



an arthroscopic chondroplasty of the medial femoral condyle. On December 10, 2002 she underwent a partial medial meniscectomy. On June 17, 2003 appellant underwent a complete medial meniscectomy followed by an open partial joint replacement with a unispacer component. On June 10, 2004 she underwent a revision of the left medial unispacer to a left unicompartmental replacement. Appellant subsequently claimed a schedule award.

To resolve a conflict between appellant's physician<sup>2</sup> and an Office medical adviser,<sup>3</sup> the Office referred appellant, together with the medical record and a statement of accepted facts, to Dr. David A. Bundens, a Board-certified orthopedic surgeon, who advised that appellant's left knee impairment should be considered based on arthritis and loss of meniscus, not range of motion. Dr. Bundens rated 20 percent for maximum cartilage loss plus three percent for loss of meniscus. Addressing the attending physician's rating for loss of motion, Dr. Bundens noted that this was not appellant's major problem. He noted that she showed greater range of motion on his examination -- 120 degrees flexion and 14 degrees flexion -- which amounted to an impairment of only 15 percent.

On June 13, 2006 the Office issued a schedule award for a 26 percent impairment of the left lower extremity.

On January 30, 2007 Dr. Bundens reiterated his impairment rating. He gave appellant the maximum rating for cartilage loss and three percent for loss of meniscus. An Office medical adviser agreed with Dr. Bundens in rating the maximum for cartilage loss, or 20 percent. But he combined this with seven percent for a one-degree anterior drawer sign, for a total rating of 26 percent.

On February 11, 2008 the Office reviewed the merits of appellant's claim and denied modification of its June 13, 2006 decision. In a decision dated August 11, 2008, an Office hearing representative affirmed this decision. He found that Dr. Bundens' opinion represented the weight of the medical evidence and established a 23 percent impairment of the left lower extremity.

### **LEGAL PRECEDENT**

Section 8107 of the Federal Employees' Compensation Act<sup>4</sup> 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment*.<sup>5</sup>

---

<sup>2</sup> Dr. David Weiss, an osteopath, found 10 percent impairment due to left knee flexion, 20 percent impairment due to left knee flexion contracture, and a three percent pain-related impairment, for a total left lower extremity impairment of 33 percent.

<sup>3</sup> The Office medical adviser reported that appellant could not receive both loss of motion and contracture, and so rated 20 percent for contracture, three percent for pain, for a total impairment of 23 percent.

<sup>4</sup> 5 U.S.C. § 8107.

<sup>5</sup> 20 C.F.R. § 10.404.

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.<sup>6</sup> When there exist opposing medical reports of virtually equal weight and rationale, and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.<sup>7</sup> When the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting a defect in the original report. When the impartial medical specialist's statement of clarification or elaboration is not forthcoming or if the specialist is unable to clarify or elaborate on the original report or if the specialist's supplemental report is also vague, speculative, or lacks rationale, the Office should submit the case record together with a detailed statement of accepted facts to a second impartial specialist for a rationalized medical opinion on the issue in question.<sup>8</sup> 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.<sup>9</sup>

### ANALYSIS

The Office has awarded compensation based on loss of cartilage interval and loss of meniscus. Appellant did have a complete medial meniscectomy on June 17, 2003, but her total meniscectomy was followed by an open partial joint replacement with a unispacer component. On June 10, 2004 she underwent a revision of the left medial unispacer to a left unicompartmental or unicondylar replacement.

Because appellant has had a partial knee replacement, the Board notes that the impartial medical specialist should have applied Table 17-33, page 547 of the A.M.A., *Guides*, under the heading "Total knee replacement including unicondylar replacement." That is the most appropriate approach for evaluating permanent impairment under the circumstances. It is an approach that allows consideration of pain, range of motion, stability, flexion contracture, extension lag and alignment.<sup>10</sup>

The Board will set aside the hearing representative's August 11, 2008 decision and will remand the case for further development of the medical evidence. The Office shall obtain an impartial medical opinion on the extent of appellant's left lower extremity impairment following the point rating system in Table 17-35, page 549 of the A.M.A., *Guides*, and the appropriate classifications (good, fair, poor) found in Table 17-33, page 547. After such further development of the evidence as may be appropriate, the Office shall issue an appropriate decision on appellant's entitlement to schedule compensation.

---

<sup>6</sup> 5 U.S.C. § 8123(a).

<sup>7</sup> *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

<sup>8</sup> *See Nathan L. Harrell*, 41 ECAB 402 (1990).

<sup>9</sup> *Harold Travis*, 30 ECAB 1071 (1979).

<sup>10</sup> A.M.A., *Guides* 549 (Table 17-35).

Appellant's attorney addressed how Dr. Bundens applied his method of evaluation and argued that appellant should be given the benefit of the doubt when there are two ways to rate impairment. He contends that loss of motion and atrophy provides for a higher rating than the method Dr. Bundens followed and that the impairment estimates of Dr. Weiss should represent the weight of medical opinion. Counsel argued that Table 18.1 allowed for combining impairment due to flexion contracture with pain. This contention is not consistent with Table 17-2, the cross usage chart, which states what impairments may be combined in a lower extremity rating.<sup>11</sup> Chapter 18 is generally not to be used in rating sensory loss.<sup>12</sup>

### **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 August 11, 2008 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: September 30, 2009  
Washington, DC

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

David S. Gerson, Judge  
Employees' Compensation Appeals Board

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

---

<sup>11</sup> *Id.* at 526.

<sup>12</sup> *See Linda Beale, 57 ECAB 429 (2006).*