United States Department of Labor
Employees' Compensation Appeals Board

L.P., Appellant	)	
and	)	**Docket No. 06-891**
	)	**Issued: December 4, 2006**
U.S. POSTAL SERVICE, POST OFFICE, New Brunswick, NJ, 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
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 8, 2006 appellant filed a timely appeal from the February 7, 2006 decision of the Office of Workers' Compensation Programs, which awarded compensation for a 29 percent permanent impairment of his right lower extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of this schedule award.

ISSUE

The issue is whether appellant has more than a 29 percent permanent impairment of his right lower extremity.

FACTUAL HISTORY

On July 19, 1997 appellant, then a 51-year-old city carrier, injured his right leg in the performance of duty: "As I proceeded to next delivery, I descended slight incline of front lawn and felt something pop in my right leg on inside, midway between ankle and knee." A July 29, 1997 magnetic resonance imaging (MRI) scan of the right knee revealed large joint effusion, a complex tear of the posterior horn of the medial meniscus, a torn anterior cruciate ligament

(ACL) and bone bruises on the posterior aspect of the proximal tibia, medially greater than laterally. The lateral meniscus showed intrameniscal degenerative change within the posterior horn without definite evidence of a tear.

On August 8, 1997 Dr. David Lessing, appellant's internist, reported that the MRI scan revealed a multitude of findings, including osteoarthritic changes, a degenerative tear of the posterior horn of the medial meniscus, a deficient ACL and bone bruises, not all of which matched the clinical history of a "relatively traumatic event" that occurred while walking on the job. He stated that the cruciate injury was probably old but that the complex tear might have been extended at the time of the accident. Dr. Lessing added:

> "I think it is worth clarifying at this time that this gentleman may have had preexisting conditions present in the knee at the time of his work-related injury, but that the work-related injury did produce the knee that he currently has. The preexisting conditions were not preventing him from carrying out the duties of his job, but whatever it was that occurred at the time of his accident a few weeks ago has interfered with his capacity to perform. The most likely diagnosis is that he extended a complex tear or [sic] degenerative medial meniscal tear."

The Office accepted appellant's claim for aggravation of the right medial meniscal tear and authorized surgery.

Appellant had surgery on January 22, 1998. He was found to have a flap tear of the posterior horn of his medial meniscus and also a radial tear at the lateral portion of the lateral meniscus. His ACL was completely torn and scarred back against the posterior cruciate ligament. The surgeon performed a partial medial and lateral meniscectomy.

On February 26, 2001 appellant filed a claim for a schedule award. On October 19, 2001 Dr. John L. Hockberg, an orthopedist, reported that appellant had reached maximum medical improvement one year after surgery. He diagnosed chronic knee pain, quadriceps atrophy with weakness, chronic internal derangement with ACL instability, chronic synovitis of the knee, ongoing degenerative joint disease resulting from work-related repetitive trauma, and residual scar. Dr. Hockberg addressed appellant's pain and functional complaints:

> "Patient suffers pain but despite this, he is able to function. He has 'give way' complaints which is a result of the ACL injury. Patient has crepitus as a result of the internal derangement. Pain also reflects from recurrent synovitis and residual internal scar from arthrofibrosis. Patient also has 'give way' as a result of quadriceps weakness which is common with quadriceps inhibition reflex as a result of chronic pain in the right knee.
>
> "Patient's pain and weakness will interfere in extensive weakness, climbing and descending stairs (more so descending) which stresses his joint. Cold temperature will aggravate patient's symptomatology and he will have difficulty with squatting and arising from a squat."

Dr. Hochberg indicated that diagnosis-based estimates were best used for rating appellant's impairment, but he did not want to trivialize appellant's weakness or crepitus or

arthritis, which he stated should be considered in addition to pain. For partial medial and lateral meniscectomies, he gave four percent of the whole person. For moderate cruciate laxity, he added 7 percent, for a total of 11. For a three millimeter cartilage interval of the knee joint and a two millimeter cartilage interval of the patellofemoral joint, he added 3 and 4 percent respectively, for a total of 18. He continued: "I calculate in pain as 1 percent of the whole body and additionally the weakness in the quadriceps an additional ([T]able 17-8) 5 percent making the total 24 percent."

An Office medical adviser reported on September 29, 2002 that the underlying problem was osteoarthritis, and so appellant's schedule award should be based on the x-ray measurements of cartilage intervals. Using the measurements reported by Dr. Hochberg, the medical adviser calculated a 17 percent impairment of the right lower extremity due to arthritis. On October 31, 2002 that is what the Office awarded. An Office hearing representative set that decision aside on August 12, 2003 and remanded the case for acceptance of the torn cruciate ligament and for a supplemental report from an Office medical adviser.

On December 8, 2003 an Office medical adviser reported that he was in agreement with Dr. Hochberg's rating of 24 percent but noted that the physician had mixed up whole person and lower extremity impairments. The medical adviser gave 7 percent for moderate ACL laxity, 7 percent for the medial meniscus tear and 17 percent for osteoarthritis. He added: "I allowed the one percent for pain but all of the conditions rated obviously contribute to pain!" The combined value of these percentages came to 29 percent, which the Office awarded on December 16, 2003. On May 19, 2005 an Office hearing representative affirmed.

Following a remand from the Board for an incomplete case record,[1] the Office reissued its final decision on appellant's claim for a schedule award. In a decision dated February 7, 2006, the Office found that he had a 29 percent permanent impairment of his right lower extremity. The present appeal followed.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[2] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[3]

[1] Docket No. 05-1658 (issued December 5, 2005).

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001 the Office began using the A.M.A., *Guides* (5th ed. 2001).

ANALYSIS

Table 17-33, page 546, of the A.M.A., *Guides* states that a partial medial meniscectomy represents a two percent impairment of the lower extremity. A partial medial and lateral meniscectomy increases the impairment to 10 percent, but appellant is not entitled to a schedule award for his partial lateral meniscectomy. The Office did not accept that he tore his right lateral meniscus on July 19, 1997 when he walked down the slight incline of a front lawn and felt something pop midway between the ankle and knee of his right leg. No physician has explained how the July 19, 1997 incident could have caused such a tear.[4] Dr. Lessing, the attending internist, stated on August 8, 1997 that appellant might have had some preexisting conditions at the time of injury, but there is no evidence that appellant had a preexisting permanent impairment related to his lateral meniscus.[5] Indeed, the MRI scan taken 10 days after the injury reflected no tear at the lateral portion of the lateral meniscus. The tear first showed itself six months later, when appellant underwent surgery authorized to repair the accepted aggravation of the right medial meniscal tear. The Board therefore finds that appellant's schedule award properly includes a two percent impairment for a single partial meniscectomy.

Table 17-33 of the A.M.A., *Guides* states that moderate cruciate laxity, which Dr. Hochberg reported on October 19, 2001, represents a 17 percent impairment of the lower extremity.[6]

Dr. Hochberg reported a three millimeter cartilage interval of the knee joint, which is a seven percent impairment of the lower extremity under Table 17-31, page 544 of the A.M.A., *Guides*. He also reported a two millimeter cartilage interval of the patellofemoral joint, which is a 10 percent impairment under the same table. Using the Combined Values Chart on page 604, 7 percent combines with 10 percent for a 16 percent impairment due to arthritis.[7]

Dr. Hochberg rated an additional one percent of the whole body for pain, but Chapter 18 of the A.M.A., *Guides* cautions that examiners should not use that chapter to rate pain-related impairment for any condition that can be adequately rated on the basis of the body and organ

[4] A claimant seeking benefits under the Act has the burden of proof to establish the essential elements of his claim by the weight of the evidence, including that he sustained an injury in the performance of duty and that any specific condition or disability for work for which he claims compensation is causally related to that employment injury. *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[5] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.0700.3.a(3) (October 1990) (the percentage should include those conditions accepted by the Office as job-related and any preexisting permanent impairment of the same member or function).

[6] The Office medical adviser mistakenly used the whole person figure of seven percent. The Act does not authorize the payment of schedule awards for the permanent impairment of "the whole person." *Ernest P. Govednick*, 27 ECAB 77 (1975). Payment is authorized only for the permanent impairment of specified members, organs or functions of the body.

[7] In general, multiple impairments of a region should be combined for a regional extremity impairment. A.M.A., *Guides* 10. Because multiple arthritis impairments under Table 17-31, page 544, can exceed 100 percent when added, the Combined Values Chart on page 604 must be used to account for the effects of multiple impairments. *See generally id*. at 9.

impairment rating systems given in other chapters.[8] Because the impairment ratings in the body and organ system chapters already make allowance for any accompanying pain,[9] Dr. Hochberg would have to explain why the diagnosis-based estimates for cruciate laxity and partial meniscectomy, and particularly the arthritis estimates for the knee and patellofemoral joints, do not adequately describe appellant's impairment. Without a sound explanation, his opinion does not support an additional pain-related impairment.

Dr. Hochberg gave an additional five percent impairment for weakness in the quadriceps. According to the cross-usage chart (Table 17-2, page 526), impairment estimates for loss of muscle strength may not be used together with diagnosis-based estimates or estimates for arthritis.[10]

Dr. Hochberg's findings support that appellant has a 2 percent permanent impairment of the right lower extremity due to a partial medial meniscectomy, a 17 percent impairment due to moderate cruciate laxity and a 16 percent impairment due to arthritis of the knee and patellofemoral joints. These values combine[11] for a 32 percent total impairment of the right lower extremity, which is more than the Office calculated. The Board will therefore modify the Office's February 7, 2006 decision to reflect a 32 percent permanent impairment of the right lower extremity and will affirm that decision as modified. The Board will remand the case for payment of additional schedule compensation.

CONCLUSION

The Board finds that appellant has a 32 percent permanent impairment of his right lower extremity and is entitled to additional compensation.

[8] A.M.A., *Guides* 571.

[9] *Id*. at 20.

[10] The muscle strength method for evaluating a single impairment may be appropriately used only with limb length discrepancy, skin loss, vascular disorders or other muscle strength losses.

[11] Again, such values are not simply added together.

ORDER

IT IS HEREBY ORDERED THAT the February 7, 2006 decision of the Office of Workers' Compensation Programs is affirmed as modified. The case is remanded for further action consistent with this opinion.

Issued: December 4, 2006
Washington, DC

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

David S. Gerson, Judge
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James A. Haynes, Alternate Judge
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