United States Department of Labor
Employees' Compensation Appeals Board

S.H., Appellant	)	
and	)	**Docket No. 07-1096**
	)	**Issued: November 20, 2007**
U.S. POSTAL SERVICE, FRIENDSHIP HEIGHTS POST OFFICE, Washington, DC, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Oral Argument October 2, 2007

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 19, 2007 appellant filed a timely appeal of the Office of Workers' Compensation Programs' merit decision dated March 1, 2007 determining the permanent impairment of her left lower extremity for schedule award purposes. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than 12 percent permanent impairment of her left lower extremity for which she received schedule awards.

FACTUAL HISTORY

This case has previously been before the Board on appeal. The Office accepted her claim for chondromalacia of the left knee and internal derangement and tear of the lateral meniscus of the right knee. On October 29, 2002 appellant underwent an arthroscopy of her right knee which resulted in partial meniscectomies of the medial and lateral menisci. She requested a schedule

award. By decision dated November 22, 2004, the Office granted appellant schedule awards for 10 percent impairment of the right lower extremity and 7 percent impairment of the left lower extremity. In the September 8, 2005 decision,[1] the Board found that the medical evidence from Dr. Roger Raiford, a Board-certified orthopedic surgeon and impartial medical examiner, was sufficient to establish that appellant had seven percent impairment of her left lower extremity due to a loss of cartilage interval as demonstrated on x-ray. The Board further found that appellant had 10 percent impairment of the right lower extremity due to her two partial meniscectomies, but that Dr. Raiford had not addressed whether appellant had a ratable impairment due to the three millimeter cartilage interval in her right knee as demonstrated on x-ray. The Board then remanded the case for the Office to determine whether appellant had more than 10 percent impairment of her right lower extremity. The facts and the circumstances of the case as set forth in the Board's prior decision are adopted herein by reference.

While her appeal was pending before the Board, appellant's left knee required additional treatment. On April 6, 2005 Dr. Rida N. Azer, her attending Board-certified orthopedic surgeon, noted that she was experiencing pain in her left knee as well as locking. He found evidence of a tear in the medial meniscus of the left knee with traumatic synovitis. Dr. Azer stated: "As noted in my note of June 7, 2002, the patient had injured her knees, the right knee and the left knee at the same time as noted in the report. [Appellant's] left knee was treated by nonsurgical measures. [She] has progressed and now needs the diagnostic and therapeutic arthroscopy. [Appellant's] conditions and recommended treatment are caused by her injury of May 29, 2002." An x-ray report of the same date demonstrated narrowing of the medial joint space and subchondral sclerosis over the femoral surface of the patella. The Office authorized left knee arthroscopy on June 1, 2005. On June 26, 2005 Dr. Azer performed a diagnostic and therapeutic arthroscopy of the left knee with partial medial meniscectomy, partial synovectomy and debridement. On June 28, 2006 he opined that appellant had reached maximum medical improvement in regard to her left knee.

In a report dated July 7, 2006, the Office medical adviser requested new x-rays of both of appellant's knees. He stated that standing anterior posterior (AP) and lateral radiographs were necessary to rate impairment due to arthritis.

Appellant submitted an additional report from Dr. Azer and Dr. Hampton J. Jackson, Jr., a Board-certified orthopedic surgeon, dated July 21, 2006 addressing the permanent impairment of her left lower extremity. Drs. Azer and Jackson reviewed the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) and noted that Chapter 18 provided for impairment ratings for pain. They stated that pain was a major cause of suffering and dysfunction and a permanent condition for appellant. Drs. Azer and Jackson applied the pain assessment protocol of found in Chapter 18 of the A.M.A., *Guides* and reached a 33.9 percent impairment due to pain. Physical examination record atrophy of the left thigh of 2½ centimeters, a 5 percent impairment of the left lower extremity. Drs. Azer and Jackson noted that appellant had weakness to extension of the left knee, a Grade 4 muscle function of the left quadriceps 12 percent impairment of the left lower extremity. They also noted that appellant had seven percent impairment of the whole person due to her limp. Drs. Azer and Jackson reviewed

[1] Docket No.05-540 (issued September 8, 2005).

x-rays and found that appellant had a three millimeter cartilage interval in the medial and lateral compartments of her left knee for seven percent impairment of the left lower extremity. They concluded that appellant had 50 percent impairment of her left lower extremity.

In a x-ray report dated August 11, 2006, Dr. Jackson stated that appellant had diminished femoral tibial joint space as well as patellofemoral joint space. He indicated that the x-rays were taken while appellant was standing. In a separate report of the same date, Dr. Jackson stated that appellant had 7 percent impairment of her right lower extremity due to loss of cartilage interval of the femoral tibia and 10 permanent impairment due to loss of cartilage interval of the patellofemoral cartilage space. He combined these figures for an additional 25 percent impairment of the right lower extremity.

The Office medical adviser reviewed appellant's x-rays on September 20, 2006. He noted that he had been provided with standing AP and lateral radiographs of the right and left knees dated July 31, 2006. The Office medical adviser found normal cartilage intervals in both knees.

Appellant requested an additional schedule award for her left knee on September 22, 2006. On January 11, 2007 the Office referred appellant's claim to the Office medical adviser. In a report dated February 1, 2007, the Office medical adviser stated that he had reviewed AP radiographs of both knees as well as lateral radiograph and merchant views of the left knee. He noted that appellant had received a schedule award for seven percent impairment due to loss of cartilage interval, but opined that her current x-rays did not support such a finding. The Office medical adviser reviewed the rating from Drs. Azer and Jackson and stated that appellant was only entitled to an impairment rating based on atrophy of the quadriceps or weakness in the extension of the knee. He found that weakness of the knee was 12 percent impairment of the lower extremity[2] and rated an additional 5 percent impairment.

By decision dated March 1, 2007, the Office granted appellant an additional schedule award of 5 percent of the left lower extremity bringing her total impairment rating for schedule award purposes to 12 percent. The Office stated: "You were previously awarded seven percent impairment to the left lower extremity in November 2004…. After review of the updated radiographs, it is the opinion of the [Office medical adviser] that the schedule award for the left knee previously paid in 2004 which was based upon loss of cartilage interval was awarded in error. Therefore, since you have already been awarded 7 percent permanent impairment in 2004 for the lower left extremity and current impairment is 12 percent due to weakness of extension of the left knee; your total residual impairment rating is 5 percent to the left lower extremity."

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulations[4] set forth the number of weeks of compensation payable to employees

[2] A.M.A., *Guides* 532, Table 17-8.

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, the Act does not specify the manner in which 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 so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[5] Effective February 1, 2001, the Office adopted the fifth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[6]

Before the A.M.A., *Guides* can be utilized, a description of a claimant's impairment must be obtained from appellant's physician. In obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment including, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation or other pertinent descriptions of the impairment. This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[7] The A.M.A., *Guides* provide and the Board has held that it is improper to combine impairments for decreased strength, muscle atrophy and gait derangement.[8] Gait derangement estimates cannot be combined with any other impairment evaluation method and whenever possible an evaluator should use a more specific method of impairment evaluation.[9] If an impairment rating is based on gait derangement, then written rationale should be included in the physician's report.[10] The A.M.A., *Guides* do provide, however, that diagnosis based estimates may be combined with ratings for arthritis.[11] If a claimant's various impairment ratings cannot be combined, she is entitled to only the greater of the evaluation methods.[12]

Chapter 18 of the A.M.A., *Guides* should be used to evaluate pain-related impairments when there is excess pain in the context of a verifiable medical condition that causes pain such as lumbar radiculopathy, when there are well-established pain syndromes without significant identifiable organ dysfunction, such as headaches or when there are other associated pain syndrome.[13] However, examiners should not use Chapter 18 to rate pain-related impairments for

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[5] *Id.*

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(a) (August 2002).

[7] *Robert B. Rozelle*, 44 ECAB 616, 618 (1993).

[8] A.M.A., *Guides* 526, Table 17.2; *Cerita J. Slusher*, 56 ECAB ____ (Docket No. 04-1584, issued May 10, 2005); *Patricia J. Horney*, 56 ECAB ___ (Docket No. 04-2013, issued January 14, 2005).

[9] A.M.A., *Guides* 529, 17.2c Gait Derangement.

[10] *Id.*

[11] A.M.A., *Guides* 526, Table 17.2.

[12] *Juantia L. Spencer*, 56 ECAB ____ (Docket No. 05-527, issued June 21, 2005).

[13] A.M.A., *Guides* 570, 18.3a.

any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*.[14]

ANALYSIS

Appellant received a schedule award on November 22, 2004 for seven percent impairment of her left lower extremity due to a three millimeter cartilage interval of the knee as demonstrated on x-ray. The Board affirmed this aspect of the Office's November 22, 2004 decision on September 8, 2005.[15] Appellant required additional treatment of her left knee condition beginning April 6, 2005. Dr. Azer, a Board-certified orthopedic surgeon, performed a partial medial meniscectomy of the left knee on June 26, 2005. In a report dated July 21, 2006, he reported his findings on physical examination including left thigh atrophy of 2½ centimeters, weakness to extension of the left knee, 12 percent impairment, a limp and distorted gait, which was rated both as 7 percent of the whole person and 33.9 percent impairment of the left lower extremity due to pain in accordance with Chapter 18 of the A.M.A., *Guides*. Dr. Azer also awarded seven percent impairment of the left lower extremity due to loss of cartilage interval as demonstrated on x-ray. He concluded that appellant had 50 percent impairment of her left lower extremity.

Dr. Azer improperly combined all of appellant's impairment estimates to reach his impairment rating of 50 percent. He found that appellant had 2½ centimeter atrophy of the left thigh. The A.M.A., *Guides* provide that atrophy of 2 to 2.9 centimeters is 8 to 13 percent impairment of the left lower extremity.[16] Appellant could receive a schedule award for atrophy. However, the Cross-Usage Chart provides that atrophy impairment may be combined with gait derangement, muscle strength, arthritis, diagnosis-based estimates or complex regional pain syndrome.[17] Dr. Azer found that appellant had weakness to extension of her left knee, a Grade 4 muscle function of the left quadriceps which is 12 percent impairment of the left lower extremity.[18] Muscle weakness cannot be combined with gait derangement, muscle atrophy, arthritis or diagnosis based-estimates.[19]

Dr. Azer determined that appellant had 33.9 percent impairment of the left lower extremity due to pain as evidenced by gait derangement in accordance with Chapter 18 of the A.M.A., *Guides* as well as 7 percent impairment of the whole person due to gait derangement.

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[14] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003); A.M.A., *Guides* 571, 18.3(b); *P.C.*, 58 ECAB ___ (Docket No. 07-410, issued May 31, 2007); *Frantz Ghassan*, 57 ECAB ___ (Docket No. 05-1947, issued February 2, 2006).

[15] The Board notes that the Office has not yet issued a final decision addressing the issue of whether appellant is entitled to an additional schedule award of her right lower extremity as directed in the September 8, 2005 decision and order.

[16] A.M.A., *Guides* 530, Table 17.6.

[17] *Id*. at 526, Table 17-2.

[18] *Id*. at 532, Table 17-8.

[19] *Id*. at 526, Table 17-2.

The A.M.A., *Guides* specifically state whenever possible a more specific method of impairment assessment should be used rather than basing an impairment rating on gait derangement. The A.M.A., *Guides* also require medical reasoning in support of such an impairment rating.[20] Dr. Azer did not provide any reasoning for selecting this impairment method despite the availability of more specific rating estimates such as loss of strength, atrophy, diagnosis-based estimates and arthritis. The Board finds that appellant has not submitted the necessary medical evidence to establish that she is entitled to an impairment rating for gait derangement.

Moreover, Dr. Azer did not comply with the requirements the A.M.A., *Guides* before applying Chapter 18 and awarding appellant 33.9 percent impairment due to pain. Dr. Azer did not offer an explanation of why appellant's knee pain was not adequately rated on the basis of the body and organ impairment rating systems in the applicable chapter of the A.M.A., *Guides*. He did not explain why he felt appellant had excess pain or a well-established pain syndrome. Without medical reasoning addressing the applicability of Chapter 18, Dr. Azer's report is not sufficient to meet appellant's burden of proof in establishing a percentage of permanent impairment due to pain alone.

Dr. Azer found that appellant had seven percent impairment of the left lower extremity due to a three millimeter cartilage interval.[21] This opinion is consistent with the September 30, 2004 report of Dr. Raiford, a Board-certified orthopedic surgeon and previously designated impartial medical examiner. The A.M.A., *Guides* provide and the Board has held that impairment estimates for patients with arthritis of the patellofemoral joint should be based on a "sunrise view" taken at 40 degrees flexion or on a true lateral view.[22] The Board notes that there is no evidence in the record that the Office medical adviser's September 20, 2006 assessment of appellant's x-rays was based on the appropriate "sunrise view" and that therefore his September 20, 2006 and February 1, 2007 reports are therefore not sufficient to overcome the weight of the September 30, 2004 report Dr. Raiford on the issue of whether appellant has bilateral three millimeter cartilage intervals entitling her to seven percent impairment of each of her lower extremities. The medical evidence of record establishes that appellant has seven percent impairment of each of her left lower extremity due arthritis. Appellant is entitled to have this arthritis-based estimate[23] combined with her diagnosis-based estimate of two percent impairment due to the partial medial meniscectomy.[24] This results in nine percent impairment to the left lower extremity.[25]

[20] *Id*. at 529, 17.2c Gait Derangement.

[21] *Id*. at 544, Table 17-31.

[22] *Id*. at 544, 17.2h Arthritis.

[23] *Id*.

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

[25] *Id*. at 604, Combined Values Chart.

Appellant received a schedule award for 12 percent impairment of the left lower extremity. The medical evidence of record does not establish more than 12 percent impairment of her left lower extremity for which she received schedule awards. The rating of Dr. Azer did not confirm with the A.M.A., *Guides*.

CONCLUSION

The Board finds that appellant's has no more than 12 percent impairment of her left leg for which she received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the March 1, 2007 decision of the Office of Workers' Compensation Programs is affirmed, as modified.

Issued: November 20, 2007
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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