United States Department of Labor
Employees' Compensation Appeals Board

S.J., Appellant	)	
and	)	**Docket No. 07-1709**
	)	**Issued: February 11, 2008**
U.S. POSTAL SERVICE, MAIN POST OFFICE, Chicago, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On June 5, 2007 appellant filed a timely appeal from the Office of Workers' Compensation Programs' May 31, 2007 merit decision finding a 75 percent impairment of her right lower extremity. Pursuant to 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 75 percent permanent impairment of the right lower extremity for which she received a schedule award.

FACTUAL HISTORY

On January 11, 1997 appellant, then a 41-year-old letter carrier, sustained injury to her right knee while delivering mail. She stepped up on a curve and slipped and fell to her knees. By letter dated February 28, 1997, the Office accepted appellant's claim for right knee sprain and knee contusion. On April 12, 1997 Dr. Robert Fink, a Board-certified orthopedic surgeon, performed surgery on appellant's right knee for a partial right medial meniscectomy. On

June 24, 1999 Dr. Fink performed a right knee arthroscopy, partial synovectomy, partial medial meniscectomy and removal of lose body.

On November 22, 1999 appellant filed a claim for a schedule award. On May 11, 2000 the Office issued a schedule award for a two percent permanent impairment of the right lower extremity. This award was set aside by the Board in a decision dated June 19, 2001.[1] On November 20, 2001 appellant's claim for a schedule award was denied.

On January 15, 2002 Dr. Fink performed the following additional surgery on appellant's right knee for a partial synovectomy, removal of lose body, debridement chondromalacia medial femoral condyle, debridement chondromalacia patella and partial right medial meniscectomy. The Office subsequently authorized a right total knee replacement. It also accepted traumatic arthritis of the right knee. On June 11, 2004 Dr. Fink performed a total right knee replacement.

On March 24, 2005 appellant was referred to Dr. Richard H. Sidell, a Board-certified orthopedic surgeon, for a second opinion. In a report dated May 11, 2005, Dr. Sidell diagnosed painful total knee arthroplasty with possible loosening. He noted that the diagnosed condition appeared to be medically connected to the January 11, 1997 employment injury due to the continuing symptoms leading up to the total knee arthroplasty. Appellant appeared to have reached maximum medical improvement from the conditions attributable to the January 11, 1997 employment injury. Dr. Sidell noted current residuals of pain and that prognosis for any further improvement was guarded. He stated, "It is anticipated the condition will remain static or deteriorate over time." Dr. Sidell recommended x-rays to evaluate possible loosening of the prosthetic components and consideration of surgical exploration. He stated that appellant was disabled and could not return to the workforce due to her level of pain and difficulty ambulating.

On June 8, 2005 Dr. Fink indicated that appellant needed repeat x-rays and a bone scan to see if her total knee prosthesis had a loose portion. If it did, she would need surgical revision of the loose portion of the prosthesis.

In a medical report dated September 14, 2005, Dr. Ram Aribindi, a general surgeon, listed his impression as persistent right knee pain following right knee replacement with likely incompetence of the medial collateral ligament as appellant had an opening of the medial joint space with valgus stress to the knee. He recommended that she see a pain specialist for potential reflex sympathetic dystrophy as possible cause of her knee pain.

On November 28, 2005 Dr. James Diesfeld, a Board certified anesthesiologist, listed his impression as "[s]tatus post total knee replacement with deconditioning scar tissue and underlying neuralgia; somatic/neuropathic pain syndrome." He treated appellant with bilateral scar infiltration. On January 19, 2006 Dr. Diesfeld performed a transcaudal epidurogram; caudal epidural steroid injections/sympathetic block; right L3-4 selective nerve blocks/transforaminal; trigger point injections time[s] three; and mechanical epiduroneurolysis of adhesions. He provided further epidural steroid injections on February 2 and 16, 2006. In a March 15, 2006

[1] *Sherlyn M. James*, Docket No. 00-2323 (issued June 19, 2001).

report, Dr. Diesfeld indicated, "in light of [appellant's] ongoing atypical pain syndrome it is again reiterated that surgical reevaluation/revisitation may be considered.

In a May 29, 2006 report, Dr. Fink summarized his treatment of appellant. He indicated that she had multiple operations over the prior 10 years all for job-related injuries. Appellant underwent right and left shoulder operations for torn rotator cuffs, right and left elbow operations for cubital tunnel entrapment of her ulnar nerves, right and left carpal tunnel releases, minor back surgery, arthroscopic surgeries for torn cartilage to the right knee and an injury to the left knee, which worsened since the surgery on her right knee and a right total knee replacement. Following these procedures, appellant underwent three epidural injections for pain by Dr. Desfield. Dr. Fink noted that Dr. Desfield stated that he obtained a full range of motion in her right knee and had manipulated the knee to do this, which broke up adhesions or scar tissue. Appellant still had an underlying condition of fibromyalgia and was still recovering from the latest injection and manipulation by Dr. Desfield. Dr. Fink noted that she might need a revision total knee replacement and was currently disabled. He noted that limitations due to appellant's arms prevented her from working overhead, lifting more than five pounds and repetitive reaching. The condition of both her knees caused an inability to stand, sit or walk for prolonged periods of time. Due to the condition of appellant's hands and wrists, she could not type or write for more than 20 minutes. Finally, Dr. Fink noted that appellant's pain medication caused drowsiness.

On July 12, 2006 appellant filed a claim for a schedule award. By letter dated July 24, 2006, the Office asked Dr. Fink to provide an impairment rating.

At Dr. Fink's request, appellant was seen by Dr. Jacob Salomon, a Board-certified general surgeon, for an impairment rating. Dr. Salomon diagnosed status post right knee total replacement, failed, with possible loosening of the prosthesis and possible complex regional pain syndrome. He noted that Dr. Fink had listed a date of maximum medical improvement as September 20, 2006. Dr. Salomon continued:

> "I shall utilize the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. Regarding the total knee replacement, it is found in the lower extremity section. From Table 17-35 on page [549] [appellant's] pain was continual, moderate, which would be 10 points. Ranges of motion: add one point per 5 degrees and we will take [negative] 20 out of 90 degrees of flexion which would be approximately 70 degrees. We get 1 point per five degrees which results in 14 points for ranges of motion. Stability anterior mediolaterally was 10 degrees which would be five points; and anteriorly five [to] nine millimeter which is five points.
>
> "We will then add those points up to obtain 34. Then for the deductions, there was an extension lag of 10 [to] 20 degrees which is 10 points. [Appellant] will not be given one for flexion contraction. Alignment was 10 degrees, 3 points per degree which would be 30 points. When subtracted, this comes up with negative points, showing the failure of the surgery. When applied to Table 17-33 on page 546, total knee replacement with poor results, is a 75 [percent] right lower

extremity impairment. [Appellant] has a total right lower extremity impairment of 75 [percent]."

By letter dated December 26, 2006, the Office asked its medical adviser to review the medical record. By letter dated January 2, 2007, the Office medical adviser agreed that appellant had a 75 percent impairment of the left lower extremity.

By letter dated January 10, 2007, the Office noted that it had asked for an impairment rating of appellant's right knee, not left and asked the Office medical adviser to determine permanent impairment of appellant's right knee. By letter dated February 3, 2007, the Office medical adviser responded:

"*Right Lower Extremity*

"Rating Knee Replacements ([T]able 17-35, [page] 549)

a. Pain-Moderate/Continual		10 points
b. Range of Motion -- 70 degrees total		14 points
c. Stability		
Anteroposterior	5-9 mm	5 points
Mediolateral	10 degrees	5 points
Total --		34 points
e. Flexion Contracture	0 degrees	0 points
f. Extension Lag	18 degrees	10 points
g. Alignment	10 degrees	15 points
Total --		15 points (d + e = f)

Rating Knee Replacement 10 points (section 1 -- section 2)

Knee Replacement Rating of 19 points = Poor Result = 75 [percent] right lower extremity permanent partial impairment] (Table 17-33, [page] 547)

Date of [maximum medical improvement] will be set on [June 11, 2005 approximately 1 year after surgery]

"RLE PPI: 75 [percent] (TOTAL, NOT IN ADDITION TO ANY PREVIOUS AWARDS)"

By decision dated May 31, 2007, the Office granted a schedule award for a 75 percent impairment of the right lower extremity, commencing on June 11, 2005, the date of maximum

medical improvement. The Office further noted that, as compensation for disability from work and a schedule award are not payable simultaneously, the compensation paid to appellant from June 11, 2005 through September 30, 2006 in the amount of $38,932.62, was deducted from her initial payment of $55,298.37, leaving her with a balance payable under the schedule award of $15,364.74.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations,[3] sets forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of schedule 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 to all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[4] 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, 2007.[5]

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.[6] 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.[7] The Board, therefore, requires a persuasive proof of maximum medical improvement for selection of a retroactive date of maximum medical improvement.[8]

ANALYSIS

Appellant does not dispute that the Office's determination that she has a 75 percent impairment to her right lower extremity. Rather, she contends that the Office erred in determining the date of maximum medical improvement.

The Board notes that the Office properly determined that appellant has a 75 percent impairment to her right lower extremity based on the opinions of Dr. Salomon and the Office

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] 20 C.F.R. § 10.404(a).

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

[6] *P.C.*, 58 ECAB ____ (Docket No. 07-410, issued May 31, 2007); *Mark A. Holloway*, 55 ECAB 321 (2004).

[7] *J.C.*, 58 ECAB ____ (Docket No. 06-1018, issued January 8, 2007); *James E. Earle*, 51 ECAB 567 (2000).

[8] *Id.*

medical adviser. Initially, in rating appellant's knee replacement results, the physicians utilized Table 17-35 of the A.M.A., *Guides*[9] and allowed 10 points for moderate continual pain, 14 points based on range of motion, with 10 points added for anteroposterior and mediolateral stability or a total of 34 points. With regard to deductions, the physicians differed somewhat in their opinions. Dr. Salomon would have deducted 10 points for extension lag and 30 points for alignment which, when subtracted from appellant's 34 points, would yield negative points showing failure of the surgery. The Office medical adviser determined after deductions, that appellant's knee replacement surgery rated 19 points according to the A.M.A., *Guides*. Despite this difference, both physicians concluded that appellant's right knee replacement yielded a poor result (less than 50 points) from surgery and awarded her the maximum amount of 75 percent permanent impairment for her right lower extremity.[10] The Office's finding that she has a 75 percent impairment of her right lower extremity is based on the medical evidence and a proper interpretation of the A.M.A., *Guides*.

The Board finds, however, that the Office erred in determining June 11, 2005 as the date of maximum medical improvement. The medical adviser provided this date as it was one year following appellant's knee replacement surgery. Based on this determination and the fact that appellant had received wage-loss compensation benefits for the period June 11, 2005 through September 30, 2006, the Office deducted $38,932.63 from her schedule award and found that she was entitled to $16,364.74, for the period June 11, 2005 through April 14, 2007.

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 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.[11] The Board, therefore, requires persuasive proof of maximum medical improvement for selection of a retroactive date of maximum medical improvement.[12] As noted, the Office medical adviser listed appellant's date of maximum medical improvement as one year after appellant's knee replacement surgery or June 11, 2005. However, the Office medical adviser did not provide a discussion of how he arrived at this date or supported his conclusion with sound medical reasoning. In contrast, Dr. Fink and Dr. Salomon stated that maximum medical improvement was September 20, 2006. Accordingly, the case will be remanded for the Office to further develop the date of maximum medical improvement.

CONCLUSION

The Board finds that appellant has no more than a 75 percent impairment of the right lower extremity for which she received a schedule award. The case is not in posture for decision with regard to the date of maximum medical improvement.

[9] A.M.A., *Guides* 549, Table 17-35.

[10] *Id*. at 547, Table 17-33.

[11] *D.R.*, 57 ECAB ___ (Docket No. 06-668, issued August 22, 2006).

[12] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the May 31, 2007 decision of the Office of Workers' Compensation Programs is affirmed with regard to the issuance of a schedule award based on a 75 percent impairment rating of appellant's right lower extremity. With regard to the period of the award and the date of maximum medical improvement, the decision is set aside and this case is remanded for further consideration consistent with this opinion.

Issued: February 11, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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