United States Department of Labor
Employees' Compensation Appeals Board

R.G., Appellant	)	
and	)	**Docket No. 09-362**
	)	**Issued: September 14, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Southeastern, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 19, 2008 appellant filed a timely appeal from August 6 and January 28, 2008 schedule award decisions 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 has greater than a 12 percent left lower extremity impairment for which he received a schedule award.

On appeal, appellant contends that the September 8, 2005 report of Dr. Nicholas Diamond, a Board-certified osteopath, should constitute the weight of medical opinion or create a conflict in medical opinion with that of the Office medical adviser.

FACTUAL HISTORY

On August 24, 2000 appellant, then a 28-year-old mail handler, sustained injury when he twisted his left leg while unloading a truck. On October 20, 2000 the Office accepted the claim for tear of the posterior horn of the left medial meniscus. The claim was later accepted for left patellar tendinitis. Appellant came under the care of Dr. Donald W. Mazur, a Board-certified orthopedic surgeon, who performed arthroscopic left knee partial medial meniscectomy and left anterior cruciate ligament (ACL) reconstruction. He returned to limited duty on March 19, 2001 and to full duty on February 15, 2002. Appellant reinjured his left knee in July 2003. A July 8, 2003 magnetic resonance imaging (MRI) scan of the left knee demonstrated a probable small recurrent tear of the medial meniscus. On September 2, 2003 Dr. Mazur noted that he had a recurrence of pain and was wearing a hinged knee brace.

On March 10, 2006 appellant filed a schedule award claim. In a September 8, 2005 report, Dr. Nicholas Diamond, an osteopath, provided examination findings and an impairment rating. He noted a history of injury, appellant's complaints of daily left knee pain and stiffness and that he wore a knee brace. Dr. Diamond diagnosed post-traumatic left knee anterior cruciate ligament tear, medial meniscus tear, osteochondral lesion of medial femoral condyle and weight bearing surface with multiple loose bodies, status post arthroscopy left knee with arthroscopic anterior cruciate ligament reconstruction using bone/tendon/bone autograft, removal of loose bodies, osteochondral grafting to the medial femoral condyle with 6.5 millimeter (mm) graft and partial medial meniscectomy and chronic tenosynovitis to the left knee secondary to apparent recurrent left medial meniscus tear, as per MRI scan. He stated that in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[1] under Table 17-8, appellant's motor strength of 4/5 of the left quadriceps yielded a 12 percent impairment and his motor strength of 4/5 of the left gastrocnemius yielded a 17 percent impairment which, when combined, equaled a 27 percent impairment. Dr. Diamond then added a 3 percent pain-related impairment under Figure 18-1 to yield 30 percent impairment for the left lower extremity.

In a January 2, 2008 report, an Office medical adviser reported that, based on the fifth edition of the A.M.A., *Guides*, under Table 17-33, a partial medial meniscectomy yielded a two percent impairment and an ACL reconstruction with mild laxity yielded a seven percent impairment which, when combined, yielded a nine percent left lower extremity impairment. He stated that appellant was entitled to an additional 3 percent for pain under Figure 18-1, for a total 12 percent impairment of the left lower extremity.

By decision dated January 28, 2008, appellant was granted a schedule award for a 12 percent left lower extremity impairment.

On January 30, 2008 appellant requested a hearing, which was held on June 25, 2008. At the hearing, he testified regarding the employment injuries and his current symptoms. Counsel argued that Dr. Diamond's report should give the weight of medical opinion or, in the alternative, that a conflict in medical evidence had been created.

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

In an August 6, 2008 decision, an Office hearing representative affirmed the January 28, 2008 decision.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[2] and section 10.404 of the implementing federal regulations,[3] schedule awards are payable for permanent impairment of 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.[4] Chapter 17 provides the framework for assessing lower extremity impairments.[5]

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.[6] For lower extremity impairments due to meniscectomies or ligament injuries involving the knees, Table 17-1, of the A.M.A., *Guides* directs the clinician to utilize section 17.2j as the appropriate method of impairment assessment. Section 17.2j, A.M.A., *Guides* entitled diagnosis-based estimates, provides that some impairment estimates are more appropriately rated on the basis of a diagnosis than on the basis of findings on physical examination and instructs the clinician to assess the impairment using the criteria in Table 17-33, entitled impairment estimates for certain lower extremity impairments.[7] When a diagnosis-based impairment rating is applied, it is generally not appropriate to calculate additional impairment based on anatomic or functional based methods (such as limitations of strength or range of motion).[8]

Section 18.3b of the fifth edition of the A.M.A., *Guides* provides that pain-related impairment should not be used if the condition can be adequately rated under another section of the A.M.A., *Guides*.[9] Office procedures provide that, if the conventional impairment adequately encompasses the burden produced by pain, the formal impairment rating is determined by the appropriate section of the A.M.A., *Guides*. However, an impairment rating can, in some

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] *See Joseph Lawrence, Jr., supra* note 1; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[5] A.M.A., *Guides* 523-64.

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

[7] A.M.A. *Guides* 545; *see James R. Hill*, 57 ECAB 583 (2006).

[8] A.M.A. *Guides* 545, section 17.2j; *Derrick C. Miller*, 54 ECAB 266 (2002).

[9] *Id.*

situations, be increased by up to three percent if pain increases the burden of the employee's condition.[10]

ANALYSIS

The Board finds that appellant has 12 percent left lower extremity impairment. Contrary to appellant's arguments on appeal, the Board finds that the September 8, 2005 report of Dr. Diamond is of diminished probative value as it is not fully in accordance with the A.M.A., *Guides*. It is not sufficient to establish entitlement to an increased schedule award or to create a conflict in medical evidence. As noted in section 17.2j, appellant's impairment is of the type that should be assessed under Table 17-33.[11] In accordance with section 17.2j, the Office medical adviser properly assessed appellant's left knee on the basis of the arthroscopic surgery performed on November 20, 2000. Under Table 17-33, appellant has two percent left lower extremity impairment for the partial medial meniscectomy and a seven percent impairment for ACL reconstruction with mild laxity.[12] Dr. Diamond based his impairment ratings for strength deficits of the quadriceps and gastrocnemius muscles. Section 17.2e of the A.M.A., *Guides*, however, notes that manual muscle testing depends on the examinee's cooperation. To be valid, if strength testing is made by one examiner, the measurements should be consistent on different occasions. Table 17-7 describes the criteria on which estimates and grades for lower extremity strength are based, with Table 17-8 listing the actual ratings for the lower extremities.[13] Although Dr. Diamond made a general reference to Table 17-8, he did not provide any explanation of how the criteria found in Table 17-7 were applied or otherwise explain how he arrived at the impairment rating for muscle weakness. His report is, therefore, insufficient to establish that appellant has greater permanent impairment of the left lower extremity or to establish a conflict in medical evidence.[14] Furthermore, Table 17-2 of the A.M.A., *Guides* describes the types of impairment that cannot be combined, noting that muscle strength cannot be combined with a diagnosis-based estimate or sensory loss.[15]

Both Dr. Diamond and the Office medical adviser found that appellant had a three percent left lower extremity impairment under Chapter 18 of the A.M.A., *Guides*. The fifth edition of the A.M.A., *Guides* allows for an impairment percentage to be increased by up to three percent for pain by using Chapter 18, if an individual appears to have a pain-related impairment that has increased the burden on his or her condition slightly.[16] A formal pain assessment, however, must be performed in accordance with Chapter 18.[17] Moreover, examiners are advised

[10] *Richard B. Myles*, 54 ECAB 379 (2003).

[11] *Supra* note 8.

[12] *Id.*

[13] A.M.A., *Guides* 531, section 17.2e.

[14] *See Mary L. Henninger*, 52 ECAB 408 (2001).

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

[16] *T.H.*, 58 ECAB ____ (Docket No. 06-1500, issued January 31, 2007).

[17] A.M.A., *Guides* 573.

not to use the Chapter for any condition that can be adequately related under the other Chapters of the A.M.A., *Guides*. Neither Dr. Diamond nor the Office medical adviser provided a formal pain-related impairment in accordance with Chapter 18. The medical evidence, does not establish that appellant is entitled to an award due to pain under Chapter 18, as rated. Consequently, there is not probative evidence showing that appellant has more than the 12 percent impairment of the left lower extremity awarded.[18]

CONCLUSION

The Board finds that appellant has no more than 12 percent impairment for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 6, 2008 be affirmed.

Issued: September 14, 2009
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

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

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

[18] The Board, however, notes that Table 17-31 of the A.M.A., *Guides* provides for arthritis impairments based on cartilage intervals determined by x-ray. Table 17-2 does not preclude the combination of diagnosis-based estimate impairment and impairment due to arthritis or sensory loss. *Id.* at 526, 544. While the record in this case does not include an x-ray demonstrating cartilage narrowing, the July 8, 2003 left lower extremity MRI scan demonstrated moderate to high grade thinning of the medial tibial plateau. Neither Dr. Diamond nor the Office medical adviser reviewed the MRI scan or provided an opinion in this regard.