United States Department of Labor
Employees' Compensation Appeals Board

R.D., Appellant	)	
and	)	**Docket No. 08-2091**
	)	**Issued: August 6, 2009**
U.S. POSTAL SERVICE, DISTRIBUTION CENTER, Minneapolis, MN, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On July 22, 2008 appellant filed a timely appeal from schedule award decisions of the Office of Workers' Compensation Programs dated February 14 and June 24, 2008. Pursuant to 20 C.F.R. §§ 510.2(c) and 501.3, the Board has jurisdiction over the merits of the appeal.

ISSUE

The issue is whether appellant has more than 38 percent impairment of his left lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On January 31, 1991 appellant, then a 46-year-old clerk, fell while in the performance of duty, sustaining injury to his left arm, head and shoulder. The Office accepted his claim for contusions of the left elbow, forearm and shoulder, left hip and thigh, left shoulder epicondylitis and impingement syndrome.[1] On May 8, 1996 appellant injured his left knee while pushing a

[1] Appellant received a schedule award for 12 percent impairment to his left arm. This claim was given Master File No. xxxxxx793.

mail cart. The Office accepted his claim for a torn medial meniscus of the left knee, an aggravation of osteoarthritis and bilateral enthesopathy of the hip region.[2]

Appellant submitted treatment notes from Dr. Christopher M. Larson, a Board-certified orthopedic surgeon, who diagnosed osteoarthritis of the left knee medial compartment and noted that appellant was recovering from a partial medial meniscectomy and debridement surgery. On June 28, 2004 Dr. Larson noted that appellant has complaints of pain with stair climbing. Physical examination findings included no laxity to varus or valgus stress with 10 degrees of flexion contracture to 110 degrees of flexion. Dr. Larson noted that appellant would eventually be a candidate for total knee arthroplasty. He continued appellant on light-duty work for six hours a day.

On October 11, 2004 Dr. David H. Garelick, an Office medical adviser, reviewed the history of appellant's June 3, 2003 meniscectomy. Under Table 17-33 at page 546 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, he assigned two percent impairment for the partial medial meniscectomy. Utilizing Table 17-31 at page 544, the Office medical adviser noted that appellant had an additional 15 percent impairment for isolated medial compartment arthritis.[3] Combining these values resulted in a total 17 percent impairment.[4] Dr. Garelick advised that maximum medical improvement was on June 28, 2004 when appellant was released by Dr. Larson.

On December 27, 2005 the Office granted appellant a schedule award for 17 percent impairment to his left leg.[5]

On October 26, 2006 appellant requested an additional schedule award. In an August 16, 2006 report, Dr. Larson reiterated that appellant had been treated for a degenerative medial meniscus tear and for progressive osteoarthritis. He noted that x-rays obtained in June 2006 showed significant arthritic changes with minimal joint space remaining about the joint compartments of both knees. Appellant was also treated by Dr. Phillip Hoversten, a Board-certified internist. On May 14, 2007 Dr. Hoversten noted that appellant had moderate left hip pain that was difficult to differentiate from his knee pain. On examination of the left knee, he noted crepitus, moderately decreased flexion and extension and Grade 2 medial collateral laxity. Range of motion of the left hip was described as 70 degrees forward flexion, 20 degrees extension, 30 degrees abduction, 10 degrees adduction, 25 degrees internal rotation and 15 degrees external rotation. Dr. Hoversten stated that appellant had 14 percent whole man impairment and had reached maximum medical improvement.

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[2] This was given File No. xxxxxx457. On April 7, 2005 the Office accepted that appellant sustained right hip trochanteric bursitis as a result of his federal employment. This was given File No. xxxxxx134.

[3] The Board notes that Dr. Garelick extrapolated this impairment rating as he did not identify any x-rays on which the estimate was based.

[4] Table 17-2, the cross usage chart, does not preclude combining impairment for arthritis with the diagnosis-based impairment for the partial meniscectomy.

[5] The schedule award also granted compensation for right leg impairment which is not an issue on appeal. On September 8, 2006 the Office accepted that appellant sustained an aggravation of degenerative arthritis of the left knee.

On May 20, 2007 Dr. Garelick evaluated the extent of left hip range of motion impairment with reference to Table 17-9, page 537. He noted that 70 degrees of flexion was 10 percent impairment and 20 degrees of extension was 0 percent impairment; 30 degrees abduction was 0 percent impairment and 10 degrees of adduction was 5 percent impairment; and internal rotation of 25 degrees was 0 impairment and 15 degrees external rotation was 10 percent impairment. Dr. Garelick added the loss of range of motion impairment to total 25 percent.

On July 9, 2007 Dr. Hoversten provided a left knee impairment evaluation, noting that appellant has surgery for his meniscus and osteoarthritis of the knee. Appellant noted complaints of pain with motion and tightness at night. On examination range of motion was listed as 75 degrees flexion; 45 degrees extension and 45 degrees of ankylosis. Dr. Hoversten noted mild atrophy bilaterally and found no ligament instability with a mild valgus deformity. The left lower extremity was described as two centimeter (cm) shorter than the right due to flexion contracture. Dr. Hoversten advised that maximum medical improvement for the left knee was reached on August 16, 2006, as reported by Dr. Larson. He found a total 19 percent whole man impairment, rating 8 percent impairment for knee flexion at Table 17-10, page 537; 5 percent impairment for loss of muscle strength at Table 17-8, page 532; 2 percent impairment under Table 17-33 for leg length discrepancy and an additional 4 percent impairment for the medial meniscectomy.[6]

On July 30, 2007 Dr. Garelick noted that his prior review in May 2007 had found 25 percent impairment for loss of range of hip motion due to residuals of the trochanteric bursitis. He stated that he was not aware that appellant had already been awarded 17 percent lower extremity impairment for his left knee. Dr. Garelick advised that, using the Combined Values Chart, combining the 25 percent left hip impairment with the 17 percent left knee impairment resulted in a total of 38 percent impairment of the left leg.

On October 4, 2007 the Office granted appellant an additional schedule award for 21 percent impairment of his left lower extremity.

Appellant requested a review of the written record before an Office hearing representative on October 30, 2007. In a January 2, 2008 decision, the Office hearing representative set aside the October 4, 2007 schedule award and remanded the case for further development of the medical evidence.

On January 21, 2008 Dr. Garelick again reviewed the medical evidence of record, noting that appellant has received ratings of impairment for residual medial compartment left knee arthritis and a partial medial meniscectomy and for loss of range of left hip motion from trochanteric bursitis. He noted that the whole person impairment rating provided by Dr. Hoversten was not recognized and could not be compensated as described. Further, Dr. Hoversten had rated impairment for weakness which, under Table 17-2, could not be combined with the loss of range of motion findings. Dr. Garelick reiterated that appellant had 38 percent impairment to his left leg.

[6] The Board notes that Dr. Hoversten did not address the cross-usage chart at Table 17-2.

In a February 14, 2008 decision, the Office found that the medical evidence of record did not establish greater than 38 percent impairment to appellant's left leg.

On February 29, 2008 appellant contended that he had greater impairment to his left leg. On April 22, 2008 he requested reconsideration of the February 14, 2008 schedule award and submitted the February 27, 2008 report of Dr. Hoversten who noted that appellant had moderate aching and pain with activity. Dr. Hoversten rated impairment of the left knee under Table 17-22, page 540, as 33 percent due to flexion contracture; 20 percent under Table 17-10 for knee flexion to 75 degrees; and 5 percent under Table 17-4, page 528 for leg length discrepancy of 2 cm. He reiterated that appellant was at maximum medical improvement.

On June 2, 2008 Dr. Garelick noted that appellant was alleging greater loss of range of motion to his left knee. He stated that Dr. Hoversten described appellant's range of motion loss to an extent that was not compatible with ambulation. Dr. Garelick did not have all his medical records to review and noted that appellant could be referred for further examination. On June 10, 2008 he again reviewed the medical record and stated that appellant's prior left leg impairment rating was based on 15 percent for left knee medial compartment arthritis, 2 percent for left knee meniscectomy and 25 percent for loss of range of motion of the left hip. Dr. Garelick reiterated that Dr. Hoversten provided an impairment rating that combined values in rating the left knee which were prohibited under the cross-usage chart. He noted that appellant was rated greater impairment of 15 percent for arthritis than for loss of range of motion to the knee of 10 to 110 degrees, as arthritis could not be rated with loss of motion. Dr. Garelick found no greater than 38 percent impairment to appellant's left leg.

In a June 24, 2008 decision, the Office denied modification of its February 14, 2008 decision. It found that appellant did not establish greater than 38 percent impairment to his left leg.

LEGAL PRECEDENT

The schedule award provision of the Act[7] and its implementing regulations 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.[8] 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 Office as the appropriate standard for evaluating schedule losses.[9]

In rating lower extremity impairment under Chapter 17, the cross-usage chart provides that not all impairment affecting the member may be combined together. For example, it

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id.*; *see Billy B. Scoles*, 57 ECAB 258 (2005).

excludes combining loss of muscle strength with loss of range of motion or arthritis.[10] Rather, when more than one rating method may be used, the medical evaluator should address that combination which is most clinically appropriate.[11]

ANALYSIS

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

The schedule award granted by the Office for impairment to appellant's left leg was based on the impairment contributed by his accepted left knee and hip conditions. In rating impairment to the left hip, Dr. Garelick relied upon the range of motion loss recorded by Dr. Hoversten on May 14, 2007, who listed 14 percent of the whole person.[12] Flexion was to 70 degrees, which under Table 17-9, page 537, is 10 percent (moderate) impairment. Extension of 20 degrees was listed by Dr. Garelick as 0 percent impairment but Table 17-9 provides that this is 10 percent (moderate) impairment. Internal rotation of 25 degrees is 0 percent impairment, as noted by Dr. Garelick. External rotation of 15 degrees represents 10 percent (moderate) impairment, as listed by the medical adviser. Abduction of 30 degrees is 0 percent impairment, as noted by Dr. Garelick and 10 degrees adduction is 5 percent (mild) impairment. On May 29, 2007 Dr. Garelick added the impairment values to find a total of 25 percent impairment for loss of left hip motion; however, Table 17-9 indicates that the impairment measured by Dr. Hoversten would total 35 percent.

In assessing the impairment to appellant's left knee, the Board notes that Table 17-2, the cross-usage chart, precludes certain methods of evaluating impairment from being combined. On June 9, 2007 Dr. Hoversten rated the extent of impairment as 19 percent of the whole person, specifying 8 percent for knee flexion under Table 17-10; 5 percent for loss of muscle strength under Table 17-8; 2 percent for leg length discrepancy and 4 percent for the medial meniscectomy under Table 17-33. As noted, however, all these impairment values may not be combined under Table 17-2. Impairment due to leg limb length discrepancy may be combined with either loss of strength, loss of range of motion or the diagnosis-based impairment, but not with each. Loss of range of motion may not be combined with weakness (loss of strength) or the diagnosis-based estimate. By combining the noted impairment values, Dr. Hoversten artificially inflated the extent of impairment to the left leg. Moreover, the Board notes that appellant underwent a partial medial meniscectomy; a two percent impairment of the knee under Table 17-33, not four percent whole person as was found. In addition, Table 17-33 does not provide the basis for rating impairment due to limb length discrepancy; rather, it is rated under Table 17-4, page 528. As noted by Dr. Garelick, the whole person impairment rating provided by Dr. Hoversten for appellant's left knee does not conform to the protocols of the Office and, it appears, was based on a misapplication of the A.M.A., *Guides*.

[10] *See Laura Heyen*, 57 ECAB 435 (2006).

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

[12] It is well established, however, that schedule awards are paid for the anatomical members defined at section 8107(c) of the Act and section 10.404(a) of the implementing regulations. *See* 5 U.S.C. § 8107(c) and 20 C.F.R. § 10.404 (c). *See also Tania R. Keka*, 55 ECAB 354 (2004); *John Year*, 48 ECAB 243 (1996). Schedule awards are not payable in terms of whole person impairment ratings.

In rating impairment to appellant's left knee, Dr. Garelick advised that the greatest extent of impairment would be achieved by rating arthritis of 15 percent with the diagnosis-based impairment of 2 percent for the partial medial meniscectomy. Combined, this resulted in a total of 17 percent to the left leg. Dr. Garelick noted that rating impairment by loss of range of motion, as reported by Dr. Larson, would not result in greater impairment. The Board notes that 110 degrees of flexion does not result in impairment under Table 17-10. However, 10 degrees of extension (flexion contracture) represents 20 percent (moderate) impairment of the knee, which is greater than the 15 percent arthritis rating on which Dr. Garelick relied. Moreover, on October 11, 2004 Dr. Garelick stated that he extrapolated the 15 percent impairment estimate from Table 17-31; he did not specify the x-rays relied upon in rating this impairment. The Board notes that the A.M.A., *Guides* provide that the estimate for the patellofemoral joint should be based on a sunrise view x-ray taken at 40 degrees or on a true lateral view.[13] Further, Dr. Hoversten reported range of motion losses which were dismissed by the medical adviser as excessive.

As assembled, the medical evidence of record does not provide a sufficiently clear depiction of the extent of permanent impairment to appellant's left leg resulting from his accepted knee and hip injuries. For this reason, the case will be remanded to the Office for appropriate development of the medical evidence and a *de novo* decision on whether he sustained greater than 38 percent impairment, as awarded.

CONCLUSION

The Board finds that the case is not in posture for decision as to whether appellant has more than 38 percent impairment to his left leg.

[13] A.M.A., *Guides* 544.

ORDER

IT IS HEREBY ORDERED THAT the June 24 and February 14, 2008 decisions of the Office of Workers' Compensation Programs be set aside. The case is remanded to the Office for further action in conformance with this decision.

Issued: August 6, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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