United States Department of Labor
Employees' Compensation Appeals Board

R.F., Appellant	)	
	)	
and	)	**Docket No. 11-931**
	)	**Issued: November 9, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Macon, GA, Employer	)	
	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On March 2, 2011 appellant, through his representative, filed a timely appeal from the February 24, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP), which increased his schedule award. Pursuant to the Federal Employees' Compensation Act (FECA)[1] 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 more than a seven percent impairment of his left leg, for which he received a schedule award.

FACTUAL HISTORY

On June 5, 2007 appellant, then a 31-year-old letter carrier, filed an occupational disease claim for compensation alleging that he had increasing left knee pain for over a year and that the

[1] 5 U.S.C. § 8101 *et seq.*

swelling and pain would worsen after walking his route. OWCP accepted his claim for internal derangement, chondromalacia and tendinitis of the left knee. Appellant received a schedule award for a two percent impairment of his left lower extremity.

In the prior appeal,[2] the Board found that further development of the medical evidence was warranted. Appellant's orthopedic surgeon, Dr. Norman M. Heyman, had rated a 29 percent impairment of his left leg, but improperly combined impairments from four diagnoses. An OWCP medical adviser noted that the selection of the most applicable single diagnosis required medical judgment. Dr. Alexander Doman, an orthopedic surgeon and OWCP referral physician, based his two percent rating on the diagnosis of partial medial meniscectomy, but he did not explain why he chose that diagnosis over the others. The Board set aside appellant's schedule award and remanded the case for a supplemental report from Dr. Doman.

Unable to obtain clarification from Dr. Doman, OWCP referred appellant, together with the medical record and a statement of accepted facts, to Dr. Harold H. Alexander, a Board-certified orthopedic surgeon, for a second opinion. On January 26, 2011 Dr. Alexander related that appellant sustained a traumatic left knee injury on January 30, 2005 when, walking downhill, he twisted his left knee on a wet surface, his right leg slipped, and he hit the ground with hyperflexed left knee. He noted that appellant subsequently had pain and swelling that worsened after walking his route. A magnetic resonance imaging (MRI) scan in May 2006 showed mild degenerative changes in the posterior horn of the medial meniscus but no definite tear. There was some mild tendinosis of the patellar tendon, otherwise the study was intact. X-rays over a year old, were reported normal. Arthroscopic surgery in February 2007 showed a tear of the medial meniscus, chondromalacia patella and an osteochondral injury to the articular surface and anterior aspect of the tibia. A second surgery in May 2008 showed degenerative changes with osteochondral injury in the anteromedial aspect of the tibia with chondromalacia patella and a meniscal tear. Appellant switched to a sedentary job. Walking and using the stairs caused pain and swelling. Appellant complained of a constant dull ache.

Dr. Alexander described his findings on physical examination. An x-ray showed no significant abnormalities. Dr. Alexander rated appellant's impairment on the diagnosis of tibial plateau fracture "because of the osteochondral injury or fracture that he had, which presumably occurred at the time of his fall." Appellant stated that the fracture fell into the class 1 category with a default impairment value of 10 percent, but mild functional history and physical findings, together with normal clinical studies, modified the default impairment value to 7 percent. An OWCP medical adviser agreed.

On February 24, 2011 OWCP issued a schedule award for an additional five percent impairment of the left lower extremity (seven percent total). It found that the weight of the medical evidence rested with Dr. Alexander's referee medical opinion. The decision stated, "This second opinion medical evaluation is deemed an independent medical evaluation or referee for these purposes."

On appeal, appellant's representative argues that Dr. Alexander was a second-opinion examiner and not a referee examiner. He asks that the Board modify OWCP's decision to reflect

[2] Docket No. 10-908 (issued November 18, 2010).

the rating given by Dr. Heyman or direct OWCP to resolve the conflict between those physicians.

LEGAL PRECEDENT

Section 8107 of FECA authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body.[3] Such loss or loss of use is known as permanent impairment. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[4]

ANALYSIS

Diagnosis-based impairment is the primary method of evaluation for the lower extremity. Once the impairment class has been determined based on the diagnosis, the grade is initially assigned the default value, which may then be modified slightly based on such nonkey factors as functional history and physical examination. This process is repeated for each separate diagnosis. In most cases, only one diagnosis in a region, such as the knee, will be appropriate. If a patient has two significant diagnoses, the examiner should use the diagnosis with the highest impairment rating in that region that is causally related.[5]

The first step in determining an impairment rating is to choose the diagnosis that is most applicable for the region being assessed. Reliability of the diagnosis is essential and the diagnosis should be consistent with the clinical history and findings at the time of the impairment assessment. Selecting the optimal diagnosis requires judgment and experience. 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. This will generally be the more specific diagnosis. Typically, one diagnosis will adequately characterize the impairment and its impact on activities of daily living.[6]

In the event that a specific diagnosis is not listed in the impairment grid, the examiner should identify a similar listed condition to be used as a guide to the impairment calculation. The rationale for this decision should be described.[7]

OWCP accepted appellant's occupational injury claim for internal derangement, chondromalacia and tendinitis of the left knee caused by walking his route. Dr. Heyman, appellant's orthopedic surgeon, did not choose the most applicable diagnosis. Instead, he

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404. As of May 1, 2009, any decision regarding a schedule award must be based on the sixth edition. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6.a (January 2010).

[5] A.M.A., *Guides* 497 (6th ed. 2009).

[6] *Id*. at 499.

[7] *Id*.

combined the impairments of several diagnoses. OWCP's medical adviser correctly noted that this was inconsistent with the methodology of the A.M.A., *Guides* and that the selection of the most applicable single diagnosis required medical judgment. Dr. Doman, the second-opinion orthopedic surgeon, selected the diagnosis of partial medial meniscectomy, but he did not explain why that diagnosis was most applicable for rating appellant's impairment.

Dr. Alexander, the most recent second-opinion orthopedic surgeon, made the same error. He based appellant's impairment rating on a diagnosis of tibial plateau fracture, but he offered no rationale for selecting that diagnosis over other internal derangements as the best reflection of appellant's impairment. For that reason alone, further development of the medical evidence is once again warranted.

There are other problems with Dr. Alexander's report. Dr. Alexander related a history of traumatic injury occurring on January 30, 2005. OWCP did not accept such an injury. When appellant filed his claim for workers' compensation and explained the employment factors that he believed were responsible for his left knee condition, he made no mention of twisting his knee or slipping and falling on a hyperflexed knee on January 30, 2005. Dr. Alexander's history of injury, therefore, is not supported by the record or consistent with the statement of accepted facts.

When he rated appellant's impairment, Dr. Alexander stated that it fit into the tibial plateau fracture diagnosis "because of the osteochondral injury or fracture that he had, which presumably occurred at the time of his fall." There was no fall, at least OWCP accepted no fall as factual and causally related to appellant's federal employment. Dr. Alexander did not explain what findings supported a diagnosis of tibial plateau fracture, or why the osteochondral lesion described during appellant's surgeries was physically or symptomatically more similar to a fractured bone than to the cartilage defects found under "primary knee joint arthritis" on page 511 of the A.M.A., *Guides*, or how he determined the angulation of the displacement to be something less than nine degrees when x-rays were normal.

The Board finds that medical evidence remains insufficient to establish the impairment of appellant's left lower extremity. The Board will set aside OWCP's February 24, 2011 decision and remand the case for a supplemental report from Dr. Alexander, one that accurately reflects the accepted history of injury and the accepted medical conditions,[8] one that provides medical rationale for selecting the one accepted diagnosis that most accurately reflects appellant's lower extremity impairment, and one that explains how he used Table 16-3 of the A.M.A., *Guides* to determine that impairment. After such further development of the evidence as might become necessary, OWCP shall issue an appropriate final decision on appellant's entitlement to a schedule award.

Appellant's representative correctly observes that Dr. Alexander was a second-opinion examiner, not an impartial medical specialist or referee examiner under section 8123(a) of FECA. There was no true conflict between Dr. Heyman and Dr. Doman because neither

[8] The accepted condition of internal derangement is nonspecific. If OWCP accepts that appellant's partial medial and lateral meniscectomies and osteochondral lesion were causally related to the physical demands of his letter carrier position, it should clarify its acceptance in the statement of accepted facts.

physician offered a probative assessment of impairment under the A.M.A., *Guides*. The matter currently rests with Dr. Alexander, who must provide rationale for his selection of the most applicable accepted diagnosis and for his determination of impairment under the A.M.A., *Guides*.

CONCLUSION

The Board finds that this case is not in posture for decision. Further development of the medical evidence is warranted.

ORDER

IT IS HEREBY ORDERED THAT the February 24, 2011 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: November 9, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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