United States Department of Labor
Employees' Compensation Appeals Board

L.R., Appellant	)	
	)	**Docket No. 07-1285**
and	)	**Issued: September 20, 2007**
U.S. POSTAL SERVICE, POST OFFICE, Hagerstown, MD, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On April 12, 2007 appellant filed a timely appeal from a March 12, 2007 Office of Workers' Compensation Programs decision, denying her request for a hearing. The Board also has jurisdiction to review an April 25, 2006 decision adjudicating her schedule award claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether appellant has more than a five percent permanent impairment of her left lower extremity; and (2) whether the Office abused its discretion in denying her request for a hearing.

FACTUAL HISTORY

On August 26, 2003 appellant, then a 34-year-old rural carrier, filed an occupational disease claim alleging that she was involved in a motor vehicle accident and struck her left knee on the dashboard. An August 26, 2003 x-ray report indicated normal alignment of the left knee without evidence of fracture. The Office accepted appellant's claim for a left knee contusion.

On June 2, 2005 Office also accepted a cartilaginous lesion of the patella and chondromalacia of the medial femoral condyle with subcondral sclerosis. On June 21, 2005 appellant underwent arthroscopic surgery consisting of chondroplasty of the left distal femur. On February 21, 2006 she filed a claim for a schedule award.

On March 14, 2006 Dr. Robert J. Cirincione, an attending Board-certified orthopedic surgeon, reviewed a history of appellant's condition and provided findings on physical examination. He stated:

> "[Appellant] [has] continuing pain in the left knee. Her pain increases with activities such as walking and climbing….
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> "Her clinical examination reveals range of motion of the right knee to be 0 to 130 degrees. Left knee 2 to 120 degrees. She has 1 [inch] of atrophy in the left thigh compared to the right. She has no effusion. She has healed arthroscopic incisions. There is noted to be a mild patellar clunk on extension. Her Q-angle is normal. She has pain and tenderness to palpation of the retropatellar surface. Functionally, she has difficulty with ascending and descending stairways. I believe that her symptoms and findings are consistent with her pathology noted on her arthroscopic examination in June of 2005.
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> "I believe [appellant] [has] reached maximum medical improvement…. I have noted her loss of motion. I have also noted her atrophy. I have noted her subjective symptoms. Using the [American Medical Association, *Guides to the Evaluation of Permanent Impairment.*[1]], I believe her impairment rating is consistent with a DBE [diagnosis based estimate] Category rating from Table 17-33, page 546, with an impairment rating of a patient who has a patellar fracture articular surface displaced more than 3 mm [millimeters]. That impairment rating is consistent with the findings noted on her arthroscopic examination. It also takes into account her functional complaints of pain with ascending and descending stairways, as well as her atrophy in the left thigh. That results in a … twelve percent (12 %) impairment of the left lower extremity."
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> On April 6, 2006 Dr. Arnold Berman, an Office medical adviser, stated:
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> "In the [March 14, 2006] report of [Dr. Cirincione], he recommended a 12 percent impairment of the left lower extremity primarily based upon using Table 17-33, Impairment Estimates for Certain Lower Extremity Impairments, page 546. He utilizes the patellar fracture classification with articular surface displacement. However, this is incorrect since there, in fact, was no patellar fracture. There was a patellofemoral articulation injury and there was no fracture. Therefore, it would not be appropriate to use the fracture category as noted on page 546, Table 17-33. In the report, Dr. Cirincione notes a 3 mm defect or loss of cartilage.

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

> "If we accept this 3 mm cartilage loss, we can apply these clinical findings to page 544, of the [A.M.A., *Guides*, fifth edition], Table 17-31, Arthritis Impairments Based on Roentgenographically Determined Cartilage Intervals. In that table under the footnote it states 'In an individual with a history of direct trauma, a complaint of patellofemoral pain and crepitation on physical examination, but without joint space narrowing on x-ray[2] a … five percent lower extremity impairment is given."[3]

By decision dated April 25, 2006, the Office granted appellant a schedule award for 14.4 weeks[4] from March 14 to June 22, 2006 based on a five percent impairment of the left lower extremity.[5] By letter postmarked June 1, 2006, appellant requested an oral hearing.

By decision dated July 7, 2006, reissued March 12, 2007,[6] the Office denied appellant's request for a hearing on the grounds that the request was untimely submitted and the issue in the case could be resolved equally well through a reconsideration request and additional evidence.[7]

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Act[8] and its implementing regulation[9] set forth the number of weeks of compensation payable to employees 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

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[2] According to Table 17-31, there is no impairment given for a cartilage level of three mm for the patellofemoral joint. A.M.A., *Guides* 544, Table 17-31.

[3] *See* Federal (FECA) Procedural Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

[4] The Federal Employees' Compensation Act provides for 288 weeks of compensation for 100 percent loss or loss of use of a lower extremity. 5 U.S.C. § 8107(c)(2). Multiplying 288 weeks by five percent equals 14.4 weeks of compensation.

[5] The appeal rights included with appellant's copy of the April 25, 2006 decision specified that, "Any hearing request must … be made in writing, within 30 calendar days after the date of this decision, as determined by the postmark of your letter."

[6] This case was previously before the Board. Docket No. 07-31. On February 28, 2007 the Board remanded the case to the Office for reconstruction because there was no copy of the July 7, 2006 decision in the case record.

[7] Subsequent to the March 12, 2007 Office decision, additional evidence was associated with the file. The Board's jurisdiction is limited to the evidence that was before the Office at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c). The Board may not consider this evidence for the first time on appeal.

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

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 regulation as the appropriate standard for evaluating schedule losses.[10]

The A.M.A., *Guides* provides for three separate methods for calculating the lower extremity permanent impairment of an individual: anatomic, functional and diagnosis-based.[11] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[12] The diagnosis-based estimates 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.[13] 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.[14] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[15] 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.[16] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[17]

ANALYSIS -- ISSUE 1

The Office granted appellant a schedule award based on a five percent impairment of the left lower extremity. The Board finds that further development of the medical evidence is necessary to determine whether appellant has more than a five percent left lower extremity impairment.

Dr. Cirincione noted that appellant had continuing pain in the left knee. He stated that examination revealed left knee range of motion of 2 to 120 degrees with one inch of atrophy in the left thigh when compared to the right. Dr. Cirincione provided an impairment rating using a DBE Category rating from Table 17-33, page 546, for a patellar fracture of the articular surface displaced more than 3 mm. That resulted in 12 percent impairment of the left lower extremity.

[10] 20 C.F.R. § 10.404.

[11] A.M.A., *Guides* 525.

[12] *Id.*

[13] *Id.*

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

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

[16] *Id*. at 526.

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

Dr. Berman found that appellant had a five percent impairment of the left lower extremity for impairment due to arthritis for a 3 mm loss of cartilage, based on Table 17-31 at page 544. He noted that a footnote to Table 17-31 regarding the patellofemoral joint stated: "In an individual with a history of direct trauma, a complaint of patellofemoral pain and crepitation on physical examination but without joint space narrowing on x-ray a … five percent lower extremity impairment is given."

Based on the A.M.A., *Guides*, appellant has no impairment for loss of range of motion based on 2 degrees of flexion contracture and 120 degrees of flexion according to Table 17-10 at page 537 of the A.M.A., *Guides.* The 12 percent impairment rating of Dr. Cirincione for a patellar fracture is not supported by the medical evidence as appellant did not have a patellar fracture.[18] Therefore, Table 17-33 at page 546 for diagnosis based estimates impairments does not apply. He stated that appellant had continuing pain but that Table 17-33 took this into account. However, since Table 17-33 does not apply, her pain or sensory deficit should be determined based on Table 17-37 at page 552 and Table 16-10 at page 482. Dr. Cirincione also indicated that appellant's thigh atrophy of one inch was accounted for in Table 17-33. As Table 17-33 cannot be applied, Table 17-6 at page 530 should be applied. This table indicates that appellant has a mild impairment of three percent for one inch of thigh atrophy. The chapter pertaining to lower extremity impairment, Chapter 17, provides a cross-usage chart, Table 17-2 at page 526, which set forth the various methods for rating lower extremity impairment. The chart indicates which impairment rating methods can or cannot be combined. According to Table 17-2, impairment due to pain or sensory loss and impairment due to atrophy cannot be combined. Impairment due to arthritis and atrophy also cannot be combined. However, impairment due to arthritis can be combined with peripheral nerve impairment. The medical reports of record do not provide for an appropriate impairment rating based on the A.M.A., *Guides*, fifth edition.

The Board finds that this case is not in posture for a decision. Further, development of the medical evidence is needed. On remand, the Office should refer appellant to an appropriate medical specialist for an evaluation of her left lower extremity and an impairment rating based on correct application of the A.M.A., *Guides*. The examining physician should provide medical rationale explaining why a particular rating method was selected. If more than one impairment rating method can be used in evaluating appellant's impairment, the method(s) that provides the higher rating should be adopted.[19]

CONCLUSION

The Board finds that this case is not in posture for a decision as to appellant's left lower extremity impairment.[20]

[18] As noted, an August 26, 2003 x-ray report indicated normal alignment of the left knee without evidence of fracture.

[19] A.M.A., *Guides* 527.

[20] In light of the Board's resolution of the first issue, the second issue is moot.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated March 12, 2007 and April 25, 2006 are set aside and the case is remanded for further development consistent with this decision.

Issued: September 20, 2007
Washington, DC

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

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