U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ROBERT S. AMENDOLA and U.S. POSTAL SERVICE,
HUNTINGTON MAIN POST OFFICE, Huntington, NY

Docket No. 97-1813; Submitted on the Record;
Issued August 23, 1999

DECISION and ORDER

Before MICHAEL J. WALSH, GEORGE E. RIVERS,
DAVID S. GERSON

The issue is whether appellant has established that he sustained greater than a two percent impairment of the left lower extremity, for which he received a schedule award.

The Office of Workers' Compensation Programs accepted that appellant, then a 44-year-old distribution clerk, sustained a fracture of the right fifth metacarpal[1] and a left knee contusion requiring partial medial meniscectomy when he fell in a parking lot on May 22, 1995.[2] The record indicates that appellant return to limited duty[3] from June to early December 1995.

Appellant submitted reports from Dr. Richard Boccio, an attending Board-certified orthopedic surgeon, regarding treatment of the left knee. On initial examination of the left knee on June 6, 1995 Dr. Boccio found "significant patellofemoral crepitation," "positive apprehension and … patellar grind" tests, tenderness to palpation along with lateral joint line and a questionable McMurray's sign.[4] He stated an impression of traumatic patellofemoral chondromalacia with a possible tear of the lateral medical meniscus. Dr. Boccio submitted

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[1] Appellant submitted medical evidence regarding the right metacarpal fracture. In a May 22, 1995 report, Dr. Jeffrey Ellstein, an attending Board-certified orthopedic hand surgeon, performed closed reduction of right fifth metacarpal, and applied a splint. Dr. Ellstein prescribed physical therapy, released appellant to light duty as of June 20, 1995 and to full duty as of October 5, 1995. In an October 12, 1995 report, Dr. Ellstein opined that appellant would reach maximum medical improvement within one year of injury, appellant can make a full fist, no deformity, abduction and adduction of the fingers; 70 pounds grip on the right, 90 on the left. The record indicates that appellant did not claim a schedule award for permanent impairment of the right fifth finger.

[2] The Office authorized a left knee magnetic resonance imaging (MRI) scan, physical therapy and left knee arthroscopy.

[3] Appellant was assigned light duty from June 1995 to December 1996, with no bending, squatting, climbing, kneeling or twisting, and limited walking, lifting and standing.

[4] Dr. Boccio noted that June 6, 1995 x-rays "did not reveal any acute fracture or pathology."

progress notes through October 1995 describing appellant's continuing left knee pain and crepitation.[5]

Dr. Boccio performed left knee arthroscopy on December 11, 1995 with a partial medial meniscectomy, partial synovectomy and debridement of the patella. He diagnosed a "medial meniscus tear with chondromalacia patella left knee."[6] Following the arthroscopy, the record indicates that appellant returned to limited duty on December 20, 1995 with one hour standing, seven hours sitting.[7]

In an April 16, 1996 form report, Dr. Boccio stated that appellant had a "[25] percent permanent disability" due to patellar chondromalacia of the left knee with a torn medial meniscus. Dr. Boccio did not refer to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, the A.M.A., *Guides*) in this report.

In a June 10, 1996 report, Dr. Boccio noted findings on April 25, 1996 examination of limitation of motion from 0 to 140 degrees, "intermittent swelling to the anterior aspect of the knee with some 'numbness' along the anterior aspect of the distal thigh," no significant effusion, good stability, no ankylosis and no muscular weakness or atrophy in the left lower extremity. He opined that the accepted injury precipitated "an underlying degenerative arthritis to his left knee," which could eventually necessitate a total knee arthroplasty. Dr. Boccio estimated a 25 percent permanent disability "[d]ue to persistent pain and permanent traumatic arthritic changes" to the articular cartilage.[8]

In an August 20, 1996 form report, Dr. Boccio stated that appellant had "reached maximum medical improvement."

In an August 30, 1996 letter, the Office advised appellant that Dr. Boccio's June 10, 1996 report did not contain the necessary information for the Office to calculate a schedule award. The Office directed appellant to submit a narrative report from his attending physician, supporting a causal relationship between the claimed permanent impairment and the accepted injury, referencing the A.M.A., *Guides*, third edition, revised. The Office also enclosed a form report for Dr. Boccio, directing him to use the third edition of the A.M.A., *Guides* and not the third edition revised as the August 30, 1996 letter had specified.

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[5] In an August 29, 1995 report, Dr. Boccio noted that appellant had "severe right hip arthritis with significant limitation of motion," and had requested a hip replacement. The record indicates that appellant's right hip condition has not been established to be related to his federal employment. In September 6 and 13, 1995 reports, Dr. Boccio diagnosed patellofemoral chondrosis of the left knee. An October 31, 1995 MRI showed a Grade 3 medial meniscus tear.

[6] In a June 10, 1996 report, Dr. Boccio stated that the December 11, 1995 arthroscopy showed "Grade 2-3 chondrosis of the lateral femoral condyle with Grade 2 chondrosis of the medial femoral condyle," and a "peripheral tear of the medial meniscus at the junction of the middle and anterior thirds," chronic anterior cruciate ligament avulsion and "Grade 3-4 chondrosis of the lateral tibial plateau."

[7] Appellant filed a January 19, 1996 claim for recurrence of disability commencing December 11, 1995 pursuant to the left knee arthroscopy. The record indicates that the Office accepted this claim.

[8] Dr. Boccio did not refer to the A.M.A., *Guides* in this report.

Dr. Boccio completed the form report on September 13, 1996. He noted that appellant had "daily" left knee pain at the patellar femoral joint line, decreasing his ability to walk, bend and squat. Dr. Boccio also noted alteration of sensation in the anterior knee area. He found a range of motion of 0 to 140 degrees flexion on the left compared with 0 to 150 degrees on the right, with no ankylosis, weakness or atrophy of the left lower extremity. Dr. Boccio stated that appellant's partial medial meniscectomy left him with a "stable rim" of cartilage, without ligament instability, varus or valgus deformity. He noted that appellant had post-traumatic irregularity or arthritis affecting both cartilage and bone. Dr. Boccio checked a box noting that he had referred to the third edition of the A.M.A., *Guides* in preparing his report.

In a January 30, 1997 report, an Office medical adviser reviewed Dr. Boccio's June 10 and August 30, 1996 reports. The adviser noted a date of maximum medical improvement as September 13, 1996. Referring to the fourth edition of the A.M.A., *Guides*, the adviser noted that knee flexion of 0 to 140 degrees equaled a 0 percent impairment, according to page 78, Table 41[9] a partial medial meniscectomy equaled a 2 percent impairment. According to page 85, Table 64,[10] a partial medial or lateral meniscectomy equaled a 2 percent impairment of the lower extremity. The adviser, therefore, concluded that appellant had a two percent permanent impairment of the left lower extremity according to the A.M.A., *Guides*.

By decision dated February 13, 1997, the Office awarded appellant a schedule award for a two percent permanent impairment of the left lower extremity. The award was equivalent to 5.76 weeks of compensation and was paid from September 13 to October 23, 1996.

The Board finds that this case is not in posture for a decision.

Under section 8107 of the Federal Employees' Compensation Act[11] and section 10.304 of the implementing regulations,[12] schedule awards are payable for permanent impairment of specified body members, functions or organs. As the Act and regulations do not specify how to determine percentages of impairment, the Office has adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment. The Board has concurred in such adoptions.[13] Proper use of the appropriate edition of the A.M.A., *Guides* ensures consistent results and equal justice for all claimants.

The A.M.A., *Guides* lists specific procedures for determining impairment of affected body parts. A physician must first determine the effect of the medical condition on life activities and determine the date of maximum medical improvement. If the effect of impairment is pain or

[9] Table 41, page 78 is entitled "Knee Impairment." The lowest category of impairment listed is a range of motion less than 100 degrees, characterized as "mild," equaling a 10 percent impairment of the lower extremity.

[10] Table 64, page 85, is entitled "Impairment Estimates for Certain Lower Extremity Impairments." According to this table, a partial medial or lateral meniscectomy equals a two percent impairment of the lower extremity.

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.304.

[13] *Leisa D. Vassar*, 40 ECAB 1287, 1290 (1989); *Francis John Kilcoyne*, 38 ECAB 168, 170 (1986).

loss of sensation, the physician first identifies the area of involvement and the innervating nerve or nerves, finds the value for maximum loss of function of the nerve or nerves due to pain or loss of sensation, grades the degree of decreased sensation or pain according to a six-level grading scheme, finally multiplies the value of the nerve, gleaned from the appropriate table, by the degree of decreased sensation or pain to reach the percentage of impairment due to pain or loss of sensation. Similar guidelines exist for evaluating impairment due to loss of motion or impairment due to motor deficits. There are specialized guidelines addressing permanent impairments due to various surgical procedures.

The first difficulty with this case is the Office's reference to inappropriate editions of the A.M.A., *Guides*. FECA Bulletin No, 94-4, issued November 1, 1993, states that effective that day, the Office shall use the fourth edition of the A.M.A., *Guides*, published in 1993. "As of that date, correspondence with treating physicians, consultants and second opinion specialists *should reflect the use of the new edition*…." (Emphasis added.) As appellant was injured on May 22, 1995 the Office should have referred to and relied exclusively on the fourth edition of the A.M.A., *Guides* in determining any permanent impairment of appellant's left knee.

However, in an August 30, 1996 letter, the Office advised appellant to submit a report from Dr. Boccio referencing the third edition, revised, of the A.M.A., *Guides*, published in 1991.[14] Compounding the confusion, the Office also enclosed a form report for Dr. Boccio, directing him to use the third edition of the A.M.A., *Guides*, published in 1990. Dr. Boccio completed the form report on September 13, 1996 and checked a box indicating that he had used the third edition of the A.M.A., *Guides*.

The questions posed by the Office in the August 30, 1996 form report are reflective of the grading schemes in place at the time the third edition was in use and vary widely from those relevant in applying the fourth edition. For example, Dr. Boccio, using the third edition form report, noted that appellant had degenerative patellofemoral arthritis attributable to the accepted injury. The Office medical adviser, who correctly used the fourth edition of the A.M.A., *Guides*, did not provide an impairment rating for arthritis. FECA Bulletin 96-17, issued September 20, 1996, notes that in the fourth edition of the A.M.A., *Guides*, Chapter 3, Table 62, page 83, regarding impairments due to arthritis, "may be used only if no other abnormality is present, with

[14] FECA Bulletin 91-27, issued September 18, 1991, directs the use of the third edition revised, published 1991, effective September 1, 1991.

the exception of joint fractures."[15] As the Office directed Dr. Boccio to refer to the incorrect edition of the A.M.A., *Guides*, Dr. Boccio included arthritis in determining the 25 percent impairment rating stated in his June 10, 1996 report.

The second problem with this case is the incompleteness of the Office medical adviser's January 30, 1997 schedule award calculation. The medical adviser noted a 0 percent impairment rating for a loss of 10 degrees flexion and a two percent impairment for partial medial meniscectomy. The adviser, therefore, concluded that appellant had a two percent permanent impairment of the left lower extremity according to the A.M.A., *Guides*, fourth edition. However, the medical adviser did not address either appellant's left knee pain or the altered sensation in the anterior aspect of the knee observed by Dr. Boccio in his June 10 and September 13, 1996 reports, or provide an explanation as to why these findings were not included in the final schedule award. Thus, the medical adviser's report is incomplete and was an insufficient basis for calculation of a schedule award. Therefore, the case must be remanded to the Office for recalculation of the schedule award.

On remand of the case, the Office shall refer the matter with detailed instructions regarding the use and application of the fourth edition of the A.M.A., *Guides*, to Dr. Boccio, who should be given the opportunity to calculate a schedule award according to the fourth edition of the A.M.A., *Guides*, reflecting the percentage of permanent impairment of the left lower extremity attributable to the May 22, 1995 injury and its sequelae. Following this and other such development as the Office deems necessary, the Office shall issue an appropriate decision in the case.

[15] Table 62 page 83, "Arthritis Impairments Based on Roentgenographically Determined Cartilage Intervals," notes that for patelllofemoral arthritis, "[i]n a patient with a history of direct trauma, a complaint of patellofemoral pain, and crepitation on physical examination, but without joint space narrowing on roentgenogram, a … 5 percent lower-extremity impairment is given." Page 82 specifies that a "sunrise view" x-ray is the only acceptable test to support a rating under Table 62, and not an MRI or other type of test.

The decision of the Office of Workers' Compensation Programs dated February 13, 1997 is hereby set aside and the case remanded to the Office for further development consistent with this decision and order.[16]

Dated, Washington, D.C.
August 23, 1999

Michael J. Walsh
Chairman

George E. Rivers
Member

David S. Gerson
Member

[16] By decision dated May 23, 1997, the Office approved an attorney's fee request from appellant's authorized attorney representative. Appellant does not contest this decision on appeal. The Board notes that the record indicates that appellant was timely provided with a copy of the attorney's fee request, and did not contest the amount requested.