U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of PATRICIA C. TRAVERS and U.S. POSTAL SERVICE,
MAIN POST OFFICE, Baltimore, MD

Docket No. 99-676; Submitted on the Record;
Issued February 14, 2001

DECISION and ORDER

Before WILLIE T.C. THOMAS, PRISCILLA ANNE SCHWAB,
VALERIE D. EVANS-HARRELL

The issue is whether appellant sustained more than a two percent permanent impairment of the left lower extremity for which she received a schedule award.

The Board has reviewed the record and finds that this case is not in posture for a decision, due to an unresolved conflict in the medical evidence.

The Office of Workers' Compensation Programs accepted that appellant sustained aggravation of chondromalacia of the left knee on March 9, 1989 in the performance of duty, with surgical repair of a torn medial meniscus on July 20, 1990. On June 9, 1997 appellant filed a claim for a schedule award. By decision dated January 20, 1998, the Office granted appellant a schedule award based upon a two percent permanent impairment of the left lower extremity. By letter dated February 4, 1998, appellant requested an oral hearing before an Office hearing representative, which was held on August 13, 1998. By decision dated October 7, 1998, the Office hearing representative affirmed the Office's January 20, 1998 decision.[1]

Section 8107 of the Federal Employees' Compensation 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 Office has adopted the American Medical Association (A.M.A.),

[1] Subsequent to the issuance of the Office's October 7, 1998 decision, appellant submitted additional evidence. The Board has no jurisdiction to review this evidence for the first time on appeal; *see* 20 C.F.R. § 501.2(c); *Robert D. Clark*, 48 ECAB 422, 428 (1997).

[2] 5 U.S.C. § 8107.

Guides to the Evaluation of Permanent Impairment as the uniform standard applicable to all claimants.[3]

In a report dated December 14, 1997, Dr. Zia A. Zakai, appellant's attending Board-certified orthopedic surgeon, provided findings on examination, noted that on July 12, 1989 she underwent arthroscopy of the knee with patellochondroplasty and a partial medial meniscectomy and opined that she had a 35 percent permanent impairment of the left knee. He did not explain how his impairment rating was derived in accordance with the A.M.A., *Guides.* Dr. Zakai related that appellant continued to complain of pain, swelling and giving way in her knee as well as pain on range of motion testing.

In a memorandum dated January 8, 1998, the Office medical adviser stated that appellant had a two percent permanent impairment of the left lower extremity, based upon a partial medial meniscectomy according to Table 64 at page 85 of the A.M.A., *Guides* (4th ed. 1993). He noted that to determine any impairment due to arthritis, standing anterior/posterior and lateral x-rays needed to be taken.

In a report dated June 22, 1998, Dr. Robert Macht, a Board-certified orthopedic surgeon and Office referral physician, provided findings on examination which included tenderness upon palpation about appellant's left knee, pain with motion and resistance against active motion of the knee, mild Grade IV weakness in flexion and extension and flexion of the knee limited to 120 degrees. He noted that x-rays revealed moderate narrowing of the medial compartment of the left knee joint with a cartilage interval of three millimeters.

Dr. Macht stated that appellant had a seven percent impairment of the left lower extremity due to the narrowing of her knee joint based on x-rays taken June 15, 1998 according to Table 62 at page 83 of the A.M.A., *Guides*, a seven percent impairment for gait derangement as per Table 36 at page 76 under mild class A, no impairment for limited range of motion as it did not exceed 110 degrees and a 2 percent diagnosis based impairment for her partial medial meniscectomy according to Table 64 at page 85. He added:

> "[Appellant], based on the rules of the [A.M.A., *Guides*], would have a [seven] percent impairment of the left leg for the arthritic changes or gait disturbance, which are equivalent…. This assessment of impairment understates her problem. Since it does not include the arthritis and limping as separate issues, it does not include the medial meniscectomy and does not include her level of pain. If the impairment figure is truly a level of her illness, how can it not include both the meniscectomy and the arthritis? It is, therefore, my conclusion that, based on [appellant's] pain, arthritis, gait and meniscectomy, there is a total 20 percent permanent impairment of her left lower extremity."

In a memorandum dated September 4, 1998, an Office medical consultant and a Board-certified orthopedic surgeon, Dr. Neven A. Popovic, reviewed the medical evidence and opined

[3] *A. George Lampo,* 45 ECAB 441, 443 (1994).

that appellant had no more than a two percent permanent impairment based upon a partial medial meniscectomy of the left lower extremity. He stated:

> "The [A.M.A., *Guides*] (Page 84, second paragraph) states that 'The physician, in general, should decide which estimate best describes the situation and should use only one approach for each anatomic part.' 'The evaluating physician must determine whether diagnostic or examination criteria best describe the impairment of a specific patient.' Simply stated, the [A.M.A., *Guides*] advised against using and adding multiple examination criteria for the same anatomic part. One should not use the diagnosis based estimate (Page 84, 3.2I) and combine the impairment values with those obtained on the basis of physical evaluations.
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> "Loss of joint cartilage is used for estimates of impairment due to arthritic changes. The measurements are obtained in a specific fashion (Page 82, 4th paragraph). X-ray report dated June 15, 1998 does not meet these criteria. In addition, [appellant's] knee x-rays shortly after injury already revealed osteoarthritic changes (report by Dr. Zakai dated March 16, 1989). Thus, these changes could not have been caused by the accepted injury and should not be used for rating purposes.
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> "The [A.M.A., *Guides*] also states that, 'In general, the impairment percents shown … make allowance for the pain that may accompany the musculoskeletal system impairment.'
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> "In the case of [appellant's] knee range of motion (flexion to 120 degrees) does not rate any knee impairment. Other conditions mentioned by Dr. Macht (letter dated June 22, 1998) such as narrowing of her knee joint (arthritis), gait derangement and pain are not ratable as per [A.M.A., *Guides*].
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> "I find no basis for ratings provided by Dr. Zakai.
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> "Taking all provided information into account, the rating is 2 [percent] impairment to the lower extremity on the basis of partial meniscectomy (Page 85, Table 64)."
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> The Board finds that the record requires further development of the evidence.

In this case, Dr. Zakai, appellant's attending Board-certified orthopedic surgeon, found that she had a 35 percent permanent impairment of her left lower extremity. Dr. Macht, an Office referral physician and also a Board-certified orthopedic surgeon, found a 20 percent permanent impairment. Dr. Popovic, an Office medical consultant and a Board-certified orthopedic surgeon, did not examine appellant but reviewed the medical evidence and determined that appellant had a two percent permanent impairment of the left lower extremity.

Section 8123(a) of the Act provides that, when there is a disagreement between the physician making the examination for the United States and the physician of the employee, a

third physician shall be appointed to make an examination to resolve the conflict.[4] When there are opposing medical reports of virtually equal weight and rationale, the case must be referred to an impartial specialist, pursuant to section 8123(a), to resolve the conflict in the medical evidence.[5] Since there is a disagreement between appellant's attending physician, Drs. Zakai, Popovic and Macht, the Office medical consultant and Office referral physician, respectively, as to the exact degree of permanent impairment to the left lower extremity, a conflict under 5 U.S.C. § 8123(a) is created.

On remand the Office should refer appellant, the case record and the statement of accepted facts to an impartial medical specialist for an evaluation consistent with the fourth edition of the A.M.A., *Guides* and the Office's procedure manual to determine the degree of permanent impairment of appellant's left lower extremity. The Office should authorize the impartial medical specialist to take appropriate x-rays and perform such diagnostic tests as he or she deems necessary to render an independent rationalized decision.

Drs. Macht and Popovic addressed the issue of whether diagnosis based impairment ratings or impairment ratings based on physical examination should be used. The Board notes that the Office's procedure manual states:

> "The fourth edition of the [A.M.A.,] *Guides* focuses more closely on specific conditions, which means that more tables are diagnosis based. These tables…include considerations such as pain and loss of strength, which in the past have usually been calculated separately. However, in using the fourth edition, it will be necessary to distinguish instances where such increments should be added from those where they should not be added because they are imbedded in the table used to calculate the impairment….
>
> "A table based on a specific diagnosis may be used either by itself, if no other impairment to the schedule member is present, or in combination with other tables if other impairments exist. For instance, Table 16 may be used to evaluate impairment from carpal tunnel syndrome, either alone or in combination with other tables if the function of the shoulder is affected. Such an evaluation would need to include any pain, atrophy and weakness for the shoulder, since this part of the body was not evaluated according to a table based on a specific diagnosis and, therefore, would not include increments for pain, atrophy and weakness….
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> "When a table based on a specific diagnosis is used, no additional increment for pain and loss of strength should be included in the determination of impairment."[6]

[4] *Robert W. Blaine*, 42 ECAB 474, 479 (1991); 5 U.S.C. § 8123(a).

[5] *See Robert D. Reynolds*, 49 ECAB 561, 565-66 (1998).

[6] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (October 1995).

The procedure manual provides a list of tables and sets of tables for determining permanent impairment which, the procedure manual states, "should be considered mutually exclusive."[7] The procedure manual also notes that the instructions in the A.M.A., *Guides* for use of the tables are "sometimes less clear" for the lower extremities than for the upper extremities.[8]

Dr. Popovic indicated that preexisting impairments are not to be considered in making a determination of permanent impairment, but the Office's procedure manual provides that "The percentage [of impairment] should include those conditions accepted by [the Office] as job related and any preexisting permanent impairment of the same member or function."[9]

The October 7, 1998 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision.

Dated, Washington, DC
February 14, 2001

Willie T.C. Thomas
Member

Priscilla Anne Schwab
Alternate Member

Valerie D. Evans-Harrell
Alternate Member

[7] *Id.*

[8] *Id.*

[9] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3(a)(3) (October 1990).