United States Department of Labor
Employees' Compensation Appeals Board

S.L., Appellant	)	
and	)	**Docket No. 09-709**
	)	**Issued: December 8, 2009**
U.S. POSTAL SERVICE, POST OFFICE, San Pablo, CA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 22, 2009 appellant filed a timely appeal from the November 26, 2008 decision of the Office of Workers' Compensation Programs concerning his schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of the schedule award claim.

ISSUE

The issue is whether the Office properly determined that appellant has no greater than 24 percent left lower extremity impairment, for which he received a schedule award.

FACTUAL HISTORY

On August 2, 2004 appellant, then a 57-year-old mail carrier, filed an occupational disease claim alleging that his left knee arthritic condition was due to years of walking up and down hills and carrying mail for 8 to 12 hours a day. The Office accepted internal derangement of the left knee, chondromalacia and medial meniscus tear as work related. By decision dated April 14, 2006, it awarded appellant a schedule award for 24 percent permanent impairment of

the left lower extremity. The period of the award ran from January 20, 2006 through May 18, 2007.

On April 22, 2008 appellant filed a claim for an increased schedule award. In an April 25, 2008 letter, the Office requested that he submit a report from his attending physician addressing the extent of any permanent impairment in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (hereinafter A.M.A., *Guides*). It noted that, while Dr. Vatche Cabayan, a Board-certified orthopedic surgeon, indicated in his January 14, 2008 report that appellant was experiencing left knee aggravation due to overload from right knee surgery, he did not indicate whether there was any increased permanent impairment of the left leg.[1]

In a May 8, 2008 report, Dr. Cabayan provided an impression of internal derangement of left knee with magnetic resonance imaging (MRI) scan showing Grade 2 to Grade 3 tear of medial meniscus. He indicated that appellant was permanent and stationary. Subjective factors of disability were noted to be frequent slight pain becoming moderate with exertional activities associated with stiffness, weather effects and limitation with prolonged sitting, jumping, hopping, squatting and the handling of stairs, ramps, inclines and hills. Objective factors of disability included MRI scan abnormalities, the loss of articular surface on standing x-ray of the knee and tenderness along the patellofemoral joint as well as mildly along the joint line. Standing x-rays revealed two millimeter (mm) of articular surface left medially and four mm of patellofemoral cartilage. Left knee examination revealed tenderness along the patellofemoral joint with mild crepitation. Utilizing the A.M.A., *Guides*, Dr. Cabayan opined that appellant had 26 percent impairment to the lower extremity. He noted that appellant had 20 percent impairment to the lower extremity under Table 17-31 and 7 percent impairment to the lower extremity under Table 17-33, which resulted in a combined impairment of 26 percent to the lower extremity.

In a June 16, 2008 report, an Office medical adviser reviewed the medical records, including Dr. Cabayan's May 8, 2008 report. He stated that the date of maximum medical improvement was January 20, 2006. The Office medical adviser opined that the additional medical records did not indicate a change in appellant's previous schedule award. Utilizing the A.M.A., *Guides*, he calculated appellant's impairment under the anatomic assessment and the diagnosed-based estimate method. The Office medical adviser stated that the anatomic assessment method resulted in 5 percent lower extremity impairment while the diagnosed-based estimate method resulted in 24 percent lower extremity impairment. Under the anatomic assessment method, he opined that appellant's pain complaints as noted in Dr. Cabayan's May 8, 2008 report represented a Grade 2 or 61 to 80 percent sensory deficit under Tables 15-15 and 16-10. The Office medical adviser recommended a mean or 70 percent sensory deficit of the maximal 7 percent impairment for the femoral nerve (Table 17-37), which would equate to 4.9 or rounded up to 5 percent impairment for pain factors. He indicated that, since the records described no atrophy or weakness of the left lower extremity and strength was noted to be a Grade 5 involving knee flexion and extension, no further impairment could be given under this

[1] In the January 14, 2008 report, Dr. Cabayan noted findings that included no patellofemoral crepitus with passive range of motion of the left knee.

method. Under the diagnosed-based estimate method, the Office medical adviser found two mm of articular cartilage preserved in the medical compartment equated to 20 percent lower extremity impairment and four mm cartilage preserved in the patellofemoral compartment equated to 0 percent lower extremity impairment under Table 17-31 of the A.M.A., *Guides*. He noted that, since appellant had crepitation involving the patellofemoral compartment with tenderness, this would equate to five percent impairment under the footnote attached to Table 17-31. The Office medical adviser advised that 20 percent impairment for the articular cartilage combined with 5 percent impairment for patellofemoral pain and crepitation equated to 24 percent lower extremity impairment.

By decision dated June 25, 2008, the Office denied appellant's claim for an increased schedule award. It noted that he had previously received an award for 24 percent impairment of the left lower extremity and the current medical evidence did not support an increase in the impairment already compensated.

On August 23, 2008 appellant requested reconsideration. In a July 3, 2008 report, Dr. Cabayan indicated that he utilized the fifth edition of the A.M.A., *Guides* in calculating his impairment rating. He explained that, under Table 17-31, two mm articular surface of the knee resulted in 20 percent lower extremity impairment. Under Table 17-33, patellar subluxation with residual instability resulted in seven percent lower extremity impairment. Dr. Cabayan advised that combining the 20 percent impairment with the 7 percent impairment resulted in 26 percent lower extremity impairment. He noted that he understood how the Office medical adviser provided five percent impairment for crepitation and chondromalacia. Dr. Cabayan further indicated that there was good argument that Table 17-30 could also be used.

In a November 12, 2008 report, the Office medical adviser reviewed the medical records including Dr. Cabayan's July 3, 2008 report. He stated that the records support patellofemoral chondromalacia with crepitation on examination but did not document patella subluxation or patella instability. The Office medical adviser stated that the utilization of Table 17-31 to assess five percent impairment for patellofemoral pathology with crepitation noted on examination would be reasonable and anatomically correct based upon the documentation of the pathology. Thus, he advised that he would affirm the previous 24 percent lower extremity impairment calculated. The Office medical adviser noted that, while Dr. Cabayan utilized an alternative method of calculating the award based on "patella subluxation and instability" to arrive at a higher award, the A.M.A., *Guides* recommend assessing the higher award when two methods are utilized. The records did not confirm patella subluxation or instability.

By decision dated November 26, 2008, the Office denied modification of its previous decision. Determinative weight was accorded to the Office medical adviser's opinion on appellant's impairment rating.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] provides for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of the Office. For consistent results and to ensure equal justice, the Board has authorized 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 as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[3] As of February 1, 2001, schedule awards are calculated according to the fifth edition of the A.M.A., *Guides*, published in 2000.[4]

The fifth edition of the A.M.A., *Guides* provides for three separate methods for calculating the lower extremity permanent impairment of an individual: anatomic, functional and diagnosis based.[5] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[6] The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligamentous instability, bursitis and various surgical procedures, including joint replacements and meniscectomies.[7] The functional method is used for conditions when anatomic changes are difficult to categorize or when functional implications have been documented and includes range of motion, gait derangement and muscle strength.[8] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[9] When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment

[2] 5 U.S.C. §§ 8101-8193.

[3] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[4] *See* FECA Bulletin No. 01-05 (issued January 29, 2001) (schedule awards calculated as of February 21, 2001 should be evaluated according to the fifth edition of the A.M.A., *Guides*. Any recalculations of previous awards which result from hearings, reconsideration or appeals should, however, are based on the fifth edition of the A.M.A., *Guides* effective February 1, 2001).

[5] A.M.A., *Guides* 525.

[6] *Id.*

[7] *Id.*

[8] *Id*.

[9] *Id*. at 548.

rating.[10] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[11]

ANALYSIS

Appellant received a schedule award on April 14, 2006 for 24 percent impairment of the left lower extremity. He subsequently claimed an additional award based on the reports of Dr. Cabayan, his treating physician, who stated that he had sustained a total of 26 percent impairment of the left lower extremity. An Office medical adviser reviewed Dr. Cabayan's medical reports and determined that the medical evidence from Dr. Cabayan was not reliable to support greater than the 24 percent impairment previously awarded.

Although Dr. Cabayan determined that appellant sustained a 26 percent impairment of the left lower extremity, it is not clear how he reached this conclusion utilizing the A.M.A., *Guides*. In his May 8, 2008 report, he opined that appellant had 20 percent impairment to the lower extremity under Table 17-31 and 7 percent impairment to the lower extremity under Table 17-33. Dr. Cabayan stated that the combined impairment resulted in 26 percent impairment to the lower extremity. In his July 3, 2008 report, he explained that the 20 percent lower extremity impairment under Table 17-31 was based on the two mm articular surface of the knee and the 7 percent lower extremity impairment under Table 17-33 was based on patellar subluxation with residual instability. The Board notes that the objective evidence from Dr. Cabayan's examination revealed two mm cartilage interval of the articular surface left medially and four mm of cartilage patellofemoral. Under Table 17-31, page 544 of the A.M.A., *Guides*, a two mm cartilage interval of the knee results in 20 percent lower extremity impairment and a four mm cartilage interval of the patellofemoral results in no lower extremity impairment. While Dr. Cabayan additionally advised that appellant had patellar subluxation with residual instability, which he rated as seven percent impairment under Table 17-33, he failed to provide sufficient information to support this finding or to provide sufficient information based on his examination findings upon which a finding of patellar subluxation with residual instability could be based or rated under Table 17-33, page 546 of the A.M.A., *Guides.*

The Office medical adviser reviewed the physical findings as reported by Dr. Cabayan and found that they did not support more than the 24 percent impairment previously awarded. In his June 16, 2008 report, he stated that appellant had 5 percent lower extremity impairment under the anatomic assessment method and 24 percent lower extremity impairment under the diagnosed-based estimate. As the diagnosed-based estimate yielded a higher impairment rating, the Office medical adviser properly recommended that the diagnosed-based method be adopted.[12] He concurred with Dr. Cabayan's assessment of 20 percent impairment for arthritis impairment based on a two mm cartilage interval of the knee under Table 17-31, page 544, of the A.M.A., *Guides*. The Office medical adviser further noted that, since appellant had crepitation involving the patellofemoral compartment with tenderness, this equated to five percent lower

[10] *Id*. at 526.

[11] *Id*. at 555.

[12] *Id*.

extremity impairment under Table 17-31, page 544 of the A.M.A., *Guides*.[13] In his November 12, 2008 report, he specifically noted that the medical records failed to document patella subluxation or patella instability to support Dr. Cabayan's seven percent impairment rating under Table 17-33 but supported patellofemoral chondromalacia with crepitation on examination. Thus, the Office medical adviser concluded that utilizing Table 17-31 to assess the five percent impairment rating for patellofemoral pathology with crepitation noted on examination would be reasonable and anatomically correct, noting the documentation of the pathology. He correctly combined the 20 percent impairment for the articular cartilage with 5 percent impairment for patellofemoral pain and crepitation to find 24 percent lower extremity impairment.[14] The Office medical adviser offered a reasonable explanation as to why Dr. Cabayan's seven percent impairment rating under Table 17-33 was not consistent with the medical evidence of record. As such, the Board agrees that utilizing Table 17-31 to assess the five percent impairment rating for patellofemoral pathology with crepitation is the more appropriate rating in this case. Thus, the Board finds that the Office medical adviser's opinion is sufficient to establish that appellant has no more than 24 percent impairment of the left leg.

Appellant already received a schedule award for 24 percent impairment of the left lower extremity and there is no other evidence to support a greater impairment. While he argues on appeal that his left knee is damaged due to overcompensation of his right knee and arthritis, the medical evidence does not support a greater impairment than that already awarded. Thus, appellant has not established greater than 24 percent impairment of his left lower extremity for which he received a schedule award.

CONCLUSION

The Board finds that appellant did not establish that he has more than 24 percent permanent impairment to the left lower extremity, for which he received a schedule award.

[13] This table of the A.M.A., *Guides* provides that five percent lower extremity impairment is given to an individual with a history of direct trauma, a complaint of patellofemoral pain and crepitation on physical examination but without joint space narrowing on x-rays. In this case, appellant had complaints of pain which became moderate with exertional activities and no evidence of joint space narrowing of the patellofemoral as four mm cartilage was preserved.

[14] A.M.A., *Guides* 604.

ORDER

IT IS HEREBY ORDERED THAT the November 26, 2008 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 8, 2009
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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