

arthroscopic surgery.¹ He returned to part-time limited-duty employment on June 20, 1996 and to his regular full-time employment on July 19, 1996.²

On October 6, 2002 appellant filed a claim for a schedule award. He submitted a report dated July 11, 2002 from Dr. Nicholas P. Diamond, an osteopath. Regarding the left knee, Dr. Diamond stated:

“Examination reveals portal arthroscopy scars. There is crepitation noted. There is medial joint space tenderness noted. There is medial midline tenderness noted. Valgus stress test is positive. The claimant has difficulty performing kneeling and squatting. Range of motion reveals flexion-extension of 0-110/140 degrees with pain.

“Manual muscle strength testing reveals the biceps femoris and quadriceps femoris are graded 4/5 on the left.

“The gastrocnemius circumferential measurements reveal 41 cm [centimeters] on the right versus 39 cm on the left.”³

Dr. Diamond determined that appellant had a 12 percent impairment due to loss of motor strength of the left quadriceps according to Table 17-8 on page 532 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001). He opined that appellant had a 13 percent impairment due to left calf atrophy under Table 17-6 on page 530 of the A.M.A., *Guides*. Dr. Diamond combined the 13 percent impairment due to atrophy with the 12 percent impairment due to loss of strength to find a 23 percent lower extremity impairment. He then added an additional 3 percent impairment due to pain pursuant to Figure 18-1 on page 574 to find a total left lower extremity impairment of 26 percent. Dr. Diamond opined that appellant reached maximum medical improvement on July 11, 2002.

An Office medical adviser reviewed Dr. Diamond’s report on September 17, 2003. He concurred with Dr. Diamond’s finding that appellant had a 12 percent impairment due to motor weakness of the left quadriceps and a 3 percent additional impairment due to pain. The Office medical adviser noted that atrophy could not be separately calculated with the impairment for muscle weakness. He stated, “Since the [left] leg is not being used as much due to motor weakness calf atrophy is not unusual [and] is included” in the impairment determination. The Office medical adviser concluded that appellant had a 15 percent permanent impairment of the left lower extremity. The Office medical adviser opined that the date of maximum medical improvement was November 26, 1996.

¹ Appellant underwent a debridement of a torn medial meniscus and arthritis of the anterior femoral trochlea.

² Appellant sustained a recurrence of disability on October 3, 1996. He worked limited-duty employment beginning October 4, 1996 and resumed his regular employment on November 26, 1996.

³ Dr. Diamond also evaluated the impairment of appellant’s right elbow.

By decision dated September 23, 2003, the Office granted appellant a schedule award for a 15 percent permanent impairment of the left lower extremity. The period of the award ran for 43.2 weeks from November 26, 1996 to September 24, 1997.

Appellant, through his attorney, requested an oral hearing. Subsequent to the June 22, 2004 hearing, he submitted a report dated July 14, 2004 from Dr. David Weiss, an osteopath, who noted that the A.M.A., *Guides* generally prohibited combining loss of muscle strength and atrophy. Dr. Weiss stated:

“[Appellant’s] atrophy and motor strength deficits were in separate muscle groups. The strength deficit was noted in the thigh, while the atrophy was noted in the calf. Since this represented two distinct muscle groups, it seemed reasonable to combine the thigh deficit with the calf deficit.”

In a decision dated October 18, 2004, the Office hearing representative set aside the September 23, 2003 decision. She instructed the Office to obtain a supplemental report from the Office medical adviser regarding whether appellant had more than a 15 percent impairment of the left lower extremity.

On August 1, 2005 an Office medical adviser reviewed the evidence, including the July 14, 2004 report of Dr. Weiss. He found that Table 17-2 on page 526 of the A.M.A., *Guides* clearly prohibited combining atrophy and weakness. The Office medical adviser determined that appellant had a 15 percent impairment of the left lower extremity.

On August 15, 2005 the Office reissued its September 23, 2003 decision. Appellant, through his attorney, requested a hearing. At the hearing, held on March 28, 2006, he argued a conflict existed between the Office medical adviser and Dr. Diamond and Dr. Weiss. Appellant submitted a report dated March 30, 2006 from Dr. Diamond who stated that he agreed with Dr. Weiss that combining muscle strength deficits and atrophy “appear[ed] appropriate since the muscle strength deficit was in the quadriceps muscle, and the muscle atrophy was noted in the calf muscle.”

In a decision dated June 8, 2006, an Office hearing representative affirmed the August 15, 2005 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees’ Compensation Act,⁴ and its implementing federal regulation,⁵ set 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. However, the Act does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404.

claimants.⁶ Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001.⁷

In evaluating lower extremity impairments, Chapter 17 of the A.M.A., *Guides* notes that alternative methods exist by which impairment may be assessed: anatomic, functional or diagnosis-based estimates.⁸ The evaluator is directed to the cross-usage chart at Table 17-2 on page 526 to determine when the methods for evaluating impairment may be combined. The Office's procedure manual also provides, "Before finalizing any physical impairment calculation that requires the combination of evaluation factors, the [Office medical adviser] should verify the appropriateness of the combination in Table 17-2."⁹

In determining which evaluation method to follow, the A.M.A., *Guides* provide the following instruction:

"The evaluator's first step is to establish the diagnosis(es) and whether or not the individual has reached MMI [maximum medical improvement]. The next step is to identify each part of the lower extremity that might possibly warrant an impairment rating (pelvis, hip, thigh, *etc.*, down to the toes). Figure 17-10 lists potential methods for each lower extremity part. The evaluator determines whether ROM [range of motion] impairment or other regional impairments are present for each relevant part and records the impairment values in the appropriate locations on the worksheet. The selection of the most specific method(s) and the appropriate combination are later considerations.

"After all potentially impairment conditions have been identified and the correct ratings recorded, the evaluator should select the clinically most appropriate (*i.e.*, most specific) method(s) and record the estimated impairment for each. The *cross-usage chart* (Table 17-2) indicates which methods and resulting impairment ratings may be combined. It is the responsibility of the evaluating physician to explain why a particular method(s) to assign the impairment rating was chosen. When uncertain about which method to choose, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating."¹⁰ (Emphasis in the original.)

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, which provides a qualitative method for evaluating impairment due to chronic pain. If an individual appears to have a pain-

⁶ 20 C.F.R. § 10.404(a).

⁷ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

⁸ A.M.A., *Guides* 525.

⁹ *Supra* note 7.

¹⁰ *Supra* note 8 at 525-26.

related impairment that has increased the burden on his or her condition slightly, the examiner may increase the percentage up to three percent. However, examiners should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*.¹¹

It is well established that the period of a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the accepted employment injury. The determination of whether maximum medical improvement has been reached is based on the probative medical evidence of record, and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by the Office.¹² The Board has noted a reluctance to find a date of maximum medical improvement which is retroactive to the award, as retroactive awards often result in payment of less compensation benefits.¹³ The Board, therefore, requires persuasive proof of maximum medical improvement for selection of a retroactive date of maximum medical improvement.¹⁴

ANALYSIS

The Office accepted that on March 19, 1996 appellant sustained a torn medial meniscus to his left knee. On October 6, 2002 he filed a claim for a schedule award. In a report dated July 11, 2002, Dr. Diamond described findings of medial tenderness and a positive valgus stress test on examination. On manual muscle strength testing, he determined that appellant had weakness in knee extension due to loss of muscle strength of the quadriceps of 4/5, which he determined constituted a 12 percent impairment.¹⁵ Dr. Diamond also found that his gastrocnemius circumference was 41 centimeters on the right and 39 centimeters on the left, which he found yielded a 13 percent impairment on the left due to calf atrophy.¹⁶ He combined the impairments due to atrophy and loss of strength to find a left lower extremity impairment of 23 percent. Under the A.M.A., *Guides*, however, an impairment due to atrophy cannot be combined with an impairment due to muscle weakness.¹⁷ Dr. Diamond also found that appellant had an additional three percent impairment due to pain according to Figure 18-1 on page 574 of the A.M.A., *Guides*. The Board notes, however, that examiners should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*.¹⁸

¹¹ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003); A.M.A., *Guides* at 18.3(b); see also *Philip Norulak*, 55 ECAB 690 (2004).

¹² *Mark A. Holloway*, 55 ECAB 321 (2004).

¹³ *James E. Earle*, 51 ECAB 567 (2000).

¹⁴ *Id.*

¹⁵ A.M.A., *Guides* 532, Table 17-8.

¹⁶ *Id.* at 530, Table 17-6.

¹⁷ *Id.* at 530, section 17-2d; see also *Philip A. Norulak*, *supra* note 11.

¹⁸ See *supra* note 7; A.M.A., *Guides* at 18.3(b); see also *Philip Norulak*, *supra* note 11.

Dr. Diamond did not explain why appellant's condition could not be adequately rated under Chapter 17 relevant to lower extremity impairments.

The Office medical adviser, in reports dated September 17, 2003 and August 1, 2005, reviewed Dr. Diamond's findings. He properly determined that Table 17-2 on page 526 of the A.M.A., *Guides* prohibited combining impairments due to both atrophy and muscle weakness. The Office medical adviser concurred with Dr. Diamond's finding that appellant had a 12 percent impairment due to motor weakness according to Table 17-8 on page 532 of the A.M.A., *Guides*. He explained that the impairment for atrophy was included in the impairment for muscle weakness. The Office medical adviser also added a 3 percent impairment for pain under Chapter 18 to find a total left lower extremity impairment of 15 percent. As discussed above, however, he did not address why appellant's condition could not be adequately rated under Chapter 17 relevant to lower extremity impairments. The Board thus finds that the evidence supports that appellant has only a 12 percent permanent impairment of the left lower extremity. Consequently, he has not established entitlement to a schedule award greater than the 15 percent awarded by the Office.

On appeal, appellant's attorney contends that a conflict exists between the Office medical adviser and Dr. Diamond and Dr. Weiss, appellant's physicians. Counsel asserts that Dr. Diamond and Dr. Weiss explained that the impairment ratings for atrophy and muscle weakness were for different muscle groups and could therefore be combined. Dr. Diamond and Dr. Weiss opined that the impairments for atrophy and muscle weakness could properly be combined because the atrophy was of the calf and the muscle weakness of the quadriceps, or knee. The A.M.A., *Guides* provides that a physician should identify each part of the lower extremity that might have an impairment rating from the pelvis to the toes.¹⁹ Figure 17-10 lists the possible methods for determining an impairment of each part of the lower extremity.²⁰ After each impairment rating is calculated, the physician selects the most appropriate and consults the cross-usage chart to determine which methods and impairment ratings can be combined.²¹ The example provided at the end of Chapter 17 illustrates that, while an impairment can be separately calculated for the thigh and the calf, methods which cannot be combined under the cross-usage chart are not combined when calculating the final impairment percentage of the lower extremity as a whole.²² The examiner is to select the method that most accurately reflects the impairment.²³

It is well established that the period of a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the accepted employment injury. The determination of whether maximum medical improvement has been reached is based on the probative medical evidence of record, and is usually considered to be the

¹⁹ A.M.A., *Guides* 525.

²⁰ *Id.* at 561, Figure 17-10.

²¹ *Id.* at 526, Table 17-2.

²² *Id.* at 562-63, Box 17-1.

²³ *Id.* at 525-26.

date of the evaluation by the attending physician which is accepted as definitive by the Office.²⁴ The Board has noted a reluctance to find a date of maximum medical improvement which is retroactive to the award, as retroactive awards often result in payment of less compensation benefits.²⁵ The Board, therefore, requires persuasive proof of maximum medical improvement for selection of a retroactive date of maximum medical improvement.²⁶ Dr. Diamond found that the date of maximum medical improvement was July 11, 2002. The Office medical adviser found that appellant reached maximum medical improvement on November 26, 1996. He did not provide adequate rationale for his finding and thus did not present the persuasive proof necessary to support a retroactive date of maximum medical improvement. The Board, therefore, finds that the period of the schedule award should commence on July 11, 2002, the date of the evaluation by Dr. Diamond upon which the Office based its schedule award determination. The case will be remanded for the Office to determine whether the change in the date of commencement of the schedule award changes the pay rate applicable to the schedule award.

CONCLUSION

The Board finds that appellant has no more than a 15 percent permanent impairment of the left lower extremity. The Board further finds that the case must be remanded to change the date the schedule award begins and to determine whether the change alters the pay rate.

²⁴ *Mark A. Holloway*, *supra* note 12.

²⁵ *James E. Earle*, 51 ECAB 567 (2000).

²⁶ *Id.*

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 8, 2006 is affirmed in part and set aside in part and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: May 31, 2007
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