

claim for left knee strain and a torn lateral meniscus. Appellant underwent knee surgery to repair a torn meniscus on May 19, 1970. He had repeat surgery on February 7, 1978, October 18, 1984 and July 5, 1990.

By decision dated April 12, 1971, the Office granted appellant a schedule award for 15 percent permanent impairment of the left lower extremity. On December 20, 1971 a hearing representative granted him an award for an additional five percent lower extremity impairment.

In a decision dated October 22, 1985, the Office granted appellant a schedule award for an additional 21 percent permanent impairment of the left leg, for a total lower extremity impairment of 41 percent.

Appellant returned to work for four hours per day with restrictions on March 30, 1997.² He retired on December 31, 2007. On March 12, 2008 the Office accepted that appellant sustained a recurrence of disability on November 24, 2007. On March 31, 2008 appellant filed a claim for a schedule award.

In a report dated March 28, 2008, Dr. George A. Pugh, a Board-certified orthopedic surgeon, noted that appellant had a history of medial and lateral meniscectomies. He found full knee extension, flexion of 112 to 120 degrees, one-quarter inch of quadriceps atrophy and seven-eighths of an inch of calf atrophy. Dr. Pugh related that x-rays of the knee showed that appellant was “entirely bone on bone in the lateral compartment of the knee.” Applying the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001) (A.M.A., *Guides*), he stated:

“Obviously the most accurate way to rate his knee would be related to the arthritis table which is found on page 544. This is [T]able 17-31. Since he is utterly bone on bone in the lateral compartment, this is considered a 20 percent whole person impairment, by looking under knee in the left hand column and going all the way to the right hand column under zero [millimeters]. I would then turn to [T]able 17-2 and note that the arthritis cannot be combined with muscle atrophy or range of motion. Hence, his loss of flexion and his thigh and calf atrophy become not relevant.

“Therefore, I would consider him to have a 20 percent whole person impairment of his left knee, related to his having gone on to develop severe symptomatic arthritis.”

On April 21, 2008 the Office referred appellant to Dr. Aubrey A. Swartz, a Board-certified orthopedic surgeon, for a second opinion examination regarding the extent of his employment-related impairment. In a report dated May 19, 2008, Dr. Swartz measured thigh circumference as 54 centimeters on the right and 52 centimeters on the left and calf circumference as 38 centimeters on the right and 36.5 centimeters on the left. He measured

² In decisions dated August 7, 2003 and August 10, 2004, the Office found that appellant had not established that he sustained a recurrence of disability beginning June 11, 2003. By decision dated November 3, 2004, it denied his request for further merit review under section 8128.

range of motion of the left knee as 0 to 125 degrees with quadriceps strength of 5/5. Dr. Swartz found no tenderness, swelling or effusion or instability of the left knee. He diagnosed post-traumatic left knee arthritis due to appellant's October 23, 1970 employment injury. Dr. Swartz found that x-rays showed advanced osteoarthritis. In an attached form, he noted that appellant complained of knee pain in the uncomfortable range, had a history of a meniscectomy and had bone on bone loss of shock absorption of the left knee.

On June 14, 2008 an Office medical adviser reviewed the March 28, 2008 report from Dr. Pugh and the May 19, 2008 report from Dr. Swartz. He found that appellant had eight percent impairment due to left thigh atrophy of 2 centimeters and six percent impairment due to left calf atrophy of 1.5 centimeters according to Table 17-6 on page 530 of the A.M.A., *Guides*. The Office medical adviser recommended, however, evaluating the impairment using Table 17-31 on page 544 of the A.M.A., *Guides*, relevant to determining impairments due to arthritis, as that yielded the greater award. He stated, "Dr. Pugh's report does document bone-on-bone contact involving the lateral compartment of the left knee, and this would be assessed a 50 percent lower extremity impairment (which is equivalent to 20 percent whole person impairment). No other value would be combined with this." The Office medical adviser found that appellant reached maximum medical improvement on March 28, 2008.

By decision dated June 27, 2008, the Office determined that appellant was entitled to a schedule award for additional 15 percent permanent impairment of the left lower extremity. It determined that his total left lower extremity impairment was 50 percent. The Office subtracted 35 percent, the amount it found previously paid, in finding that he was entitled to an award for an additional 15 percent.³ The period of the award ran for 43.20 weeks from March 28, 2008 to January 24, 2009.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,⁴ and its implementing federal regulations,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* (5th ed. 2001) as the uniform standard applicable to all 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

³ The Board notes that it appears from the record that appellant previously received prior schedule award for a 41 percent permanent impairment rather than a 35 percent permanent impairment of the left lower extremity.

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404.

⁶ *Id.* at § 10.404(a).

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

Where a claimant has previously received a schedule award and subsequently claims an additional schedule award due to a worsening of his or her condition, the claimant bears the burden of proof to establish a greater impairment causally related to the employment injury.⁸

ANALYSIS

The Office accepted that appellant sustained a left knee strain and a torn lateral meniscus due to a January 23, 1970 employment injury. Appellant underwent multiple knee surgeries on May 19, 1970, February 7, 1978, October 18, 1984 and July 5, 1990. By decision dated April 12, 1971, the Office granted him a schedule award for a 15 percent permanent impairment of the left lower extremity. On December 20, 1971 it increased the schedule award by five percent. In a decision dated October 22, 1985, the Office granted appellant a schedule award for an additional 21 percent left lower extremity impairment, for a total impairment of 41 percent.

On March 31, 2008 appellant filed a claim for an increased schedule award. In a March 28, 2008 impairment evaluation, Dr. Pugh discussed his history of medial and lateral meniscectomies. He measured flexion of 112 to 120 degrees and found quadriceps atrophy of one-quarter inch and calf atrophy of seven-eighths of an inch. Dr. Pugh determined that x-rays revealed zero millimeters of cartilage interval in appellant's knee. Utilizing Table 17-31 on page 544 of the A.M.A., *Guides*, he found that zero millimeters of cartilage interval by x-rays constituted 20 percent whole person impairment due to knee arthritis. The Act, however, does not provide for impairment of the whole person.⁹

The Office referred appellant to Dr. Swartz for a second opinion evaluation. In a report dated May 19, 2008, Dr. Swartz diagnosed post-traumatic left knee arthritis causally related to the January 23, 1970 work injury. He found that appellant had two centimeters less of thigh circumference and one and a half centimeters less of calf circumference on the left side. Dr. Swartz found quadriceps strength of 5/5 and range of motion from 0 to 125 degrees. He noted that x-rays revealed advanced osteoarthritis, and listed impairment factors of knee pain, a history of a meniscectomy and bone-on-bone loss of shock absorption of the left knee.

An Office medical adviser reviewed the reports of Dr. Pugh and Dr. Swartz. He determined that appellant's impairment should be evaluated under Table 17-31 relevant to arthritis as that would yield the greatest award. The medical adviser concurred with Dr. Pugh's finding of bone-on-bone contact in the lateral left knee, which he found constituted 50 percent lower extremity impairment.¹⁰ The Office determined that appellant's impairment due to arthritis could not be combined with any other impairment and thus concluded that he had a total lower extremity impairment of 50 percent.

⁸ *Edward W. Spohr*, 54 ECAB 806 (2003).

⁹ 5 U.S.C. § 8107(c); *Tania R. Keka*, 55 ECAB 354 (2004).

¹⁰ A.M.A., *Guides* 544, Table 17-31.

The A.M.A., *Guides* lists 13 methods to assess lower extremity impairment. These methods fall into three basic categories: (1) anatomic impairment, including atrophy, arthritis and nerve injury; (2) functional impairment, including range of motion and muscle strength; and (3) diagnosis-based impairment, including fractures and meniscectomies.¹¹ Many of these methods, however, may not be used together for evaluating a single impairment. The A.M.A., *Guides* provides a cross-usage chart at Table 17-2 showing which combinations are allowed and which are prohibited.¹² Table 17-2 prohibits the combination of an impairment due to arthritis with gait derangement, muscle atrophy, strength and range of motion/ankylosis. An impairment due to arthritis, however, may be combined with impairments due to diagnosis-based impairments, including meniscectomies.¹³ Appellant underwent multiple left knee surgeries, including lateral and medial meniscectomies. The Office medical adviser did not include an impairment due to his meniscectomies as he found that no impairment could be combined with an impairment due to arthritis. The case, therefore, will be remanded for the Office to include any impairment due to appellant's meniscectomies in calculating his total left knee impairment. The Office should then subtract the amount it has previously awarded appellant from his total left knee impairment to determine the amount of any additional award.

CONCLUSION

The Board finds that the case is not in posture for decision.

¹¹ *Id.* at 525, Table 17-1.

¹² *Id.* at 526, Table 17-2.

¹³ *Id.*

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 27, 2008 is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: June 16, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board