United States Department of Labor
Employees' Compensation Appeals Board

I.P., Appellant	)	
and	)	**Docket No. 08-2187**
	)	**Issued: September 4, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On August 5, 2008 appellant filed a timely appeal from a July 9, 2008 Office of Workers' Compensation Programs' schedule award decision dated July 9, 2008. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination.

ISSUE

The issue is whether appellant met his burden of proof to establish that he has more than 15 percent impairment of his right lower extremity or more than 12 percent impairment of his left lower extremity, for which he received schedule awards.

FACTUAL HISTORY

On June 27, 2007 appellant, then a 42-year-old letter carrier, filed an occupational disease claim alleging that he developed a knee condition as a result of walking for long periods of time and up and down stairs while in the performance of duty. He realized that his disease or illness was caused or aggravated by his employment on June 19, 2007. Appellant did not stop work.

The Office accepted the claim for aggravation of degenerative arthritis of both knees. Appellant received compensation benefits.

In a June 19, 2007 report, Dr. Fred Kleinbart, a Board-certified orthopedic surgeon, noted appellant's complaints of increased bilateral knee pain for over a year. Examination of the knees revealed 0 to 135 degrees of active motion. Dr. Kleinbart advised that appellant had significant crepitus in both knees on patellar stress but no evidence of laxity, medial or lateral, no anterior drawer, no Lachman, no medial joint line tenderness, no effusion and no evidence of erythema. He diagnosed bilateral patellofemoral pain. In a July 9, 2007 report, Dr. James A. Tom, an orthopedic surgeon, noted appellant's history and examined his right knee. His findings included patellar facet tenderness and retropatellar crepitation with passive range of motion, medial joint line tenderness and a negative McMurray. For the left knee, Dr. Tom advised that appellant had no patellar facet tenderness and retropatellar crepitation with passive range of motion and medial joint line tenderness, with a negative McMurray. Appellant had active/passive extension of 0 and flexion of 118 degrees. Dr. Tom noted that the remainder of examination of the left knee was unremarkable.

In a February 21, 2008 report, Dr. Daisy A. Rodriguez, a Board-certified internist, noted appellant's history and rated his impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (5th ed. 2001) (*hereinafter,* A.M.A., *Guides*). For the right leg, she referred to Table 17-31 of the A.M.A., *Guides*[1] and indicated that appellant had 12 percent arthritis impairment of the right leg due to a cartilage interval for the knee of 3 millimeters which equaled 7 percent impairment and a cartilage interval of 4.5 millimeters of the patellofemoral joint for 5 percent impairment. Dr. Rodriquez provided range of motion measurements for the right knee and referred to Table 17-10.[2] She determined that flexion of 90 degrees yielded 10 percent impairment and 1 degree of varus yielded 10 percent impairment for a total impairment of 20 percent. For muscle atrophy, Dr. Rodriquez referred to Table 17-6[3] and advised that appellant had a two centimeter difference in thigh and calf circumference, compared to the left leg that equated to 8 percent impairment for each or a combined impairment of 15 percent. Under Table 16-19 and section 17.2g, she advised that appellant had impairment of 10 percent for mild joint swelling or 7 percent lower extremity impairment.[4] Dr. Rodriguez noted that, under section 18.3d,[5] the maximum pain impairment allowed for the body or organ systems was three percent whole person impairment or eight percent for the leg, which she reduced to five percent relative to knee function. She indicated that the total impairment for the right leg was 48 percent. For the left leg, Dr. Rodriquez found that appellant had mild joint swelling equal to 10 percent joint impairment or 7 percent lower extremity impairment under Table 16-

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

[2] *Id.* at 537.

[3] *Id.* at 570.

[4] *Id.* at 500, 540.

[5] *Id.* at 570.

19.[6] She noted that appellant had seven percent arthritis impairment under Table 17-31[7] due to a 3 millimeter cartilage interval of the left knee and five percent impairment due to a 4.5 millimeter cartilage interval of the patellofemoral joint related to his complaints of patellofemoral pain with crepitus without joint space narrowing on x-rays. Dr. Rodriquez indicated that this resulted in 12 percent impairment. She referred to Table 17-10[8] and noted that flexion of 105 degrees for the knee was equal to 10 percent impairment and varus of 3 degrees resulted in 20 percent impairment, which when added, resulted in 30 percent impairment. Dr. Rodriquez' findings for ratable pain on the left were the same as on the right and she advised that appellant had five percent lower extremity impairment for ratable pain. She concluded that appellant had reached maximum medical improvement and had 45 percent impairment of the left leg.[9]

In a February 26, 2008 report, Dr. Donald Underwood, a Board-certified diagnostic radiologist, stated that right knee x-rays revealed no fracture or dislocation, mild degenerative changes, a small suprapatellar bursal effusion and a seven millimeter osseous loose body near the medial aspect of the posterior patella. The left knee had mild degenerative changes.

In a March 6, 2008 report, Dr. Rodriguez noted that appellant's left knee flexion was still limited to 110 degrees and the right knee was limited to 90 degrees. She also indicated that appellant had crepitus with passive range of motion. In an April 3, 2008 report, Dr. Rodriguez advised that appellant's left knee flexion was now limited to 80 degrees and the right knee was limited to 85 degrees. She also indicated that appellant had crepitus with passive range of motion, greater on the left. Dr. Rodriquez treated appellant and submitted reports dated April 21, 25, 30 and May 7, 2008.

An April 8, 2008 magnetic resonance imaging (MRI) scan of the right knee read by Dr. Howard C. Hutt, a Board-certified diagnostic radiologist, showed small suprapatellar joint effusion, a minimal Baker's cyst, a normal patella and cruciate ligaments which were well maintained with normal thickness and normal signal. Appellant did not have a meniscal tear or a cruciate ligament tear. An April 21, 2008 MRI scan of the left knee read by Dr. Hutt, revealed minimal soft tissue anterior and lateral to the patella with a minimal Baker's cyst, no meniscal tear and no cruciate ligament tear and no bony abnormality.

On May 20, 2008 appellant filed a Form CA-7 claim for a schedule award. In a May 8, 2008 report, Dr. Rodriguez advised that left knee flexion was limited to 70 degrees and the right knee was limited to 80 degrees. She also advised that appellant continued to exhibit crepitus with passive range of motion. Dr. Rodriguez reiterated her findings in a June 10, 2008 report.

On June 10, 2008 the Office medical adviser explained that Dr. Rodriguez did not correctly apply the A.M.A, *Guides* because she improperly combined range of motion with

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[6] *Id.* at 500.

[7] *Id.* at 544.

[8] *Id.* at 537.

[9] Dr. Rodriquez also converted the rating to whole person impairment.

muscle atrophy and arthritis. He noted that, under Table 17-2,[10] range of motion could not be combined with muscle atrophy and arthritis. The Office medical adviser also explained that 10 percent impairment for joint swelling was incorrect as Table 16-19[11] related to mild joint swelling in the arm, not the leg, while page 540 applied to ankylosis with deformity which did not apply since appellant had range of motion. Dr. Rodriguez also incorrectly rated pain pursuant to section 18.3a, as appellant did not meet the three criteria in that section of the A.M.A., *Guides*. The Office medical adviser noted that appellant was also examined by Dr. Kleinbart on June 19, 2007, who advised that he had 135 degrees of active motion bilaterally, which was quite different from her measurements of 105 degrees on the left and 90 degrees on the right. He noted that Dr. Rodriguez was not an orthopedic surgeon. The Office medical adviser opined that Dr. Kleinbart represented the weight of the medical opinion and recommended that the Office use Dr. Kleinbart's range of motion findings. He advised that thigh and calf circumference on the left was greater than that on the right suggesting atrophy on the right. In rating right leg atrophy, the Office medical adviser referred to Table 17-6, and stated that three centimeter thigh and two centimeter calf atrophy each equaled 8 percent impairment for a combined total of 15 percent. For the left leg, he referred to Table 17-31 for arthritis impairments based on x-ray determined cartilage intervals, and determined that a knee interval of three millimeters yielded seven percent impairment. The Office medical adviser advised that patellofemoral joint pain with crepitation on examination but without space narrowing on x-rays according to the footnote of Table 17-31, was a five percent leg impairment. As they were from the same table, the Office medical adviser added these findings and arrived at a total of 12 percent impairment for the left leg arthritis. He concluded that appellant had 12 percent left leg impairment and 15 percent right leg impairment of 15 percent. The Office medical adviser opined that appellant reached maximum medical improvement on February 21, 2008.

On July 9, 2008 the Office granted appellant a schedule award for 15 percent permanent impairment of his right leg and 12 percent permanent impairment of his left leg. The award covered a period of 77.16 weeks from February 21, 2008 to August 18, 2009.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[12] sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.[13] The Act, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the

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

[11] A.M.A., *Guides* 500.

[12] 5 U.S.C. §§ 8101-8193.

[13] *Id.* at § 8107.

use of uniform standards applicable to all claimants.[14] The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[15]

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.[16] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[17] The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligament us instability, bursitis and various surgical procedures, including joint replacements and meniscectomy.[18] 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.[19] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[20] 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.[21] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[22]

ANALYSIS

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

Appellant provided a February 21 2008 report from Dr. Rodriguez, who opined that appellant had 48 percent impairment of the right lower extremity and 45 percent to the left lower extremity. However, Dr. Rodriguez' report is of limited probative value as it did not comport with the A.M.A., *Guides.* For example, she provided arthritis impairment with findings for range of motion and muscle atrophy. The chapter pertaining to lower extremity impairment, Chapter 17, provides a cross-usage chart, Table 17-2 at page 526, which sets forth the various methods for rating lower extremity impairment. According to Table 17-2, impairment due to arthritis, lost range of motion and atrophy also cannot be combined.

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[14] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[15] 20 C.F.R. § 10.404.

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

[17] *Id.*

[18] *Id.*

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

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

[21] *Id.* at 526.

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

Dr. Rodriguez' report was also deficient in that she did not fully explain how certain of her calculations comported with the A.M.A., *Guides*. For example, she referred to Chapter 16 pertaining to the upper extremity for rating appellant's synovitis and also referenced a page in the A.M.A., *Guides*, page 540, pertaining to ankylosis of the knee even though the evidence does not suggest that his knee is ankylosed. Dr. Rodriguez did not explain how this rating comported with the A.M.A., *Guides*.[23] Furthermore, she also provided differing range of motion findings. For example, in Dr. Rodriguez' February 21, 2008 report, she advised that right knee flexion was 90 degrees while it was 105 degrees on the left. In her March 6, 2008 report, she noted that right knee flexion was 90 degrees while it was 110 degrees on the left. On April 3, 2008 report, Dr. Rodriguez indicated that right knee flexion was 85 degrees and 80 degrees on the left. In May 8 and June 10, 2008 reports, she advised that right knee flexion was 80 degrees while it was 70 degrees on the left. Dr. Rodriguez did not explain the reasons for this disparity or which finding was most accurate.

Dr. Rodriguez also provided impairment for pain under Chapter 18 of the A.M.A., *Guides*.[24] However, she did not explain why appellant was entitled to a pain-related impairment of five percent for each leg and why this pain could not be adequately under rating systems in other chapters of the A.M.A., *Guides*. The Board notes that physicians 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*.[25]

Board precedent is well settled that when an attending physician's report gives an estimate of impairment but does not address how the estimate is based upon the A.M.A., *Guides* the Office may follow the advice of its medical adviser where he or she has properly applied the A.M.A., *Guides*.[26]

The Office medical adviser reviewed Dr. Rodriguez' report and concluded that appellant had left lower extremity impairment of 12 percent and right lower extremity impairment of 15 percent. After noting the aforementioned deficiencies above, he explained that he utilized the range of motion findings provided by another treating physician, Dr. Kleinbart, who was also a Board-certified orthopedic surgeon, as opposed to Dr. Rodriguez, a Board-certified internist. However, the Office medical adviser did not base any impairment finding on Dr. Kleinbart's reported range of motion findings. The Board also notes that the range of motion findings from Dr. Rodriguez, while not consistent, are more current and appear to show decreasing range of motion. In view of this, it is unclear why Dr. Kleinbart's findings from 2007 would be deemed more accurate, especially when the Office medical adviser opined that appellant reached

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[23] It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his or her opinion is of diminished probative. *Linda Beale*, 57 ECAB 429 (2006).

[24] A.M.A., *Guides* 570.

[25] *Frantz Ghassan*, 57 ECAB 349 (2006); A.M.A., *Guides* 571. *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[26] *See Ronald J. Pavlik*, 33 ECAB 1596 (1982); *Robert R. Snow*, 33 ECAB 656 (1982); *Quincy E. Malone*, 31 ECAB 846 (1980).

maximum medical improvement on February 21, 2008, and why the Office did not seek further clarification regarding this.

The Office medical adviser essentially concurred with Dr. Rodriguez regarding appellant's atrophy findings, finding that his thigh and calf atrophy, when combined, yielded 15 percent impairment on the right under Table 17-6.[27]

For the left knee, the Office medical adviser referred to Table 17-31[28] for arthritis impairments based on x-ray determined cartilage intervals and concurred with Dr. Rodriguez' that a knee interval of three millimeters equaled seven percent impairment. He advised that patellofemoral joint pain with crepitation on physical examination but without space narrowing on x-rays according to the footnote of Table 17-31, equated to five percent leg impairment.[29] However, the Board notes that, under Table 17-31, impairment without a cartilage interval determined by x-ray only applies if there is a history of direct trauma, a complaint of patellofemoral pain and crepitus on physical examination.[30] The record does not contain a history of direct trauma to the left knee and there is no explanation from Dr. Rodriguez or the Office medical adviser as to why this caveat to Table 17-31 applies to appellant's situation.

Accordingly, the Board finds that the medical evidence of record does not provide a probative medical opinion on the nature and extent of appellant's impairment of his lower extremities.[31] The reports of Dr. Rodriguez and the Office medical adviser do not sufficiently comply with the A.M.A., *Guides* and do not to establish appellant's permanent impairment of each leg.

The Board will set aside the Office's July 9, 2008 decision and remand the case to the Office. Upon remand, it should refer appellant for a second opinion medical examination to properly determine the impairment to his right and left lower extremities utilizing the proper tables and figures of the A.M.A., *Guides.* Following this and any other development deemed necessary, the Office shall issue an appropriate decision regarding appellant's entitlement to a schedule award.

CONCLUSION

The Board finds that this case is not in posture for decision

[27] A.M.A., *Guides* 530.

[28] *Id.* at 544.

[29] *Id*.

[30] *Id.*

[31] *See Philip Norulak,* 55 ECAB 690 (2004).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs' dated July 9, 2008 is set aside and remanded for further action consistent with this decision.

Issued: September 4, 2009
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