United States Department of Labor
Employees' Compensation Appeals Board

M.A., Appellant	)	
and	)	**Docket No. 08-717**
	)	**Issued: August 21, 2008**
U.S. POSTAL SERVICE, POST OFFICE, Winigan, MO, Employer	)	

Appearances:
Thomas S. Harkins, 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 14, 2008 appellant filed a timely appeal from an October 29, 2007 decision of the Office of Workers' Compensation Programs that granted her a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award issue.

ISSUE

The issue is whether appellant met her burden of proof in establishing that she had more than seven percent impairment of the right leg, for which she received a schedule award.

FACTUAL HISTORY

On July 7, 2004 appellant, then a 53-year-old postmaster, fractured her right ankle when she fell while delivering mail to a customer. She stopped work on July 7, 2004. On that day, Dr. E. Glenn Browning, an osteopath, performed an open reduction and internal fixation of the right ankle and diagnosed trimalleolar fracture dislocation of the right ankle. On July 22, 2004 he stated that appellant was recovering well from her surgery. The Office accepted appellant's claim for right ankle trimalleolar fracture.

On August 19, 2004 Dr. Browning advised that appellant was able to bear weight. However, on September 9, 2004 he stated that appellant had not transitioned to full weight bearing as instructed. Dr. Browning explained that she complained of continued pain and swelling but that he advised her that her swelling would not reside until she resumed normal motion and that she might have residual swelling thereafter.

On September 28, 2004 appellant accepted a light-duty position and returned to work effective October 15, 2004.

In an October 7, 2004 report, Dr. Browning stated that appellant's transition to cane-assisted weight bearing seemed to have precipitated pain and tenderness with swelling of the joint line of the right knee. He opined that her knee problem was related to her work injury. In an October 12, 2004 magnetic resonance imaging (MRI) scan report, Dr. Edward J. LaRow, a Board-certified diagnostic radiologist, diagnosed torn medial meniscus, extensive intraosseous edema throughout the medial femoral condyle, and findings compatible with superficial intra-patellar bursitis of the right knee. On October 14, 2004 Dr. Browning recommended that appellant undergo a right knee arthroscopy.

On October 22, 2004 the Office accepted a tear of the posterior horn of the right medial meniscus. It authorized a right knee arthroscopy and meniscectomy. On October 25, 2004 Dr. Browning performed a right knee arthroscopy. He recorded a postoperative diagnosis of no torn meniscus and an interosseous edema noted on an MRI scan. Dr. Browning stated that he found bruising of the medial femoral condyle with edema. He stated that, in the posterior horn of the meniscus, there was an area that where there had been a possible tear that had healed on its own. Dr. Browning stated that he could find no actual tear. In a November 2, 2004 duty status report, he released appellant to return to full-duty work as of November 3, 2004. Appellant returned to work effective November 12, 2004.

In a March 17, 2005 report, Dr. Browning stated that appellant had reached maximum medical improvement and released her from treatment. Although she had some residual soreness, she did not appear to have degenerative arthritis. Dr. Browning concluded that appellant had eight percent whole person impairment; however he did not state whether his impairment rating was based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[1] He also noted that appellant had no residual knee disability.

On October 26, 2005 appellant claimed a schedule award.

In a February 22, 2006 report, an Office medical adviser stated that Dr. Browning's impairment rating was unacceptable because he did not establish that it was based on the A.M.A., *Guides*. He also explained that Dr. Browning did not present findings concerning residual weakness or measurements of the range of motion of appellant's knee or ankle.

On March 7, 2006 the Office referred appellant to Dr. Robert Conway, a Board-certified physiatrist, for a second opinion. In a March 20, 2006 report, Dr. Conway noted appellant's complaints of pain and weakness in her right knee and ankle. On examination, he found some

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

patellofemoral crepitus and tenderness along the medial joint line and a mildly positive patellofemoral compression test as well as diffuse tenderness of the ankle involving both the medial and lateral aspect. With regard to right ankle range of motion, Dr. Conway measured an average 12 degrees of dorsiflexion and 27 degrees of plantar flexion, 16 degrees of inversion and 0 degrees of eversion. He concluded that appellant had two percent impairment for loss of inversion of the right ankle and two percent impairment for loss of eversion of the right ankle, based on Table 17-12 of the A.M.A., *Guides*, which allows two percent impairment for inversion measured between 10 and 20 degrees and two percent impairment for eversion measured between 0 and 10 degrees.[2] Dr. Conway found normal strength in the lower extremities, including hip abduction, adduction, knee flexion and extension and ankle dorsiflexion, plantar flexion, inversion, eversion and toe extension and so concluded that appellant had no ratable impairment for weakness. He found 120 degrees of flexion and 0 degrees of extension of appellant's knee, applied Table 17-10 on page 537 of the A.M.A., *Guides* and found no ratable impairment for loss of knee range of motion. Dr. Conway explained that appellant had no diagnosis based impairment or other ratable impairment for weakness, loss of range of motion of the knee, limitation of ankle flexion or hindfoot deformity based on Tables 17-10,[3] 17-11[4] and 17-13[5] of the A.M.A., *Guides*.

By correspondence dated March 27, 2006, the Office requested clarification from Dr. Conway concerning why he did not recommend two percent impairment based on a medial meniscectomy. On April 10, 2006 Dr. Conway replied that appellant had not undergone a meniscectomy, as Dr. Browning had performed only an arthroscopy and found no tear of the ligaments or menisci, and therefore she was not entitled to two percent impairment for a meniscectomy. In an August 7, 2006 report, the Office medical adviser agreed with Dr. Conway's assessment of appellant's impairment.

On August 14, 2006 the Office granted appellant a schedule award for four percent impairment of the right leg. On May 15, 2007 appellant requested reconsideration. By decision dated July 2, 2007, the Office denied appellant's request for reconsideration without conducting a merit review.

On August 14, 2007 appellant requested reconsideration and submitted a July 6, 2007 report from Dr. Joann Mace, a Board-certified physiatrist, noting her complaints of sharp pain with occasional cramping and tenderness in the knee and ankle. On examination, Dr. Mace noted pain with dorsiflexion, inversion and eversion, with passive range of motion for dorsiflexion limited to neutral and limited inversion. She diagnosed right trimalleolar ankle fracture, dislocated, status post open reduction internal fixation of right trimalleolar ankle fracture and right knee injury. Dr. Mace explained that the meniscal tear apparently healed prior to surgical intervention, but that this did not negate the fact that the meniscus was torn. With regard to right knee range of motion, he measured full extension and 100 degrees of flexion,

[2] *Id.* at 537, Table 17-12.

[3] *Id.* at 537, Table 17-10.

[4] *Id.* at 537, Table 17-11.

[5] *Id.* at 537, Table 17-13.

beyond which appellant complained of pain. Examining appellant's right ankle range of motion, she found "function" eversion but "limited" inversion. Dr. Mace determined that appellant reached maximum medical improvement by March 20, 2005. She concluded that appellant had 20 percent right leg impairment for intra-articular fracture with dislocation, based on Table 17-33 of the A.M.A., *Guides*,[6] two percent lower extremity impairment for partial medial meniscectomy, based on Table 17-33,[7] and ratable impairment for grade two moderate pain pursuant to Tables 18-6 and 18-7 of the A.M.A., *Guides*.[8]

In an August 19, 2007 report, the Office medical adviser addressed Dr. Mace's July 6, 2007 report and impairment rating. He noted that she found additional right ankle impairment based on Table 17-33 of the A.M.A., *Guides*, which relies upon documented displacement of the intra-articular fracture at the time of maximum medical improvement. The medical adviser explained that while the medical evidence reflected that appellant had such displacement, it was corrected by surgery and was therefore no longer present and documented at the time that she reached maximum medical improvement. Therefore, she was not entitled to impairment on that basis. He also stated that Dr. Mace's recommended two percent impairment for a partial medial meniscectomy was not appropriate as the record reflected that appellant did not undergo a partial medial meniscectomy. However, the medical adviser agreed with her recommendation that appellant receive an additional three percent impairment rating for pain based on Chapter 18 of the A.M.A., *Guides*.

By decision dated October 24, 2007, the Office granted appellant a schedule award for an additional three percent impairment.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[9] and its implementing regulation[10] 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 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.[11]

[6] *Id.* at 546-47, Table 17-33.

[7] *Id.* at 546.

[8] *Id.* at 586, Tables 18-6, 18-7.

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404 (1999).

[11] *See id; see also B.C.*, 58 ECAB ___ (Docket No. 06-925, issued October 13, 2006).

ANALYSIS

The Office accepted that appellant sustained a right ankle trimalleolar fracture and a tear of the posterior horn of the right medial meniscus. Appellant claimed a schedule award and submitted a March 17, 2005 report from Dr. Browning, who stated that she had eight percent impairment of the whole person. However, he did not explain how his rating was based on the A.M.A., *Guides.* Accordingly, the Office properly referred appellant to Dr. Conway for a second opinion examination and impairment rating.[12]

In a March 20, 2006 report, Dr. Conway noted appellant's history of injury and treatment, as well as her current symptoms, and determined that she had four percent impairment of the right leg based on loss of ankle range of motion pursuant to Table 17-12 of the A.M.A., *Guides*.[13] He found that appellant had no impairment based on weakness, loss of range of motion of the knee, limitation of ankle flexion or hindfoot deformity. The Board finds that Dr. Conway properly applied Table 17-12 and added the values to determine that appellant was entitled to four percent lower extremity impairment for loss of hindfoot range of motion.[14] He measured 16 degrees of inversion, which entitles appellant to two percent impairment for inversion based on Table 17-12 of the A.M.A., *Guides*.[15] Dr. Conway also found zero degrees of eversion, which entitles appellant to two percent impairment for eversion pursuant to Table 17-12.[16] He found that appellant had no impairment based on a partial medial meniscectomy because the medical evidence indicated that appellant underwent only an arthroscopy, not a partial medial meniscectomy. This finding is supported by Dr. Browning's October 25, 2004 operative report which clearly noted that there was no meniscal tear.

Appellant disagreed with Dr. Conway's impairment rating and provided a July 6, 2007 report from Dr. Mace, who determined that she had 20 percent lower extremity impairment for intra-articular ankle fracture with displacement based on Table 17-33 of the A.M.A., *Guides*.[17] However, the Board notes that appellant's ankle fracture was repaired in the course of the surgery performed by Dr. Browning on July 7, 2004. When Dr. Browning released appellant from treatment on March 17, 2005, he stated that x-rays showed good healing with no evidence of degenerative arthritis. The Board finds that appellant is not entitled to a schedule award for additional impairment based on intra-articular ankle fracture with displacement under Table 17-33 because Dr. Mace did not provide sufficient rationale to explain how examination findings

[12] *See Jennifer A. Guillary*, 57 ECAB 485 (2005) (the attending physician should make the evaluation of permanent impairment when possible but the Office may request an opinion from a second opinion specialist when the medical evidence from the attending physician is inadequate). The Board also notes that the Act does not authorize schedule awards for whole person impairment. *D.H.,* 58 ECAB ___ (Docket No. 06-2160, issued February 12, 2007).

[13] A.M.A., *Guides* 537, Table 17-12.

[14] *Id.* at 533, 537.

[15] *Id*. at 537, Table 17-12.

[16] *Id.*

[17] *Id.* at 546-47, Table 17-33.

supported that appellant had remaining displacement following the surgical repair of her ankle fracture. This is particularly important since neither the surgeon, Dr. Browning, the referral physician, Dr. Conway, or the Office medical adviser noted any continuing displacement following the surgery.

Dr. Mace also found two percent impairment for a partial medial meniscectomy. However, as the Office medical adviser noted in his August 19, 2007 report, and as Dr. Browning indicated in his October 22, 2004 surgical report, appellant did not undergo a partial medial meniscectomy and that the meniscus was not torn. Therefore, the Board finds that she is not entitled to a schedule award for lower extremity impairment based on meniscectomy. Dr. Mace also recommended that the Office grant appellant impairment for pain under Chapter 18 of the A.M.A., *Guides*. The Office medical adviser concurred with Dr. Mace regarding pain and the Office increased appellant's schedule award by three percent for pain impairment under Chapter 18.[18] Dr. Mace provided no other basis, pursuant to the A.M.A., *Guides*, on which a greater schedule award may be based.

Therefore, the medical evidence does not establish that appellant has greater than seven percent impairment of the right leg for which she has received a schedule award.

CONCLUSION

The Board finds that appellant has not met her burden of proof in establishing that she has more than seven percent impairment of the right lower extremity, for which she received a schedule award.

[18] The Board notes that the Office improperly found an additional three percent impairment for pain under Chapter 18 of the A.M.A., *Guides*. The Board has held that examiners should not use Chapter 18 to rate pain-related impairments for 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*. *P.C.*, 58 ECAB ___ (Docket No. 07-410, issued May 31, 2007); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003); A.M.A., *Guides* 18.3(b). Neither Dr. Mace nor the Office medical adviser explained why any impairment for pain could not be adequately rated under other chapters of the A.M.A., *Guides*.

ORDER

IT IS HEREBY ORDERED THAT the October 29, 2007 decision of the Office of Workers' Compensation Programs is affirmed, as modified.

Issued: August 21, 2008
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