

FACTUAL HISTORY

The Office accepted that, on July 10, 1990, appellant, then a 57-year-old claims and inquiry clerk, sustained a left knee strain in the performance of duty with consequential aggravation of degenerative joint disease of the right knee and a tear of the posterior horn of the medial meniscus of the right knee.² She underwent left knee arthroscopy on October 30, 1990 which revealed severe degenerative osteoarthritis. On April 2, 1991 Dr. Edward A. Lember, an attending Board-certified orthopedic surgeon, performed a right medial meniscus repair and valgus osteotomy. Appellant returned to regular duty in late 1991.

On April 1, 1993 appellant claimed a schedule award. In support of her claim, she submitted an April 26, 1993 report from Dr. Lember noting chronic pain and swelling in the left knee, “giving out,” a left-sided antalgic limp, slight valgus deformity and flexion limited to 130 degrees. He opined that appellant had reached maximum medical improvement. Based on Dr. Lember’s reports, on July 20, 1993 an Office medical adviser found that appellant had a 28 percent permanent impairment of the left lower extremity according to the third edition (revised) of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*): 8 percent for pain and 8 percent for restricted motion, combined with 10 percent for osteoarthritis and 5 percent for partial medial meniscectomy. The Office issued a schedule award on February 2, 1994 for a 28 percent permanent impairment of the left lower extremity.

The record indicates that the Office accepted a September 20, 1996 recurrence of disability due to locking and instability of the left knee. Appellant retired from postal employment in late 1996. She continued to require medical care for bilateral knee conditions.

In a March 4, 1999 report, Dr. Troy H. Smith, an attending Board-certified orthopedic surgeon, diagnosed a tear of the right medial meniscus “secondary to her injury of July 10, 1990 ... due to her having to favor the left knee because of” the accepted injury. On June 17, 1999 Dr. Smith performed an arthroscopic partial medial meniscectomy and chondroplasty of the medial femoral condyle.³ He submitted periodic progress notes through August 1999.

Appellant was then treated by Dr. Malcolm E. Ghazal, a Board-certified orthopedic surgeon. In a November 10, 1999 report, Dr. Ghazal diagnosed severe end-stage osteoarthritis and synovitis of both knees. Dr. Ghazal performed a total right knee arthroplasty on December 28, 1999 with lateral retinacular release and complete synovectomy. On May 9, 2000 he performed a total left knee arthroplasty with lateral retinacular release and removal of hardware from the April 1991 osteotomy.

² The record contains reports from August 1999 to September 2001 pertaining to bilateral carpal tunnel syndrome, lumbar stenosis, neck and bilateral shoulder pain. There are no claims, of Office decisions, for these conditions before the Board on the present appeal.

³ The right knee arthroscopy was authorized by the Office.

On May 23, 2001 appellant claimed an additional schedule award and submitted new medical evidence.⁴ In a July 30, 2001 report, Dr. Ghazal found that appellant had reached maximum medical improvement. He noted a bilateral loss of flexion of 10 degrees and a 25 percent loss of strength. A November 30, 2001 report prepared by Nurse Practitioner Kenneth Bangs and signed by Dr. Ghazal, noted bilateral knee pain, a left-sided limp, bilateral weakness and atrophy, flexion restricted to 110 degrees bilaterally, sensory alterations with hyposthesia and an unspecified functional loss.

In a February 20, 2002 report, an Office medical adviser reviewed the medical record and concurred that appellant had reached maximum medical improvement. He opined that the bilateral total knee arthroplasties constituted a 37 percent permanent impairment of each lower extremity according to the fifth edition of the A.M.A., *Guides*. The medical adviser explained that Table 17-35, page 549, entitled “Rating Knee Replacement Results,” provided point rating scales for pain, reduced range of motion and instability, with deductions for flexion contracture, extension lag or misalignment. He found that appellant’s pain was mild or occasional, equaling 45 points, “no instability for zero points” and 25 points for limited range of motion at 0 to 125 degrees bilaterally. There were no deductions for contractures, extension lag or misalignment. The medical adviser then added the points to equal “95 points which would be considered a ‘Good Result,’ as per Table 17-33, page 547, or a 37 percent impairment of each lower extremity or leg.”⁵ The medical adviser noted that both arthroplasties appeared work related.⁶

By decision dated March 25, 2002, the Office issued appellant a schedule award for a 37 percent permanent impairment of the left and right lower extremities, a 9 percent increase over the 28 percent previously awarded for the left lower extremity and a new award for the right lower extremity.⁷ Appellant then requested an oral hearing, held January 14, 2003. At the hearing, she described constant pain and significant difficulty in walking. She alleged that pain medications masked her symptoms and made her physicians believe she was more functional than she actually was. Following the hearing, appellant submitted a February 10, 2003 letter reiterating her assertions.⁸

By decision dated and finalized April 7, 2003, an Office hearing representative affirmed the March 25, 2002 decision, finding that the Office medical adviser’s February 20, 2002 report

⁴ In a June 13, 2001 report, Dr. Ahsan K. Bajwa, an attending Board-certified neurologist, diagnosed peripheral neuropathy of an unspecified lower extremity with “severe pain with difficulty walking.”

⁵ Table 17-33, page 547 of the A.M.A., *Guides* (5th ed.) entitled “Impairment Estimates for Certain Lower Extremity Impairments” provides that a “good” result for a total knee replacement was equivalent to 85 to 100 points or a 37 percent impairment of the lower, and that a “fair” result was equivalent to 50 to 84 points or a 50 percent impairment of the lower extremity according to Table 17-35.

⁶ Dr. Ghazal submitted a February 28, 2002 report noting left knee pain with radiation into the groin and tibia. Dr. Ghazal did not offer an alternative schedule award calculation.

⁷ The schedule award was equivalent to 132.48 weeks of compensation, with the period of award running from July 30, 2001 to February 12, 2004.

⁸ At the hearing and in the February 10, 2003 letter, appellant requested that the Office approve additional treatment by Dr. Ghazal as an attending physician. In a March 6, 2003 letter, the Office authorized continued treatment by Dr Ghazal.

continued to represent the weight of the medical evidence. The hearing representative noted that the Office medical adviser “utilized the data provided by the physicians of record ... explained how he arrived at his rating and how he used the A.M.A., *Guides*.” The hearing representative found that appellant did not submit medical evidence demonstrating a greater percentage of impairment.

LEGAL PRECEDENT

An employee seeking compensation under the Federal Employees’ Compensation Act⁹ has the burden of establishing the essential elements of her claim by the weight of the reliable, probative and substantial evidence.¹⁰

The schedule award provision of the Act¹¹ and its implementing regulation¹² 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. The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants.¹³ The Office has adopted the A.M.A., *Guides* as the appropriate standard for evaluating scheduled losses. As of February 1, 2001, all new schedule awards are based on the fifth edition of the A.M.A., *Guides*.¹⁴

ANALYSIS

In this case, the Office issued an April 7, 2003 decision denying appellant’s request for an increased schedule award beyond the 37 percent awarded for each lower extremity on March 25, 2002. The Office found that the February 20, 2002 report of an Office medical adviser, finding a 37 percent impairment of each lower extremity based on the fifth edition of the A.M.A., *Guides*, continued to represent the weight of the medical evidence. The Board finds, however, that the February 20, 2002 report contains a significant error.

In his February 20, 2002 report, the Office medical adviser referred to Table 17-35 at page 549 of the A.M.A., *Guides*, entitled “Rating Knee Replacement Results.” This table provides a range of points to be applied for pain, loss of motion and instability, with deductions for contractures, extension lag or malalignment. The medical adviser noted 45 points for pain and 25 points for restricted motion. He stated that there were no points indicated for instability and no applicable deductions. Thus, the Office medical adviser’s calculations support a result of

⁹ 5 U.S.C. §§ 8101-8193.

¹⁰ *Gary J. Watling*, 52 ECAB 278 (2001).

¹¹ 5 U.S.C. § 8107.

¹² 20 C.F.R. § 10.404 (1999).

¹³ *Rose V. Ford*, 55 ECAB ____ (Docket No. 04-15, issued April 6, 2004).

¹⁴ *Id.* See FECA Bulletin 01-05 (issued January 29, 2001).

70 points. According to Table 17-33 at page 547 of the A.M.A., *Guides*, 70 points constituted a “fair” result equal to a 50 percent impairment of the lower extremity. However, the medical adviser stated that he arrived at a total of “95 points which would be considered a ‘Good Result,’ as per Table 17-33 ... or a 37 percent impairment of each lower extremity or leg.” The Board finds that the discrepancy between the 70 point and 95 point totals and the 37 percent and 50 percent impairment ratings they support must be resolved by remanding the case for additional medical development.

On remand of the case, the Office shall request that the Office medical adviser provide a supplemental report clarifying his February 20, 2002 calculations. The medical adviser shall be instructed to provide a detailed schedule award calculation according to the appropriate tables and grading schemes of the fifth edition of the A.M.A., *Guides*, specifying the appropriate percentage of permanent impairment for each lower extremity. Following this and any other development deemed necessary, the Office shall issue an appropriate decision in the case.

CONCLUSION

The Board finds that the case is not in posture for a decision as the case requires further development regarding the correct percentage of permanent impairment of the right and left lower extremities.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers’ Compensation Programs dated April 7, 2003 is set aside and the case remanded for further development consistent with this opinion.

Issued: July 26, 2004
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member