United States Department of Labor
Employees' Compensation Appeals Board

M.J., Appellant	)	
and	)	**Docket No. 06-2090**
	)	**Issued: April 5, 2007**
SOCIAL SECURITY ADMINISTRATION, CENTER FOR HUMAN RESOURCES, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 7, 2006 appellant filed a timely appeal from a March 28, 2006 decision of a hearing representative of the Office of Workers' Compensation Programs who denied her claim for an increased schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination in this case.

ISSUE

The issue is whether appellant has met her burden of proof to establish that she has greater than a 13 percent impairment of each lower extremity for which she has received schedule awards.

FACTUAL HISTORY

This case has previously been before the Board. In an April 2, 2003 decision, the Board affirmed decisions of the Office dated November 9, 2001 and August 19, 2002, which denied

authorization for bilateral total knee replacement surgery.[1] The law and the facts of the previous Board decision are incorporated herein by reference.

On August 15, 2003 appellant filed a schedule award claim and submitted a May 22, 2003 report from Dr. Nicholas Diamond, an osteopath, who noted the history of injury, a review of certain medical records and provided findings on examination. Dr. Diamond stated that appellant complained of bilateral knee pain and stiffness daily and graded her pain at 6/10 on the left and 5/10 on the right. Appellant occasionally limped and had difficulty climbing stairs and sleeping. Dr. Diamond diagnosed post-traumatic internal derangement of the left knee with a torn lateral meniscus; medial synovial plica syndrome; post-traumatic chondromalacia of the left knee, status post arthroscopic surgery with partial lateral meniscectomy on December 2, 1999; status post chondroplasty of the lateral femoral condyle and the lateral tibial plateau; status post resection of medial synovial plica; retear of the lateral meniscus to the left knee secondary to work-related injury of January 25, 2000; post-traumatic osteoarthritis to the left knee; status post arthroscopic surgery to the left knee with partial lateral meniscectomy and chondroplasty of the lateral femoral condyle and patellar chondroplasty on June 29, 2000. He also diagnosed post-traumatic internal derangement to the right knee with a torn meniscus; post-traumatic chondromalacia patellae to the right knee; status post arthroscopic surgery to the right knee with meniscectomy and chondroplasty on May 12, 2000; aggravation of preexisting right knee pathology, personal injury 1991 and history of bilateral total knee arthroplasties on February 21, 2002. Dr. Diamond advised that appellant had reached maximum medical improvement and, in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[2] she had bilateral lower extremity impairments of 30 percent each. Under Table 17-8 appellant had a quadriceps strength deficit of 12 percent and a gastrocnemius strength deficit of 17 percent and that under Figure 18-1, she had a pain-related impairment of 3 percent.

On April 8, 2004 the Office referred the medical record including Dr. Diamond's report and a statement of accepted facts to an Office medical adviser for an opinion regarding appellant's impairment. By report dated April 20, 2004, an Office medical adviser advised that under Table 17-33 of the A.M.A., *Guides*, appellant had 10 percent impairment to each lower extremity for meniscectomies and an additional 3 percent for pain. He advised that maximum medical improvement had been reached on March 22, 2003. By decision dated May 18, 2004, the Office granted appellant a schedule award for 13 percent permanent impairment of the right and left lower extremities, for a total of 74.88 weeks, to run from March 23, 2003 to August 28, 2004.

On May 21, 2004 appellant, through her attorney, requested a hearing. In a January 11, 2005 decision, an Office hearing representative remanded the case to the Office to obtain a supplementary report from the Office medical adviser. He was asked to provide rationale for his use of the diagnosis-based table for total knee replacement in calculating appellant's impairment rating. By report dated February 6, 2005, an Office medical adviser stated that Tables 17-33 and 17-35 should not be used because, as noted in section 17.2e of the A.M.A., *Guides*, strength

[1] Docket No. 03-330 (issued April 2, 2003).

[2] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

testing was not the most appropriate method to be used. He further advised that, as appellant's total knee replacement surgery had been found not to be employment related, the most appropriate method to use would be under Table 17-33. The Office medical adviser found that appellant was entitled to a 10 percent impairment for each lower extremity, based on her prior medial and lateral meniscectomies plus an additional 3 percent impairment bilaterally for pain, to total a 13 percent impairment for each lower extremity.

In a decision dated March 9, 2005, the Office found that appellant was not entitled to an increased schedule award. On March 14, 2005 appellant, through counsel, requested a hearing, that was held on February 8, 2006. Her attorney argued that Dr. Diamond's opinion should be credited or, in the alternative, a conflict in medical opinion had been created between his opinion and that of the Office medical adviser. By decision dated March 28, 2006, an Office hearing representative affirmed the March 9, 2005 decision.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[3] and section 10.404 of the implementing federal regulation,[4] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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 Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[5] Chapter 17 provides the framework for assessing lower extremity impairments.[6]

Office procedures indicate that referral to an Office medical adviser is appropriate when a detailed description of the impairment from the attending physician is obtained.[7] When a diagnosis-based impairment rating is applied, it is generally not appropriate to calculate additional impairment based on anatomic or functional based methods (such as limitations of strength or range of motion).[8] It is well established that in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included. As noted by Larson,

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *See Joseph Lawrence, Jr., supra* note 2; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[6] A.M.A., *Guides*, *supra* note 2 at 523-64.

[7] *Thomas J. Fragale*, 55 ECAB 619 (2004).

[8] A.M.A., *Guides*, *supra* note 2, section 17.2j at 545; *Derrick C. Miller*, 54 ECAB 266 (2002).

this is "sometimes expressed by saying that the employer takes the employee as he finds him." Conditions acquired subsequent to the employment injury are not to be considered in schedule award determinations.[9]

For lower extremity impairments due to meniscectomies or ligament injuries involving the knees, Table 17-1, of the A.M.A., *Guides* directs the clinician to utilize section 17.2j as the appropriate method of impairment assessment. Section 17.2j of the A.M.A., *Guides*, entitled Diagnosis-Based Estimates, provides that some impairment estimates are more appropriately rated on the basis of a diagnosis than on the basis of findings on physical examination and instructs the clinician to assess the impairment using the criteria in Table 17-33, entitled Impairment Estimates for Certain Lower Extremity Impairments.[10]

Section 18.3b of the fifth edition of the A.M.A., *Guides* provides that pain-related impairment should not be used if the condition can be adequately rated under another section of the A.M.A., *Guides*.[11] Office procedures provide that, if the conventional impairment adequately encompasses the burden produced by pain, the formal impairment rating is determined by the appropriate section of the A.M.A., *Guides.* However, an impairment rating can, in some situations, be increased by up to three percent if pain increases the burden of the employee's condition.[12]

ANALYSIS

The Board finds that appellant has lower extremity impairment of 13 percent of each leg. In accordance with section 17.2j of the A.M.A., *Guides*, the Office medical adviser properly assessed appellant's knees on the basis of her prior approved bilateral knee meniscectomies and, in accordance with Table 17-33, awarded her a 10 percent lower extremity impairment for the partial medial and lateral meniscectomies that she underwent in 1999 and 2000. Appellant would not be entitled to a rating for total knee replacements under Table 17-33 as the Board previously found that this surgery was not authorized.[13] Dr. Diamond awarded an additional impairment rating for strength deficits of the quadriceps and gastrocnemius muscles. Section 17.2e of the A.M.A., *Guides* provides that, to be valid, if strength testing is made by one examiner, the measurements should be consistent on different occasions and Table 17-7 describes the criteria on which estimates and grades for lower extremity strength are bases, with Table 17-8 listing the actual ratings for lower extremities.[14] While Dr. Diamond generally referenced Table 17-8, he did not provide any explanation using the criteria found in Table 17-7 or other account of how he arrived at the impairment rating for muscle weakness. His report is,

[9] *See generally Michael C. Milner*, 53 ECAB 446 (2002).

[10] A.M.A., *Guides*, *supra* note 2 at 545; *see James R. Hill*, 57 ECAB ____ (Docket No. 05-1899, issued May 12, 2006).

[11] A.M.A., *Guides*, *supra* note 2 at 569.

[12] *Richard B. Myles*, 54 ECAB 379 (2003).

[13] *Supra* note 1.

[14] A.M.A., *Guides*, *supra* note 2 at 531.

therefore, insufficient to establish that appellant is entitled to an increased schedule award for either lower extremity based on muscle weakness.[15] Furthermore, Table 17-2 of the A.M.A., *Guides* describes the types of impairment that cannot be combined, noting that muscle strength cannot be combined with a diagnosis-based estimate.[16] Dr. Diamond also found a three percent impairment due to pain. He described appellant's knee pain as occurring daily, that she occasionally limped and had difficulties climbing stairs and sleeping. Intermittent pain, so long as it is permanent, may constitute a basis for the payment of a schedule award.[17] The Board, therefore, finds that the Office medical adviser allowed an additional three percent bilaterally for appellant's lower extremity pain.

CONCLUSION

The Board finds that appellant has no more than 13 percent impairment of both lower extremities.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 28, 2006 be affirmed.

Issued: April 5, 2007
Washington, DC

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

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

[15] *See Mary L. Henninger*, 52 ECAB 408 (2001).

[16] A.M.A., *Guides*, *supra* note 2 at 526.

[17] *Tania R. Keka*, 55 ECAB 354 (2004).