# United States Department of Labor
# Employees' Compensation Appeals Board

| | | |
|---|---|---|
| **A.C., Appellant** | ) | |
| **and** | ) | **Docket No. 08-2316** |
| | ) | **Issued: May 22, 2009** |
| **U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Winter Springs, FL, Employer** | ) | |

*Appearances:*
*Ronald S. Webster, Esq.*, for the appellant
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

### ***JURISDICTION***

On August 22, 2008 appellant filed a timely appeal from a July 2, 2008 decision of the Office of Workers' Compensation Programs denying her request for reconsideration and an August 27, 2007 decision denying her claim for an additional schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this schedule award decision.

### ***ISSUES***

The issues are: (1) whether appellant has more than two percent permanent impairment of the right lower extremity for which she received a schedule award; and (2) whether the Office properly denied appellant's request for reconsideration pursuant to section 8178(a).

## ***FACTUAL HISTORY***

This is the second appeal in this case.[1] By decision dated April 16, 2007, the Board remanded the case for further development of the medical evidence. The facts of the previous Board decision are incorporated herein by reference.

On May 8, 2004 appellant, then a 58-year-old mail handler, sustained a right knee sprain and strain when she tripped on a piece of metal and twisted her knee. In a June 7, 2004 report and June 8, 2004 addendum, Dr. Joseph B. Billings, an attending Board-certified orthopedic surgeon, indicated that appellant had preexisting mild right knee degenerative arthritis. However, appellant had not experienced any trauma to the knee prior to the May 8, 2004 accident at work. A May 27, 2004 magnetic resonance imaging (MRI) scan revealed a right meniscal tear. Findings included patellofemoral articular cartilage that appeared somewhat thinned and irregular consistent with chondromalacia patella. On July 30, 2004 appellant underwent arthroscopic surgery and a partial medial meniscectomy of the right knee performed by Dr. Billings. On October 20, 2004 Dr. Billings stated that x-rays revealed moderate degenerative arthritis of the medial compartment of the right knee. He opined that she had not reached maximum medical improvement following her surgery due, in part, to an exacerbation of her preexisting right knee arthritis. On December 1, 2004 Dr. Billings stated that appellant had reached maximum medical improvement. He calculated three percent impairment based on her meniscectomy. In a May 9, 2005 report, Dr. Billings calculated 32 percent right knee impairment, including 25 percent impairment for Grade 1 weakness and 7 percent for mild arthritis in her knee, based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] He calculated three percent impairment under the 1996 Florida Uniform Permanent Impairment Rating Schedule. On May 20, 2005 appellant filed a claim for a schedule award. In a July 7, 2005 report, Dr. James W. Dyer, a Board-certified orthopedic surgeon and an Office medical adviser, stated that appellant had two percent impairment of her right knee for the partial medial meniscectomy performed on July 30, 2004, based on Table 17-33 at page 546 of the A.M.A., *Guides,* fifth edition (diagnosis-based estimates). He stated that Dr. Billings calculated 32 percent impairment based on a state impairment guide which is not used to determine impairment under the Federal Employees' Compensation Act.[3] By decision dated November 29, 2005, the Office granted appellant a schedule award based on two percent impairment of the right lower extremity for 5.76 weeks, from May 9 to June 18, 2005.

[1] Docket No. 07-199 (issued April 16, 2007).

[2] It appears that Dr. Billings based the 25 percent impairment due to Grade 1 muscle weakness of appellant's right knee on Tables 17-7 and 17-8 at pages 531 and 532 of the fifth edition of the A.M.A., *Guides.* It appears that he based the seven percent impairment for mild arthritis based on Table 17-31 at page 544. However, Dr. Billings did not provide cartilage level measurement as shown by x-ray which is required for the use of Table 17-31.

[3] The Board notes that Dr. Dyer misstated the source of the impairment guidelines used by Dr. Billings in his May 9, 2005 impairment calculation. Dr. Billings calculated 32 percent impairment of appellant's right knee, including 25 percent for Grade 1 weakness and 7 percent for mild arthritis, based on the fifth edition of the A.M.A., *Guides.* He calculated three percent impairment under the state impairment guidelines.

Following the Board's April 16, 2007 decision, the Office referred appellant for a second opinion evaluation. In a June 22, 2007 report, Dr. David B. Lotman, a Board-certified orthopedic surgeon, reviewed the medical history and provided findings on physical examination. He stated that appellant moved without antalgia and was not using a brace or assistive device. There was no right knee effusion. There was some patellofemoral crepitation on passive range of motion and on patellofemoral manipulation. There was tenderness from the medial joint line down to the medial tibial plateau. There was also tenderness on palpation of the lateral femoral condyle. Passive range of motion was from 0 degrees of extension to 160 degrees of flexion. There was very slight nonreproducible medial compartment crepitation. The knee was stable to varus and valgus and anterior and posterior stress. There was no rotary instability. There was a varus deformity of approximately 15 degrees which antedated the accepted right knee sprain. Dr. Lotman found no impairment due to sensory or motor deficits. He calculated two percent right lower extremity impairment for appellant's partial medial meniscectomy based on Table 17-33 at page 546 of the A.M.A., *Guides*. Dr. Lotman stated, "I believe that this is a more efficient way to rate her knee than to consider range of motion, weakness, etc." The Office asked Dr. Lotman to provide a measurement of appellant's right knee cartilage level shown on x-ray. Dr. Lotman responded that he based his impairment rating on the diagnosis-based estimates section of the A.M.A., *Guides* which did not require measurement of cartilage thickness. For that reason, no x-rays were taken. Dr. Lotman indicated that he would provide a right knee cartilage measurement if the Office felt it was necessary and would "see if it alters my rating at all."

On August 9, 2007 Dr. Dyer stated that appellant had two percent impairment of the right lower extremity based on the report from Dr. Lotman and the A.M.A., *Guides*.[4] He opined that there was no need for measurement of appellant's right knee cartilage level by x-ray because arthritis of the right knee was not an accepted condition.

By decision dated August 27, 2007, the Office denied appellant's claim for an additional schedule award.

Appellant requested reconsideration and submitted clinical notes dated April 28, 2008 from a physician assistant.[5] By decision dated July 2, 2008, the Office denied appellant's request

[4] *See* Federal (FECA) Procedural Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(d) (October 2005) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

[5] A physician assistant does not qualify as a physician under the Act. *See* 5 U.S.C. § 8101(2) which provides: "'physician' includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by state law"; *see also Roy L. Humphrey*, 57 ECAB 238 (2005); *Jennifer L. Sharp*, 48 ECAB 209 (1996). Physician assistants, registered nurses, licensed practical nurses and physical therapists are not physicians as defined under the Act and their opinions are of no probative value.

for reconsideration on the grounds that the evidence was insufficient to warrant further merit review.[6]

## ***LEGAL PRECEDENT -- ISSUE 1***

Section 8107 of the Federal Employees' Compensation Act[7] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[8]

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.[9] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[10] 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.[11] 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.[12] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[13] 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.[14] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[15]

---

[6] Subsequent to the July 2, 2008 Office decision, appellant submitted additional evidence. The Board's jurisdiction is limited to the evidence that was before the Office at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c). The Board may not consider this evidence for the first time on appeal.

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

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

[10] *Id.*

[11] *Id.*

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

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

[14] *Id.* at 526.

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

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 [of Labor] shall appoint a third physician who shall make an examination."[16] 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.

## ***ANALYSIS -- ISSUE 1***

The Board finds that this case is not in posture for a decision due to a conflict between Dr. Billings and Dr. Lotman as to the degree of appellant's right knee impairment.

Dr. Lotman found no impairment of appellant's right knee due to loss of range of motion or sensory or motor deficit. He calculated two percent right lower extremity impairment for her partial medial meniscectomy based on Table 17-33 at page 546 of the A.M.A., *Guides*. Dr. Lotman stated, "I believe that this is a more efficient way to rate her knee than to consider range of motion, weakness, etc." However, he did not provide sufficient rationale for his choice of impairment rating method. As noted, if more than one rating method can be used, the method that provides the higher impairment rating should be adopted. Dr. Lotman did not consider whether appellant had impairment due to muscle weakness. As noted, Dr. Billings included muscle weakness in his impairment rating.

Regarding impairment due to arthritis, Dr. Billings indicated in June 2004 that appellant had preexisting mild right knee degenerative arthritis. However, appellant had not experienced any trauma to the knee prior to the May 8, 2004 accident at work when she twisted and fell on her knee. On October 20, 2004 Dr. Billings opined that appellant had not reached maximum medical improvement following her July 30, 2004 right knee surgery due, in part, to an exacerbation of her preexisting right knee arthritis. In a May 9, 2005 report, Dr. Billings calculated 32 percent right knee impairment, including 25 percent impairment for Grade 1 muscle weakness and 7 percent for mild arthritis in her knee, based on the fifth edition of the A.M.A., *Guides*. Although arthritis is not an accepted condition, he indicated that the May 8, 2004 employment injury aggravated appellant's preexisting arthritis and caused seven percent right knee impairment due to arthritis. It is well established that, in determining the amount of the schedule award for a member of the body that sustained an employment-related impairment, preexisting impairments are to be included in the evaluation of permanent impairment.[17] The Office asked Dr. Lotman to provide a measurement of appellant's right knee cartilage level by x-ray. He responded that his impairment rating was based on the diagnosis-based estimates section of the A.M.A., *Guides*, which did not require measurement of cartilage thickness. However, Dr. Lotman did not explain why he did not consider the separate section in the A.M.A., *Guides* regarding impairment due to arthritis, section 17.2h at pages 544 to 545. He indicated that he would provide a right knee cartilage measurement only if the Office felt it was necessary. In its April 16, 2007 decision, the Board specifically instructed the Office to obtain a medical report

[16] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

[17] *See Beatrice L. High*, 57 ECAB 329, 332 (2006).

which included cartilage level measurements as shown on x-ray. The Board also noted in its decision that the cross-usage chart, Table 17-2, permits the combination of diagnosis-based impairment from Table 17-33 with Table 17-31 for impairment related to arthritis. The Board further noted that an alternative rating method was the use of Table 17-8 at page 532 of the A.M.A., *Guides* for muscle weakness. Dr. Billings included impairment for muscle weakness in his impairment rating. However, Table 17-2 does not permit the combination of impairment for muscle weakness with impairment due to arthritis.

Due to the conflict in the medical opinion evidence between Dr. Billings and Dr. Lofton regarding appellant's right lower extremity impairment, the case is remanded for referral to an impartial medical specialist.

## ***CONCLUSION***

The Board finds that this case is not in posture for a decision. On remand, the Office should refer appellant to an impartial medical specialist to resolve the conflict in the medical opinion evidence. The impartial medical specialist should provide a comprehensive medical report which provides an impairment rating for appellant's right lower extremity, based on correct application of the A.M.A., *Guides.* The impairment rating should be based on the method which provides the highest percentage of impairment. The Board's resolution of the first issue renders the second issue moot.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the decisions of the Office of Workers' Compensation Programs dated July 2, 2008 and August 27, 2007 are set aside and the case is remanded for further action consistent with this decision of the Board.

Issued: May 22, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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