United States Department of Labor
Employees' Compensation Appeals Board

H.M., Appellant	)	
and	)	**Docket No. 09-243**
	)	**Issued: August 11, 2009**
U.S. POSTAL SERVICE, WEST GLEN STATION, Peoria, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On November 3, 2008 appellant filed a timely appeal from a July 24, 2008 schedule award decision of the Office of Workers' Compensation Programs. 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 met his burden of proof to establish that he has greater than 10 percent left lower extremity impairment for which he received schedule awards.[1] On appeal appellant generally argues that he is entitled to an increased schedule award.

[1] The Board notes that the July 24, 2008 schedule award decision contains a typographical error in that it states that the schedule award is for the left upper extremity.

FACTUAL HISTORY

On August 4, 2005 appellant, then a 35-year-old city letter carrier, filed a Form CA-2, occupational disease claim, alleging that his job duties caused bilateral knee pain. His supervisor indicated that he was on restricted duty performing office work only. Appellant did not stop work. On October 3, 2005 the Office accepted that he sustained bilateral knee sprains/strains. On October 21, 2005 Dr. Michael J. Gibbons, a Board-certified orthopedic surgeon, performed a left knee arthroscopy with chondroplasty of the patella. On November 15, 2005 the Office accepted that appellant sustained bilateral chondromalacia patella. On January 27, 2006 Dr. Gibbons performed right knee arthroscopy with chondroplasty. Appellant received compensation and returned to limited duty. He missed intermittent periods for medical therapy and treatment.

In a May 19, 2006 report, Dr. Gibbons diagnosed bilateral knee patellofemoral chondral damage and bilateral shoulder rotator cuff tendinopathy with impingement, and advised that appellant's physical conditions impacted his ability to work.[2] On June 19, 2006 he advised that appellant had reached maximum medical improvement.

Appellant filed a schedule award claim on June 27, 2006. In a November 28, 2006 report, Dr. Gibbons diagnosed right hip pain of uncertain etiology, mild hip osteoarthritis, possible impingement and possible labral tear.

By letter dated December 28, 2006, the Office informed appellant of the evidence needed to support a schedule award claim. In a one-page form report dated January 11, 2007, Dr. Daniel R. Hoffman, Board-certified in internal and geriatric medicine, advised that examination of the left knee demonstrated no flexion and 220 degrees of extension with 90 degrees of ankylosis. He advised that a prosthesis was required for knee stability and that appellant had an additional impairment of 75 percent due to weakness, atrophy, pain or discomfort, for a total 100 percent impairment of the left lower extremity. Appellant retired on January 25, 2007. By letter dated June 26, 2005, the Office again informed appellant of the evidence required to support a schedule award claim. In a June 30, 2007 report, Dr. Hoffman noted appellant's surgical history provided examination findings for appellant's right knee.

The Office forwarded appellant's medical records to Dr. David H. Garelick, an Office medical consultant Board-certified in orthopedic surgery. In a July 23, 2007 report, Dr. Garelick advised that maximum medical improvement was reached on June 19, 2006. In accordance with Table 17-31 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[3] appellant had a five percent impairment of each knee for residual patellofemoral pain without evidence of joint space narrowing on x-ray.

---

[2] Appellant also submitted a November 22, 2005 report in which Dr. Gary H. Cohen, an osteopath, provided an impairment rating for bilateral carpal tunnel syndrome.

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

In an August 15, 2007 schedule award decision, appellant was granted five percent impairment for both the left and right lower extremities, a total of 28.8 weeks to run from January 20 to August 9, 2007.

On August 27, 2007 appellant requested a review of the written record. In an August 22, 2007 report, Dr. Hoffman reiterated his previous findings and conclusions regarding appellant's right knee. By decision dated December 21, 2007, an Office hearing representative remanded the case to the Office for further review. The Office subsequently referred appellant to Dr. Lisa Snyder, Board-certified in physical and pain medicine.[4]

In a May 23, 2008 report, Dr. Snyder reviewed the medical records and appellant's complaint of bilateral knee pain. She noted that he ambulated with bilateral canes and wore a knee brace on the left. Physical examination demonstrated no evidence of muscle wasting or atrophy in the lower extremities with good muscle definition in all major muscle groups. Strength with manual muscle testing demonstrated give-way weakness, particularly in the left lower extremity with strength of 5/5 in all major muscle groups in the lower extremities. Reflexes at the knees and ankles were 2+ and symmetrical, and sensation to pin was intact in all dermatomes in the lower extremities. Examination of the knees demonstrated no swelling or erythema and no joint line tenderness. Anterior and posterior drawer signs were negative. Compression of the left patella caused pain but none on the right. Dr. Synder stated that the left knee could be actively ranged to 108 degrees. Bilateral knee extension revealed no extension lag. Dr. Synder advised that, using Table 17-10 of the A.M.A., *Guides*, appellant had a mild left knee flexion impairment that yielded a 10 percent lower extremity disability.

In a June 16, 2008 report, Dr. Garelick reviewed the medical evidence and advised that, in accordance with Table 17-2 of the A.M.A., *Guides*, an impairment rating could not be awarded for both degenerative joint disease and range of motion deficits. As appellant had previously been awarded five percent permanent impairment for residual patellofemoral pain syndrome under Table 17-31, an additional impairment rating could not be awarded for his slight loss of left knee motion. Dr. Garelick concluded that appellant did not have greater impairment of either lower extremity.

By decision dated June 18, 2008, the Office found that appellant was not entitled to an increased schedule award for either lower extremity. In a July 24, 2008 decision, it advised appellant to disregard the June 18, 2008 decision as it was issued in error, and granted him an additional 5 percent left lower extremity impairment, for a total impairment of 10 percent of the left lower extremity.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[5] and section 10.404 of the implementing federal regulations,[6] schedule awards are payable for permanent impairment of

[4] Appellant was out of the country from April 2 to May 22, 2008.

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

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.[7] Chapter 17 provides the framework for assessing lower extremity impairments.[8] 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.[9]

It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of an employment injury. Office procedures provide that, to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred ("date of maximum medical improvement"), describes the impairment in sufficient detail to include, 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 description of the impairment and the percentage of impairment should be computed in accordance with the fifth edition of the A.M.A., *Guides*.[10] The procedures further provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for an opinion concerning the nature and percentage of impairment.[11]

ANALYSIS

The Board finds that Dr. Hoffman's January 11, 2007 report is insufficient to establish the extent of impairment to appellant's left lower extremity. Schedule awards are to be based on the A.M.A., *Guides*,[12] and an estimate of permanent impairment is of diminished probative value where it is not based on the A.M.A., *Guides*.[13] Dr. Hoffman merely provided a percentage of impairment without addressing the A.M.A., *Guides*. His report does not constitute probative medical evidence regarding the degree of permanent impairment to appellant's left lower extremity.

---

[7] *See Joseph Lawrence, Jr., supra* note 3; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[8] A.M.A., *Guides, supra* note 4 at 523-64.

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

[10] *Supra* note 3.

[11] *J.P.*, 60 ECAB ___ (Docket No. 08-832, issued November 13, 2008).

[12] *Joseph Lawrence, Jr., supra* note 3.

[13] *Shalanya Ellison*, 56 ECAB 150 (2004).

Appellant's schedule award on August 15, 2007 was based on the opinion of Dr. Garelick, an Office medical consultant. In his July 23, 2007 report, Dr. Garelick advised that appellant had five percent impairment to each lower extremity, in accordance with Table 17-31 of the A.M.A., *Guides*. This table which provides that a complaint of patellofemoral pain without joint space narrowing on x-rays is equal to a five percent lower extremity impairment.[14] Dr. Snyder, however, provided a second opinion evaluation for the Office. In a May 23, 2008 report, she found that under Table 17-10 appellant had a mild left knee flexion impairment that yielded a 10 percent left lower extremity impairment. As noted, however, Table 17-2 precludes combining impairment ratings for degenerative joint disease, as found in Table 17-31, and range of motion deficits, as found in Table 17-10.[15]

It is the responsibility of the evaluating physician to explain in writing why a particular method to assign the impairment rating was chosen. When uncertain about which method to choose, the evaluator should calculate the impairment using the different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.[16] In this case, both Dr. Garelick and Dr. Snyder provided proper analysis under the A.M.A., *Guides.* As Dr. Snyder's recommendation utilizing Table 17-10 is more favorable to appellant, the Board finds that her report establishes that he has 10 percent left lower extremity impairment, the amount awarded with a July 24, 2008 decision.

Finally, the Board notes that the impairment rating of appellant's right lower extremity is in an interlocutory position. In a December 21, 2007 decision, an Office hearing representative remanded the case to the Office for a second opinion evaluation regarding both lower extremities. In the June 18, 2008 decision, the Office determined that appellant was not entitled to an additional schedule award for his right lower extremity. It subsequently determined that the June 18, 2008 decision was issued in error. However, the July 24, 2008 decision, adjudicated only appellant's left lower extremity. The Board's jurisdiction is limited to consider and decide appeals from final decisions of the Office issued within one year prior to the filing of the appeal.[17] As the Office has not issued a final decision regarding appellant's right lower extremity impairment, the Board lacks jurisdiction to consider this issue in the current appeal.

CONCLUSION

The Board finds that appellant is entitled to a 10 percent left lower extremity impairment.

---

[14] A.M.A., *Guides, supra* note 3 at 544.

[15] *Id*. at 526; *see Phillip A. Norulak*, 55 ECAB 690 (2004).

[16] *Tara L. Hein*, 56 ECAB 431 (2005).

[17] 20 C.F.R. § 501.2c (2007); *see Annette Louise*, 54 ECAB 783 (2003).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 24, 2008 be affirmed.

Issued: August 11, 2009
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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