U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of VERA R. PRICE and U.S. POSTAL SERVICE,
POST OFFICE, Indianapolis, IN

Docket No. 03-928; Submitted on the Record;
Issued June 23, 2003

DECISION and ORDER

Before COLLEEN DUFFY KIKO, WILLIE T.C. THOMAS,
MICHAEL E. GROOM

The issues are: (1) whether appellant has more than a 29 percent permanent impairment of the left leg, for which she has received schedule awards; and (2) whether the Office of Workers' Compensation Programs properly denied appellant's September 30, 2002 request for reconsideration.

In the prior appeal of this case,[1] the Board found that the medical evidence did not fully describe the impairment of appellant's left leg. Appellant's orthopedic surgeon neglected to report cartilage interval measurements and the Office did not request the information. According to the Office medical adviser, appellant's impairment rating of 28 percent would have been "much higher" if that information was available. As the evidence did not accurately represent appellant's impairment, the Board remanded the case for further development. The facts of this case as set forth in the Board's prior decision are hereby incorporated by reference.[2]

On January 19, 2001 the Office advised appellant's attending physician, Dr. Joseph C. Randolph, a Board-certified orthopedic surgeon, that it was authorizing total left knee replacement surgery.

On February 7, 2001 the Office asked Dr. Randolph to obtain appellant's current cartilage interval measurements and to submit a brief report. The Office acknowledged that appellant would be undergoing surgery and advised that "once she reaches MMI [maximum medical improvement] again we will rerate her.…"

[1] Docket No. 99-2514 (issued September 25, 2000).

[2] In a matter unrelated to the present appeal, the Board issued a decision on September 14, 2000 finding that the medical evidence of record was insufficient to establish that appellant's right knee condition was causally related to the left knee injury she sustained on May 7, 1975.

On February 12, 2001 Dr. Randolph responded as follows:

> "[Appellant] returned to my office on February 12, 2001. I had tried to set her up for a total knee replacement previously. As you know, she has already been rated. I am not sure this rating was done correctly. However, the medical advis[e]r who calculated permanent partial impairment [PPI] ratings, in my opinion, has not done this correctly either.
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> "I am contemplating doing a total knee replacement on her, as you know. I do not think it is appropriate for me to give her a new PPI [rating]. The results of my calculated PPI, I think, to her satisfaction, a total knee replacement frankly will be doomed.
>
> "I am going to set her up with Dr. Scott Bowen and have him evaluate her for a PPI. He can do that and if she then is desirous of a total knee replacement, I will be happy to do that."[3]

The Office referred appellant, together with the medical record and a statement of accepted facts, to Dr. Arthur Lorber, a Board-certified orthopedic surgeon, for evaluation.

In a report dated March 8, 2001, Dr. Lorber related appellant's history. He noted that appellant was scheduled for a left total knee arthroplasty on April 18, 2001. Findings on physical examination included the following with respect to the left knee: full extension; 100 degrees flexion; 12 degrees valgus; Grade II out of IV crepitation at the left patellar femoral joint; complaint of pain with motion; complaint of tenderness; no sensory loss to light touch; negative sitting root test and straight leg raising test; no gross instability. An x-ray demonstrated minimal narrowing of the joint spaces four millimeters wide, laterally more than medially, significantly irregular articular surfaces and loose bodies medially and laterally.

Dr. Lorber diagnosed advanced osteoarthritis, left knee, status postoperative partial lateral meniscectomy[4] and excision of popliteal cyst. He reported that appellant was qualified only for sedentary activities with restrictions on standing and walking and no climbing, kneeling or squatting or repetitive use of the lower extremities to operate foot pedals. He stated that appellant would probably benefit from a left total knee replacement: "If [appellant] elects not to proceed with the total knee arthroplasty procedure, then she should be considered to have achieved maximum medical benefits as of this date."

[3] Dr. Randolph did not sign or initial this report.

[4] On July 17, 1975, with a diagnosis of torn lateral meniscus of the left knee, appellant underwent an arthrotomy and the torn lateral meniscus was removed. Dr. Lorber made no diagnosis with respect to the left medial meniscus, but earlier in his report he noted that a partial medial meniscectomy was performed in July 1981. The postoperative diagnosis from the operative report of July 7, 1981 was complete peripheral tear of the medial meniscus, left knee, which was seen floating in the center of the joint. The anterior aspect was grasped and cut loose and a meniscus clamp attached. The posterior horn was removed in *toto* and the meniscus was removed. The scope also showed a remnant of a lateral meniscus, which from previous history revealed a lateral meniscectomy.

Dr. Lorber reported that, because x-rays demonstrated medial and lateral joint spaces at least four millimeters in height, the use of Table 17-31, page 544, of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001), roentgenographically determined cartilage intervals, was not applicable. He determined that appellant had a permanent impairment of the left knee of 28 percent.

An Office medical adviser reviewed Dr. Lorber's clinical findings and determined that appellant had a combined total left leg impairment[5] of 29 percent: 10 percent for range of motion to 100 degrees;[6] 10 percent for 12 degrees valgus;[7] 7 percent for lateral meniscectomy;[8] 5 percent for crepitus post trauma;[9] and 0 percent for joint space interval of 4 millimeters.[10]

In a decision dated April 26, 2001, the Office denied appellant's claim for an increased schedule award on the grounds that the weight of the medical evidence established that the work-related injury to her left leg had not worsened.

Appellant requested an oral hearing before an Office hearing representative. After the hearing, which was held on April 30, 2002, appellant submitted additional medical records, including the operative report for her June 6, 2001 total left knee replacement. Dr. Randolph reported on March 21, 2002 that appellant complained of medial knee pain, but at nine months after surgery it was a bit early to rate a total knee replacement. He would wait until one year had passed to give an impairment rating. On June 10, 2002 Dr. Randolph indicated that appellant's current condition was unchanging. He rated appellant's impairment as follows:

> "I saw [appellant] back in the office on June 10, 2002. She is a year after left total knee replacement. Her x-rays look great. She has excellent alignment. She has no evidence of loosening. Range of motion is 0 to about 95. She has been operated on before. She does have range of motion of 0 to about 95. I rate this a fair result. She has minimal instability medially in extension and mid flexion and flexion. Based on this being a fair result, I have given her a permanent partial impairment rating of 50 percent of the lower extremity or 20 percent of the person as a whole."[11]

In a decision dated June 27, 2002, the hearing representative affirmed the denial of appellant's claim for an increased schedule award. She found that Dr. Randolph's opinion was of limited probative value because he provided only the degree of impairment; he did not discuss

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[5] *See* A.M.A., *Guides*, 604 (Combined Values Chart).

[6] *Id*. at 537 (Table 17-10).

[7] *Id*.

[8] *Id*. at 546 (Table 17-33).

[9] *Id*. at 544 (Table 17-31).

[10] *Id*.

[11] Dr. Randolph did not sign or initial this report.

specific findings on examination or how he arrived at the rating, nor did he indicate that he based his rating on the A.M.A., *Guides*.

On July 10, 2002 appellant requested reconsideration. She stated that Dr. Randolph would be forwarding additional medical evidence, and she argued that Dr. Lorber was very unkind.

In a decision dated July 17, 2002, the Office denied appellant's request for reconsideration on the grounds that it neither raised substantive legal questions nor included any new and relevant evidence.

On August 7, 2002 appellant again requested reconsideration. She submitted a July 8, 2002 report initialed by Dr. Randolph:[12]

> "This is in response to your request for further information concerning [appellant]. She did undergo total knee replacement. Dr. Randolph has last seen her on June 10, 2002. [Appellant] has achieved a maximal medical improvement, and Dr. Randolph did render a PPI rating at that time. It would be 50 percent of the lower extremity. This is based upon diagnosis and a fair subsequent result.
>
> "If you have any further questions or concerns, please contact our office."

Appellant also submitted an August 9, 2002 treatment note from Dr. David S. Batt, who noted pain, especially on range of motion of appellant's left knee and chronic swelling.

In a decision dated September 16, 2002, the Office reviewed the merits of appellant's claim and denied modification of its decision denying an increased schedule award. The Office found that the July 8, 2002 report contained no objective findings and no explanation of how Dr. Randolph arrived at a rating of 50 percent. The Office added that physicians' assistants are not recognized as physicians and a medical report from a physician's assistant is acceptable only if countersigned by a physician.

On September 30, 2002 appellant requested reconsideration. She submitted a September 27, 2002 report from Dr. Randolph:

> "I have been asked to state specifically the rationale for [appellant's] impairment rating. I would rate her total knee result as a fair result and according to the [f]ifth [e]dition of the A.M.A., *Guides* …, [p]age 547, Table 17-33, this would give her 50 percent impairment of the lower extremity, 20 percent personal.
>
> "I think this is pretty straightforward. If you have any problems, please call me."[13]

[12] Below Dr. Randolph's mark, the closing read: "Ted J. Westlund, P.A. for Joseph C. Randolph, M.D."

[13] Dr. Randolph did not sign or initial this report.

In a decision dated November 12, 2002, the Office denied appellant's request for reconsideration. The Office found that Dr. Randolph's September 30, 2002 report was unsigned and repetitious of evidence previously reviewed and considered. There was no new evidence providing relevant objective findings.

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

Compensation is provided for specified periods of time for the permanent loss or loss of use of certain members, organs and functions of the body. Such loss or loss of use is known as permanent impairment. Compensation for proportionate periods of time is payable for partial loss or loss of use of each member, organ or function. The Office evaluates the degree of impairment to scheduled members, organs and functions as defined in 5 U.S.C. § 8107 according to the standards set forth in the specified edition of the A.M.A., *Guides*.[14]

According to the fifth edition of the A.M.A., *Guides*:

> "Some impairment estimates are assigned more appropriately on the basis of a diagnosis than on the basis of findings on physical examination. A good example is that of an individual impaired because of a successful replacement of a hip. This person may function well but require prophylactic restrictions of activities of daily living to prevent a further impairment, such as premature failure of the prosthesis. Table 17-33 provides impairment estimates for certain lower extremity impairments. For most diagnosis-based estimates, the ranges of impairment are broad, and the estimate will depend on the clinical manifestations and their impact on the ability to perform activities of daily living. Hip replacements should first be rated using Table 17-34 and knee replacements using Table 17-35. The points obtained from the assessment are then applied to Table 17-33 for the diagnosis impairment rating. If limb length discrepancy also exists, that impairment rating should be combined with the impairment from the joint replacement using the Combined Values Chart (p. 604)."[15]

Table 17-35, page 549, rating knee replacement results, assigns points for pain, range of motion and stability. Points are then deducted for flexion contracture, extension lag and alignment. Table 17-33, page 547, is then applied to determine whether the point total describes a good, fair or poor result and the respective impairment.

Without comparing Dr. Randolph's clinical findings to the descriptions in Table 17-35, without knowing the point total for rating appellant's knee replacement results, the A.M.A., *Guides* makes clear that appellant is entitled to an increased schedule award. Under Table 17-33, page 547, a total knee replacement can result in no less than a 37 percent impairment of the lower extremity. Therefore, assuming the very best results from her total left knee replacement, *i.e.*, no pain, range of motion to 125 degrees, no instability in either the anteroposterior or mediolateral plane, flexion contracture of 5 to 9 degrees, extension lag less than 10 degrees and

[14] *Id*. at § 10.404 (1999).

[15] A.M.A., *Guides*, 545 (5th ed. 2001).

perfect alignment, appellant would be entitled to a schedule award greater than the 29 percent the Office previously awarded. On this basis, the Board will set aside the Office's September 16 and June 27, 2002 decisions denying an increased schedule award and remanded the case for further development.

When he rated appellant's impairment, Dr. Randolph judged left knee replacement results to be "fair." Under Table 17-33, page 547, "fair results" represents a lower extremity impairment of 50 percent. To qualify as fair results, however, the clinical manifestations and their impact on the ability to perform activities of daily living must total from 50 to 84 points under Table 17-35. Dr. Randolph did not provide a rating of appellant's knee replacement results under Table 17-35. He assigned no points for any of the categories listed and his clinical findings do not describe appellant's results sufficiently to permit a proper application of Table 17-35. His assessment of fair results and his rating of 50 percent, therefore, are not well rationalized.

The Board also finds that the Office properly denied appellant's September 30, 2002 request for reconsideration.

The Federal Employees' Compensation Act provides that the Office may review an award for or against compensation upon application by an employee (or his or her representative) who receives an adverse decision. The employee shall exercise this right through a request to the district Office. The request, along with the supporting statements and evidence, is called the "application for reconsideration."[16]

An employee (or representative) seeking reconsideration should send the application for reconsideration to the address as instructed by the Office in the final decision. The application for reconsideration, including all supporting documents, must be in writing and must set forth arguments and contain evidence that either: (1) shows that the Office erroneously applied or interpreted a specific point of law; (2) advances a relevant legal argument not previously considered by the Office; or (3) constitutes relevant and pertinent new evidence not previously considered by the Office.[17]

A timely request for reconsideration may be granted if the Office determines that the employee has presented evidence and/or argument that meets at least one of these standards. If reconsideration is granted, the case is reopened and the case is reviewed on its merits. Where the request is timely but fails to meet at least one of these standards, the Office will deny the application for reconsideration without reopening the case for a review on the merits.[18]

Appellant's September 30, 2002 request for reconsideration does not show that the Office erroneously applied or interpreted a specific point of law, nor does it advance a relevant legal argument not previously considered by the Office. Instead, appellant supported her request by submitting a September 27, 2002 report from Dr. Randolph. Medical reports that are not signed

[16] 20 C.F.R. § 10.605 (1999).

[17] *Id*. at § 10.606.

[18] *Id*. at § 10.608.

by a "physician" as defined by 5 U.S.C. § 8101(2) cannot be considered as evidence.[19] This defect aside, the September 27, 2002 report is repetitive, clarifying only that Dr. Randolph rated appellant's results as fair under Table 17-33 of the A.M.A., *Guides*, a fact in his previous reports. The report offered no clarification of the points assigned under Table 17-35, page 549. The Board therefore finds that the evidence submitted does not constitute relevant and pertinent new evidence not previously considered by the Office.

As appellant's September 30, 2002 request for reconsideration fails to meet one of the three standards for obtaining a merit review of her case, the Board finds that the Office properly denied that request. The Board will affirm the Office's November 12, 2002 decision.

The November 12, September 16 and June 27, 2002 decisions of the Office of Workers' Compensation Programs are set aside and the case remanded for further action consistent with this opinion to be followed by an appropriate decision on appellant's entitlement to a schedule award.

Dated, Washington, DC
June 23, 2003

Colleen Duffy Kiko
Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

[19] *Cherie L. Hutchings*, 39 ECAB 639 (1988) (claimant requested reconsideration and submitted an unsigned medical report pertaining to a medical examination).