United States Department of Labor
Employees' Compensation Appeals Board

M.D., Appellant	)	
and	)	**Docket No. 13-1561**
	)	**Issued: November 22, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Conway, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq. for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On June 19, 2013 appellant, through his attorney, filed a timely appeal from the June 10, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of this case.

ISSUE

The issue is whether appellant has more than a 25 percent impairment of his left lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On January 8, 2010 appellant, a 52-year-old regular carrier, sustained a traumatic injury in the performance of duty when he hyperextended his left knee while walking up some snowy

[1] 5 U.S.C. § 8101 *et seq.*

steps. OWCP accepted his claim for left knee sprain and, later, for acceleration of preexisting left knee osteoarthritis.

OWCP authorized a left total knee replacement, which was performed on January 13, 2011. Dr. Andrew S. Kaye, the Board-certified orthopedic surgeon, saw appellant on January 24, 2011 and noted 0 to 110 degrees of motion and no instability. On May 18, 2011 Dr. Kaye found a little bit of laxity medially and laterally, "but certainly he has got stability." There was no anterior or posterior instability. Dr. Kaye did not feel any give on rotation, but in full extension appellant had a millimeter or two of give medially and laterally, though it was equal. Motion was 0 to 120 degrees.

On June 20, 2011 Dr. Kaye noted 0 to 130 degrees of motion. He did not feel any instability at 0 to 30 degrees of flexion and extension. Dr. Kaye saw no signs of loosening or abnormality from x-rays obtained that day. He offered much the same findings on August 26 and December 12, 2011.

On September 11, 2012 appellant saw Dr. Richard L. McGough III, a Board-certified orthopedic surgeon with associate professor status who took over appellant's care. Dr. McGough found "a lot of sagittal instability." Radiographic examination of plain films showed a perfectly seated knee. Dr. McGough diagnosed flexion instability. On October 11, 2012 he clarified that appellant's diagnosis was failed knee arthroplasty. Appellant had perfect alignment of his components, but his knee was too loose in flexion, moving abnormally when he walked. By "a lot of sagittal motion," Dr. McGough meant that when he pulled appellant's knee forward, it moved to an abnormal degree. "This is one cause of pain and disability in a patient with a knee that looks perfect on radiographs, and can only be remedied by revision surgery. It was not tested by [other physicians] as per the notes."

On December 3, 2012 Dr. McGough found that appellant was "grossly loose in flexion."

Dr. S. Joshua Szabo, a Board-certified orthopedic surgeon and OWCP second opinion physician, examined appellant on December 20, 2012. He found the left knee to be well aligned with motion from 0 to 120 degrees. Anterior drawer did not demonstrate significant excursion. Dr. Szabo stated: "It is Dr. McGough's belief that [appellant's] present symptoms are due to flexion instability of his present knee arthroplasty however by subjective history and objective findings, I am unable to support this finding."

Dr. McGough examined appellant on February 4, 2013. On physical examination he stated he could sublux appellant's knee anteriorly at least 12 to 14 millimeters. Dr. McGough diagnosed mid flexion instability and told appellant that he thought his knee was too loose in flexion and was causing a lot of his symptoms.

In an April 8, 2013 narrative report, Dr. McGough noted that appellant had complained of a sensation of instability, and upon evaluation, he felt that appellant did have a substantial amount of instability in his prosthetic.

> "Since that point in time [appellant] has had multiple other evaluations of his knee, and some of his examiners have been able to find this instability, some have not. In examining him by sagittal motion I can nearly dislocate his knee, I think

that it is substantially loose in flexion. … I noted that many of the secondary examiners did not choose to perform this exam[ination].”

* * *

“In my most recent physical examination which was dated [February 4, 2013] I noted that I could sublux him anteriorly approximately 12 [to] 14 millimeters -- this is far looser than one should have, and would produce a knee that has the anterior pain and instability that he describes as he puts undue tension on his patellofemoral mechanism.”

In examining appellant’s knee currently, Dr. McGough found to a reasonable degree of medical certainty that “this is a knee that is too loose in flexion” and would benefit from revision surgery.

Appellant filed a schedule award claim. He submitted an April 25, 2013 impairment evaluation from Dr. Michael J. Platto, a Board-certified physiatrist, who related appellant’s history and complaints. Findings on physical examination included left knee flexion to 113 degrees and extension lacking 8 degrees. It was Dr. Platto’s opinion that under Table 16-3, page 511 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009), the most appropriate classification for appellant’s left total knee replacement was class 3 or a fair result from his total knee replacement: fair position, mild instability and/or mild motion deficit. This gave appellant a default impairment rating of 37 percent for his left lower extremity. Dr. Platto reduced the rating to 31 percent, given appellant’s moderate functional history and moderate physical examination.

On the issue of preexisting conditions, Dr. Platto noted that appellant did mention left ankle pain and arthritis. An x-ray on April 26, 2013 showed an ankle joint space interval of greater than three millimeters. “These mild findings on x-ray would not meet any of the criteria for receiving an impairment according to Table 16-2, page 506, *i.e.*, there is no evidence of impingement, full-thickness articular cartilage defect, cystic changes, focal area of avascular necrosis or ununited osteochondral fracture.” Dr. Platto concluded that appellant’s final impairment rating remained at 31 percent for the left leg.

On May 8, 2013 Dr. Arnold T. Berman, a Board-certified orthopedic surgeon and OWCP medical adviser, reviewed the record to determine whether Dr. Platto’s rating was in accordance with the A.M.A., *Guides*. He noted that Dr. Kaye, the operating surgeon, found full range of motion and no instability on December 12, 2011. On the basis of that examination, therefore, appellant’s total knee replacement fell into class 2, or a good result with good position, stability and function. Dr. Berman found Dr. Platto’s class 3 rating for a fair result to be incorrect: “indicating that it was a fair result rather than a good result with fair position, which is incorrect, mild instability, which according to his treating physician, is incorrect, and mild motion deficit is also incorrect since it was documented that he had 120 degrees of flexion by his treating physician.” The medical adviser concluded that appellant had a final impairment rating of 25 percent.

On June 10, 2013 OWCP granted appellant a schedule award for a 25 percent impairment of his left lower extremity.

On appeal appellant's representative argues two errors. First, the medical adviser used Dr. Kaye's out-of-date findings from 2011 instead of Dr. Platto's more recent findings. He stated that Dr. Kaye's later reports documented the deterioration of appellant's condition. Second, although it did not appear to change the rating, the medical adviser did not consider appellant's preexisting ankle condition.

LEGAL PRECEDENT

The schedule award provisions of FECA[2] and the implementing regulations[3] set forth the number of weeks of compensation payable to employees who sustain permanent impairment of a scheduled member, function or organ 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.[4]

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. OWCP has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[5] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[6]

If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[7]

ANALYSIS

Diagnosis-based impairment is the primary method of evaluating the lower limb. Impairment is determined first by identifying the relevant diagnosis, then by selecting the class of the impairment: no objective problem, mild problem, moderate problem, severe problem, very severe problem approaching total function loss. This provides a default impairment rating,

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

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

[5] 20 C.F.R. § 10.404; *Ronald R. Kraynak*, 53 ECAB 130 (2001).

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

[7] 5 U.S.C. § 8123(a).

which can be adjusted slightly up or down using grade modifiers or nonkey factors, such as functional history, physical examination and clinical studies.[8]

The impairment values for a total knee replacement are found in Table 16-3, page 511 of the A.M.A., *Guides* or the Knee Regional Grid. A good result -- good position, stable, functional -- has a default impairment value of 25 percent. A fair result -- fair position, mild instability and/or mild motion deficit -- has a default impairment value of 37 percent.

The proper classification of appellant's left total knee replacement thus depends on how the medical evidence documents position, stability and motion following the January 13, 2011 surgery. Dr. Berman reviewed the record and relied on the findings of Dr. Kaye, the operating orthopedic surgeon, who found no instability on December 12, 2011. Nine months later, Dr. McGough, the treating orthopedic surgeon, found sagittal instability. When he pulled appellant's knee forward, a maneuver other physicians did not perform, it moved to an abnormal degree. On December 3, 2012 Dr. McGough found that appellant's knee was grossly loose in flexion.

Dr. Szabo, the orthopedic surgeon and OWCP second opinion physician, examined appellant on December 20, 2012. He was unable to support Dr. McGough's findings of flexion instability. An anterior drawer pull did not demonstrate significant excursion.

Dr. McGough reexamined appellant on February 4, 2013 and found that he could sublux appellant's knee anteriorly at least 12 to 14 millimeters. On April 8, 2013 he explained that he could almost dislocate appellant's left knee with sagittal motion. Appellant's prosthetic, he found, was far looser than one should have and was consistent with appellant's complaint of anterior pain and instability.

The Board finds a conflict in medical opinion, pursuant to 5 U.S.C. § 8123(a), between Dr. McGough and Dr. Szabo on the extent of any instability following appellant's left total knee replacement. There is also a conflict between Dr. Platto, appellant's Board-certified physiatrist, and Dr. Szabo on the extent of any loss of motion. Consistent with the findings of other physicians, Dr. Szabo found full range of motion. Dr. Platto, however, found extension lacking eight degrees. As the extent of any instability and the extent of any motion deficit directly bear on the proper classification of appellant's surgical result under Table 16-3 of the A.M.A., *Guides*,[9] the Board will set aside OWCP's June 10, 2013 decision and remand the case for an impartial medical evaluation to resolve the conflict.

Following such further development of the evidence as may be necessary, OWCP shall issue a *de novo* decision on appellant's schedule award claim.

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[8] A.M.A., *Guides* 497 (6th ed. 2009).

[9] There is no conflict on the positioning of appellant's prosthetic, which all agree is good.

CONCLUSION

The Board finds that this case is not in posture for decision. Referral to an impartial medical specialist, pursuant to 5 U.S.C. § 8123(a), is warranted to resolve a conflict on the extent of any instability and motion deficit in appellant's left knee.

ORDER

IT IS HEREBY ORDERED THAT the June 10, 2013 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this decision of the Board.

Issued: November 22, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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