United States Department of Labor
Employees' Compensation Appeals Board

RICHARD C. JORDAN, Appellant	)	
and	)	**Docket No. 05-98**
	)	**Issued: April 15, 2005**
U.S. POSTAL SERVICE, POST OFFICE, Los Angeles, CA, Employer	)	

Appearances:
Richard C. Jordan, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On October 12, 2004 appellant filed an appeal of a June 9, 2004 merit decision of the Office of Workers' Compensation Programs granting a schedule award for a four percent permanent impairment of each lower extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision in this case.[1]

ISSUE

The issue is whether appellant has met his burden of proof to establish that he has more than a four percent impairment of both lower extremities.

[1] In a letter received November 9, 2004, appellant indicated that he was seeking a monthly allowance as compensation for his inability to work. The Office has not issued a final decision regarding compensation benefits, the only decision over which this Board has jurisdiction is the June 9, 2004 schedule award. *See* 20 U.S.C. § 501.2(c) (the Board has jurisdiction to consider and decide appeals from final decisions; there shall be no appeal with respect to any interlocutory matter disposed of during the pendency of the case).

FACTUAL HISTORY

On December 4, 2003 appellant, then a 53-year-old retired mail handler, filed a Form CA-2, occupational disease claim, alleging that he injured his back and knees in the performance of duty. In support of his claim, appellant stated that, during his six years of employment, he was required to perform heavy lifting and to spend many hours on his feet. He indicated that he delayed filing a claim for his injuries because he did not want to delay his application for civil service retirement, which occurred on December 31, 2002.

The Office accepted appellant's claim for aggravation of degenerative disc disease, by decision dated December 15, 2003. On February 2, 2004 appellant filed a request for a schedule award.

In a report dated December 2, 2003, Dr. Muhammad H. Sizar, D.O.[2] Provided a diagnosis of lumbosacral disc protrusion at L2-3 and L4-5 disc height loss; and DJD of bilateral knees. He further indicated the need to rule out any ligamentous or meniscal injury at the knee joint. Dr. Sizar opined that appellant's low back problem could have been aggravated by the nature of his employment in a gradual process. He explained that appellant's loss of disc height can result in protrusion of other discs as a compensatory response in stabilizing the spine. He further stated that "it is quite possible" that appellant's longstanding job history of heavy lifting may contribute to or aggravate his knee pain in addition to his existing gouty arthritic problem. Appellant submitted a December 5, 2003 report of a magnetic resonance imaging (MRI) scan. In a report dated February 3, 2004, Dr. Sizar provided a diagnosis of lumbosacral radiculitis secondary to L2-3 disc protrusion; bilateral meniscal tear; bilateral knee and low back pain; and restricted mobility secondary to vertebral/spinal compensatory response and knee joints pain. He indicated that appellant had excruciating radicular signs in the lumbosacral area limiting his mobility, particularly in side bending and rotation and moderate to severe bilateral knee joints pain and tenderness. He opined that appellant's condition occurred gradually and was most likely caused by heavy weight bearing/lifting process in which the vector forces transmitted from the lumbosacral area through the knee joints symmetrically causing bilateral injury of the knee joints in symmetrical pattern. Dr. Sizar stated that appellant refused surgery due to fear of worsening his existing symptoms. An assessment of appellant's permanent impairment of the lower extremities was not provided.

The Office referred appellant, together with a statement of accepted facts and the entire medical record, to Dr. Bunsri T. Sophon for a second opinion examination and an evaluation of permanent functional loss of use of both lower extremities.[3] In a report dated April 1, 2004, Dr. Sophon opined that appellant's date of maximum medical improvement was April 1, 2004. His examination of appellant's knees revealed tenderness over the medial and lateral joint lines of both knees, with no evidence of joint effusion; medial meniscus tear bilaterally; knee

[2] Although Dr. Sizar represents himself to be a Board-certified family physician, his credentials cannot be verified.

[3] Although Dr. Sophon represents himself to be a Diplomate in the American Board of Orthopedic Surgery, his credentials cannot be verified.

extension 0/0 degrees bilaterally and flexion 120/150 degrees bilaterally. Examination of the spine revealed normal curvature; no evidence of swelling, inflammation, tenderness, muscle atrophy or spasm; flexion 80/90 degrees; extension 20/25 degrees; and lateral bending 25/25 degrees bilaterally. Dr. Sophon indicated that appellant's motor strength was grossly within normal limits and sensation was diminished to touch and pinprick over the anterior area of the left thigh. He provided diagnoses of lumbosacral spine sprain/strain, lumbosacral spine osteoarthritis and tear, medial meniscus, bilateral knees and opined that the conditions were causally related to appellant's employment. He reported objective findings to include tenderness in both knees, restriction of motion of both knees, positive McMurray sign for medial meniscus bilaterally and abnormal MRI scan of the lumbar spine and both knees. Subjective complaints included constant, slight bilateral knee pain, frequent, slight lumbar spine pain and constant numbness of the left anterior thigh. Dr. Sophon opined that appellant's disability interfered with his daily activities, including standing, walking, climbing and squatting. A memorandum dated April 19, 2004 from the Office to the district medical adviser reflects that the Office accepted the additional diagnoses of lumbosacral strain; lumbosacral osteoarthritis; and tear of medial meniscus bilateral as work related.

The Office forwarded the medical record to Dr. Leonard A. Simpson, a district medical consultant, for review and determination of permanent functional loss of use of both lower extremities. In a report dated May 10, 2004, Dr. Simpson summarized appellant's medical records. He stated that an MRI scan of the right knee revealed a tear through the middle and posterior thirds of the medial meniscus and a small peripheral tear through the middle third of the lateral meniscus and that an MRI scan of the left knee revealed a tear through the middle and posterior thirds of the medial meniscus, edema of the medial collateral ligament suggesting a partial tear and a small area of osteochondritis dissecans involving the posterior articular surface of the medial femoral condyle. Dr. Simpson further summarized Dr. Sophon's second opinion evaluation, referring to his documentation of appellant's subjective complaints of constant burning, bilateral knee pain, as well as frequent burning in the low back and constant numbness in the left anterior thigh. Dr. Simpson stated that these subjective complaints would be graded a maximum Grade 3 pursuant to Table 16-10 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] He further stated that "this would be pain and/or altered sensation that may interfere with activities, or a 60 [percent] grade of maximum 7 [percent] (femoral nerve), equivalent to a 4.2 [percent] or rounded off to a 4 [percent] impairment for pain factors." Referring to Table 17-10, he indicated that range of motion documented at 0/0 through 120/150 would be rated at 0 percent impairment. He added that the records indicated no lower extremity atrophy or weakness for a 0 percent impairment. Dr. Simpson concluded that appellant has a four percent impairment of each lower extremity and that the date of maximum medical improvement would have been reached no later than December 10, 2003.

By decision dated June 9, 2004, the Office granted appellant a schedule award for a four percent loss of use of each lower extremity for a total of 23.04 weeks, to run from December 10, 2003 to May 19, 2004.

[4] A.M.A., *Guides* (5th ed. 2001).

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[5] and its implementing regulation[6] sets 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. The Act, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of the Office.[7] 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 implementing regulation as the appropriate standard for evaluating schedule losses.[8]

The Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[9]

Chapter 17 of the A.M.A., *Guides* provides multiple grading schemes and procedures for determining the impairment of a lower extremity due to gait derangement,[10] muscle atrophy,[11] muscle weakness,[12] arthritis,[13] nerve deficits[14] and other specific pathologies. The A.M.A., *Guides* also provides impairment ratings of the lower extremities for diagnosis-based estimates, including specific disorders of the knee, such as a meniscectomy.[15]

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[5] 5 U.S.C. §§ 8101-8193.

[6] 20 C.F.R. § 10.404.

[7] *Linda R. Sherman*, 56 ECAB ___ (Docket No. 04-1510, issued October 14, 2004); *Daniel C. Goings*, 37 ECAB 781, 783-84 (1986).

[8] *Ronald R. Kraynak*, 53 ECAB 130, 132 (2001).

[9] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (March 1995).

[10] A.M.A., *Guides* 529, Table 17-5.

[11] *Id.* at 530, Table 17-6.

[12] *Id.* at 532, Table 17-31.

[13] *Id.* at 544, Table 17-31.

[14] *Id.* at 552, Table 17-37.

[15] *Id.* at 545-48, Table 17-33.

ANALYSIS

The Office accepted appellant's claim for aggravation of degenerative disc disease, which was later expanded to include the additional diagnoses of lumbosacral strain; lumbosacral osteoarthritis; and tear of medial meniscus bilateral. Dr. Sophon, an orthopedic surgeon, indicated that his examination of appellant's knees revealed tenderness over the medial and lateral joint lines of both knees, with no evidence of joint effusion; medial meniscus tear bilaterally; knee extension 0/0 degrees bilaterally and flexion 120/150 degrees bilaterally. Examination of the spine revealed normal curvature; no evidence of swelling, inflammation, tenderness, muscle atrophy or spasm; flexion 80/90 degrees; extension 20/25 degrees; and lateral bending 25/25 degrees bilaterally. Dr. Sophon indicated that appellant's motor strength was grossly within normal limits and sensation was diminished to touch and pinprick over the anterior area of the left thigh. He provided diagnoses of lumbosacral spine sprain/strain, lumbosacral spine osteoarthritis and tear, medial meniscus, bilateral knees and opined that the conditions were causally related to appellant's employment. He reported objective findings to include tenderness in both knees, restriction of motion of both knees, positive McMurray sign for medial meniscus bilaterally and abnormal MRI scan of the lumbar spine and both knees. Subjective complaints included constant, slight bilateral knee pain, frequent, slight lumbar spine pain and constant numbness of the left anterior thigh.

Dr. Simpson, a district medical consultant, reviewed Dr. Sophon's report and applied the appropriate tables and pages of the A.M.A., *Guides* to his findings, concluding that appellant had a four percent impairment of each lower extremity and that the date of maximum medical improvement would have been reached no later than December 10, 2003. Dr. Simpson stated that appellant's subjective complaints of bilateral knee pain, frequent burning in the low back and constant numbness in the left anterior thigh would be graded a maximum Grade 3 pursuant to Table 16-10 of the fifth edition of the A.M.A., *Guides*.[16] He further stated that "this would be pain and/or altered sensation that may interfere with activities, or a 60 [percent] grade of maximum 7 [percent] (femoral nerve), equivalent to a 4.2 [percent] or rounded off to a 4 [percent] impairment for pain factors." Referring to Table 17-10, he indicated that range of motion documented at 0/0 through 120/150 would be rated at 0 percent impairment. He added that the records indicated no lower extremity atrophy or weakness for a zero percent impairment. In that appellant had no loss of motion, atrophy or weakness, Dr. Simpson correctly evaluated the lower extremity impairment due to the femoral nerve impairment. The Board notes that Chapter 17 of the A.M.A., *Guides* provides the grading schemes and procedures for determining the impairment of a lower extremity, as well as impairment ratings of the lower extremities for diagnosis-based estimates, including specific disorders of the knee, such as a meniscectomy. Dr. Simpson properly referred to Table 17-10 indicating that appellant's range of motion documented at 0/0 through 120/150 would be rated at 0 percent impairment. Additionally, Table 17-33 provides impairment estimates for medial or lateral meniscectomy. Appellant did not undergo a meniscectomy, he is not entitled to a schedule award in this regard. As Dr. Simpson properly applied the A.M.A., *Guides* to Dr. Sophon's findings, his report establishes that appellant has no more than a four percent impairment of each lower extremity.

[16] *Supra* note 4.

Dr. Simpson opined that appellant had reached maximum medical improvement no later than December 10, 2003. It is well established that the period covered by the schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the accepted employment injury. The Board has explained that maximum medical improvement means that the physical condition of the injured member of the body has stabilized and will not improve further.[17] Based upon a thorough review of the probative medical evidence of record, Dr. Simpson concluded that the date of maximum medical improvement would have been reached no later than one year following the onset of his condition, to-wit: December 10, 2003. The Board finds that the date appellant reached maximum medical improvement was December 10, 2003.

CONCLUSION

The Board finds that appellant has not established that he has more than a four percent impairment to both lower extremities.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 9, 2004 is affirmed.

Issued: April 15, 2005
Washington, DC

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member

[17] *Mark A. Holloway*, 55 ECAB ___ (Docket No. 03-2144, issued February 13, 2004).