United States Department of Labor
Employees' Compensation Appeals Board

R.W., Appellant	)	
and	)	**Docket No. 14-1451**
	)	**Issued: September 15, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Carol Stream, IL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 9, 2014 appellant, through counsel, filed a timely appeal from the March 27, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP), which denied appellant's schedule award claim. 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 28 percent impairment of his right lower extremity and any ratable impairment of his left lower extremity.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On July 11, 2007 appellant, then a 60-year-old building equipment mechanic, filed an occupational disease claim alleging that ascending and descending stairs in the performance of duty aggravated his right and left knee pain. OWCP accepted his claim for bilateral knee sprain.

On March 24, 2010 appellant underwent an authorized right total knee arthroplasty. An x-ray obtained on July 16, 2010 showed excellent alignment with no evidence of loosening or periprosthetic fracture.

Appellant filed a schedule award claim on March 29, 2011.

Dr. Paul T. Prinz, the Board-certified orthopedic surgeon, who performed the surgery, examined appellant on August 23, 2012. Appellant was doing much better with respect to his right knee. He had no significant pain. Appellant demonstrated painless range of motion, no significant periarticular edema and no effusions. He had a nonantalgic gait. Dr. Prinz noted: "This patient has had a workup for loosening which thus far has been negative. He states his symptoms have resolved now."

Dr. Neil Allen, a Board-certified internist and neurologist, examined appellant on January 10, 2013 and rated his impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009). For the right lower extremity, Dr. Allen identified a diagnosis-based default impairment rating of 37 percent, presumably for the diagnosis of total knee replacement.[2] This indicated that appellant's impairment was severe and that he had only a fair result from his surgery, characterized by fair position of the prosthesis, mild instability or mild motion deficit. Dr. Allen adjusted the default rating to 31 percent based on a mild functional history, moderate physical examination,[3] and mild clinical studies.[4]

For the left lower extremity, Dr. Allen identified a diagnosis-based default impairment rating of two percent, presumably for the diagnosis of muscle/tendon strain, tendinitis, or ruptured tendon.[5] This indicated that appellant's impairment was mild, characterized by palpatory or radiographic findings. Dr. Allen made no adjustment to the default rating, as functional history was used to classify the impairment, physical examination findings were also mild,[6] and no clinical studies were available.

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[2] There are several diagnoses under the Knee Regional Grid, pages 509-11, with a default impairment value of 37 percent.

[3] Dr. Allen found tenderness through the medial aspect of the joint and at the central aspect of the joint line. He also found mild (grade 1) anterior instability, 4/5 muscle strength in flexion, and range of motion to 108 degrees of flexion with eight degrees of flexion contracture.

[4] X-rays obtained on March 23, 2012 at Dr. Prinz' office showed the prosthesis to be in good alignment, free of perioprosthetic fracture or loosening.

[5] There are three diagnoses under the Knee Regional Grid with a default impairment value of two percent.

[6] Dr. Allen found tenderness to palpation in the region of the tibial tuberosity and inferior to the joint line. He also found 4/5 muscle strength in flexion.

Dr. Prinz reexamined appellant's right knee on March 21, 2013. Appellant noted no pain but did note some stiffness. There was no effusion, calf swelling, or significant periarticular edema. Appellant exhibited full extension and about 110 degrees of flexion. An x-ray showed no definite periprosthetic fracture or loosening. Dr. Prinz found that appellant was doing well with some permanent stiffness with respect to limited flexion.

An OWCP medical adviser reviewed the medical record. With respect to the right lower extremity, he noted that his previous review of the matter in 2011, together with the findings from Dr. Prinz, indicated that appellant had a good result following surgery. Dr. Prinz had made no mention of instability, and 110 degrees of flexion was near normal for a patient following a knee replacement; it would not be construed as a mild motion deficit. Under the Knee Regional Grid, a good result following total knee replacement had a default impairment value of 25 percent.

With respect to the left lower extremity, OWCP medical adviser noted that apart from subjective complaints, there was absolutely no evidence of any injury to the left knee. Dr. Allen's examination of the left knee was normal except for some loss of knee flexion strength, which was a very subjective component. "Thus, I find no objective evidence for any impairment to the left leg."

In a decision dated August 8, 2013, OWCP denied appellant's schedule award claim. It noted that appellant had previously received schedule awards for a 28 percent impairment of the right lower extremity due to a knee injury under another claim, and the medical evidence did not support an increase in the impairment already compensated.

On March 27, 2014 an OWCP hearing representative affirmed. He noted that appellant had received schedule award compensation for a 28 percent impairment of the right lower extremity under OWCP File No. xxxxxx392, which was accepted for right lateral meniscus tear due to a May 9, 1978 trip and fall injury. The hearing representative found that OWCP medical adviser provided a well-rationalized assessment of appellant's impairment based on his review of Dr. Allen's evaluation and the medical evidence of record. As his opinion constituted the weight of the medical evidence, the hearing representative affirmed OWCP's August 8, 2013 decision to deny appellant's schedule award claim.

LEGAL PRECEDENT

The schedule award provisions of FECA[7] and the implementing regulations[8] set forth the number of weeks of compensation payable for the permanent loss or loss of use of scheduled members or functions 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.[9]

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

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

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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the appropriate standard for evaluating schedule losses.[10] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[11]

ANALYSIS

Diagnosis-based impairment is the primary method of evaluating the lower extremity. Impairment is determined first by identifying the most appropriate 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) based on the criteria provided. Each class of impairment is given a default impairment rating, which can be adjusted up or down based on such modifiers as functional history, physical examination and clinical studies.[12]

With respect to the right lower extremity, the most appropriate diagnosis is total right knee replacement. Table 16-3, page 511 of the A.M.A., *Guides*, shows three classes of impairment: good result, fair result, and poor result. A good result is characterized by good position of the prosthesis, stability, and functionality. It has a default impairment value of 25 percent of the lower extremity. A fair result is characterized by fair position, mild instability or mild motion deficit. It has a default lower extremity impairment value of 37 percent.

X-rays obtained after the surgery showed excellent alignment. The position of the prosthesis thus appeared to be good and indicative of a good result. However, Dr. Allen, the evaluating internist, found a mild (grade 1) anterior instability. Mild instability is indicative of a fair result.

OWCP medical adviser questioned the finding. He previously reviewed the matter in 2011 and had classified appellant's knee replacement as a good result. This classification was further supported by more recent findings from Dr. Prinz, the attending orthopedic surgeon. Dr. Prinz made no mention of instability.

While Dr. Prinz made no mention of instability, he did not indicate that he evaluated it. Studies showed no definite evidence of loosening or periprosthetic fracture, but there is no evidence that Dr. Prinz performed an anterior drawer test or otherwise evaluated the stability of appellant's prosthesis. Indirectly, it can be said, his examinations of appellant tended to support that stability was not an issue. At the same time, it was not a matter he directly addressed.

Stability is a critical issue. It is one of the three criteria that determine whether appellant had a good result from his surgery or only a fair result and it can therefore be determinative of

[10] 20 C.F.R. § 10.404; *Ronald R. Kraynak*, 53 ECAB 130 (2001).

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

[12] A.M.A., *Guides* 497.

whether appellant is entitled to an additional schedule award. Under the circumstances, the Board finds that further development of the medical evidence is warranted. Dr. Allen examined appellant on only one occasion, and his finding of mild (grade 1) anterior instability raised a novel issue in the case that Dr. Prinz did not and was not asked to address.

Accordingly, the Board finds that this case is not in posture for decision. The Board will set aside OWCP's March 27, 2014 decision on the issue of right lower extremity impairment and will remand the case for further development of the medical evidence. As Dr. Prinz performed the surgery and followed appellant thereafter, OWCP should ask him to evaluate the anterior stability of appellant's right knee prosthesis and to identify what testing he performed.

OWCP should also ask Dr. Prinz to address appellant's range of motion. Dr. Allen found a flexion contracture of eight degrees, but Dr. Prinz subsequently found full extension. Also, Dr. Allen reported 108 degrees of flexion and Dr. Prinz reported about 110. Under Table 16-23, page 549 of the A.M.A., *Guides*, these flexion measures straddle the line between normal motion and mild motion deficit. A precise and reliable goniometric finding, performed according to Figure 16-8, page 546 of the A.M.A., *Guides* and following the assessment steps on page 548, will therefore help determine whether appellant had a good or fair result from his knee replacement surgery.

With respect to the left lower extremity, Dr. Allen found tenderness to palpation in the region of the tibial tuberosity and inferior to the joint line. However, he did not explain how he knew this was a residual of the knee sprain appellant sustained in 2007 from going up and down stairs at work. Dr. Allen did not explain how this work exposure caused any permanent left knee injury. He offered no review of the medical evidence to document bridging symptoms or complaints or continuing medical attention. OWCP medical adviser reviewed Dr. Allen's examination of appellant, and apart from subjective complaints, there was absolutely no evidence of any injury to the left knee.

As the record does not establish that the 2007 employment-related left knee sprain caused a permanent impairment to appellant's left lower extremity, the Board finds that appellant has not met his burden to establish that he is entitled to a schedule award for that extremity. The Board will, therefore, affirm OWCP's March 27, 2014 decision on the issue of left lower extremity impairment.

CONCLUSION

The Board finds that this case is not in posture for decision with respect to the impairment of appellant's right lower extremity. Further development of medical evidence is warranted. The Board also finds that appellant has not met his burden to establish that he is entitled to a schedule award for permanent impairment to his left lower extremity causally related to the accepted left knee sprain in 2007.

ORDER

IT IS HEREBY ORDERED THAT the March 27, 2014 decision of the Office of Workers' Compensation Programs is affirmed in the matter of appellant's left lower extremity and is otherwise set aside. The case is remanded for further action.

Issued: September 15, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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