sup> See A.M.A., *Guides* 83, Table 62 (4<sup>th</sup> ed. 1993); *see also* A.M.A., *Guides* 544, Table 17-32 (5<sup>th</sup> ed. 2001).

<sup>11</sup> A.M.A., *Guides*, *supra* note 6 at 531-02.

consideration was given for arthritis in addition to weakness because this would be contrary to the cross usage chart in Table 17-2, page 526 of the A.M.A., *Guides*.

In a decision dated April 13, 2004, the Office denied appellant claim for an additional schedule award on the grounds that the evidence of record failed to establish that appellant sustained any impairment greater than what he has been granted.

### **LEGAL PRECEDENT**

The schedule award provision of the Federal Employees' Compensation Act<sup>12</sup> and its implementing regulation<sup>13</sup> 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.

As relevant to this appeal, FECA Bulletin No. 01-5 provides that in making an impairment rating for the lower extremities, different evaluation methods cannot be used in combination. For example, arthritis impairments obtained from Table 17-31 cannot be combined with impairment determinations based on gait derangement (Table 17-5); muscle atrophy (Table 17-6); muscle strength (Tables 17-7 and 17-8) or range of motion loss (section 17.2f). Before finalizing any physical impairment calculation, the Office medical adviser is to verify the appropriateness of the combination of evaluation methods with that listed in Table 17-2, the cross-usage chart.<sup>14</sup>

### **ANALYSIS**

On appeal, appellant argues that he is entitled to an 18 percent permanent impairment of the left lower extremity as set forth by his physician Dr. Morris on January 13, 2003. The Office accepted appellant's claim for left patella tendinitis and arthroscopic surgery was authorized and performed on February 28, 2000, April 10 and September 25, 2002.

The Board has carefully reviewed Dr. Morris' report of January 13, 2003 and notes that Dr. Morris did not adequately explain how his determination was reached in accordance with the relevant standards of the A.M.A., *Guides*.<sup>15</sup> In his report, Dr. Morris noted upon physical examination of the left leg that flexion was 122 degrees for 0 percent impairment,<sup>16</sup> flexion

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<sup>12</sup> 5 U.S.C. § 8107.

<sup>13</sup> 20 C.F.R. § 10.404 (1999).

<sup>14</sup> See FECA Bulletin No. 01-5 (issued January 29, 2001); see also A.M.A., *Guides* 526, Table 17-2 (5<sup>th</sup> ed. 2001).

<sup>15</sup> See *Tonya R. Bell*, 43 ECAB 845, 849 (1992).

<sup>16</sup> A.M.A., *Guides*, *supra* note 3 at 537.

contracture was 2 degrees for a 0 percent impairment,<sup>17</sup> muscle weakness during extension was Grade 4, with active movement against gravity with some resistance for a 12 percent impairment<sup>18</sup> and arthritis of the left knee at 3 millimeter cartilage interval for a 7 percent impairment.<sup>19</sup> He combined these impairments in determining that appellant sustained an 18 percent permanent partial impairment of the left lower extremity. However, the A.M.A., *Guides*, Table 17-2, provides that if the evaluator uses the arthritis analysis then the evaluator cannot also use the loss of muscle atrophy, muscle strength, range of motion and ankylosis loss, gait derangement analysis or the diagnostic based estimates.<sup>20</sup> Therefore, the Board finds that Dr. Morris did not properly follow the A.M.A., *Guides*, and an attending physician's report is of little probative value where the A.M.A., *Guides* were not properly followed.<sup>21</sup> However, the Board notes that Dr. Morris properly determined that appellant sustained a 12 percent permanent impairment of the left lower extremity based on his findings of muscle weakness during extension at a Grade 4, with active movement against gravity with some resistance.<sup>22</sup>

The medical adviser properly utilized the findings in Dr. Morris' January 13, 2003 report and correlated them to specific provision in the A.M.A., *Guides* (5<sup>th</sup> ed.) to determine the impairment rating. The medical adviser determined that appellant sustained a 12 percent permanent impairment of the left lower extremity due to muscle weakness in the lower extremity.<sup>23</sup> The Office medical adviser further noted that Table 17-10 of the A.M.A., *Guides* provides guidance for evaluating knee impairments and indicates that flexion of greater than 110 degrees is equal to 0 percent lower extremity impairment. In this case, flexion was 122 for 0 percent impairment.<sup>24</sup> Furthermore, the medical adviser noted that no consideration was given for arthritis in addition to weakness because this would be contrary to the cross usage chart in Table 17-2, page 526 of the A.M.A., *Guides*. The medical adviser properly applied the A.M.A., *Guides* to the information provided in Dr. Morris' report and reached an impairment rating of 12 percent for the left lower extremity. This evaluation conforms to the A.M.A., *Guides* and establishes that appellant has no more than a 12 percent impairment of the left lower extremity.

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<sup>17</sup> *Id.* at 537.

<sup>18</sup> A.M.A., *Guides*, *supra* note 4 at 532.

<sup>19</sup> A.M.A., *Guides*, *supra* note 10 at 534.

<sup>20</sup> See A.M.A., *Guides* 526, Table 17-2, page 526 (5<sup>th</sup> ed. 2001).

<sup>21</sup> See *Paul R. Evans, Jr.*, 44 ECAB 646 (1993); *John Constantin*, 39 ECAB 1090 (1988) (medical report not explaining how the A.M.A., *Guides* are utilized is of little probative value).

<sup>22</sup> A.M.A., *Guides*, *supra* note 4 at 532.

<sup>23</sup> A.M.A., *Guides*, *supra* note 6 at 531-32.

<sup>24</sup> A.M.A., *Guides*, *supra* note 3 at 537.

**CONCLUSION**

The Board finds that appellant has not established that he has greater than a 12 percent impairment of the left lower extremity, for which he received a schedule award.

**ORDER**

**IT IS HEREBY ORDERED THAT** the April 13, 2004 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 18, 2004  
Washington, DC

Alec J. Koromilas  
Chairman

Colleen Duffy Kiko  
Member

Willie T.C. Thomas  
Alternate Member