U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ELEANOR E. SMITH and U.S. POSTAL SERVICE,
POST OFFICE, Long Beach, CA

Docket No. 01-210; Submitted on the Record;
Issued January 17, 2002

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
MICHAEL E. GROOM

The issue is whether appellant has more than a two percent permanent impairment of the right lower extremity.

On May 3, 1991 appellant, then a 57-year-old distribution clerk, injured her right leg at work while placing a tub of mail in a utility cart. The Office of Workers' Compensation Programs accepted her claim for right calf sprain, right medial meniscus tear with surgery and thrombophlebitis. Appellant received compensation for periods of disability.

On January 30, 1995 appellant filed a claim for a schedule award. The Office referred her to Dr. Newt Wakeman, a Board-certified orthopedic surgeon, for an evaluation of permanent impairment resulting from the accepted employment injury.

On July 22, 1999 Dr. Wakeman related appellant's history and reviewed her records. He noted a partial meniscectomy of the right medial meniscus, a subsequent partial meniscectomy of the right medial meniscus and chondromalacic changes, Grade 3, of the medial femoral and tibial articular surfaces requiring chondroplasty. He also noted venous valvular incompetence in the deep and superficial venous system bilaterally, as well as ankle brachial indices suggesting mild intermittent claudication range. Complaints included limited range of walking, limited sitting and occasional knee pain without specific localization. After describing his findings on examination, Dr. Wakeman diagnosed status post partial excision of the right knee; medial meniscus; post phlebitic syndrome of the right leg, secondary to deep vein thrombosis, stable under Coumadin therapy; and persistent pain in the right medial gastrocnemius. He evaluated appellant's impairment as follows:

> "Using the fourth edition (the A.M.A., *Guides*) A[merican] M[edical] A[ssociation,] *Guides to the Evaluation of Permanent Impairment* she would be allowed 1 percent whole person and 2 percent lower extremity impairment according to Table 64. Table 14, on page 198, appears to describe [appellant's] current condition under Class 2 for pain with walking activity, persistent edema

> and venous valvular incompetence per doppler signals September 16, 1996 with 39 percent whole person being the top degree. The medial gastroc pain is in the region supplied by the saphenous branch of the femoral nerve, which using Table 68 assigns 3 percent whole person and 7 percent lower extremity impairments for dysesthesia. Table 11 for pain which interferes with activity, Grade 3, 60 percent would result in a 2 percent whole person and 4 percent lower extremity impairment. However, Table 64 and Table 68 are incompatible."

On September 12, 1999 an Office medical adviser reviewed Dr. Wakeman's findings. He noted that Dr. Wakeman chose to evaluate impairment for the partial medial meniscectomy using Table 64, page 85, of the A.M.A., *Guides*. The medical adviser also noted that Dr. Wakeman found no indication of clinical symptomatology associated with thrombophlebitis in the right lower extremity. Although there was mild intermittent claudication, the medical adviser explained that claudication was an arterial condition not associated with the accepted condition of thrombophlebitis, which is a venous condition.

The medical adviser noted that Dr. Wakeman failed to use Table 20, page 150, to grade the severity of pain, making any rating for residual pain impossible. He noted, however, that if a grade for pain were offered based on the history of the complaint, the impairment would be approximately two percent. The medical adviser concluded that the permanent impairment of appellant's right lower extremity was two percent.

On September 14, 1999 the Office issued a schedule award for a two percent permanent impairment of the right lower extremity.

On April 5, 2000 Dr. James H. Ceasar, appellant's attending cardiologist, reported as follows:

> "I have followed [appellant] regularly for the last four years. I follow her for her chronic venous insufficiency and for her hypertension. [Appellant] has a history of phlebitis primarily in her right leg. She has had problems with pain and swelling of this leg since that time which is common following an episode of severe phlebitis. This can render the valves in the leg incompetent which can lead to these symptoms. [Appellant] has had Doppler studies of her lower extremities that have shown evidence of valvular incompetence on the right leg. The last time these were done was approximately two years ago. She continues to have symptoms of pain and edema of her right lower extremity any time she has to stand with her leg in a dependent position for a length of time. [Appellant] otherwise has been stable medically. I think this is a problem that does limit her activity. I think it is a result of the phlebitis that she had and I think it is a permanent condition. She will need to be on anti-coagulant chronically as she will always have an increased risk of recurrent phlebitis in this leg."

On May 26, 2000 Dr. Ronald Pak, a physiatrist, saw appellant for the purpose of rating the impairment of her right lower extremity according to the A.M.A., *Guides*. Dr. Pak related appellant's history, medical course and complaints. After describing his findings on physical examination, he diagnosed: "Chronic insufficiency with dependent edema, right lower

extremity. Activity and pattern of swelling is as described above. [Appellant] does restrict activity significantly due to the levels of swelling. She does not have any persistent pain. There are no skin changes." Dr. Pak reported that appellant's level of impairment correlated with a Class II impairment for lower extremity peripheral vascular disease as described in Table 14, page 198. "In my view," he stated, "her condition, as it relates to the venous insufficiency correlates with a 25 percent whole person impairment."

In a decision dated July 27, 2000, an Office hearing representative affirmed the September 14, 1999 schedule award.

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

The schedule award provision of the Federal Employees' Compensation 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.

Table 64, page 85, of the fourth edition of the A.M.A., *Guides*[3] provides a two percent impairment of the lower extremity for a partial meniscectomy of either the medial or lateral meniscus. As Dr. Wakeman reported, appellant twice had partial meniscectomies of the right medial meniscus. Appellant therefore has a two percent permanent impairment of the right lower extremity due to the partial meniscectomies, which the Office awarded. The Board will affirm the Office's July 27, 2000 decision on the issue of impairment due to partial meniscectomies.

The Office medical adviser denied an impairment rating for pain. He explained that Dr. Wakeman failed to use Table 20, page 150, to grade the severity of pain, making any rating for residual pain impossible. Dr. Wakeman instead used Table 11, page 48, which was meant for determining impairment of the upper extremity due to pain or sensory deficit resulting from peripheral nervous disorders. Table 11, page 48, is practically the same as Table 20, page 150, providing the same procedure and essentially the same grading scheme and percentage deficits, so Dr. Wakeman's failure to use Table 20 is not a sufficient reason in this case for denying an impairment rating for pain. Dr. Wakeman identified the area of involvement, identified the nerve innervating the area and multiplied the maximum loss of function of the nerve due to dysesthesia under Table 68, page 89, by the degree of decreased sensation or pain under Grade 3. He concluded that appellant had a four percent impairment of the right lower extremity due to pain or sensory deficit.

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404 (1999).

[3] A.M.A., *Guides* 85 (4th ed. 1993).

The question is whether the two percent impairment for partial meniscectomies should be combined with a four percent impairment for medial gastrocnemius pain. The Office's Procedure Manual states that Table 64, page 85, which Dr. Wakeman used to determine impairment for partial meniscectomies, is incompatible with Table 68, page 89, which he used to determine impairment due to pain. The Office's Procedure Manual also states that Table 64, page 85, is incompatible with Table 20, page 151, which the Office medical adviser suggested Dr. Wakeman should have used. Table 64, page 85, should not be used together with these tables "because doing so will result in duplicate measurements and an artificially high percentage of impairment."[4] The Board will affirm the Office's July 27, 2000 decision to the extent that it did not apply Table 68 or Table 20 in conjunction with Table 64.

The question that remains is whether appellant's schedule award should reflect any additional impairment of the right lower extremity under Table 69, page 89, entitled "Lower Extremity Impairment Due to Peripheral Vascular Disease." Noting appellant's pain with walking activity, persistent edema and venous valvular incompetence as per Doppler signals obtained September 16, 1996, Dr. Wakeman graded appellant's impairment as a Class 2 impairment. A Class 2 impairment is described by one of the following: "[Appellant] experiences intermittent claudication on walking at least 100 yards at an average pace"; or "There is persistent edema of a moderate degree, controlled by elastic supports"; or "There is vascular damage evidenced by a sign, such as that of a healed, painless stump of an amputated digit showing evidence of persistent vascular disease or a healed ulcer." A Class 2 impairment represents an impairment of the lower extremity of 10 to 39 percent.

The Office medical adviser recommended no impairment due to peripheral vascular disease because he explained claudication is an arterial condition not associated with the accepted condition of thrombophlebitis, which is a venous condition. It would appear, however, that claudication may be either arterial or venous[5] and the record supports that appellant has venous valvular incompetence and chronic venous insufficiency. Also, it makes no difference whether appellant's claudication is arterial or whether it is associated with the accepted condition of thrombophlebitis if appellant's peripheral vascular disease preexisted her employment injury. It is well established that preexisting impairments of the body are to be included when determining the amount of a schedule award for an employment-related permanent impairment.[6]

[4] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (October 1995).

[5] "Claudication" means limping or lameness. Intermittent claudication is a complex of symptoms characterized by absence of pain or discomfort in a limb when at rest, the commencement of pain, tension and weakness, after walking is begun, intensification of the condition until walking becomes impossible and the disappearance of the symptoms after a period of rest. The condition is seen in occlusive arterial diseases of the limbs, such as thromboangiitis obliterans and in compression of the *cauda equina*. Called also *Charcot's syndrome* and *angina cruris*. Venous claudication is intermittent claudication caused by venous stasis. Dorland's Illustrated Medical Dictionary 343 (27th ed.1988).

[6] *Walter R. Malena*, 46 ECAB 983 (1995); *Dale B. Larson*, 41 ECAB 481, 490 (1990); *Pedro M. DeLeon, Jr.*, 35 ECAB 487, 492 (1983).

Moreover, claudication is not the only criterion for evaluating impairment of the lower extremity due to peripheral vascular disorder. The record supports that appellant has dependent edema, and this alone would qualify her for an impairment rating under Table 69, page 89.

As Table 69 (peripheral vascular disease) and Table 64 (partial meniscectomy) are not incompatible, according to the Office's Procedure Manual, the Board will set aside the Office's July 27, 2000 decision on the issue of impairment due to peripheral vascular disease and remand the case for the Office to consider Table 69 in conjunction with Table 64. After such further development as may be necessary, the Office shall issue an appropriate final decision on appellant's entitlement to schedule compensation.

The July 27, 2000 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part. The case is remanded for further action consistent with this opinion.

Dated, Washington, DC
January 17, 2002

Michael J. Walsh
Chairman

David S. Gerson
Member

Michael E. Groom
Alternate Member