United States Department of Labor
Employees' Compensation Appeals Board

WILLIAM A. HARRISON, Appellant	)	
and	)	**Docket No. 04-1645**
	)	**Issued: January 26, 2005**
U.S. POSTAL SERVICE, POST OFFICE, Springfield, IL, Employer	)	

Appearances:
William A. Harrison, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member

JURISDICTION

On June 14, 2004 appellant filed a timely appeal from an April 26, 2004 merit decision of the Office of Workers' Compensation Programs which found that he had no more than a two percent impairment to the left leg with no ratable impairment to the right leg. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the schedule award issue.

ISSUE

The issue is whether appellant has greater than a two percent impairment of the left lower extremity, for which he received a schedule award beginning June 17, 2002 and no ratable impairment to the right leg.

FACTUAL HISTORY

On May 20, 2001 appellant, then a 56-year-old letter carrier, filed an occupational disease claim for bilateral knee problems which he attributed to the amount of walking in his job. The Office originally accepted his condition for bilateral medial meniscus tears, but subsequently amended its acceptance to a left medial meniscus tear. The record reflects that appellant

underwent two arthroscopic surgeries to the left knee in May and November 2001. He returned to work with restrictions in January 2002.

On October 4, 2002 appellant filed a claim for a schedule award. He submitted a September 18, 2002 report from Dr. Gaylin D. Lack, an orthopedic surgeon and appellant's treating physician, who advised that appellant had been followed for the past year for problems related to a left knee injury which occurred as a result of work. He stated that appellant underwent an arthroscopy with partial medical meniscectomy and a chondroplasty on May 29, 2001 but after he worked for approximately three months, he underwent a subtotal medial meniscectomy for a tearing of the medial meniscus. Dr. Lack stated that appellant returned to work with restrictions in January 2002 and was released without restrictions in June 2002. Maximum medical improvement was reached on June 17, 2002. He stated that subjectively appellant had complaints of discomfort associated with kneeling and squatting and negotiation of stairs. Dr. Lack was unable to squat to 100 percent flexion of the knee, but this was only minimally limited. Persistence of mild swelling was noted in the left knee, with full extension with flexion well beyond 90 degrees and a trace of swelling in the left knee. A little tenderness was noted around the patella with good strength. Based on appellant's current complaints and mild limitation of motion, Dr. Lack opined that appellant had a permanent impairment of the lower extremity of approximately 15 percent.

In a memorandum dated February 27, 2003, the Office requested that its Office medical adviser provide an impairment rating based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.

In a March 3, 2003 report, the Office medical adviser noted that appellant underwent an arthroscopic medial meniscectomy, chondroplasty of the patellofemoral joint and medial femoral condyle on May 29, 2001. He reviewed Dr. Lack's records and noted that appellant experienced occasional discomfort in the left knee with kneeling and squatting. Physical examination findings were noted as having full range of motion, with mild swelling in the knee and stable ligaments. Under Table 17-33, page 546 of the A.M.A., *Guides*, the Office medical adviser assessed a two percent left lower extremity permanent impairment for a partial medial meniscectomy. The date of maximum medical improvement was noted as being August 16, 2001, when appellant was released to work without restrictions.

In a decision dated October 30, 2003, the Office granted appellant a schedule award for two percent impairment of the left lower extremity. The schedule award was granted for the period August 16 to September 25, 2001.

In a November 17, 2003 letter, appellant requested reconsideration of the October 30, 2003 decision noting that he had two surgeries and was judged to have reached maximum medical improvement on June 17, 2002 following his second surgery. He further stated that his attending physician had deemed him to be 15 percent permanently disabled.

Copies of medical evidence previously of record were submitted along with a December 3, 2003 report from Dr. Lack. In his December 3, 2003 report, Dr. Lack advised that there was never a point of maximal improvement after the first operation and that appellant's complete recovery was not assessed to have happened until June 2002, after he had a significant

period of rehabilitation following his second surgical procedure. He additionally stated that his impairment estimate of 15 percent was based on two separate criteria. Utilizing the fourth edition of the A.M.A., *Guides*, Dr. Lack assigned a seven percent total body impairment based on his limp which was noted as being mild secondary to antalgic. He stated that appellant has an antalgic gait with a shortened stance base with documented arthritic changes as noted by arthroscopy and by photographs which were taken then. Dr. Lack further indicated that based on Table 41, page 3/78, appellant had a 10 percent loss of the extremity as he had flexion less than 110 degrees or mild. He further indicated that appellant had a specific permanent impairment based on region and condition from Table 64, page 3/85 where one looks at meniscectomy, medial or lateral, partial and was provided with a one percent lower extremity impairment or two percent whole body. Dr. Lack stated that this impairment value would have to be doubled as appellant had a partial medial meniscectomy done on both occasions. He also stated that as appellant had some residual loss of motion with some persistent swelling and pain, his actual true impairment would be somewhat more. Dr. Lack, thus, concluded that appellant would have at least 15 or 16 percent impairment in the lower extremity itself.

In an April 14, 2004 memorandum to the Office medical adviser, the Office noted that appellant's claim had been accepted for bilateral medial meniscus tears. Appellant was noted to have undergone two arthroscopic surgeries to the left knee in May and November 2001, suffered from a right lower leg strain on March 8, 2003 and a right knee strain on January 31, 2004. The Office requested that the Office medical adviser review all the medical evidence of record and provide an impairment percentage for both lower extremities.

In an April 12, 2004 report, received April 26, 2004, the Office medical adviser noted that appellant continued to complain of discomfort with kneeling, squatting and use of the stairs. Physical examination of the left knee demonstrated a minimal effusion, tenderness around the patella and good strength. Range of motion findings were evaluated from the physical therapy reports from March to May 2002. Utilizing Table 17-10, page 537 of the A.M.A., *Guides*, 5th ed. (2000), range of motion for the left knee revealed flexion of 125 degrees and extension of negative 3 degrees, which equated to a 0 percent impairment. Range of motion for the right knee revealed flexion of 128 degrees and extension of 2 degrees, which also equated to a 0 percent impairment. The Office medical adviser noted that, as he stated in his previous note, according to Table 17-33, page 546, a two percent left lower extremity permanent impairment was awarded for a partial medical meniscectomy. He stated that there did not appear to be any objective basis on which to award any right lower extremity impairment. Date of maximum medical improvement was estimated to have occurred on June 17, 2002. The Office medical adviser noted that Dr. Lack's 15 percent left lower extremity permanent impairment rating was based on the fact that appellant has an antalgic gait. According to 17-15, page 529 of the A.M.A., *Guides*, gait abnormalities award whole person permanent partial impairment. However, the Federal Employee's Compensation Act does not recognize whole person permanent partial impairment, only that of the extremity. The Office medical adviser further noted that, although Dr. Lack recommended additional impairment for loss of motion, the multiple physical therapy notes show that the range of motion was above the threshold at which partial permanent impairment is awarded. Accordingly, the Office medical adviser concluded that the left lower extremity had a two percent permanent impairment, the right lower extremity had zero percent impairment and the date of maximum medical improvement was June 17, 2002.

In an April 26, 2004 decision, the Office denied modification of its previous finding that appellant had a two percent permanent impairment to his left leg and no ratable impairment to the right leg. The Office modified the date of maximum medical improvement to June 17, 2002.

LEGAL PRECEDENT

The schedule award provision 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 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.

The A.M.A., *Guides* Chapter 17[3] provides multiple grading schemes and procedures for determining the impairment of a lower extremity due to gait derangement,[4] muscle atrophy,[5] muscle weakness,[6] arthritis,[7] nerve deficits[8] and other specific pathologies. The A.M.A., *Guides* also provides impairment ratings of the lower extremities for diagnosis-based estimates, including specific disorders of the knee, such as torn meniscus or meniscectomy.[9] The evaluator should, in general, use only one approach for each anatomic part, however, there are certain exceptions in which elements from both diagnostic and examination approaches will apply.

The period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the employment injury. Maximum medical improvement means that the physical condition of the injured member of the body had stabilized and will not improve further. The determination of maximum medical improvement is factual in nature and depends primarily on the medical evidence.[10]

---

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404 (1999).

[3] American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001), Chapter 17, *The Lower Extremities*, pages 523-61.

[4] *Id*. at Table 17-5, page 529.

[5] *Id*. at Table 17-6, page 530.

[6] *Id*. at Table 17-8, page 532.

[7] *Id*. at Table 17-31, page 544.

[8] *Id*. at Table17-37, page 552.

[9] *Id*. at Chapter 17.2j, Table 17-33, pages 545, 548.

[10] *Albert Valverde*, 36 ECAB 233 (1984).

ANALYSIS

In his September 18, 2002 report, Dr. Lack opined that appellant had a lower extremity impairment of approximately 15 percent, but did not provide any objective evidence to document appellant's mild limitation of motion or provide an explanation on how the impairment rating was determined based on the A.M.A., *Guides*. In his December 3, 2003 report, Dr. Lack advised that he used the fourth edition of the A.M.A., *Guides* to calculate appellant's impairment rating. The specific sections he utilized in calculating the schedule award in this case, however, remains virtually unchanged in the fifth edition of the A.M.A., *Guides.*[11] The Board notes that Dr. Lack utilized a diagnosis-based estimate in determining that appellant was entitled to a two percent impairment rating for his left lower extremity for having undergone two partial medial meniscectomy procedures. He also stated that appellant had some residual loss of motion with some persistent swelling and pain and indicated, without providing any objective evidence or documenting where such information was obtained, that appellant had flexion less than 110 degrees, which, based on the relevant section of the A.M.A., *Guides* resulted in a 10 percent loss of the left lower extremity. The Board notes that the A.M.A., *Guides* provide that the evaluating physician should decide whether the diagnostic or examination criteria best describe the impairment specific to the patient and should, in general, use only one approach for each anatomic part.[12] As Dr. Lack failed to provide any objective evidence or document where his range of motion finding came from, there is no way to ascertain if appellant's range of motion figures yield the greater impairment estimate. Although Dr. Lack provided a seven percent total body impairment rating based on appellant's antalgic gait, the Board notes that a schedule award is not payable under section 8107(a) of the Act for an impairment of the whole person.[13] As neither of his reports contained a complete and detailed description of appellant's impairments, they can not be considered to be derived from proper application of the A.M.A., *Guides* and, therefore, cannot constitute the weight of the medical opinion evidence of record. Dr. Lack did, however, determine the date of maximum medical improvement as being June 17, 2002.

It is well settled that, when an attending physician's report gives an estimate of permanent impairment but does not indicate that the estimate is based on the application of the A.M.A., *Guides,* the Office may follow the advice of its medical adviser or consultant, where he or she has properly utilized the A.M.A., *Guides.*[14]

In his April 12, 2004 report, the Office medical adviser analyzed the medical evidence of record, including Dr. Lack's reports and physical therapy notes and opined that appellant reached maximum medical improvement on June 17, 2002 based on Dr. Lack's report that the left lower extremity had a two percent impairment based on two partial medial meniscectomy as set forth at Table 17-33, page 546 of the A.M.A., *Guides* and there was no ratable impairment for the right

[11] A.M.A., *Guides,* p. 3/75-93, "The Lower Extremity" (4th ed. 1993); pages 523-61 "The Lower Extremities" (5th ed. 2000). See FECA Bulletin No. 01-5 (issued January 29, 2001) which advised that the fifth edition of the A.M.A., *Guides*, became effective February 1, 2001.

[12] A.M.A., *Guides,* pages 545-48, "Diagnosis-Based Estimates" (5th ed. 2000).

[13] *See Gordon G. McNeill,* 42 ECAB 140 (1990).

[14] *Paul R. Evans, Jr*., 44 ECAB 646 (1993).

lower extremity. The Office medical adviser evaluated the physical therapy notes for the period March to May 2002, under Table 17-10, page 537 of the A.M.A., *Guides* and properly found that the range of motion findings for the left knee and the right knee did not qualify for ratable impairment. The Office medical adviser also properly recognized that appellant was not eligible for a schedule award based on a gait abnormality as the Act does not recognize whole person impairment which is the basis of a gait abnormality.[15]

The Board finds the opinion of the Office medical adviser in this case to be sufficiently rationalized and based upon a proper application of the physical findings to the A.M.A., *Guides.* The Board, therefore, concludes that appellant is not entitled to more than a two percent permanent impairment of the left lower extremity, for which he received an award and that there is no ratable impairment of the right lower extremity.

Furthermore, the record reflects that the Office initially granted appellant a schedule award commencing August 16, 2001 based on the Office medical adviser's finding that maximum medical improvement was achieved when appellant was released to work without restrictions on August 16, 2001. However, the Office later amended the date of maximum medical improvement to June 17, 2002 based on Dr. Lack's reports that appellant reached maximum medical improvement on June 17, 2002 following his second partial medial meniscectomy. As noted above, the determination of maximum medical improvement is factual in nature and depends primarily on the medical evidence. The Board finds that the medical evidence from Dr. Lack and the Office medical adviser supports this date of maximum medical improvement.

CONCLUSION

The Board finds that appellant is not entitled to more than a two percent permanent impairment of the left lower extremity, for which he received an award and that there is no ratable impairment of the right lower extremity. Additionally, the Board finds that he has not established that he is entitled to any additional compensation based on the amended date of maximum medical improvement.

[15] A.M.A., *Guides*, Table 17-15, page 529. *See also Gordon G. McNeill, supra* note 13.

ORDER

IT IS HEREBY ORDERED THAT the April 26, 2004 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 26, 2005
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member