United States Department of Labor
Employees' Compensation Appeals Board

T.B., Appellant	)	
and	)	**Docket No. 12-639**
	)	**Issued: August 3, 2012**
U.S. POSTAL SERVICE, GENERAL MAIL FACILITY, Harrisburg, 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:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 27, 2012 appellant's counsel timely appealed the January 25, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP), which granted a schedule award. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 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 greater than 21 percent impairment of the left lower extremity.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

Appellant, a 59-year-old retired information systems manager, has an accepted claim for left lower leg traumatic arthropathy, which arose on or about April 11, 1983.[2] OWCP authorized a left total knee arthroplasty, which he underwent on August 13, 2010. Appellant later filed a claim for a schedule award (Form CA-7).

In support of his claim, appellant submitted a September 8, 2011 impairment rating from Dr. James J. Sullivan, a Board-certified physiatrist, who found a combined 27 percent impairment of the left lower extremity pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (2008). The overall rating included components for left total knee replacement (21 percent) and preexisting patellofemoral arthritis (14 percent). Both combined rating was based on Table 16-3, Knee Regional Grid (LEI), A.M.A., *Guides* 509-11 (6th ed. 2008). Regarding the impairment due to patellofemoral arthritis, Dr. Sullivan explained that FECA allowed for the inclusion of preexisting impairments affecting the same scheduled member. He relied on an April 22, 2010 left knee x-ray that reportedly revealed a complete loss of cartilage interval at the medial joint space. According to Dr. Sullivan, appellant's latest postarthroplasty x-ray revealed "no relevant abnormal findings on left knee...." Noting that it had been 13 months since appellant's left total knee replacement, Dr. Sullivan found that he had reached maximum medical improvement (MMI).

The district medical adviser (DMA), Dr. Arnold T. Berman, a Board-certified orthopedic surgeon, reviewed appellant's medical records, including Dr. Sullivan's September 8, 2011 impairment rating. In a January 3, 2012 report, the DMA found 21 percent impairment of the left lower extremity. He agreed with Dr. Sullivan's 21 percent rating for left total knee replacement under Table 16-3, A.M.A., *Guides* 511 (6th ed. 2008). With respect to the additional 14 percent rating for patellofemoral arthritis, the DMA explained that combining regional impairments for two separate diagnoses was not an acceptable approach under the latest edition of the A.M.A., *Guides*. He indicated that only one diagnosis could be chosen and Dr. Berman believed the total knee replacement represented appellant's single best diagnosis under Table 16-3, A.M.A., *Guides* 511 (6th ed. 2008). The DMA found appellant reached MMI as of September 8, 2011; the date of Dr. Sullivan's examination.

By decision dated January 25, 2012, OWCP found that appellant had 21 percent impairment of the left lower extremity. The award covered a period of 60.48 weeks from September 8, 2011 to November 4, 2012.

LEGAL PRECEDENT

Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[3] FECA,

[2] Appellant initially injured his left knee while serving in the military in the 1970s. He also sustained employment-related left knee injuries on January 3, 1981 (xxxxxx323) and March 1, 1983 (xxxxxx165). Appellant retired from the employing establishment effective December 3, 2010.

[3] For a total loss of use of a leg, an employee shall receive 288 weeks' compensation. 5 U.S.C. § 8107(c)(2).

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. The implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[4] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2008).[5]

ANALYSIS

Dr. Sullivan and the DMA both agreed that the results of appellant's August 13, 2010 left total knee arthroplasty represented 21 percent impairment of the lower extremity pursuant to Table 16-3, A.M.A., *Guides* 511 (6th ed. 2008). Based on Dr. Sullivan's September 8, 2011 examination findings, the surgery produced a good result, which represented class 2 impairment (moderate problem) with a default grade "C" or 25 percent lower extremity impairment. Taking into account grade modifiers for Functional History (2), Physical Examination (1), and Clinical Studies (0), both physicians concurred that there was a net adjustment of -3, which warranted a grade adjustment from the default value of "C" to grade "A" or 21 percent lower extremity impairment under Table 16-3, A.M.A., *Guides* 511 (6th ed. 2008).

The DMA and Dr. Sullivan disagree as to the appropriateness of an additional 14 percent impairment for patellofemoral arthritis. The DMA correctly noted that the diagnosis-based approach to rating impairment under the latest edition of the A.M.A., *Guides* is premised on the selection of a single diagnosis that is most applicable for the region being assessed.[6] If there are multiple diagnoses at MMI, the examiner should determine if each diagnosis should be considered or if the impairments are duplicative.[7] Where there are multiple diagnoses within a specific region, then the most impairing diagnosis is rated, because it is probable this will incorporate the functional losses of the less impairing diagnoses.[8] In rare cases of complex injury or occupational exposure, the examiner may combine multiple impairments in a single region, if the most impairing diagnosis does not adequately reflect the losses.[9] The evaluating physician must explain in writing the rationale for the rating methodology that is used.[10]

[4] 20 C.F.R. § 10.404.

[5] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a (January 2010).

[6] *See* section 16.2a, A.M.A., *Guides* 499 (6th ed. 2008). If more than one diagnosis in a region can be used, the one that provides the most clinically accurate and causally-related impairment rating should be used. *Id.* Typically, one diagnosis will adequately characterize the impairment and its impact on activities of daily living. *Id.*

[7] *See* section 16.3f, A.M.A., *Guides* 529 (6th ed. 2008).

[8] *Id.*

[9] *Id.*

[10] *Id.*

Dr. Sullivan provided no rationale for combining the two left knee impairments other than noting that FECA allowed for the inclusion of preexisting conditions. He is correct that under certain circumstances, previous impairments may be included in calculating the percentage of loss.[11] However, in this instance there is no evidence of ongoing patellofemoral arthritis. That condition was presumably resolved by the August 13, 2010 left total knee arthroplasty. Dr. Sullivan based the additional 14 percent lower extremity arthritis rating on an April 22, 2010 left knee x-ray that revealed a significantly decreased cartilage interval. At the time of his September 8, 2011 examination, he also noted that appellant's most recent August 9, 2011 postarthroplasty x-ray revealed "no relevant abnormal findings on left knee...." Thus, Dr. Sullivan appears to have rated appellant for a left knee arthritic condition that no longer existed. Accordingly, the additional impairment for patellofemoral arthritis is unwarranted. Appellant has not submitted any credible medical evidence indicating he has greater than 21 percent impairment of the left lower extremity.

The Board finds that the DMA's December 13, 2011 impairment rating conforms to the A.M.A., *Guides* (6th ed. 2008), and thus, represents the weight of the medical evidence regarding the extent of appellant's left lower extremity impairment.

CONCLUSION

Appellant has not established that he has greater than 21 percent impairment of the left lower extremity.[12]

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.7a(2); *see R.D.*, 59 ECAB 127, 130 (2007).

[12] Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

ORDER

IT IS HEREBY ORDERED THAT the January 25, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 3, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board