U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of EDWARD C. YACKOBOVITZ and DEPARTMENT OF THE NAVY, AVIATION SUPPLY OFFICE, Philadelphia, PA

Docket No. 99-2389; Submitted on the Record;
Issued December 6, 2000

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether appellant has more than a 24 percent permanent impairment to his right lower extremity for which he received a schedule award.

On May 25, 1989 appellant, then a 43-year-old auto mechanic, was injured in the performance of duty when he struck his right knee on the frame of a snowplow. He was initially treated by Dr. William C. Hamilton, a Board-certified orthopedic surgeon, for a large tear of the posterior horn of the medial meniscus as well as a partial tear of the middle aspect of the patellar tendon. The Office of Worker's Compensation Programs accepted the claim for a contusion of the right knee and torn medial meniscus. Appellant was off work from May 25 to June 6, 1989, when he returned to light duty. When conservative measures failed to alleviate appellant's right knee pain, the Office approved surgical intervention and appellant underwent a partial medial meniscectomy on May 21, 1990. Over the next years, he received appropriate compensation for intermittent periods of wage-loss and medical benefits.[1]

In a CA-7 claim form dated July 10, 1997, appellant requested a schedule award.

In support of his schedule award claim, appellant submitted a June 9, 1997 report from Dr. Ronald J. Potash, his treating physician and a Board-certified orthopedist. Applying the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, Dr. Potash stated that appellant's right knee showed atrophy of the quadriceps and muscle weakness measured at 17 percent (Table 39, page 77). He stated that appellant's range of motion impairment measured by flexion (Table 41, page 78) and extension (Table 41, page 78) equaled 10 percent each, for a total of 20 percent. Dr. Potash diagnosed status post contusion strain and sprain of the right knee with tendinitis, chronic diffuse joint synovitis and medial meniscus tear, status post arthroscopic surgery. He rated appellant's total combined right lower

[1] The record indicates that appellant sustained a minor right knee strain on March 2, 1992 and that he was involved in a slip and fall injury on November 5, 1995 causing hypertension on the left shoulder.

extremity impairment as 34 percent and opined that appellant reached maximum medical improvement on May 6, 1997.

By memorandum dated March 26, 1999, the Office forwarded a copy of Dr. Potash's report along with a statement of accepted facts to a district medical adviser for review. In a June 22, 1998 report, the district medical adviser found that appellant had atrophy of the right quadriceps equal to 2.6 cm, which warranted a 13 percent impairment rating at Table 37, page 7 of the A.M.A., *Guides*. He noted that "[since] this measurement is objective and weakness is subjective, this is the more supportable rating." The district medical adviser agreed with Dr. Potash that, under Table 41, page 78 of the A.M.A., *Guides*, the flexion and extension measurements rated 10 percent impairment respectively. He noted, however, that since the values were both contained in the same table, the higher value had to be used and not both values. The district medical adviser further found that appellant had a two percent meniscectomy under Table 64, page 85. Using the table of combined values, the district medical adviser concluded that appellant had a 24 percent impairment of the right upper extremity.

In a decision dated June 25, 1998, the Office issued a schedule award for a 24 percent permanent impairment of the right lower extremity. The period of the award was from May 6, 1997 to June 2, 1998.

Appellant requested a hearing, which was held on February 9, 1999. At the hearing, appellant's counsel argued that there was a conflict in the record between appellant's treating physician and the district medical adviser as to whether appellant was entitled to 24 or 34 percent impairment of the right lower extremity.

Additional medical development pursued by the Office hearing representative subsequent to the hearing resulted in a report dated March 26, 1999 from Dr. Neven A. Popovic, an Office medical adviser. Dr. Popovic reported that district medical adviser had correctly interpreted Table 41, page 78 of the A.M.A., *Guides* to require that only one value be used for rating knee flexion/extension impairment.

This is in accordance with the example provided by the A.M.A., *Guides* (pages 77/78, section 3.2e, example dealing with a 45-year-old woman. The A.M.A., *Guides* clearly state that the diminished muscle function should be estimated under only one of several parts of the chapter related to gait derangement, muscle atrophy or manual muscle testing (page 67, section 3.2c). The A.M.A., *Guides* also [state] that the physician should determine which method and approach best applies to the patients' impairment and use the most objective method that applies. The district medical adviser correctly used the quadriceps atrophy more objective than muscle "weakness."

However, the district medical adviser on June 22, 1999 incorrectly added two percent impairment for the meniscectomy (page 85, Table 64). The A.M.A., *Guides* clearly state on page 84, section 3.2I, that the physician should decide which estimate (on the basis of diagnosis or on the basis of findings on physical examination) best describes the situation and should use only one approach for each anatomic part.

Dr. Popovic concluded that the medical evidence did not support an impairment of the right lower extremity greater than 24 percent, since under his calculation, appellant's impairment of the right lower extremity measured only 22 percent.

In a decision dated April 1, 1999, an Office hearing representative affirmed the Office's June 25, 1998 decision granting a schedule award for 24 percent impairment of the right lower extremity.

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

Section 8107 of the Act provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[2] Neither the Act nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the Office as a standard for evaluating schedule losses and the Board has concurred in such adoption.[3]

In this case, the Board finds that a conflict exists in the record as to how to properly calculate appellant's permanent partial impairment of the right lower extremity. It is the opinion of appellant's treating physician that appellant has a 10 percent impairment for each flexion and extension measurements under Table 41, page 78 of the A.M.A., *Guides.* Dr. Potash therefore totaled appellant's impairment under Table 41 as 20 percent. In contrast, the district medical adviser reviewed Dr. Potash's report and stated that only one measurement for either flexion or extension can be used at Table 41, page 78 for rating appellant's range of motion impairment to the right knee. The district medical adviser specifically opined that appellant had only a 10 percent impairment under Table 41.[4] Consequently, depending on the proper application of Table 41, appellant may be entitled to an additional 10 percent impairment.

Section 8123(a) of the Act[5] provides that, "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."

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[2] 5 U.S.C. § 8107(a).

[3] *James Kennedy, Jr.*, 40 ECAB 620 (1989); *Quincy E. Malone*, 31 ECAB 846 (1980).

[4] Following the hearing in this case, it appears that the Office hearing representative requested a report by an Office medical adviser, Dr. Popovic, who agreed with the district medical adviser's application of the A.M.A., *Guides.* Contrary to the findings of the Office hearing representative, the opinion from Dr. Popovic does not serve to resolve the conflict in the medical evidence between Dr. Potash and the Office medical adviser. Dr. Popovic's opinion is not entitled to controlling weight since he incorrectly cited the example (45-year-old woman) provided at pages 77-78 of the A.M.A., *Guides* as support for applying only one value at Table 41. The Board notes that the example cited by Dr. Popovic involved an ankle and toe impairment under Tables 42 and 45. It did not mention Table 41. Under Table 42, it is clear that flexion and extension measurements can not be added together, but the proper application of Table 41 is less obvious.

[5] 5 U.S.C. § 8123(a).

The Board finds that the conflicting ratings obtained by the district medical adviser and Dr. Potash require remand of the case for resolution of how to apply Table 41, page 78 of the A.M.A., *Guides*.[6] On remand, the Office should refer appellant, along with a copy of the case record and a statement of accepted facts, to an appropriate medical specialist for an impartial evaluation pursuant to section 8123(a). The impartial medical specialist should be directed to evaluate appellant with respect to the extent of the partial permanent impairment in her right lower extremity. After such development of the case record as the Office deems necessary, a *de novo* decision shall be issued.

The decision of the Office of Workers' Compensation Programs dated April 1, 1999 is hereby set aside and the case is remanded for further development consistent with this decision of the Board.

Dated, Washington, DC
December 6, 2000

David S. Gerson
Member

Willie T.C. Thomas
Member

A. Peter Kanjorski
Alternate Member

[6] *See Joseph D. Lee*, 42 ECAB 172, 181 (1990) (remanding the case because of a conflict in the impairment ratings of appellant's physician and the Office medical adviser).