



knee meniscus tear. It also approved a partial medial meniscectomy, which appellant underwent on January 17, 2005.<sup>2</sup> Appellant received appropriate compensation benefits. He returned to full duty on March 2, 2005.

By letter dated November 30, 2005, appellant claimed a schedule award and submitted a July 7, 2005 report from Dr. Nicholas Diamond, an osteopath, utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5<sup>th</sup> ed. 2001) (A.M.A., *Guides*) and noted appellant's history of injury and treatment. Dr. Diamond referred to Figure 17-8 and noted that appellant had a grade of four out of five for motor strength deficit of the left quadriceps for knee extension.<sup>3</sup> Dr. Diamond referred to Table 18 and indicated that appellant had an impairment of three percent for his pain-related impairment.<sup>4</sup> He opined that appellant had an impairment of 15 percent to the left lower extremity.

In a December 12, 2005 report, an Office medical adviser applied the findings of Dr. Diamond to the A.M.A., *Guides*.<sup>5</sup> He referred to Table 17-33 and noted that appellant underwent a partial medial meniscectomy which represented two percent impairment to the left lower extremity.<sup>6</sup> Dr. Diamond also explained that appellant would not be entitled to an additional 12 percent for muscle weakness based on manual muscle testing. He referred to section 17.2p manual muscle testing, and explained that this "depends on the examinee's cooperation and is subject to his or her conscious or unconscious control." Dr. Diamond referred to section 17.2p manual muscle testing, and noted that this was not considered an objective measurement.<sup>7</sup> He also explained that, according to Table 17-2,<sup>8</sup> diagnosis-based estimates could not be combined with muscle strength testing. Additionally, the Office medical adviser referred to Figure 18-1 and noted that appellant should receive an award of two percent for pain.<sup>9</sup> He concluded that appellant reached maximum medical improvement on July 7, 2005 and recommended a schedule award of four percent to the left lower extremity.

On March 1, 2006 the Office granted appellant a schedule award for four percent permanent impairment of the left lower extremity. The award covered a period of 80.64 days from July 7 to September 25, 2005.

On March 13, 2006 appellant's representative requested a hearing, which was held on July 31, 2006.

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<sup>2</sup> The Office also accepted appellant's claim for a recurrence on January 17, 2005.

<sup>3</sup> A.M.A., *Guides* 532.

<sup>4</sup> *Id.* at 574.

<sup>5</sup> He also noted that, while Dr. Diamond had provided findings for the right shoulder, this was not an accepted condition.

<sup>6</sup> A.M.A., *Guides* 546.

<sup>7</sup> *Id.* at 531, 532.

<sup>8</sup> *Id.* at 526.

<sup>9</sup> *Id.* at 574.

In a November 20, 2006 decision, the Office hearing representative determined that there was a conflict between Dr. Diamond, who indicated that appellant had an impairment of 15 percent to the left lower extremity and the Office medical adviser, who opined that appellant had four percent impairment to the left lower extremity. The Office hearing representative remanded the case for referral to an impartial medical examiner to resolve the conflict.

On February 6, 2007 the Office referred appellant, together with a statement of accepted facts and the medical record, to Dr. Jerry Case, a Board-certified orthopedic surgeon, for an impartial medical evaluation. In a March 12, 2007 report, Dr. Case noted appellant's history of injury and treatment. He conducted a physical examination and noted that appellant had well-healed scars from his surgery, walked with a normal gait and had no instability. Appellant had negative McMurray's, Lachman's and anterior drawer tests and no atrophy. Dr. Case noted that appellant had flexion to 125 degrees and full extension. He opined that no further medical treatment was necessary and that appellant reached maximum medical improvement one year after his January 17, 2005 surgery. Dr. Case utilized the A.M.A., *Guides* and advised that appellant had two percent impairment for a partial meniscectomy and an additional two percent impairment for the partial medial meniscectomy performed about four years earlier. He concluded that appellant had a total four percent impairment of the left lower extremity.

In a March 21, 2007 report, the Office medical adviser agreed that appellant had four percent impairment to the left lower extremity.

By decision dated April 4, 2007, the Office denied appellant's claim for an additional award.

By letter dated April 10, 2007, appellant requested a hearing.

In a July 3, 2007 decision, the Office hearing representative set aside and remanded the April 4, 2007 decision. The Office hearing representative noted that, because the Office medical adviser was involved in the conflict, he could not review the report of the impartial medical examiner. The Office hearing representative indicated that the impartial medical examiner's report should be referred to another Office medical adviser and a *de novo* decision should be issued.

In a July 17, 2007 report, the second Office medical adviser reviewed appellant's history of injury and treatment. He utilized the A.M.A., *Guides* and indicated that appellant was entitled to an impairment of two percent for his first partial medial meniscectomy and an additional impairment of two percent for his second partial medial meniscectomy. The medical adviser indicated that there was no rating for pain as Dr. Case noted that appellant did not have any pain or swelling. He concluded that appellant had no more than the four percent schedule award to the left lower extremity.

By decision dated July 24, 2007, the Office found that the evidence was insufficient to establish that appellant was entitled to an additional schedule award.

On July 26, 2007 appellant's representative requested a hearing, which was held on November 29, 2007.

By decision dated February 12, 2008, the Office hearing representative affirmed the Office's July 24, 2007 decision.

### **LEGAL PRECEDENT**

The schedule award provision of the Act<sup>10</sup> and its implementing regulations<sup>11</sup> set 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. The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.<sup>12</sup> The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.<sup>13</sup>

For lower extremity impairments due to meniscectomies or ligament injuries involving the knees, Table 17-1, page 525 of the A.M.A., *Guides*<sup>14</sup> directs the clinician to utilize section 17.2j, beginning at page 545,<sup>15</sup> as the appropriate method of impairment assessment. Section 17.2j, entitled Diagnosis-Based Estimates, instructs the clinician to assess the impairment using the criteria in Table 17-33 at page 546, entitled Impairment Estimates for Certain Lower Extremity Impairments.<sup>16</sup> According to Table 17-33, a partial medial meniscectomy is equivalent to a two percent impairment of the lower extremity.<sup>17</sup>

The A.M.A., *Guides* provides for three separate methods for calculating the impairment of an individual: anatomic, functional and diagnosis based.<sup>18</sup> The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.<sup>19</sup> The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligamentous instability, bursitis and various surgical procedures, including joint replacements and meniscectomies.<sup>20</sup> In

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<sup>10</sup> 5 U.S.C. § 8107.

<sup>11</sup> 20 C.F.R. § 10.404 (1999).

<sup>12</sup> *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

<sup>13</sup> 20 C.F.R. § 10.404.

<sup>14</sup> A.M.A., *Guides* 525, Table 17-1 (5<sup>th</sup> ed. 2001).

<sup>15</sup> *Id.* at 545.

<sup>16</sup> *Id.* at 546, Table 17-33 (5<sup>th</sup> ed. 2001).

<sup>17</sup> *Id.*

<sup>18</sup> *Id.* at 525.

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

certain situations, diagnosis-based estimates are combined with other methods of assessment.<sup>21</sup> The functional method is used for conditions when anatomic changes are difficult to categorize or when functional implications have been documented and includes range of motion, gait derangement and muscle strength.<sup>22</sup> The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.<sup>23</sup> When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.<sup>24</sup> If more than one method can be used, the method that provides the higher impairment rating should be adopted.<sup>25</sup>

The Federal Employees' Compensation Act<sup>26</sup> provides that, if there is disagreement between the physician making the examination for the Office and the employee's physician, the Office shall appoint a third physician who shall make an examination.<sup>27</sup> In cases where it has referred appellant to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.<sup>28</sup>

### ANALYSIS

The Office accepted appellant's claim for a left knee meniscus tear and authorized a partial medial meniscectomy, which appellant underwent on January 17, 2005.

The Office determined that a conflict of medical opinion existed regarding the nature and extent of appellant's impairment due to the March 15, 2000 work injury between Dr. Diamond, appellant's physician, who supported an impairment of 15 percent to the left lower extremity and the Office medical adviser, who opined that appellant had an impairment of 4 percent to the left lower extremity. It properly referred appellant to Dr. Case, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the conflict.

In a March 12, 2007 report, Dr. Case noted appellant's history of injury and treatment and conducted a physical examination. Using the diagnosis-based estimates in Table 17-33,

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<sup>21</sup> The A.M.A., *Guides* specifically excludes combining diagnosis-based estimates with range of motion deficits due to ankylosis. A.M.A., *Guides* 526 Table 17-2.

<sup>22</sup> A.M.A., *Guides* at 525, Table 17-1.

<sup>23</sup> *Id.* at 548, 555.

<sup>24</sup> *Id.* at 526.

<sup>25</sup> *Id.* at 527, 555.

<sup>26</sup> 5 U.S.C. §§ 8101-8193, 8123(a).

<sup>27</sup> 5 U.S.C. § 8123(a); *Shirley Steib*, 46 ECAB 309, 317 (1994).

<sup>28</sup> *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

page 546, he reported that appellant had a two percent lower extremity impairment due to a partial meniscectomy on the left. Dr. Case utilized the A.M.A., *Guides* and noted that appellant should receive an impairment of two percent for a partial meniscectomy. He also rated an additional two percent for a prior partial medial meniscectomy four years prior. Dr. Case examined appellant and reported essentially normal findings. He concluded that appellant four percent impairment to the left lower extremity and had reached maximum medical improvement one year after his January 17, 2005 surgery.

The Board finds that Dr. Case's opinion is entitled to special weight as his report is sufficiently well rationalized and based upon a proper factual background. The Office properly relied upon his report in finding that appellant had no more than four percent impairment of the left lower extremity. Dr. Case examined appellant, reviewed his medical records and reported accurate medical and employment histories. There is no probative medical evidence of record establishing that appellant has more than a four percent impairment of the left lower extremity.

On appeal, appellant contended that the impartial medical examiner's report was deficient, as he did not appear to be aware of appellant's prior surgery. However, Dr. Case took into account appellant's prior surgery in rating his overall impairment. Furthermore, appellant asserted that it was error for the first Office medical adviser, who created the medical conflict with Dr. Diamond, to review the report of Dr. Case, the impartial specialist. However, this procedural error was noted by the Office hearing representative in a July 3, 2007 decision.<sup>29</sup> The Office hearing representative remanded the use for review by having a second Office medical adviser. This action by the hearing representative remedied the procedural error.<sup>30</sup>

### CONCLUSION

The Board finds that appellant has more than four percent impairment of his left lower extremity, for which he received a schedule award.

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<sup>29</sup> See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.11(d) (April 1993).

<sup>30</sup> See *Richard R. LeMay*, 56 ECAB 341 (2005) (where the same Office medical adviser who created a medical conflict reviewed the impartial specialist's report, the Board remanded the case for another Office medical adviser to review the impartial specialist's report).

**ORDER**

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs' hearing representative dated February 12, 2008 is affirmed.

Issued: January 13, 2009  
Washington, DC

David S. Gerson, Judge  
Employees' Compensation Appeals Board

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

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