U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of DOUGLAS L. CLARKE and U.S. POSTAL SERVICE,
FLUSHING POST OFFICE, Flushing, NY

Docket No. 00-1850; Submitted on the Record;
Issued September 4, 2001

DECISION and ORDER

Before WILLIE T.C. THOMAS, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issues are: (1) whether appellant has established that he sustained a herniated lumbar disc and internal derangement of the left knee, resulting from an accepted January 18, 1996 injury; and (2) whether appellant sustained greater than a 25 percent permanent impairment of his left lower extremity, for which he received a schedule award.

The Office of Workers' Compensation Programs accepted that on January 18, 1996 appellant, then a 41-year-old letter carrier, sustained a left knee contusion, left knee sprain, lumbar sprain and pelvis sprain/contusions when a brick step he was standing on gave way. He returned to limited duty on August 26, 1996 and to full duty on October 21, 1996. The Office also accepted recurrences of disability beginning May 10, 1997, March 11 and October 29, 1998.[1]

In January 18 and 22, 1996 reports, Dr. Paul A. Cooperman, an attending osteopath, related that appellant had fallen down the steps on January 18, 1996, "landing on his back," also striking and twisting his left knee. He diagnosed "left knee sprain/contusion," "lumbosacral sprain/contusion" and "contusions of the left forearm and left hip."

In a February 13, 1996 report, Dr. Martin A. Lehman, an attending Board-certified orthopedic surgeon, noted objective findings demonstrating an "acute severe sprain of the lumbosacral spine with radiculitis and nerve root irritation of the left lower extremity," "contusions and sprains of the pelvis," "traumatic synovitis with injury to medial and lateral ligaments and cartilage of the left knee." He reiterated these findings, including lumbar radiculopathy and left knee pain, in reports through October 1996.

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[1] Appellant worked limited duty for four hours per day from March 7, 1998 to approximately September 1998, when he increased his schedule to eight hours per day. The Office accepted appellant's claim for an October 29, 1998 recurrence of disability due to the arthroscopy and recovery. Appellant returned to full duty on December 2, 1998.

A June 12, 1996 magnetic resonance imaging (MRI) scan of the left knee showed "degenerative changes in the posterior horn of the medial and lateral meniscus," a sprained anterior cruciate ligament, a "small joint space effusion" and a "subcortical cyst in the tibial plateau."

In a March 27, 1997 report, Dr. Leo Varriale, a Board-certified orthopedic surgeon, diagnosed a torn left medial meniscus.

Appellant submitted progress notes from attending physicians Drs. Aric and Allan Hausknecht, Board-certified in neurology, psychiatry and pain management, dated May 13, 1997 to July 20, 1998, describing continued left knee and lumbar pain and restricting appellant to sedentary duty with lifting limited to 10 pounds and no driving.[2]

In a May 13, 1997 report, Dr. Fawzy W. Salama, an attending Board-certified neurologist associated with Dr. Hausknecht, found left-sided lumbar immobility, bilaterally positive straight leg raising tests and diagnosed chronic low back pain and lumbosacral radiculopathy, related to the January 18, 1996 fall.

In an April 29, 1998 report, Dr. Arthur Eisenstein, a Board-certified orthopedic surgeon, recommended left knee arthroscopy to repair a torn medial meniscus.

In June 10 and July 4, 1998 reports, Dr. Richard S. Goodman, a Board-certified orthopedic surgeon and second opinion physician, opined that appellant did not exhibit any objective clinical findings to substantiate his symptoms and that the radiographic studies of record showed no abnormalities.

In July 31 and September 3, 1998 reports, Dr. Alan Meyers, a Board-certified orthopedic surgeon and associate of Dr. Hausknecht, diagnosed "[d]erangement of the left knee with synovitis and degenerative changes in the posterior horns of both the medial and lateral menisci" requiring arthroscopic repair and "disc herniation at L5-S1."

In August 17, 1998 reports, Dr. Allan Hausknecht diagnosed "post-traumatic lumbosacral/thoracic radiculopathy" due to the January 18, 1996 incident.

In an October 6, 1998 report, Dr. Robert Garroway, a Board-certified orthopedic surgeon and impartial medical examiner, appointed to resolve a conflict of medical opinion between Dr. Hausknecht, for appellant and Dr. Goodman, for the government, reviewed the medical record and statement of accepted facts. Dr. Garroway noted findings on orthopedic examination and diagnosed a lumbosacral strain and a left knee sprain with "probable tear of medial meniscus." Dr. Garroway opined that these diagnoses, "including the small herniated disc at L4-5, are related to the accident of January 18, 1996." Dr. Garroway recommended left knee arthroscopy to further evaluate and repair the torn medial meniscus as demonstrated by the June 21, 1996 MRI scan.

[2] The Office authorized physical therapy for the left knee and low back from November 5, 1997 through 1998, as well as a lumbar MRI and EMG/NCV (electromyography and nerve conduction velocity) testing.

Dr. Charles DeMarco, a Board-certified orthopedic surgeon, performed left knee arthroscopy with a partial meniscectomy on October 29, 1998, which revealed a tear of the anterior horn of the medial meniscus.[3] In a December 30, 1998 report, Dr. DeMarco opined that appellant's January 18, 1996 injury was "completely consistent with meniscal tear of the left knee. [Appellant] described a twisting injury with intermittent pain and swelling over a prolonged period of time. This is consistent with meniscal tear. This is causally related to the accident [appellant] had on January 18, 1996. [Appellant] denies any prior history of any knee problem prior to that accident." Dr. DeMarco added that appellant's lumbar radiculopathy had been persistent since the January 18, 1996 incident.

In an April 22, 1999 report, Dr. Aric Hausknecht diagnosed "[l]umbosacral sprain, strain and radiculopathy with L5-S1 disc herniation and L1-2, L2-3 and L4-5 disc bulges with associated spondylosis"[4] and "[i]nternal derangement of the left knee with tear of the medial horn and associated joint effusion, requiring surgical intervention." Dr. Hausknecht attributed these conditions to the January 18, 1996 incident as his knee and back symptoms and objective findings were present from the time of the January 18, 1996 accident onward, with no prior history of such conditions.

In an August 5, 1999 report, Dr. Aric Hausknecht opined that appellant had a 25 percent permanent impairment of the left lower extremity according to Table 62, page 83, of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.), (hereinafter, the A.M.A., *Guides*),[5] as he had a cartilage interval of one millimeter. Dr. Hausknecht also found a 35 percent "whole person" impairment due to impairment of the thoracolumbar spine.

In an October 25, 1999 pleading, appellant, through his representative, asserted that he sustained lumbar radiculopathy, a herniated lumbar disc, disc bulges at L1-2, L2-3 and L4-5 with spondylosis and "[i]nternal derangement of the left knee with tear of the medial horn and associated joint effusion" causally related to the accepted injuries. Appellant also asserted that he was entitled to a schedule award for impairment of the lumbosacral spine.

In a January 15, 2000 note, an Office medical adviser indicated that the Office should not accept lumbar radiculopathy, L5-S1 disc herniation and disc bulges at L1-2, L2-3 and L4-5 with spondylosis as causally related to the accepted injuries.

In a February 16, 2000 note, an Office medical adviser concurred with Dr. Hausknecht's August 5, 1999 report finding a 25 percent permanent impairment of the left lower extremity and that appellant had reached maximum medical improvement.

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[3] Dr. Hausknecht submitted progress notes from October 1998 to March 10, 1999, finding improvement of the left knee following arthroscopy and continued low back pain.

[4] A March 19, 1998 lumbar MRI showed mild spondylosis, congenital stenosis, "bulging L1-2, L2-3 L4-5 intervertebral discs" with desiccation from L4-S1, and a "[s]mall left paracentral disc herniation L5-S1 level without significant mass effect." A March 26, 1998 EMG examination showed L5-S1 radiculopathy.

[5] Table 62, page 83, is entitled "Arthritis Impairments Based on Roentgenographically Determined Cartilage Intervals."

By decision dated February 25, 2000, the Office awarded appellant a schedule award for a 25 percent permanent impairment of the left lower extremity, with the period of the award running from August 5, 1999 to December 21, 2000.

By letter decision dated February 25, 2000, the Office denied appellant's claim for lumbar radiculopathy, L5-S1 disc herniation and disc bulges at L1-2, L2-3 and L4-5 with spondylosis. The Office noted that an Office medical adviser opined "that these issues should NOT be expanded to the accepted condition." (Emphasis in the original.) The Office also found that the "medical [evidence] submitted does not support that these conditions should be included to the accepted condition." The Office noted that "the other issue was the schedule[] award, which was approved and has been processed for payment."[6]

The Board finds that appellant has established that he sustained a herniated lumbar disc, lumbar radiculopathy and internal derangement of the left knee resulting from the accepted January 18, 1996 incident.

When an employee claims a new injury or condition causally related to an accepted employment injury, he or she must submit rationalized medical evidence, based on a complete and accurate factual and medical background, showing a causal relationship between the employment injury and the claimed conditions.[7] As applied to this case, appellant has the burden of establishing by the weight of the substantial, reliable and probative evidence, a causal relationship between his claimed herniated lumbar discs, internal derangement of the left knee, and the January 18, 1996 incident and accepted injuries.[8]

In support of his claim for a herniated lumbar disc, appellant submitted a series of reports from his attending physicians, dated January 18, 1996 onward, demonstrating that he sustained a spinal injury. In January 18 and 22, 1996 reports, Dr. Cooperman, an attending osteopath, related that on January 18, 1996 appellant fell off a step, landing on his back and diagnosed a "lumbosacral sprain/contusion." In reports from February 13 to June 5, 1996 report, Dr. Lehman, an attending Board-certified orthopedic surgeon, diagnosed an "acute severe sprain of the lumbosacral spine with radiculitis and nerve root irritation of the left lower extremity due to the January 18, 1996 fall. In a May 13, 1997 report, Dr. Salama, a Board-certified neurologist, diagnosed lumbosacral radiculopathy caused by the January 18, 1996 fall.

[6] The Board notes that the February 25, 2000 letter decision does not contain or refer to appeal rights. Appellant's attorney representative noted this in a March 13, 2000 letter and requested that the Office issue a formal decision. However, the Board finds that the February 25, 2000 letter decision qualifies as a formal decision, as it refers to specific issues, makes findings of fact and provides rationale for the Office's decision. The Office's failure to include appeal rights with the February 25, 2000 letter decision is not fatal under the facts and circumstances of this case. The Board also finds that the letter decision's language referring to the schedule award as a separate issue, in addition to the fact that both the letter and the schedule award were dated and issued the same day, is sufficient to establish that the February 25, 2000 letter is a formal decision of the Office.

[7] *See Armando Colon*, 41 ECAB 563 (1990).

[8] *Dominic M. DeScala*, 37 ECAB 369, 372 (1986); *Bobby Melton*, 33 ECAB 1305, 1308-09 (1982).

In progress notes dated May 13, 1997 to August 17, 1998, Drs. Aric and Allan Hausknecht, Board-certified in neurology, psychiatry and pain management, diagnosed continued lumbar pain with radiculopathy, which they attributed to the January 18, 1996 fall. In an April 22, 1999 report, Dr. Aric Hausknecht diagnosed an "L5-S1 disc herniation and L1-2, L2-3 and L4-5 disc bulges with associated spondylosis" attributable to the January 18, 1996 incident, as his back pain started upon falling and had not remitted.

In addition to the opinion of appellant's attending physicians, Dr. Garroway, a Board-certified orthopedic surgeon and the impartial medical specialist in this case, supports a causal relationship between an L4-5 herniated disc and the January 18, 1996 fall. In an October 6, 1998 report, Dr. Garroway diagnosed lumbosacral strain and a "small herniated disc at L4-5," as demonstrated by a March 19, 1998 lumbar MRI scan, "related to the accident of January 18, 1996." The Board finds that Dr. Garroway's report is based upon a complete and accurate history and statement of accepted facts and contains sufficient rationale to establish a causal relationship between the January 18, 1996 incident and the herniated L4-5 disc. Also, Dr. Garroway's status as an impartial medical examiner entitles his opinion to great weight.[9]

Appellant also submitted a series of medical reports from his attending physicians supporting a causal relationship between internal derangement of the left knee and the January 18, 1996 incident. He was first diagnosed with internal derangement of the left knee on February 13, 1996 by Dr. Lehman, an attending Board-certified orthopedic surgeon, who found "traumatic synovitis with injury to medial and lateral ligaments and cartilage of the left knee."[10] Dr. DeMarco, an attending Board-certified orthopedic surgeon, who performed left knee arthroscopy with partial meniscectomy on October 29, 1998, explained in a December 30, 1998 report that the January 18, 1996 fall was "completely consistent with meniscal tear of the left knee" due to the twisting type of injury, clinical course, and that appellant had "no history of any knee problem prior to that accident."

In addition to appellant's attending physicians' support for causal relationship, Dr. Garroway, in his October 6, 1998 report, diagnosed a left knee sprain with "probable tear of medial meniscus … related to the accident of January 18, 1996."

The Board further finds that appellant has not submitted sufficient rationalized medical evidence to establish a causal relationship between lumbar spondylosis, the bulging discs from L1-4 and the accepted January 18, 1996 incident. While Dr. Aric Hausknecht's April 22, 1999 report notes the presence of "L1-2, L2-3 and L4-5 disc bulges with associated spondylosis," he did not explain how and why these findings were related to the accepted January 18, 1996 incident. Also, Dr. Garroway did not support such causal relationship.

[9] *Aubrey Belnavis*, 37 ECAB 206, 212 (1985).

[10] The diagnosis of a torn left medial meniscus was also made on March 27, 1997 by Dr. Varriale, an attending Board-certified orthopedic surgeon, on April 29, 1998 by Dr. Eisenstein, an attending Board-certified orthopedic surgeon, on April 22, 1999 by Dr. Aric Hausknecht, and on July 31 and September 3, 1998 by Dr. Meyers, an attending Board-certified orthopedic surgeon. Each of these physicians attributed the torn meniscus with internal derangement of the left knee to the January 18, 1996 fall.

The Board finds that appellant has met his burden of proof in establishing that he sustained a herniated lumbar disc, lumbar radiculopathy and internal derangement of the left knee, causally related to the accepted January 18, 1996 incident. Therefore, the case will be returned to the Office to determine any periods of disability, wage loss or medical expenses related to the left knee derangement, herniated lumbar disc and radiculopathy for payment of appropriate benefits.

The Board also finds that appellant has not established that he sustained greater than a 25 percent permanent impairment of his left lower extremity, for which he received a schedule award.

The schedule award provisions of the Federal Employees' Compensation Act and its implementing regulations[11] set forth the number of weeks of compensation to be paid for permanent loss or loss of use of the members of the body listed in the schedule.[12] However, as the Act does not specify the manner in which the percentage of loss of a member shall be determined, the method of determination is left to the sound discretion of the Office.[13] To ensure consistent results and equal justice under the law, the Office has adopted the A.M.A., *Guides* as an appropriate, uniform standard for evaluating schedule losses and to ensure equal justice for all claimants.[14] The Board has concurred with the adoption of these A.M.A., *Guides*.

The only report from an attending physician directly addressing the schedule award issue is Dr. Aric Hausknecht's August 5, 1999 report, finding a 25 percent permanent impairment of the left lower extremity due to arthritic impairment of the knee, with no other factors included. In his February 16, 2000 report, the Office medical adviser concurred with Dr. Hausknecht and the method of his calculation. Appellant has not submitted any other medical evidence indicating that he sustained greater than a 25 percent impairment of the left lower extremity. Therefore, the Board finds that the February 25, 2000 schedule award was proper under the law and facts of this case.[15]

The February 25, 2000 schedule award decision of the Office of Workers' Compensation Programs is hereby affirmed. The February 25, 2000 decision is hereby modified to find the conditions of herniated lumbar disc and internal derangement of the left knee as causally related

[11] 20 C.F.R. § 10.404.

[12] 5 U.S.C. §§ 8107-8109.

[13] *Danniel C. Goings*, 37 ECAB 781 (1986); *Richard Beggs*, 28 ECAB 387 (1977).

[14] FECA Bulletin No. 89-30 (issued September 28, 1990).

[15] Appellant also asserted, through his attorney representative, that he was entitled to a schedule award for a permanent impairment of the whole body due to pathologies of the thoracolumbar spine. However, neither the Act nor its implementing regulations provides for a schedule award for impairment to the back or to the body as a whole. Furthermore, the back is specifically excluded from the definition of organ under the Act. As neither the Act nor the implementing regulations provide for the payment of a schedule award for the permanent loss of use of the spine or any portion thereof, no claimant is entitled to such an award. *See George E. Williams*, 44 ECAB 530 (1993); *James E. Mills*, 43 ECAB 215, 219 (1991); *James E. Jenkins*, 39 ECAB 860, 866 (1990).

to the accepted injury, and affirmed in finding that the bulging lumbar discs and spondylosis are not causally related to the accepted injury.

Dated, Washington, DC
September 4, 2001

Willie T.C. Thomas
Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member