United States Department of Labor
Employees' Compensation Appeals Board

G.W., Appellant	)	
and	)	**Docket No. 08-1767**
	)	**Issued: May 14, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Newark, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 10, 2008 appellant filed a timely appeal from the Office of Workers' Compensation Programs' hearing representative decision dated March 5, 2008 which affirmed a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination.

ISSUE

The issue on appeal is whether appellant has more than a 26 percent permanent impairment of his right lower extremity, for which he received a schedule award.

FACTUAL HISTORY

This case has previously been on appeal before the Board.[1] In a January 7, 2002 decision, the Board found that the case was not in posture for decision on the extent of appellant's permanent impairment as the report of the impartial medical examiner was

[1] Docket No. 00-1935 (issued January 7, 2002).

insufficient to resolve the conflict in the medical evidence between an Office medical adviser, who found a 24 percent impairment to the right leg and appellant's physician, Dr. Ronald Potash, a Board-certified surgeon, who found 65 percent impairment of the right leg. The Board remanded the case to the Office for a supplemental report regarding the extent of appellant's impairment in accordance with the relevant standards of the A.M.A., *Guides.* The facts and the history contained in the prior appeal are incorporated by reference.[2]

On February 23, 2004 the Office referred appellant to Dr. Robert Dennis, a Board-certified orthopedic surgeon, for an impartial medical evaluation to resolve the conflict in opinion between Dr. Potash and the Office medical adviser.

In a report dated March 12, 2004, Dr. Dennis reviewed appellant's history of injury and treatment. He examined appellant and noted that his right knee had "actually undergone three surgeries, one prior to this injury and unrelated to this injury the year before 1987." Dr. Dennis considered that his comparison of the two knees, "knowing that the left knee had surgery when [appellant] was 18 years old, leaving it less than normal even at this time and not available for full comparison" with the full range of motion of the left knee diminished by 10 degrees in flexion and 5 degrees in extension compared to normal and compared to the opposite side. He indicated that appellant had "ankylosis of about 12 degrees of varus deformity on the right side." Dr. Dennis also advised that appellant had weakness and atrophy but explained that he only measured atrophy as his right leg was about equal in length to the left leg, noting that he was aware that the left leg was less than normal because of the prior surgery. He advised that he was utilizing the diagnosis-based estimate (DBE) method.[3] Dr. Dennis noted that atrophy of the muscles, hamstrings and quadriceps was considered moderate according to Table 17-6 and resulted in an impairment of 10 percent.[4] He referred to Table 17-8 and noted that strength loss was not utilized as it was "redundant."[5] Dr. Dennis referred to Table 17-10 and determined that appellant had a loss of range of motion in the mild category which correlated to six percent impairment.[6] He found that appellant's varus deformity was very mild with comparison of the left knee and prior surgery and concluded that he had three percent impairment under Table 17-20.[7] Pursuant to Table 17-31,[8] Dr. Dennis estimated seven percent impairment for

[2] Subsequently, on April 15, 2002, the Office referred appellant to Dr. Carl Mercurio for an impartial examination, who opined that appellant had 17 percent impairment. In a March 25, 2003 decision, an Office hearing representative directed the Office to obtain a new impartial medical evaluation as Dr. Mercurio regularly performed fitness-for-duty examinations for the employing establishment. The Office referred appellant for an impartial examination with Dr. David Rubinfeld, a Board-certified orthopedic surgeon, who, on July 17, 2003, opined that he had no more than 17 percent impairment. In a January 20, 2004 decision, an Office hearing representative remanded for referral to a new referee physician, finding that Dr. Rubinfeld's opinion was tainted as the Office improperly failed to remove Dr. Mercurio's report from the case file record as previously instructed.

[3] A.M.A., *Guides* 526.

[4] *Id*. at 530.

[5] *Id*. at 532.

[6] *Id*. at 537.

[7] *Id*. at 540.

[8] *Id*. at 544.

cartilage damage based upon the fact that appellant was offered a high tibial osteotomy and an eventual total knee replacement. He found that appellant had 26 percent impairment of the right lower extremity.

On May 29, 2004 an Office medical adviser responded to certain questions posed by the Office and recommended that Dr. Dennis' conclusions be accepted since there had been so much "confusion and so many referee exam[ination]s to resolve the conflict."

On April 5, 2004 the Office granted appellant a schedule award for an additional nine percent impairment of the right lower extremity. The award covered a period of 25.92 weeks from March 12 to September 9, 2004. On April 12, 2004 appellant's representative requested a hearing.

In a May 3, 2007 decision, an Office hearing representative found that the Office medical adviser did not adequately explain why he accepted the ratings of Dr. Dennis in view of certain problematic aspects of his report, such as not specifying range of motion measurements or addressing impairment findings for cartilage damage. The hearing representative remanded the case to obtain a reasoned opinion from the Office medical adviser and, if necessary, a supplemental report from Dr. Dennis.

On June 1, 2007 the Office medical adviser explained that there was no impairment provided for cartilage damage because there were no x-rays taken to demonstrate joint space loss. He advised that there was no table in the A.M.A., *Guides,* for knee valgus unless a fracture was present, which was not appellant's case. The Office medical adviser noted that Dr. Dennis rated valgus as three percent and he "agreed that a mild [valgus] of 1 [to] 10 caused some impairment, this is a judgment call." He also determined that appellant had some atrophy, which was mild and he allowed the maximum provided by the A.M.A., *Guides* "for mild quad atrophy." The Office medical adviser referred to Table 17-10[9] and noted that 5 degrees of extension would warrant 10 percent impairment, 110 degrees of flexion would warrant 0 percent. He note that 12 degrees of varus would equate to three percent but there was no table or figure in the A.M.A., *Guides*. The Office medical adviser referred to Table 17-31[10] and indicated that appellant had five percent impairment for patella femoral crepitus. He referred to Table 17-6[11] and noted that appellant had mild quadriceps atrophy, with an impairment range of three to eight percent and awarded him eight percent. The Office medical adviser concluded that appellant had 26 percent impairment of the right leg.

In a July 24, 2007 decision, the Office found that appellant did not have greater than a 26 percent permanent impairment to the right lower extremity.

On August 7, 2007 appellant's representative requested a hearing, which was held on December 12, 2007. Counsel alleged that Dr. Dennis' opinion was flawed because he reviewed medical evidence from the disqualified July 7, 1998 report of a prior impartial medical examiner,

[9] *See supra* note 6.

[10] *See supra* note 8.

[11] *See supra* note 4.

Dr. Joseph Andolino. Appellant's representative also alleged that Dr. Dennis erroneously compared appellant's right knee to his left knee instead of a normal left knee.

On December 19, 2007 appellant submitted comments regarding his claim. He indicated that he was hit by a car in November 1964 and was placed in two body casts over a period of six months. Appellant underwent surgery to his left femur in June 1965 and was unable to bend his left knee until a year later. He also questioned Dr. Dennis' statement regarding the length of his examination and persons who were present. Appellant related that he had a completely torn posterior cruciate ligament and he did not have surgery on his left knee. He also noted several errors in Dr. Dennis report, which included an incorrect statement that he had orthopedic surgery November 2, 1995. Appellant also indicated that, despite a recommendation for a total knee replacement, he declined because of his age and life expectancy.

By decision dated March 5, 2008, the Office hearing representative affirmed the July 24, 2007 decision.[12]

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[13] and its implementing regulations[14] 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.[15] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[16]

The A.M.A., *Guides* provides for three separate methods for calculating the lower extremity permanent impairment of an individual: anatomic, functional and diagnosis based.[17] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[18] The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as

[12] The Office hearing representative noted appellant's allegations regarding the report of Dr. Andolino and explained that his report was not disqualified and the referral to his findings was not inappropriate. He also noted appellant's allegations regarding Dr. Dennis and his comparison of the right knee to the left knee and found that the physician was aware of the conditions of both knees and provided appellant with the maximum impairment rating for atrophy provided by the A.M.A., *Guides.*

[13] 5 U.S.C. § 8107.

[14] 20 C.F.R. § 10.404 (1999).

[15] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[16] 20 C.F.R. § 10.404.

[17] A.M.A., *Guides* 525.

[18] *Id.*

ligamentous instability, bursitis and various surgical procedures, including joint replacements and meniscectomies.[19] 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.[20] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[21] 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.[22] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[23]

Section 8123(a) of the Act 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.[24] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[25]

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 or elaboration, it must secure a supplemental report from the specialist to correct the defect in his original report.[26] However, when the impartial specialist is unable to clarify or elaborate on the original report or if the 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 another impartial specialist for the purpose of obtaining a rationalized medical opinion on the issue.[27] Unless this procedure is carried out by the Office, the intent of section 8123(a) of the Act will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.[28]

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[19] *Id.*

[20] *Id.* at 525, Table 17-1.

[21] *Id.* at 548, 555.

[22] *Id.* at 526.

[23] *Id.* at 527, 555.

[24] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan*), 45 ECAB 207 (1993).

[25] *See Roger Dingess*, 47 ECAB 123 (1995); *Glenn C. Chasteen*, 42 ECAB 493 (1991).

[26] *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232 (1988); *Ramon K. Ferrin, Jr.*, 39 ECAB 736 (1988).

[27] *Roger W. Griffith*, 51 ECAB 491 (2000); *Talmadge Miller*, 47 ECAB 673 (1996).

[28] *Roger W. Griffith, id.*; *Harold Travis*, 30 ECAB 1071 (1979).

ANALYSIS

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

The Office referred appellant to Dr. Dennis for an imparted medical examination. On March 12, 2004 Dr. Dennis provided findings on physical examination and determined that appellant had an impairment of 26 percent to the right lower extremity. He reviewed appellant's history of injury and treatment and addressed his preexiting condition to his left knee. However, Dr. Dennis' report is not sufficiently rationalized to be given special weight.[29] While he indicated that he was utilizing the DBE method to determine appellant's impairment, he actually used four impairment rating methods. The Board notes that he utilized arthritis (Table 17-31), muscle weakness (Table 17-8), muscle atrophy (Table 17-6) and the anatomic method for varus deformity (Table 17-20).[30] As noted, the A.M.A., *Guides* provides that, if more than one rating method can be used, the method that provides the higher rating should be adopted. However, Dr. Dennis did not address why he combined several impairment methods such as loss of atrophy or range of motion to a DBE, which are not permitted under the cross-usage chart, Table 17-2 at page 526 of the A.M.A., *Guides*. He merely added all of the various ratings. Dr. Dennis also failed to provide any measurements to show how he arrived at 10 percent impairment for atrophy under Table 17-6 or 6 percent impairment for loss of range of motion under Table 17-10.[31] Furthermore, he provided an estimate of seven percent for cartilage damage based upon the fact that appellant was offered a high tibial osteotomy and an eventual total knee replacement pursuant to Table 17-31. However, Dr. Dennis did not provide cartilage interval measurements as shown on an x-ray or otherwise explain this rating pursuant to the A.M.A., *Guides*.[32]

The Board finds that Dr. Dennis did not rate impairment in conformance with the A.M.A., *Guides*. His report is not entitled to special weight or sufficient to resolve the conflict in the medical opinion regarding appellant's right lower extremity impairment. The conflict in the medical evidence has not been resolved.

There remains an unresolved conflict in the medical opinion regarding the extent of appellant's right leg permanent impairment. The case will be remanded for the Office to request a supplemental opinion from Dr. Dennis. If he is unwilling or unavailable to render such an opinion, the Office should select another impartial medical specialist for an evaluation of appellant and an opinion on the extent of impairment to the right lower extremity.

CONCLUSION

The Board finds that the conflict in the medical evidence was not properly resolved and the case requires further development.

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[29] *See supra* note 25.

[30] A.M.A., *Guides* 530, 540.

[31] *Id*. at 530, 537.

[32] *See supra* note 8.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers Compensation Programs' hearing representative dated March 5, 2008 is set aside and the case remanded for further action consistent with this decision.

Issued: May 14, 2009
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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