United States Department of Labor
Employees' Compensation Appeals Board

JAMES R. HILL, SR., Appellant	)	
and	)	**Docket No. 05-1899**
	)	**Issued: May 12, 2006**
U.S. POSTAL SERVICE, POST OFFICE, Washington, DC, Employer	)	

Appearances:
James R. Hill, Sr., pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On September 13, 2005 appellant filed a timely appeal from the Office of Workers' Compensation Programs' schedule award decision dated March 10, 2005 and a July 12, 2005 decision, which denied modification of the schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant met his burden of proof to establish that he had more than a two percent permanent impairment of his right lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On July 5, 2000 appellant, then a 53-year-old letter carrier, filed a traumatic injury claim alleging that he sustained a right knee injury on that date while trying to prevent a 25-pound parcel from falling from a vehicle. Appellant stopped work on July 6, 2000 and returned on July 10, 2000. On July 11, 2001 the Office accepted the claim for a sprained right knee and, on January 10, 2003, for a right knee medial meniscus tear and arthroscopic surgery.

On January 23, 2003 appellant underwent laser arthroscopy and a partial medial meniscectomy of the right knee performed by Dr. Hamid R. Quraishi, a Board-certified orthopedic surgeon. Appellant returned to regular duty on April 7, 2003. The Office subsequently authorized further right knee arthroscopic surgery, which was performed on October 17, 2003, by Dr. Quraishi. He performed an arthroscopy of the right knee, a partial medial meniscectomy, shaving followed by laser chondroplasty of the patella, extensive excision of the large multilocular cyst, repair of the medial collateral ligament and placement of knee immobilizer. The Office also authorized physical therapy.

On August 4, 2004 appellant requested a schedule award. By letter dated November 15, 2004, the Office advised appellant to provide an opinion from his physician regarding whether he had reached maximum medical improvement and whether he had sustained any permanent impairment.

In a November 23, 2004 report, Dr. Quraishi advised that appellant was seen for a final evaluation. He evaluated appellant's right knee and determined that his gait was normal and that he could squat. Appellant had a healed scar over the medial side with tenderness and a persistent burning sensation. He advised that, along the infrapatellar branch of the long saphenous nerve, the range of motion was satisfactory, although appellant did have some discomfort on the va1gus stress. Dr. Quraishi obtained measurements of the thigh and calf, noting normal measurements of the calf and a difference of one centimeter on the thigh, which he advised was consistent with the surgery appellant underwent. X-rays of the right knee showed minimum degenerative changes in the medial compartment. Dr. Quraishi advised that the first surgery was on January 23, 2003, when appellant had a partial medial meniscectomy and patella chondroplasty. A second surgery was on October 17, 2004,[1] when appellant had a repeat partial meniscectomy and chondroplasty of the patella with excision of the multilocular cyst and repair of the medial collateral ligament. Dr. Quraishi indicated that appellant had reached maximum medical improvement and was discharged. He utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (hereinafter A.M.A., *Guides*) (5th ed. 2001) and referred to pages 530 and 545.[2] Considering that appellant had atrophy of the right thigh, partial medial meniscectomy twice, shaving of the patella and repair of the capsule, Dr. Quraishi estimated impairment of 13 percent of the right lower extremity.

On February 17, 2005 the Office medical adviser utilized the A.M.A., *Guides* and reviewed the medical records, including the October 17, 2003 operative report of Dr. Quraishi. He referred to Table 17-33[3] to find that a partial meniscectomy would result in two percent impairment to the right lower extremity. Dr. Quraishi opined that appellant was at maximum medical improvement on October 17, 2004, which was one year post surgery.

[1] This appears to be a typographical error as the surgery was actually October 17, 2003.

[2] Page 530 pertains to atrophy while page 545 pertains to diagnosis-based estimates. A.M.A., *Guides* (5th ed. 2001).

[3] A.M.A., *Guides* 546.

On March 10, 2005 the Office granted appellant a schedule award for two percent permanent impairment of the right lower extremity. The award covered a period of 5.76 weeks from October 17 to November 25, 2004.

The Office subsequently received several reports from appellant's treating physician, Dr. Charles F. Colao, Board-certified in internal medicine. In a May 25, 2005 report, he opined that appellant had surgery twice on his right knee, which included a partial medial meniscectomy and patellar chondroplasty, with excision of the multilocular cyst and repair of the medial collateral ligament and recommended that appellant continue with his home exercise program. Dr. Colao continued to treat appellant and submit reports; however, he did not address appellant's schedule award or provide an impairment rating in these reports.

On June 7, 2005 the Office received appellant's undated request for reconsideration. Appellant explained that he underwent two surgeries, one on January 23, 2003 and one on October 17, 2004.[4] Appellant noted that there was a wide discrepancy and he had more injuries than he was being rated on.

In a letter dated May 31, 2005, appellant advised that there was an "obvious discrepancy in the disability rating." He noted that his physician provided a rating of 13 percent as compared to the 2 percent provided by the Office medical adviser. He requested an additional 11 percent. Appellant also submitted a copy of Dr. Quraishi's November 23, 2004 report.

By merit decision dated July 12, 2005, the Office denied modification of the March 10, 2005 schedule award.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[5] sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[6] The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[7] The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[8]

For lower extremity impairments due to meniscectomies or ligament injuries involving the knees, Table 17-1, page 525 of the A.M.A., *Guides*[9] directs the clinician to utilize section

[4] This appears to be a typographical error as the surgery was October 17, 2003.

[5] 5 U.S.C. §§ 8101-8193.

[6] 5 U.S.C. § 8107.

[7] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[8] 20 C.F.R. § 10.404.

[9] A.M.A., *Guides* (5th ed. 2001) 525, Table 17-1.

17.2j, beginning at page 545,[10] as the appropriate method of impairment assessment. Section 17.2j, entitled Diagnosis-Based Estimates, instructs the clinician to assess the impairment using the criteria in Table 17-33 at page 546, entitled Impairment Estimates for Certain Lower Extremity Impairments.[11] According to Table 17-33, a partial medial meniscectomy is equivalent to a two percent impairment of the lower extremity.[12] Additional percentages of impairment are awarded for laxity of the cruciate or collateral ligaments.[13]

The A.M.A., *Guides* provides for three separate methods for calculating the impairment of an individual: anatomic, functional and diagnosis based.[14] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[15] The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligamentous instability, bursitis and various surgical procedures, including joint replacements and meniscectomies.[16] In certain situations, diagnosis-based estimates are combined with other methods of assessment.[17] The functional method is used for conditions when anatomic changes are difficult to categorize or when functional implications have been documented and includes range of motion, gait derangement and muscle strength.[18] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[19] When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.[20] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[21]

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[10] *Id.* at 545.

[11] *Id.* at 546, Table 17-33.

[12] *Id.*

[13] *Id.*

[14] *Id*. at 525.

[15] *Id.*

[16] *Id.*

[17] The A.M.A., *Guides* specifically excludes combining diagnosis-based estimates with range of motion and ankylosis deficits. A.M.A., *Guides* 526, Table 17-2.

[18] *Id.* at 525, Table 17-1.

[19] *Id.* at 548, 555.

[20] *Id.* at 526.

[21] *Id*. at 527, 555.

ANALYSIS

The Office accepted the case for a sprained right knee, a right knee medial meniscus tear and for arthroscopic surgery. Dr. Quraishi, appellant's attending Board-certified orthopedic surgeon, opined that appellant had reached maximum medical improvement in a November 23, 2004 report. He utilized the A.M.A., *Guides* and noted that appellant had atrophy of the thigh on the right, underwent two partial medial meniscectomies, shaving of the patella and repair of the capsu1e. He opined that appellant had an impairment of 13 percent of the right lower extremity and referenced sections of the A.M.A., *Guides* pertaining to atrophy and diagnosis-based impairments. However, the Board notes that Table 17-2 of the A.M.A., *Guides* indicates that it is not appropriate to combine diagnosis-based estimates with impairment for atrophy.[22] Dr. Quraishi did not offer any other explanation pursuant to the A.M.A., *Guides* regarding how he calculated appellant's 13 percent impairment rating. Therefore, his rating of the percentage of permanent impairment is of diminished probative value.[23]

The Office referred Dr. Quraishi's report to an Office medical adviser for review. In a February 17, 2005 report, the Office medical adviser referred to Table 17-33, at page 546 of the A.M.A., *Guides*, to note that a partial medial meniscectomy equaled two percent impairment of the lower extremity. He opined that appellant reached maximum medical improvement on October 17, 2004. However, the Office medical adviser did not explain why he utilized this diagnosis-based estimate of impairment. The record reflects that appellant also had a loss of one centimeter atrophy of the thigh. The Board notes that, if the anatomic based measurement of atrophy was utilized, appellant would be entitled to an award in the area of three to eight percent of the lower extremity based upon Table 17-6 of the A.M.A., *Guides.* The Office medical adviser did not explain why the diagnosis-based rating was selected as opposed to the rating utilizing the anatomic method of measurement. The Board finds that the Office medical adviser's opinion is insufficient to establish the degree of appellant's permanent impairment as he did not explain why he selected one method for rating impairment over the other. As noted, if more than one impairment method can be used, the method that provides the higher impairment rating should be adopted.

The case will be remanded for the Office to seek clarification from its medical adviser regarding appellant's permanent impairment.

CONCLUSION

The Board finds that this case is not in posture for a decision and will be remanded for further development of the medical evidence. After such further development as the Office deems necessary, it should issue an appropriate merit decision.

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[22] *Id.* at 526.

[23] *Norman D. Armstrong*, 55 ECAB ___ (Docket No. 04-306, issued June 23, 2004). *See also Shalanya Ellison*, 56 ECAB ___ (Docket No. 04-824, issued November 10, 2004) (schedule awards under the Act are to be based on the A.M.A., *Guides*; an estimate of permanent impairment is irrelevant and of diminished probative value where it is not based on the A.M.A., *Guides*).

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated July 12 and March 10, 2005 are set aside and the case remanded for further action consistent with this decision of the Board.

Issued: May 12, 2006
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board