United States Department of Labor
Employees' Compensation Appeals Board

J.F., Appellant	)	
and	)	**Docket No. 09-1664**
	)	**Issued: August 24, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Oak Brook, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On June 23, 2009 appellant filed a timely appeal of the June 25, 2008 schedule award decision of the Office of Workers' Compensation Programs finding two percent impairment of the right leg. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than two percent impairment of the right lower extremity for which he received a schedule award.

On appeal appellant contends that the impairment to his right leg is greater than awarded.

FACTUAL HISTORY

The Office accepted that on January 10, 2006 appellant, then a 52-year-old letter carrier, sustained internal derangement of the right knee while in the performance of his work duties. On April 14, 2006 appellant underwent right knee arthroscopy and a chondroplasty of the medial tibial plateau performed by Dr. Steven J. Mash, an attending Board-certified orthopedic surgeon.

On July 21, 2006 appellant filed a claim (Form CA-7) for a schedule award. On July 24, 2006 the Office requested that he submit a medical report from an attending physician which provided an impairment rating based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001).

In an August 2, 2006 report, Dr. Mash noted appellant's persistent complaints of aching about the knee joint. He listed normal findings on physical examination. Dr. Mash stated that range of motion was full, without effusion, swelling, atrophy or loss of strength in the quads or hamstrings. He advised that appellant had reached maximum medical improvement. Dr. Mash rated five percent impairment of the right lower extremity based on the arthroscopy and appellant's discomfort.

On October 30, 2006 Dr. David H. Garelick, an Office medical adviser, reviewed the medical evidence. He determined that appellant did well following surgery and did not sustain any permanent impairment to the right leg. Dr. Garelick stated that Dr. Mash did not report any objective findings of impairment to support the impairment rating provided. He advised that appellant reached maximum medical improvement on August 2, 2006.

By letter dated December 27, 2006, the Office requested that Dr. Mash submit a supplemental report addressing impairment to appellant's right leg.

In a January 12, 2007 report, Dr. Mash stated that his five percent impairment rating of the right lower extremity was based on the A.M.A., *Guides* which allowed the calculation of permanent impairment for loss of function secondary to pain, discomfort or sensory alteration. He advised that appellant had discomfort and hip dyesthesias about the knee joint. Dr. Mash considered his subclinical aching and discomfort about the knee joint localized to the lateral aspect of the knee. He stated that appellant's range of motion was otherwise normal and that he disagreed with Dr. Garelick's finding of no permanent impairment.

On February 5, 2007 Dr. Garelick reviewed Dr. Mash's January 12, 2007 report. He noted that the impairment described by Dr. Mash pertained to loss of function due to pain or sensory alteration. Dr. Garelick noted that it was customary to describe pain in terms of the distribution of a particular nerve, but Dr. Mash did not identify which nerve caused impairment. As the knee derived sensory innervation from the femoral nerve, Dr. Garelick recommended two percent impairment with general reference to Table 17-37 and Table 16-10 and dyesthesias.

In an April 5, 2007 decision, the Office granted appellant a schedule award for two percent impairment of the right leg.

On April 30, 2007 appellant requested a review of the written record by an Office hearing representative.

In a May 4, 2007 report, Dr. Jacob Salomon, a surgeon, reviewed appellant's medical records. He determined that appellant sustained 23 percent impairment of the right leg. Dr. Salomon noted his complaint of limited motion and pain. Appellant rated his pain as 6 out of 10 with weightbearing and 3 out of 10 on average. Dr. Salomon listed essentially normal findings on physical examination with positive MacIntosh pivotal/shift and Apley's compression test results and Grade 4 muscle weakness of both quadriceps and hamstrings. He could not rate appellant's dysthesias because he did not complain of any along the femoral route or infrapatellar

area. Dr. Salomon rated seven percent impairment for arthritis based on Table 17-31, but stated that this rating did not consistently or fairly rate his impairment. In the alternative, he noted that Grade 4 muscle weakness on flexion and extension each constituted 12 percent impairment of the leg. By combining the 12 percent impairment for weakness, appellant had a total 23 percent impairment of the right lower extremity.

On May 26, 2007 Dr. Robert Wysocki, an Office medical adviser, reviewed appellant's medical records. He agreed with the prior two percent impairment rating provided by Dr. Garelick. Although, Dr. Salomon noted 4/5 muscle strength of the right quadriceps and hamstrings, Dr. Wysocki stated that the A.M.A., *Guides* provided that decreased strength could not be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevented effective application of maximal force in the region being evaluated.[1] He stated that manual muscle testing would not be a reliable assessment and should not be used to rate impairment. Dr. Wysocki noted that although Dr. Salomon considered rating appellant's arthritis, Dr. Mash's January 19, 2006 treatment note reported normal x-rays.[2] He advised that appellant had impairment related to pain in his knee.

In an August 17, 2007 decision, an Office hearing representative affirmed the April 5, 2007 decision, finding that appellant had more than a two percent impairment of the right leg.

On November 20, 2007 appellant requested reconsideration. In a November 8, 2007 report, Dr. Lafayette Singleton, a Board-certified neurologist, determined that appellant sustained 13 percent impairment of the right leg. He reviewed appellant's medical records which listed normal findings on physical examination. Dr. Singleton stated that it was difficult to rate impairment based on normal ranges of motion and strength measurements. He stated that an impairment rating had to be based on appellant's surgery. Dr. Singleton noted that x-rays of the right knee showed cartilage interval between the patellofemoral area of two millimeters which indicated chondromalacia and chondroplasty. He determined that patellofemoral at two millimeters constituted 10 percent impairment based on Table 17-31. Dr. Singleton further determined that appellant sustained an additional three percent impairment for pain. He combined the 10 percent arthritis impairment and 3 percent impairment for pain to total 13 percent impairment to the right leg.

On December 24, 2007 Dr. Garelick reviewed Dr. Singleton's November 8, 2007 findings. He found that the medical evidence did not support greater impairment. Dr. Garelick noted Dr. Singleton's difficulty in rating appellant's impairment as his findings on examination were essentially normal. While Dr. Singleton found that appellant sustained 10 percent impairment of the right lower extremity based on loss of cartilage as demonstrated by x-ray, Dr. Mash found normal x-rays in his January 19, 2006 treatment note.[3] Given the differing opinions, Dr. Garelick relied on Dr. Mash's opinion over that of Dr. Singleton, stating that

[1] A.M.A., *Guides* 508.

[2] In a January 19, 2006 report, Dr. Mash ruled out internal derangement of the right knee based on x-ray examination.

[3] In a January 19, 2006 treatment note, Dr. Mash reviewed a history of appellant's January 10, 2006 employment injury and medical treatment. He reported his normal findings on physical and x-ray examination of appellant's right knee. Dr. Mash ruled out internal derangement of the right knee.

Dr. Mash was better qualified as a Board-certified orthopedic surgeon while Dr. Singleton was a Board-certified neurologist. Dr. Garelick further stated that appellant had already been awarded two percent impairment for pain based on his February 5, 2007 opinion. He concluded that there were no objective findings upon which to award additional impairment.

By decision dated January 9, 2008, the Office denied modification of the August 17, 2007 decision. It found that appellant had no more than two percent impairment of the right lower extremity.

By letter dated April 1, 2008, appellant requested reconsideration. In a March 7, 2008 report, Dr. Singleton diagnosed internal derangement of the right knee with residuals and determined that appellant sustained 19 percent impairment of the right lower extremity. He listed findings on physical examination which included less than 110 degrees of flexion which he determined represented 10 percent impairment under Table 17-10, page 537. Dr. Singleton stated that appellant had 10 degrees of flexion contracture, but passively appellant could obtain another 5 degrees of extension. He subtracted 5 degrees from 10 degrees of active flexion. Dr. Singleton determined that appellant sustained 10 percent impairment for flexion contracture under Table 17-10. He combined the 10 percent loss of range of motion impairment ratings to calculate 19 percent impairment of the right lower extremity.

On May 5, 2008 Dr. Garelick reviewed appellant's medical records. He found that appellant did not sustain any additional impairment. Dr. Garelick stated that residual impairment was minimal based on Dr. Mash's normal physical examination findings. He again relied on Dr. Mash's findings primarily due to his professional qualifications. Dr. Garelick again concluded that there was no objective evidence to grant appellant an additional schedule award.

By decision dated June 25, 2008, the Office denied modification of the January 9, 2008 decision. The medical evidence was found to be insufficient to establish that appellant had more than a two percent impairment of the right lower extremity.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[4] and its implementing regulations[5] set forth the number of weeks of compensation to be paid for permanent loss or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[6] However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[7]

[4] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[5] 20 C.F.R. § 10.404.

[6] 5 U.S.C. § 8107(c)(19).

[7] *Id*.

ANALYSIS

Appellant contends that he has more than two percent permanent impairment of the right lower extremity, for which he received a schedule award on April 5, 2007. The Office accepted his claim for internal derangement of the right knee. Appellant underwent right knee arthroscopy and a chondroplasty of the medial tibial plateau on April 14, 2006 to treat the accepted right lower extremity condition.

The Office based its schedule award decision on the December 24, 2007 and May 5, 2008 reports of Dr. Garelick, an Office medical adviser, who largely dismissed the findings by Dr. Singleton, based on the physician's specialty in neurology rather than orthopedic surgery. The Board finds that this was error. As a result, Dr. Garelick failed to provide a comprehensive review of the medical evidence submitted from appellant.

On November 7, 2008 Dr. Singleton provided a rating of impairment to appellant's right leg based on atrophy and pain. He obtained x-rays of the right knee that showed a two millimeter patellofemoral cartilage interval which would constitute 10 percent impairment to the right knee under Table 17-31. Dr. Garelick stated that Dr. Mash had previously reported normal x-rays in a January 19, 2006 report. The Board notes that the 2006 x-ray, purported to be normal, apparently was obtained prior to appellant's surgery and chondroplasty on April 14, 2006. Dr. Garelick's reliance on the January 2006 x-ray over the studies obtained by Dr. Singleton is not well explained. The medical adviser did not adequately explain why a study obtained prior to surgery should be considered more relevant than one obtained following surgery. Dr. Singleton also allowed 3 percent for pain, to find 13 percent total impairment to the right knee. He appeared to rely on Chapter 18-3d, as he noted that appellant had pain-related impairment that increased the burden of his condition. In response to this application of the A.M.A., *Guides*, Dr. Garelick merely noted that appellant had already been rated two percent for pain. He did not adequately address any specific deficiency in the rating provided by Dr. Singleton.

Dr. Singleton provided a March 7, 2008 report in which he rated impairment of appellant's right leg at 19 percent. In this regard, he utilized the loss of range of motion deficits under Table 17-10 at page 537. Appellant had flexion of less than 110 degrees that represented a mild impairment of 10 percent. He also had flexion contracture less than 10 degrees, which also represents mild impairment of 10 percent. Dr. Singleton noted that he combined these ratings to find 19 percent total impairment to the right leg. On May 5, 2008 Dr. Garelick reiterated his prior impairment rating of two percent. Again, he relied upon Dr. Mash's prior findings that reported appellant's examination as normal. Dr. Singleton's specialty in neurology was cited as a reason for discounting the impairment rating. Dr. Garelick found Dr. Mash to be 'the more skilled and experienced person." With little explanation for this determination the opinion of the medical adviser is not persuasive.

Proceedings under the Act are not adversary in nature. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence to see that justice is done.[8] Accordingly, once it undertakes to develop the medical

[8] *Richard E. Simpson*, 55 ECAB 490 (2004).

evidence, the Office has the responsibility to do so in the proper manner.[9] The Office should have referred the matter to an appropriate medical specialist to determine whether appellant sustained impairment due to arthritis or loss of range of motion as reported by Dr. Singleton.

The Board will remand the case to the Office for referral of appellant for examination and evaluation regarding whether he has more than two percent permanent impairment to his right knee. Following such other development as deemed necessary, the Office shall issue an appropriate merit decision on appellant's schedule award claim.

CONCLUSION

The Board finds that the case is not in posture for decision as to whether appellant has more than a two percent permanent impairment of the right leg.

ORDER

IT IS HEREBY ORDERED THAT the June 25, 2008 decision of the Office of Workers' Compensation Programs be set aside. The case is remanded to the Office for further action consistent with this decision.

Issued: August 24, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[9] *Melvin James*, 55 ECAB 406 (2004).