United States Department of Labor
Employees' Compensation Appeals Board

E.V., Appellant	)	
and	)	**Docket No. 06-646**
	)	**Issued: October 27, 2006**
U.S. POSTAL SERVICE, NEWTOWN POST OFFICE, Newtown, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
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 January 25, 2006 appellant, through his attorney, filed a timely appeal from the January 18, 2006 merit decision of the Office of Workers' Compensation Programs, granting a schedule award for a nine percent impairment of the right lower extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this schedule award case.

ISSUE

The issue is whether appellant established that he has more than a nine percent impairment of the right lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On March 30, 2001 appellant, then a 36-year-old letter carrier, filed a traumatic injury claim alleging that on that date he felt a pull, pain and swelling in his right knee when his foot became caught between a mail truck and the curb. He fell awkwardly, twisting his right knee. By letter dated May 24, 2001, the Office accepted appellant's claim for right knee sprain and left

wrist sprain. The Office subsequently authorized arthroscopic surgery for anterior cruciate ligament (ACL) reconstruction and a partial lateral meniscectomy on the right knee, which was performed on May 15, 2001 by Dr. Christopher M. Aland, an attending Board-certified orthopedic surgeon. Appellant returned to full-duty work on July 6, 2001.

On December 19, 2003 appellant filed a claim alleging that he sustained a recurrence of disability on December 18, 2003. He stopped work on December 19, 2003. On January 28, 2004 Dr. Aland requested authorization to perform arthroscopic surgery for a partial medial meniscectomy with inspection of the cruciate in appellant's right knee. He stated that appellant had a history of prior right knee anterior cruciate ligament reconstruction. A magnetic resonance imaging scan suggested a torn meniscus with concern over the possibility of a rupture of the cruciate reconstruction. On March 15, 2004 the Office approved the surgery, which was performed on February 23, 2004. Appellant's preoperative and postoperative diagnoses were torn medial meniscus, possible rerupture of the anterior cruciate ligament and retained hardware of the knee. Appellant returned to full-time limited-duty work on March 4, 2004.

On June 3, 2004 the Office approved a request from Dr. Robert W. Frederick, an attending Board-certified orthopedic surgeon, to perform an arthroscopy of the right knee. On June 14, 2004 he removed hardware, performed a partial lateral meniscectomy and trochlear chondroplasty and revised an ACL reconstruction with Achille's tendon allograft. Appellant's preoperative and postoperative diagnoses included anterior cruciate ligament tear status post failed ACL reconstruction, retained hardware, degenerative lateral meniscus tear, remote history of subtotal knee meniscectomy and post-traumatic degenerative arthritis, medial and patellofemoral compartments with mesotrochlear osteophytes. Dr. Frederick released appellant to return to part-time limited-duty work on September 27, 2004. On October 26, 2004 Dr. Frederick released him to return to full-duty work which was scheduled for October 29, 2004.

On June 1, 2005 appellant filed a claim for a schedule award. By letters dated June 8, 2005, the Office advised him to make an appointment with his attending physician to determine the extent of any permanent impairment of the right lower extremity based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001).

In a September 8, 2005 medical report, Dr. Frederick noted that appellant had residual symptomatology primarily related to early post-traumatic arthritis in the right knee. Utilizing the A.M.A., *Guides* 546, Table 17-33, he determined that revisions of the ACL reconstruction with mild cruciate ligament laxity and a subtotal medial meniscectomy resulted in a three percent impairment each of the whole person. Dr. Frederick determined that a partial lateral meniscectomy warranted a one percent impairment of the whole person. Based on the A.M.A., *Guides* 544, Table 17-31, he found that appellant's degenerative arthritis with a two millimeter (mm) cartilage interval constituted an eight percent impairment of the whole person. Dr. Frederick concluded that appellant's total lower extremity impairment was 15 percent impairment, which was the equivalent of a 6 percent impairment of the whole person based on the A.M.A., *Guides* 527, Table 17-3. On September 22, 2005 the Office requested that an Office medical adviser review Dr. Frederick's September 8, 2005 report.

Appellant submitted an October 4, 2005 report of Dr. George L. Rodriguez, a Board-certified physiatrist, who presented a history of appellant's March 30, 2001 employment injuries and medical treatment and social and occupational background. Dr. Rodriguez reported his findings on physical examination and reviewed appellant's medical records. With regard to his right knee, he diagnosed an ACL tear that was status post reconstruction and replacement, a lateral meniscal tear that was status post partial meniscectomy, a medial meniscal tear that was status partial resection of the posterior horn and lateral patellar subluxation with right partial thickness defect causally related to the accepted employment injuries. Dr. Rodriguez stated that appellant suffered significant right lower extremity dysfunction and pain. Appellant reached maximum medical improvement on December 14, 2004 and there was no evidence of symptom magnification or nonphysiological complaints. Utilizing the A.M.A., *Guides* 546, Table 17-33, Dr. Rodriguez determined that a patellar subluxation constituted a 7 percent impairment and the partial medial and lateral meniscectomies constituted a 10 percent impairment, combining for a 16 percent impairment of the right lower extremity based on the Combined Values Chart on page 604 of the A.M.A., *Guides*.

On January 11, 2006 an Office medical adviser reviewed appellant's medical records. He provided a history of his March 30, 2001 employment injuries and medical treatment. Utilizing the A.M.A., *Guides* 546, Table 17-33, the Office medical adviser determined that mild laxity of the cruciate or collateral ligament constituted a seven percent impairment and a partial medial or lateral meniscectomy constituted a two percent impairment, combining for a nine percent impairment of the right lower extremity.

By decision dated January 18, 2006, the Office granted appellant a schedule award for a nine percent impairment of the right lower extremity based on the Office medical adviser's opinion.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulation[2] sets 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. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[3] However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[4]

[1] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[2] 20 C.F.R. § 10.404.

[3] 5 U.S.C. § 8107(c)(19).

[4] *See supra* note 2.

ANALYSIS

The Office accepted that appellant sustained a right knee sprain and left wrist sprain while in the performance of duty on March 30, 2001. On May 15, 2001 Dr. Aland, an attending physician, performed reconstruction of the ACL and a partial lateral meniscectomy on the right knee. On February 23, 2004 he performed a partial medial meniscectomy on the right knee. On June 14, 2004 Dr. Frederick, an attending physician, performed a partial lateral meniscectomy and trochlear chondroplasty and revised an ACL reconstruction with Achille's tendon allograft on the right knee.

Dr. Rodriguez diagnosed an ACL tear that was status post reconstruction and replacement, a lateral meniscal tear that was status post partial meniscectomy, a medial meniscal tear that was status post partial resection of the posterior horn and lateral patellar subluxation with right partial thickness defect causally related to the accepted employment injuries. He determined that appellant had a 7 percent impairment due to a patellar subluxation and a 10 percent impairment due to partial medial and lateral meniscectomies based on the A.M.A., *Guides* 546, Table 17-33. Dr. Rodriguez combined these impairment ratings in finding that appellant had a 16 percent impairment of the right lower extremity.[5] As Dr. Rodriguez properly applied the tables in the A.M.A., *Guides*, his opinion represents the weight of the medical evidence.

Dr. Frederick found that appellant had residual symptomatology primarily related to early post-traumatic arthritis in the right knee. Utilizing the A.M.A., *Guides* 546, Table 17-33, he determined that revision of the ACL reconstruction with mild cruciate ligament laxity and a remote history of a subtotal medial meniscectomy resulted in a three percent impairment each of the whole person. Dr. Frederick further determined that a partial lateral meniscectomy constituted a one percent impairment of the whole person. He found that appellant's degenerative arthritis with a two mm cartilage interval constituted an eight percent impairment of the whole person based on the A.M.A., *Guides* 544, Table 17-31. Dr. Frederick concluded that the total right lower extremity impairment was 15 percent, which constituted a 6 percent impairment of the whole person according to the A.M.A., *Guides* 527, Table 17-3. The Board notes that, while the A.M.A., *Guides* provide for impairment to the individual member and to the whole person, neither the Act nor its regulations allow schedule awards for impairment to the whole person.[6] However, Dr. Frederick's whole person impairments can be converted into an impairment of the right lower extremity under Tables 17-31 and 17-33. Further, the cross-usage chart, Table 17-2 on page 526 of the A.M.A., *Guides*, indicates that ratings from diagnosis-based estimates for the knee pursuant to Table 17-33 can be combined with an impairment rating for arthritic changes.[7] According to Table 17-33, a three percent whole person impairment for mild cruciate ligament laxity and a subtotal medial meniscectomy each converts into a seven person impairment and a one percent whole person impairment for a partial lateral meniscectomy

[5] *Id.*

[6] 5 U.S.C. § 8107; *see also Phyllis F. Cundiff*, 52 ECAB 439 (2001); *Jay K. Tomokiyo*, 51 ECAB 361 (2000); *Richard R. Lemay*, 56 ECAB ___ (Docket No. 04-1652, issued February 16, 2005).

[7] A.M.A., *Guides* 526, Table 17-2.

converts into a two percent impairment of the right lower extremity. According to Table 17-31, an 8 percent impairment of the whole person for degenerative arthritis with a 2 mm cartilage interval converts into a 20 percent impairment. Utilizing the Combined Values Chart on page 604 of the A.M.A., *Guides*,[8] the noted impairment ratings yield a 33 percent impairment of the right lower extremity. The Board, however, notes that, contrary to Dr. Frederick's assignment of impairment for a subtotal medial meniscectomy, the record does not establish that appellant underwent the stated surgery. Rather, the record indicates that he underwent partial medial and lateral meniscectomies on May 15, 2001 and February 23 and June 14, 2004. Consequently, the Board finds that Dr. Frederick's opinion is not sufficient to establish the degree of appellant's permanent impairment of the right lower extremity.

An Office medical adviser found that appellant's mild laxity of the cruciate or collateral ligament constituted a seven percent impairment and a partial medial or lateral meniscectomy constituted a two percent impairment, combining for a nine percent impairment of the right lower extremity based on the A.M.A., *Guides* 546, Table 17-33. However, the record establishes that appellant underwent both a partial medial and lateral meniscectomy and the Office medical adviser did not explain why he did not assign a percentage for both surgeries under Table 17-33, as indicated by this table. Thus, the Board finds that the Office medical adviser's opinion is not sufficient to establish the degree of appellant's permanent impairment.

The Board will set aside the Office's January 18, 2006 decision and remand the case for further development of the impairment to appellant's right lower extremity impairment.

CONCLUSION

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

[8] *Id.* at 604.

ORDER

IT IS HEREBY ORDERED THAT the January 18, 2006 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to the Office for further action consistent with this decision.

Issued: October 27, 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