



March 2, 2000 to repair appellant's anterior cruciate ligament in her right knee. He performed a diagnostic arthroscopy and partial synovectomy on appellant's right knee on December 6, 2000. Appellant returned to full-time light-duty work on June 14, 2001.

Appellant requested a schedule award on January 8, 2002. In a report dated October 12, 2001, Dr. David Weiss, an osteopath and a Board-certified orthopedic surgeon, noted her history of injury, provided his physical findings and determined that appellant had an 8 percent impairment due to quadriceps atrophy, a 17 percent impairment due to motor strength deficit and 3 percent impairment due to pain for a total of 27 percent impairment of the right lower extremity.

An Office medical adviser reviewed Dr. Weiss' report on August 13, 2002 and questioned his impairment findings. He recommended a second opinion evaluation.

The Office referred appellant to Dr. Kenneth Falvo, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a report dated September 23, 2002, Dr. Falvo noted appellant's history of injury, found that she had reached maximum medical improvement and based his impairment rating on her loss of flexion of 120 degrees, which he found represented a 5 percent impairment.

By letter dated March 15, 2003, the Office informed appellant that there was a conflict of medical opinion evidence between Dr. Weiss who found a 27 percent impairment of her right lower extremity due to atrophy, loss of muscle strength and pain, and Dr. Falvo, the second opinion physician, who found a 5 percent impairment due to loss of flexion.

The Office referred appellant to Dr. Howard Blank, a Board-certified orthopedic surgeon, for an impartial medical examination. On August 27, 2003 Dr. Blank examined appellant, noted her history of injury and provided his diagnoses and an impairment rating. He diagnosed anterior cruciate ligament deficiency of the right knee, with reconstruction, arthroscopy and chondromalacia. Dr. Blank reviewed plain standing x-rays of appellant's right knee. He stated that appellant reported pain when going up and down stairs and aching in her knee at the end of the day. He found that she had ½ inch visible atrophy of the right quadriceps, and 125 degrees of flexion on the right which he determined was a 10 degree loss of flexion. Dr. Blank concluded that appellant had a 10 percent impairment of her right lower extremity and noted that her disability was likely to increase over time due to the progress of her chondromalacia.

The Office medical adviser examined Dr. Blank's report on September 17, 2003 and found that appellant had a five percent impairment due to loss of flexion, and five percent impairment due to loss of cartilage space based on the diagnosis of chondromalacia. He concluded that appellant was entitled to a schedule award for a 10 percent permanent impairment of her right lower extremity.

By decision dated November 25, 2003, the Office granted appellant a schedule award for a 10 percent impairment of her right lower extremity.

Appellant requested an oral hearing on December 2, 2003. By decision dated October 14, 2004, the hearing representative affirmed the November 25, 2003 schedule award.

## LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act<sup>1</sup> and its implementing regulation<sup>2</sup> sets 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 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. The American Medical Association, *Guides to the Evaluation of Permanent Impairment* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.

The A.M.A., *Guides*, Chapter 17, provides multiple grading schemes and procedures for determining the impairment of a lower extremity due to gait derangement,<sup>3</sup> muscle atrophy,<sup>4</sup> muscle weakness,<sup>5</sup> arthritis,<sup>6</sup> nerve deficits<sup>7</sup> and other specific pathologies. Section 17.2d of the fifth edition of the A.M.A., *Guides* that values for unilateral atrophy and muscle weakness are not to be combined.<sup>8</sup>

The Act provides that, if there is a 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.<sup>9</sup> The implementing regulation states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician of an Office medical adviser or consultant, the Office shall appoint a third physician to make an examination. This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case.<sup>10</sup>

When the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification

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<sup>1</sup> 5 U.S.C. § 8107.

<sup>2</sup> 20 C.F.R. § 10.404 (1999).

<sup>3</sup> A.M.A., *Guides* at 529, Table 17-5.

<sup>4</sup> *Id.* at 530, Table 17-6.

<sup>5</sup> *Id.* at 532, Table 17-8.

<sup>6</sup> *Id.* at 544, Table 17-31.

<sup>7</sup> *Id.* at 552, Table 17-37.

<sup>8</sup> *Id.* at 530, section 17.2d. Atrophy ratings should not be combined with any of the other three possible ratings of diminished muscle function (gait derangement, muscle weakness and peripheral nerve injury).

<sup>9</sup> 5 U.S.C. §§ 8101-8193, 8123.

<sup>10</sup> 20 C.F.R. § 10.321.

or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in the original report.<sup>11</sup>

### ANALYSIS

Appellant submitted a report from Dr. Weiss who found that she had a right lower extremity impairment of 24 percent due to atrophy and motor strength deficit with an additional 3 percent impairment due to pain. As section 17.2d of the A.M.A., *Guides*<sup>12</sup> precludes using both atrophy and muscle strength in assessing impairment, Dr. Weiss did not properly apply the A.M.A., *Guides* in reaching his impairment rating. He also accorded appellant an additional three percent impairment due to pain in accordance with Chapter 18 of the A.M.A., *Guides*, but did not address why appellant's pain could not be adequately assessed under the protocols of Chapter 17 as required by the A.M.A., *Guides*.<sup>13</sup> As Dr. Weiss' report did not comply with the A.M.A., *Guides*, the Office properly referred appellant for a second opinion evaluation.

Dr. Falvo submitted a report dated September 23, 2002 and opined that appellant had no more than a 5 percent impairment due to loss of flexion in accordance with the A.M.A., *Guides* Table 17-22.<sup>14</sup> The Board notes that this table provides that 20 to 29 degrees of ankylosis in flexion is a whole person impairment of 5 percent or a lower extremity impairment of 12 percent.

Due to the disagreements between Dr. Weiss and Dr. Falvo regarding the nature and extent of appellant's permanent impairment, the Office found a conflict of medical evidence and referred appellant for an impartial referee examination by Dr. Blank, a Board-certified orthopedic surgeon.

In his August 27, 2003 report, Dr. Blank noted appellant's complaints of soreness and pain in her right knee, ½ atrophy of the right quadriceps, flexion of 125 degrees and examined standing plain x-rays. He found that appellant's impairment was 10 percent. Dr. Blank did not provide any citations to the A.M.A., *Guides* and did not explain how he reached his impairment rating.

The Office medical adviser reviewed Dr. Blank's report on September 17, 2003 and found that appellant had a five percent impairment due to loss of flexion in accordance with the A.M.A., *Guides*. The Board notes that the A.M.A., *Guides* do not provide a ratable impairment for more than 110 degrees of flexion. As appellant's flexion was 125 degrees, she is not entitled to an impairment rating for loss of range of motion.<sup>15</sup> The Office medical adviser also granted appellant a five percent impairment due to chondromalacia in accordance with Table 17-31, Arthritis Impairments Based on Roentgenographically Determined Cartilage Intervals. He stated

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<sup>11</sup> *Raymond A. Fondots*, 53 ECAB 637, 641 (2002).

<sup>12</sup> A.M.A., *Guides* at 530, section 17.2d.

<sup>13</sup> See *Philip A. Norulak*, 55 ECAB \_\_\_\_ (Docket No. 04-817, issued September 3, 2004).

<sup>14</sup> A.M.A., *Guides* at 540, Table 17-22.

<sup>15</sup> *Id.* at 537, Table 17-10.

that he made this finding without x-rays of cartilage space loss. The Board has previously found that Table 17-31 is the only table provided for determining impairment resulting from an arthritic condition to the lower extremity and that this table is applicable only when the appropriate x-rays have been utilized to determine the cartilage interval.<sup>16</sup>

As there was a conflict under section 8123(a) that must be resolved by the impartial medical specialist, he must provide a reasoned opinion as to the permanent impairment to appellant's right lower extremity in accordance with the A.M.A., *Guides*. Dr. Blank did not indicate that he reviewed the A.M.A., *Guides* and did not provide a reasoned opinion explaining how he reached his impairment rating applying the protocols of the A.M.A., *Guides*. Accordingly, the case will be remanded to the Office to secure a supplemental report from Dr. Blank.<sup>17</sup>

### **CONCLUSION**

The Board finds that the August 27, 2003 report of the referee examiner, Dr. Blank is not sufficiently detailed and did not comport with the A.M.A., *Guides* and was therefore insufficient to resolve the conflict of medical opinion evidence. The case will be remanded for the Office to secure a supplemental report.

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<sup>16</sup> *Norman D. Armstrong*, 55 ECAB \_\_\_\_ (Docket No. 04-306, issued June 23, 2004).

<sup>17</sup> When the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, the Office must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue. *Raymond A. Fondots*, *supra* note 11.

**ORDER**

**IT IS HEREBY ORDERED THAT** the October 14, 2004 decision of the Office of Workers' Compensation Programs is set aside and remanded for additional development consistent with this decision of the Board.

Issued: July 20, 2005  
Washington, DC

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

Colleen Duffy Kiko, Judge  
Employees' Compensation Appeals Board

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