United States Department of Labor
Employees' Compensation Appeals Board

M.M., Appellant	)	
and	)	**Docket No. 12-1737**
	)	**Issued: February 20, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Sioux City, IA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On August 9, 2012 appellant filed a timely appeal from the June 22, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP), which denied an increased schedule award. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 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 a 34 percent impairment of his right lower extremity causally related to his accepted right knee sprain or authorized arthroscopy.

FACTUAL HISTORY

On December 8, 1988 appellant, a 32-year-old director of human services, sustained a traumatic injury in the performance of duty when he leaned back in his chair and it broke. He felt pain in his lower back and right lower extremity.

[1] 5 U.S.C. § 8101 *et seq.*

OWCP accepted appellant's claim for lumbar strain and right knee sprain.[2] In 1989, it approved a right knee arthroscopy, debridement and abrasion arthroplasty of the femoral trochlea and removal of an osteophytic projection, inferior pole of the patella with parapatellar synovectomy. In 1990, appellant received a schedule award for a 34 percent impairment of his right lower extremity.[3] OWCP subsequently accepted left hip trochanteric bursitis.[4]

Dr. Anil K. Agarwal, a Board-certified orthopedic surgeon and OWCP referral physician, examined appellant in 1996 and reviewed his medical record. He noted that appellant had a very significant preexisting right knee injury. Dr. Agarwal found that the work injury in 1988 did not contribute in a significant way. He determined that appellant's moderate osteoarthritis was the result of the preexisting injury and that further arthroscopic debridement for arthritis would not be beneficial. Appellant nonetheless underwent a right knee debridement with partial medial meniscectomy, medial femoral condyle and patellofemoral debridement.

In 2003, appellant underwent a right knee arthroscopy, patellofemoral chondroplasty with arthrotomy and Unispacer uni-compartmental arthroplasty.

Appellant claimed an increased schedule award. In 2010, Dr. John W. Ellis, Board-certified in family medicine, evaluated appellant's impairment. He found a 69 percent combined diagnosis-based impairment of the right lower extremity due to a total knee replacement (59 percent), moderately severe laxity of the anterior cruciate ligament and moderate laxity of the medial collateral ligament (24 percent). Dr. Ellis found another six percent due to peripheral nerve impairment of the L5 and S1 spinal nerves. He combined this peripheral nerve impairment with the diagnosis-based impairment for a 71 percent total impairment of the right lower extremity.

An OWCP medical adviser noted that Dr. Ellis graded appellant's right knee replacement as a poor result without consistent findings on range of motion or instability to support such a grade. Further, the medical adviser observed that Dr. Ellis incorrectly combined two diagnosis-based impairments, one of which he derived from laxity findings never reported by any other evaluator.

[2] An examination on December 29, 1988 noted that appellant had experienced significant discomfort in the right knee as well as a popping and a click from time to time. It sometimes locked. These symptoms were noted to be very similar to an injury he had in 1977 when he tore his ligaments and ended up with surgery. The examination of "the left [sic] knee" showed some tenderness both medially and laterally but no bruising or swelling. The cruciates were found to be intact. Appellant was given a diagnosis of knee sprain and questionable meniscal tear. An examination on January 23, 1989 revealed no swelling or effusion. Appellant had full active knee extension and flexion beyond 90 degrees. There was minimal patellar tenderness and general tenderness around the joint but nothing very specific to the lateral joint line.

[3] This represented the combined impairment from a total medial meniscectomy, mild chondromalacia patella, loss of motion and moderate-to-severe and occasionally intense pain preventing activity.

[4] Appellant also received schedule awards for a total 20 percent impairment of his left lower extremity. He appeals his right lower extremity rating to the Board and argues that this case "specially deals with my right lower extremity."

In 2011, Dr. Michael J. Jung, Board-certified in family medicine, evaluated appellant's right lower extremity based on knee range of motion. He found a 45 percent impairment due to 88 degrees loss of flexion and 29 degrees flexion contracture. Dr. Jung found that the functional history net modifier was 2, representing a 10 percent add-on to the range of motion impairment. The total impairment due to loss of motion was therefore 49.5 percent.

Dr. Jung found a 34 percent diagnosis-based impairment due to a fair result from total knee replacement and a net adjustment of -1. Further, he found a 34 percent diagnosis-based impairment due to severe laxity in the cruciate and collateral ligament with a net adjustment of -1. Dr. Jung combined these diagnosis-based impairments for a total diagnosis-based impairment of 56 percent.

Dr. Jung explained that his earlier office notes indicating that appellant had a normal gait, full range of motion and no instability were generated on an electronic medical record during a routine medical examination for appellant's personal internal medical problems and not specifically directed at his musculoskeletal work injury. He stated that he did not review the defaulted program for the musculoskeletal examination and did not consider the documentation to be valid.

An OWCP medical adviser found that Dr. Jung's report on the right lower extremity did not contain all the proper elements. The medical adviser explained that diagnosis-based impairment could not be combined with range of motion impairment.

In 2012, Dr. Jung responded with an itemization of the medical reports and other communications he had reviewed. He noted that the medical reports documented severe cruciate and medial collateral ligament laxity. Dr. Jung noted that appellant's history showed very severe loss of motion, as well as internal derangement of the right knee with traumatic arthritis, aggravation of patellofemoral chondromalacia, tearing of the anterior cruciate ligament, right knee arthroscopy, debridement and abrasion arthroscopy of the femoral trachea and removal of an osteophytic projection, inferior pole of the patella with parapatellar synovectomy.

Dr. Jung classified appellant's total knee replacement as a poor result with a functional history grade modifier 2 (consistent antalgic limp, external brace) and a physical examination grade modifier 3 (history of serious instability with external and internal prosthetic stabilizers). He concluded that appellant's final right lower extremity impairment was 59 percent.

An OWCP medical adviser found that the rating of Dr. Jung had no relationship to the accepted condition for which a schedule award was issued.

On June 22, 2012 OWCP reviewed the merits of appellant's case and denied an additional schedule award.

On appeal, appellant explained his efforts to provide OWCP with the information it sought, but it seemed an OWCP medical adviser was going to find some error in his physician's report.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and the implementing regulations[6] set forth the number of weeks of compensation payable to employees who sustain permanent impairment from the loss, or loss of use, of scheduled members, organs or functions of the body. FECA, 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 OWCP.[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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) has been adopted by regulations as the appropriate standard for evaluating schedule losses.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9]

A claimant seeking compensation under FECA has the burden to establish the essential elements of his claim by the weight of the reliable, probative and substantial evidence.[10] A claimant seeking a schedule award under section 8107 therefore has the burden to establish that he sustained a permanent impairment of a scheduled member or function as a result of an injury sustained while in the performance of duty.[11]

ANALYSIS

Appellant injured his right knee at work on December 8, 1988 when the back of his chair broke. OWCP accepted his claim for right knee sprain. It did not accept chondromalacia patella or osteoarthritis or any aggravation thereof. Indeed, Dr. Agarwal, the referral orthopedic surgeon, found that appellant's moderate osteoarthritis in 1996 was the result of a very significant preexisting injury. The Board can find no evidence that OWCP authorized a medial meniscectomy or arthrotomy and uni-compartmental arthroplasty. OWCP did not authorize a total knee replacement. It accepted a sprain.

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[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

[8] 20 C.F.R. § 10.404; *Ronald R. Kraynak*, 53 ECAB 130 (2001).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010).

[10] *Nathaniel Milton*, 37 ECAB 712 (1986); *Joseph M. Whelan*, 20 ECAB 55 (1968) and cases cited therein.

[11] *See, e.g., Ernest P. Govednik*, 27 ECAB 77 (1975) (no medical evidence that the employment injury caused the claimant to have a permanent loss of use of a leg or any other member of the body specified in the schedule).

OWCP authorized arthroscopy in 1989, which entailed debridement and abrasion arthroplasty of the femoral trochlea, removal of an osteophytic projection at the inferior pole of the patella and parapatellar synovectomy.

Appellant's entitlement to a schedule award or an increased scheduled award depends on whether his 1988 knee sprain or 1989 arthroscopy caused a permanent impairment to his right lower extremity. The issue is not whether he has more than a 34 percent impairment of his right lower extremity regardless of cause or origin. The issue is whether appellant has more than a 34 percent impairment of his right lower extremity causally related to his accepted knee sprain or authorized arthroscopy.

Dr. Ellis, the family physician, found a 24 percent lower extremity impairment due to moderately severe laxity of the anterior cruciate ligament and moderate laxity of the medial collateral ligament. He did not make it clear whether the 1988 work injury caused this laxity. An OWCP medical adviser observed that no other evaluator had previously reported such laxity. Further, the 24 percent impairment attributed to laxity did not exceed the 34 percent impairment for which appellant previously received a schedule award. Dr. Ellis' rating for laxity does not support that appellant is entitled to an increased award.

Dr. Ellis' rating for total knee replacement and peripheral nerve impairment of the L5 and S1 spinal nerves appears to have no bearing on whether appellant's 1988 knee sprain or 1989 arthroscopy caused more than a 34 percent impairment of his right lower extremity.

Dr. Jung, a family physician, found a 34 percent lower extremity impairment due to severe cruciate and collateral ligament laxity. He did not indicate which cruciate or collateral ligament or explain why this laxity apparently worsened since the evaluation by Dr. Ellis' the previous year. Again, it is unclear whether the 1988 incident caused ligament laxity; and Dr. Jung offered no medical reasoning to support a causal relationship. Medical opinions unsupported by rationale are of little probative value.[12]

Further, Dr. Jung's 34 percent rating for ligament laxity does not exceed the 34 percent rating appellant previously received. It does not support that appellant is entitled to an increased award. Dr. Jung's rating for a total knee replacement does not support appellant's claim.

Dr. Jung found a 49.5 percent lower extremity impairment due to loss of right knee motion. He did not offer sound medical reasoning, however, to establish how this loss of motion was a result of appellant's right knee sprain on December 8, 1988 or his authorized arthroscopy in 1989. Moreover, under the sixth edition of the A.M.A., *Guides* diagnosis-based impairment is the primary method of evaluation for the lower extremity, with range of motion used as a physical examination adjustment factor. Range of motion is only used to determine actual impairment values when it is not possible otherwise to define impairment. Ratings based on range of motion cannot be combined with other approaches.[13] Dr. Jung did not adequately explain that it was not possible otherwise to rate appellant's impairment, it was improper for him

[12] *Ceferino L. Gonzales*, 32 ECAB 1591 (1981); *George Randolph Taylor*, 6 ECAB 968 (1954).

[13] A.M.A., *Guides* (6th ed. 2009).

both to use range of motion as an alternative method of evaluation and to combine that method with his diagnosis-based estimate.

In his 2012 evaluation, Dr. Jung referred to traumatic arthritis and aggravation of patellofemoral chondromalacia. OWCP did not accept that these medical conditions were causally related to the December 8, 1988 work injury. Dr. Jung also referred to a tearing of the anterior cruciate ligament, but he did not attempt to establish, through sound medical reasoning and documentary evidence, that this was the injury appellant sustained when the back of his chair broke on December 8, 1988.

Although Dr. Jung stated that medical reports documented severe cruciate and medial collateral laxity, he did not identify these reports or otherwise rebut an OWCP medical adviser's observation that no evaluator prior to Dr. Ellis in 2010 had reported such laxity findings. If appellant tore his anterior cruciate ligament on December 8, 1988 or otherwise suffered permanent cruciate or collateral ligament laxity as a result of leaning back in his chair that day, Dr. Jung has not pointed to any reasonably contemporaneous medical documentation to support such a view nor has he attempted to reconcile this view with the examination findings reported in the first month after the injury.

Appellant expressed his frustration with an OWCP medical adviser's review of the impairment evaluations; but the evaluations were indeed flawed, in part because the evaluators improperly attempted to combine impairments, a diagnosis-based impairment with another diagnosis-based impairment or with a range of motion impairment. Further, the impairment ratings provided are not well established to be causally related to the 1988 right knee sprain or 1989 arthroscopy. The physicians who provided the evaluations have not adequately addressed how the knee sprain or arthroscopy caused more than a 34 percent impairment of appellant's right lower extremity. Accordingly, the Board finds that he has not met his burden to establish that he is entitled to an increased schedule award. The Board will affirm OWCP's June 22, 2012 decision.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that the medical opinion evidence fails to establish that appellant has more than a 34 percent impairment of his right lower extremity causally related to his accepted right knee sprain or authorized arthroscopy.

ORDER

IT IS HEREBY ORDERED THAT the June 22, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 20, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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