United States Department of Labor
Employees' Compensation Appeals Board

R.L., Appellant	)	
	)	
and	)	**Docket No. 07-2161**
	)	**Issued: March 6, 2008**
U.S. POSTAL SERVICE, TALLEYVILLE BRANCH, Wilmington, DE, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 21, 2007 appellant filed a timely appeal from a decision of the Office of Workers' Compensation Programs dated April 3, 2007. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination in this case.

ISSUE

The issue is whether appellant has more than 26 percent left lower extremity impairment, and 18 percent right lower extremity impairment for which he has received schedule awards.

FACTUAL HISTORY

On July 1, 2002 appellant, then a 31-year-old letter carrier, sustained injury to his right knee when he slipped and fell while exiting his postal vehicle that day. On August 30, 2002 the claim was accepted for anterior cruciate ligament (ACL) tear, bone bruises and posterior meniscal tear with multiple stress fractures in the posterior tibial plateau of the right knee and torn medial meniscus and bone bruising of the left knee. Appellant came under the care of Dr. William A. Newcomb, a Board-certified orthopedic surgeon, who performed a left knee

partial medial meniscectomy on September 9, 2002. A right knee arthroscopic meniscectomy and ACL reconstruction and graft was performed on October 16, 2002. Dr. Newcomb provided restrictions to appellant's physical activity and he returned to limited duty on November 27, 2002.

On June 25, 2003 the Office referred appellant to Dr. Robert Draper, a Board-certified orthopedic surgeon, for a second opinion evaluation. In reports dated July 28, 2003, Dr. Draper agreed with the physical restrictions set by Dr. Newcomb.

On August 16, 2004 appellant filed a schedule award claim. In a May 13, 2004 report, Dr. Nicholas Diamond, an osteopath, provided examination findings and provided an impairment rating. He noted appellant's complaints of daily bilateral knee pain and stiffness and that he had to ice his left knee daily. Dr. Diamond diagnosed status post left knee arthroscopic medial meniscectomy, post-traumatic right knee ACL tear and multiple tibial plateau stress fractures, and posterior horn medial meniscus tear, status post ACL reconstruction with allograft right knee, and chronic post-traumatic right and left knee refractory tenosynovitis with degenerative malalignment. He stated that in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[1] under Table 16-8, a motor strength of 4/5 of the quadriceps, knee extensors, equaled 12 percent impairment bilaterally, and a motor strength of 4/5 of the quadriceps, ankle plantar flexion, equaled 17 percent bilateral impairment, which when combined equaled a 27 percent impairment. Dr. Diamond then added 3 percent impairment for pain under Figure 18-1 to reach 30 percent impairment for each lower extremity. By report dated September 22, 2004, Dr. Newcomb advised that he concurred with Dr. Diamond's conclusions.

In a September 30, 2004 report, an Office medical adviser advised that, based on the fifth edition of the A.M.A., *Guides*, under Table 17-33, a medial meniscectomy equaled two percent impairment. He stated that appellant was entitled to an additional 2 percent for pain under Figure 18-1, for a total 4 percent impairment of the left lower extremity, and under Table 17-33, for a moderate ACL laxity, appellant was entitled to 17 percent right lower extremity impairment.[2]

By decision dated May 10, 2005, appellant was granted a schedule award for an additional 4 percent right lower extremity impairment and an additional 17 percent left lower extremity impairment.

On May 13, 2005 appellant, through his attorney, requested a hearing. In a November 23, 2005 decision, an Office hearing representative determined that a conflict in medical evidence was created between the opinion of Dr. Diamond and that of the Office medical adviser. The case was remanded to the Office to obtain an impartial evaluation regarding appellant's lower extremity impairments.

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

[2] Dr. Diamond and the Office medical adviser also provided findings and conclusions regarding appellant's left upper extremity, not at issue in the instant case.

On February 21, 2006 the Office referred appellant to Dr. Charles A. Mauriello, a Board-certified osteopath specializing in orthopedic surgery, for an impartial evaluation. In reports dated April 2 and 3, 2006, Dr. Mauriello noted his review of the medical record. He advised that appellant had returned to full duty in 2005. Dr. Mauriello reported appellant's complaint of constant bilateral knee pain with occasional swelling and buckling that occurred weekly, right more than left. A July 28, 2005 x-ray demonstrated a two-millimeter narrowing of the left medial compartment. Dr. Mauriello provided examination findings and diagnosed status post tibial plateau fracture with healing, status post partial medial meniscectomy, status post right ACL reconstruction and post-traumatic arthrosis of the right knee. Regarding the left knee, he diagnosed status post partial arthroscopic meniscectomy and post-traumatic arthrosis. Dr. Mauriello provided an impairment rating based on the fifth edition of the A.M.A., *Guides*, stating that, under Table 17-31, appellant had 20 percent permanent impairment of the left lower extremity due to two-millimeter narrowing of the medial compartment of his left knee, under Table 17-31, 5 percent permanent impairment secondary to direct trauma to the patella with the complaint of patellofemoral pain associated with crepitation, and under Table 17-33, 2 percent permanent impairment secondary to a partial arthroscopic medial meniscectomy, for a combined total of 26 percent impairment of the left lower extremity. Regarding the right lower extremity, under Table 17-31 Dr. Mauriello found that 5 percent permanent impairment secondary to direct knee trauma with patellofemoral pain associated with crepitation, and that, under Table 17-33, 7 percent impairment secondary to mild ACL laxity, 2 percent permanent impairment secondary to arthroscopic meniscectomy, and 5 percent impairment secondary to a plateau fracture with no angulation, which combined for 18 percent permanent impairment of the right lower extremity.

In a July 24, 2006 report, an Office medical adviser agreed with Dr. Mauriello's impairment rating.

By decision dated August 9, 2006, appellant was granted additional schedule award for 9 percent left lower extremity impairment and 14 percent right lower extremity impairment.

On August 14, 2006 appellant, through his attorney, requested a hearing that was held on December 14, 2006. At the hearing, appellant testified regarding his physical limitations. Counsel contended that the opinion of Dr. Diamond represented the weight of medical opinion. In a January 11, 2007 letter, he argued that the Office medical adviser was not provided with an accurate list of the accepted conditions. Therefore the Office medical adviser's report was insufficient to create a conflict in medical evidence. Counsel argued that Dr. Mauriello should therefore be considered a second opinion physician rather than a referee examiner.

In an April 3, 2007 decision, an Office hearing representative affirmed the August 9, 2006 schedule award decision. He noted that the Office medical adviser noted all conditions and referred to all conditions in his opinion.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[3] and section 10.404 of the implementing federal regulations,[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] For lower extremity impairments due to meniscectomies or ligament injuries involving the knees, Table 17-1, of the A.M.A., *Guides* directs the clinician to utilize section 17.2j as the appropriate method of impairment assessment. Section 17.2j of the A.M.A., *Guides*, entitled Diagnosis-Based Estimates, provides that some impairment estimates are more appropriately rated on the basis of a diagnosis than on the basis of findings on physical examination and instructs the clinician to assess the impairment using the criteria in Table 17-33, entitled Impairment Estimates for Certain Lower Extremity Impairments.[8] When a diagnosis-based impairment rating is applied, it is generally not appropriate to calculate additional impairment based on anatomic or functional based methods (such as limitations of strength or range of motion).[9]

Section 18.3b of the fifth edition of the A.M.A., *Guides* provides that pain-related impairment should not be used if the condition can be adequately rated under another section of the A.M.A., *Guides*.[10] Office procedures provide that, if the conventional impairment adequately encompasses the burden produced by pain, the formal impairment rating is determined by the appropriate section of the A.M.A., *Guides.* However, an impairment rating can, in some situations, be increased by up to three percent if pain increases the burden of the employee's condition.[11]

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[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* 523-64.

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

[8] A.M.A., *Guides* 545; *see James R. Hill*, 57 ECAB ____ (Docket No. 05-1899, issued May 12, 2006).

[9] A.M.A., *Guides* 545, section 17.2j; *Derrick C. Miller*, 54 ECAB 266 (2002).

[10] A.M.A., *Guides* 569.

[11] *Richard B. Myles*, 54 ECAB 379 (2003).

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.[12] 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.[13] Office procedures indicate that referral to an Office medical adviser is appropriate when a detailed description of the impairment from a physician is obtained.[14]

ANALYSIS

The Board notes that Dr. Mauriello was properly selected as the referee physician. The Office found a conflict in medical opinion arising between Dr. Diamond and the Office medical adviser.[15] The Board finds that appellant has no more than 26 percent left lower extremity impairment and 18 percent right lower extremity impairment.

In accordance with section 17.2j of the A.M.A., *Guides*, Dr. Mauriello, the referee examiner, properly assessed appellant's knees on the basis of his prior bilateral knee surgeries in accordance with Table 17-33.[16] In accordance with Table 17-2, he found that the impairment rating for arthritis, listed at Table 17-31,[17] can be combined with diagnosis-based impairments.[18]

Regarding appellant's left lower extremity, the physician properly found that, under Table 17-31, appellant had a 20 percent permanent impairment of the left lower extremity due to a two-millimeter narrowing of the medial compartment of his left knee.[19] Under Table 17-31 Dr. Mauriello allowed five percent impairment for direct trauma to the patella with the complaint of patellofemoral pain associated with crepitation without point space narrowing.[20] Two percent impairment was allowed for the partial arthroscopic medial meniscectomy under Table 17-33.[21] Dr. Mauriello then properly combined appellant's left lower extremity impairments under the

[12] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

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

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

[15] The record reflects that the Office medical adviser's opinion was based on an accurate history of the medical condition accepted in this claim

[16] A.M.A., *Guides* 546.

[17] *Id.* at 544.

[18] *Id.* at 526.

[19] *Id*. at 544.

[20] *Id.* at Table 17-31 rates arthritis to the patella-femoral joint, noting a maximum of five percent impairment for patella-femoral pain and crepitation, without joint space narrowing, in an individual with a history of direct trauma.

[21] *Id.* at 546.

Combined Value Charts of the A.M.A., *Guides*, to find a total of 26 percent impairment of the left lower extremity.[22]

Regarding the right lower extremity, Dr. Mauriello utilized Table 17-31 to rate five percent impairment to the patellofemoral joint for direct knee trauma with pain associated with crepitation and no joint space narrowing.[23] Under Table 17-33, seven percent impairment is allowed for mild ACL laxity, two percent impairment for a partial meniscectomy and five percent impairment for a plateau fracture with no angulation.[24] Dr. Mauriello then properly combined appellant's right lower extremity impairments to find a total 18 percent permanent impairment of the right lower extremity.

Dr. Diamond found additional impairment ratings for strength deficits of the quadriceps and ankle plantar flexion in both lower extremities. Section 17.2e of the A.M.A., *Guides* provides that to be valid, if strength testing is made by one examiner, the measurements should be consistent on different occasions, and Table 17-7 describes the criteria on which estimates and grades for lower extremity strength are based, with Table 17-8 listing the actual ratings for lower extremities.[25] While Dr. Diamond generally referenced Table 17-8, he did not provide any explanation using the criteria found in Table 17-7 or other account as to how he arrived at the impairment ratings for muscle weakness. His report is, therefore, insufficient to establish that appellant is entitled to an increased schedule award for either lower extremity based on muscle weakness.[26] Moreover, under Table 17-2, muscle strength cannot be combined with a diagnosis-based estimate.[27] Under Figure 18-1, Dr. Diamond also rated three percent impairment to each lower extremity due to pain. Examiners should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in others chapters of the A.M.A., *Guides.*[28] In this case, appellant had previously received two percent impairment for left lower extremity pain in the schedule award granted on May 10, 2005. Dr. Mauriello considered appellant's pain complaints under Table 17-31 and rated five percent impairment to each lower extremity based on patellofemoral pain and crepitation without joint space narrowing.[29] Since he provided examination findings and rationale for his opinion regarding appellant's lower extremity impairments, the Board finds that it is entitled to special weight.[30]

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[22] *Id*. at 603-06.

[23] *Id*. at 544, *see supra* note 19.

[24] *Id*. at 546.

[25] *Id*. at 531.

[26] *See Mary L. Henninger*, 52 ECAB 408 (2001).

[27] A.M.A., *Guides* 526.

[28] *P.C.*, 58 ECAB ____ (Docket No. 07-410, issued May 31, 2007).

[29] A.M.A., *Guides* 544.

[30] *Supra* note 12.

CONCLUSION

The Board finds that appellant has no more than 26 percent left lower extremity impairment and 18 percent right lower extremity impairment, for which he has received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 3, 2007 be affirmed.

Issued: March 6, 2008
Washington, DC

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

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

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