U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of DONNIE R. MARCUM and U.S. POSTAL SERVICE,
POST OFFICE, London, KY

Docket No. 02-1261; Submitted on the Record;
Issued January 8, 2003

DECISION and ORDER

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

The issue is whether appellant sustained a permanent impairment of his left lower extremity.

The Office of Workers' Compensation Programs accepted that appellant, a 45-year-old collection and delivery clerk, sustained pes anserinus bursitis and tendinitis of the left knee due to repetitive twisting and walking while casing mail.

Appellant submitted treatment notes from January to April 1998 from Dr. Michael Grefer, an attending Board-certified orthopedic surgeon. On April 23, 1998 Dr. Grefer performed laparoscopy on appellant's left knee to correct chondral lesions of the medial femoral condyle and patellofemoral joint and excise a large symptomatic medial plica. Appellant was off work through May 26, 1998, returned to light duty, stopped work again, returned to light duty in August 1998 and full duty in January 1999.

On May 8, 1998 appellant claimed a schedule award.

In a July 22, 1998 letter, the Office requested that Dr. Grefer explain whether appellant had any permanent impairment of the left lower extremity according to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (4th ed.).

In a September 21, 1998 report, Dr. Grefer found left knee flexion of 125 out of 135 degrees and opined that appellant had a 10 percent impairment of the left lower extremity. In a December 7, 1998 report, Dr. Grefer noted an improved range of left knee motion and strength, continued symptoms at the jointline and that appellant was medically able to work full time.

The Office referred Dr. Grefer's report to an Office medical adviser, who opined in a January 6, 1999 report, that appellant did not have a ratable impairment of the left lower extremity according to the A.M.A., *Guides*. The Office medical adviser explained that according

to Table 41, page 78 of the A.M.A., *Guides*, flexion of 125 degrees did not constitute a ratable impairment.[1]

In a January 25, 1999 report, Dr. Grefer found appellant "[n]eurologically and neurovascularly … stable," with "no signs of any ongoing problems" other than some discomfort while delivering mail and morning stiffness. Dr. Grefer noted "full extension" and "good flexion" of the left knee with no instability." He released appellant from treatment.

In an April 12, 1999 letter, the Office requested that Dr. Grefer correlate his determination of a 10 percent impairment of the left lower extremity with the A.M.A., *Guides.* Dr. Grefer responded on May 20, 1999, stating that appellant had reached maximum medical improvement as of January 25, 1999 when he was discharged from care. He noted that appellant continued to have soreness, stiffness, restricted motion and weakness." Dr. Grefer opined that appellant "still ha[d] a 10 percent impairment to the body as a whole related to his left knee based on the A.M.A., *Guides* … Tables 39, 41 and 64 of Chapter 3."[2]

The Office referred Dr. Grefer's May 20, 1999 letter to an Office medical adviser for a review. In a June 2, 1999 report, the Office medical adviser stated that there was no basis for an impairment rating resulting from the accepted injury.

By July 1, 1999 letter, the Office again asked Dr. Grefer to provide an impairment rating, noting that there was no provision under the Federal Employees' Compensation Act for a schedule award for a whole body impairment.

Dr. Grefer responded on July 6, 1999, repeating the statements made in his May 20, 1999 letter, adding that appellant had a 10 percent "impairment to the left lower extremity left knee based on the A.M.A., *Guides* … Tables 39, 41 and 64 of Chapter 3."

In an August 23, 1999 report, Dr. Grefer stated that appellant would have "permanent residuals that will be worse at times … especially with … repetitive standing, walking, stooping, etc. The 10 percent impairment is based upon continued weakness, pain, stiffness and decreased motion of his knee."

The Office referred Dr. Grefer's reports back to the Office medical adviser. In July 21 and September 8, 1999 reports, the Office medical adviser opined that as appellant was discharged from care on January 25, 1999 with no loss of range of motion or impairment due to stiffness, Dr. Grefer had not provided a sufficient basis for making an impairment rating of the left lower extremity.

[1] Table 41, page 78 of the A.M.A., *Guides* (4th ed.), entitled "Knee Impairment," provides that flexion greater than 110 degrees does not constitute an impairment.

[2] Table 39, page 77 of the A.M.A., *Guides* (4th ed.), is entitled "Impairments from Lower Extremity Muscle Weakness." Table 64, pages 85 and 86, is entitled "Impairment Estimates for Certain Lower Extremity Impairments." Dr. Grefer did not refer to specific impairments or percentages of impairment appearing in these tables in his report.

The Office referred appellant, the medical record and a statement of accepted facts, to Dr. Paul Forberg, a Board-certified orthopedic surgeon, for a second opinion examination. In a December 7, 1999 report, Dr. Forberg reviewed the medical record and noted findings on examination of a slightly antalgic gait, no weakness, no loss of range of motion, 135 degrees of left knee flexion and minor patellofemoral crepitus. He diagnosed chondromalacia of the femoral condyles and patella. Dr. Forberg opined that this represented a 10 percent impairment according to the A.M.A., *Guides*.

The Office requested that Dr. Forberg clarify his opinion regarding the percentage of impairment. He submitted a January 27, 2000 note stating that appellant had a 20 percent impairment of the left lower extremity due to pain, as set forth in Chapter 15 of the A.M.A., *Guides*.[3]

The Office referred Dr. Forberg's opinion to the Office medical adviser, who stated that Dr. Forberg's report provided no basis for an impairment rating.

The Office referred appellant to Dr. Billy Parson, a Board-certified orthopedic surgeon, for a second opinion examination. In an August 8, 2000 report, Dr. Parson provided a history of injury and treatment, reviewed the medical record and noted findings on examination. He diagnosed patellofemoral arthropathy or chondromalacia of the patella. On examination Dr. Parson noted no left knee swelling, no neurologic abnormalities, negative Drawer's and Lachman's signs, a full range of motion, normal pliability of the patella, no medial or lateral instability, but "some crepitation when [he held] the hand on the patella and [appellant was] put through a range of motion." Dr. Parson opined that appellant had an "A.M.A., impairment rating of approximately 10 percent to the body as a whole based upon the patellofemoral arthritis noted on arthroscopic examination and … a slightly decreased range of motion."

The Office then referred Dr. Parson's report to an Office medical adviser, who opined in a September 27, 2000 report, that Dr. Parson did not observe any abnormality that would qualify as a ratable impairment according to the A.M.A., *Guides*.

By decision dated September 29, 2000, the Office denied appellant's claim for a schedule award.

Appellant disagreed with this decision and in an October 24, 2000 letter requested an oral hearing before an Office hearing representative. A hearing was held on April 24, 2001. At the hearing, appellant described his work at the employing establishment as a letter carrier since July 1977. He attributed his left knee condition to prolonged standing and walking in the performance of duty. Appellant asserted that his continued left knee symptoms entitled him to a schedule award. He submitted an April 11, 2001 physical therapy report.

By decision dated and finalized July 10, 2001, the Office hearing representative affirmed the September 29, 2000 decision denying appellant's schedule award claim.

[3] Chapter 15 of the A.M.A., *Guides*, 4th ed., is entitled "Pain."

The Board finds that appellant has not established that he sustained an impairment of the left lower extremity.

The schedule award provisions of the Act[4] and its implementing regulation[5] 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 how 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 and guidelines so that there are uniform standards applicable to all claimants. The Office has adopted the A.M.A., *Guides* as the appropriate standard for evaluating scheduled losses. As of February 21, 2001, the Office uses the fifth edition of the A.M.A., *Guides* to calculate new claims for a schedule award or to recalculate prior schedule awards pursuant to an appeal, request for reconsideration or decision of an Office hearing representative.[6]

The standards for evaluation the permanent impairment of an extremity under the A.M.A., *Guides* are based on loss of range of motion, together with all factors that prevent a limb from functioning normally, such as pain, sensory deficit and loss of strength. All of the factors should be considered together in evaluating the degree of permanent impairment.[7]

In support of his schedule award claim, appellant submitted numerous reports from Dr. Grefer, an attending orthopedic surgeon, who stated, in a September 21, 1998 report, that appellant had a 10 percent permanent impairment of the left lower extremity due to the accepted occupational knee conditions. However, Dr. Grefer did not explain the nature of appellant's impairment or how he applied the specific tables and grading schemes of the A.M.A., *Guides* that provided for such an impairment. In a January 25, 1999 report, he found no abnormalities of the left knee, indicating that appellant did not have an impairment of the left knee. Yet, in May 20 and July 6, 1999 reports, Dr. Grefer again opined that appellant had a 10 percent impairment of the left lower extremity. Although he referred to three tables in the A.M.A., *Guides*, he did not explain how he used those tables to arrive at the stated percentage of impairment. In an August 23, 1999 report, Dr. Grefer explained that the 10 percent impairment was due to "weakness, pain, stiffness and decreased motion" of the left knee, but did not specify how he arrived at this percentage.

As Dr. Grefer did not explain his rationale for assigning a 10 percent impairment rating, the Office referred appellant to Dr. Forberg, a Board-certified orthopedic surgeon, for a second opinion examination. He submitted a highly detailed December 7, 1999 report, finding minor patellofemoral crepitus without instability or weakness and a full, normal range of motion.

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404 (1999).

[6] *See* FECA Bulletin 01-05 (issued January 29, 2001) (awards calculated according to any previous edition should be evaluated according to the edition originally used; any recalculations of previous awards which result from hearings, reconsideration or appeals should, however, be based on the fifth edition of the A.M.A., *Guides* effective February 1, 2001).

[7] *See Paul A. Toms*, 28 ECAB 403 (1987).

Although he also recommended a 10 percent permanent impairment rating, Dr. Forberg did not explain this percentage according to the A.M.A., *Guides*. Moreover, Dr. Forberg did not address why he changed his impairment rating to 20 percent due to pain in a January 2000 addendum.

The Office thereafter referred appellant to Dr. Parsons, a Board-certified orthopedic surgeon, for a second opinion examination. In an August 8, 2000 report, he noted mild patellar crepitation but no other abnormality and assigned a 10 percent permanent impairment to the "body as a whole" based on the presence of patellofemoral arthritis. Dr. Parsons did not refer to any specific table, figure or grading scheme in the A.M.A., *Guides* to support this percentage of impairment.

The only objective abnormal finding observed by the physicians of record is mild patellar crepitation in the absence of any instability. The Office referred the medical record to an Office medical adviser. In June 2, September 8 1999, January 31 and September 27, 2000 reports, the Office medical adviser explained that the physicians of record did not find any element of appellant's left knee condition that constituted a ratable impairment. The Office medical adviser referred to the appropriate tables and grading schemes of the A.M.A., *Guides* to support his opinion. The Board finds that the Office medical adviser properly applied the appropriate tables and grading schemes of the A.M.A., *Guides* in determining that appellant did not have a ratable impairment of the left lower extremity.

Consequently, appellant has not established that he sustained a ratable impairment of the left lower extremity, as he submitted insufficient medical evidence to support the presence of any element of permanent impairment.[8]

[8] Accompanying his request for appeal, appellant submitted new medical evidence which he alleged demonstrated that he sustained at least a 24 percent permanent impairment of the left lower extremity. The Board may not consider evidence for the first time on appeal that was not before the Office at the time it issued the final decision in the case. Therefore, the Board may not consider this new medical evidence. Appellant may submit this evidence to the Office accompanying a valid request for reconsideration. 20 C.F.R. § 501.2(c).

The decision of the Office of Workers' Compensation Programs dated and finalized July 10, 2001 is hereby affirmed.

Dated, Washington, DC
January 8, 2003

Michael J. Walsh
Chairman

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member