United States Department of Labor
Employees' Compensation Appeals Board

B.T., Appellant	)	
	)	
and	)	**Docket No. 10-1276**
	)	**Issued: April 6, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Elkins Park, PA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 6, 2010 appellant, through counsel, filed a timely appeal of the December 9, 2009 merit decision of the Office of Workers' Compensation Programs that affirmed a schedule award decision. Pursuant to the Federal Employees' Compensation Act[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than 16 percent impairment of the right lower extremity, for which she received a schedule award.

On appeal, counsel contends that appellant has more than 16 percent impairment of the right lower extremity. He argues that the Office erred in failing to seek clarification from Dr. Menachem M. Meller, a Board-certified orthopedic surgeon and impartial medical specialist, regarding appellant's right lower extremity impairment rating as it was not properly based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A.,

[1] 5 U.S.C. § 8101 *et seq.*

Guides). Counsel further contends that the medical opinion of Dr. Morley Slutsky, an Office medical adviser, cannot resolve a conflict in the medical opinion evidence regarding the A.M.A., *Guides* impairment rating.

FACTUAL HISTORY

The Office accepted that on February 13, 2006 appellant, then a 52-year-old letter carrier, sustained a right knee sprain/strain when she slipped on a loose brick while delivering mail.[2]

On November 6, 2007 appellant filed a claim for a schedule award. In an October 1, 2007 medical report, Dr. David O. Weiss, an attending Board-certified orthopedic surgeon, found that she had 34 percent impairment of the right lower extremity based on Table 17-8 and Figure 18-1 at pages 532 and 574, respectively, of the fifth edition of the A.M.A., *Guides*.

On August 1, 2008 Dr. Arnold T. Berman, an Office medical adviser, reviewed the medical evidence, including Dr. Weiss' October 1, 2007 findings. He determined that appellant had 16 percent impairment of the right lower extremity based on Table 17-33 at page 546 of the fifth edition of the A.M.A., *Guides*.[3] Dr. Berman concluded that she reached maximum medical improvement on October 1, 2007.

On October 1, 2008 the Office referred appellant, together with a statement of accepted facts (SOAF) and the medical record, to Dr. Steven J. Valentino, a Board-certified orthopedic surgeon, for a second opinion medical examination. In an October 15, 2008 report, Dr. Valentino found that she did not have any impairment of the right lower extremity causally related to the February 13, 2006 employment injury.

On October 27, 2008 Dr. Berman reviewed Dr. Valentino's October 15, 2008 findings and reiterated his opinion that appellant had 16 percent impairment of the right lower extremity. He noted that Dr. Valentino did not mention anterior cruciate ligament (ACL) laxity as noted by prior physicians.

By letter dated November 13, 2008, the Office requested that Dr. Valentino clarify whether he addressed ACL laxity in his October 15, 2008 report. In a January 6, 2009 report, Dr. Valentino stated that he performed anterior and posterior drawer signs on appellant and found no evidence of ACL laxity. He reviewed the medical records which indicated that she had a torn ACL for which she underwent reconstruction surgery. Dr. Valentino stated, "Any ACL injury could not be apportioned to the February 13, 2006 employment injury and, thus, it could not be double rated." He noted that the medical record showed that the ACL graft was intact and appellant had a stable knee. Appellant underwent medical treatment for osteoarthritis of the right knee as opposed to ligamentous laxity. Dr. Valentino reviewed Dr. Weiss' October 1, 2007

[2] Prior to the instant claim, the Office accepted appellant's claim under File No. xxxxxx755 for internal derangement of the right knee which she sustained on August 8, 1997. It authorized anterior cruciate ligament repair with partial medial meniscectomy.

[3] Dr. Berman determined, among other things, that appellant had seven percent impairment for mild cruciate ligament laxity.

report and agreed with his finding that a drawer and Lachman's tests were negative. He stated, the drawer sign test for ACL laxity revealed that no laxity existed.

On January 14, 2009 the Office found a conflict in the medical opinion evidence between Dr. Weiss, Dr. Valentino and Dr. Berman regarding the extent of appellant's right lower extremity impairment and whether she had ACL laxity causally related to the February 13, 2006 injury. It referred appellant, together with a SOFA and the medical record, to Dr. Meller for an impartial medical examination.

In a February 17, 2009 report, Dr. Meller noted that appellant was able to stand and walk with a slight limitation and a limp which occurred during certain gait cycles. On physical examination, he reported that she had equal leg lengths and no thigh atrophy. Appellant's legs had 51 centimeters of circumference bilaterally and her thighs had 10 centimeters of circumference above the patella bilaterally. Mid-patellar circumference was 37 centimeters bilaterally. There was mild synovitis of the right knee and none on the left. Appellant had a 12 degree valgus alignment to the right knee and a 10 degree valgus alignment on the left. She had a nine centimeter scar over the anterior medial of the right knee at the cruciate reconstruction and over the lateral femoral condyle. Drawer testing of the right and left knees was negative both anteriorly and posteriorly. Appellant had a fully functional ACL and/or secondary stabilizers. Varus stress testing of the right knee extension in a supine configuration revealed no pathologic laxity. There was no pathologic laxity of knee flexion at 30, 60 and 90 degrees. Dr. Meller stated that it was not entirely clear whether appellant was completely relaxed, although there was no clear evidence of co-contraction of the quadriceps or hamstrings. Valgus stress testing of both knees revealed no significant pathologic laxity. The left knee had no varus instability on stress testing with extension at 30, 60 and 90 degrees. Range of motion (ROM) of the right knee had full extension to 105 degrees flexion with a soft end point indicating that additional movements were possible. The left knee had 0 to 125 degrees of flexion without any guarding or apprehension. There was mild-to-moderate crepitus of the patellofemoral bilaterally. There was no tightness over the medial or lateral retinaculum and a negative patellar inhibition. The patella had normal height. There was no quadriceps or patellofemoral discomfort. There was no effusion in either knee.

Dr. Meller reexamined appellant as she sat on an examining table. Appellant was able to flex the right knee to 90 degrees and allow the knee to relax fully. The knee was elevated to approximately 45 degrees and varus stress testing of the knee revealed two plus laxity. There was no laxity on valgus stress testing. The Lachman's anterior and posterior drawer tests were repeated and they appeared to be unremarkable. There were no rotatory components. Quadriceps active test was negative. There was no meniscal tenderness. There was some discomfort over the lateral patellofemoral compartments on the right with none on the left. There were no reflex, sensory or motor deficits, particularly no demonstrable weakness on quadriceps or hamstring testing.

Dr. Meller advised that laxity existed in the lateral collateral ligament (LCL) of appellant's right knee. He stated that while the knee was in extension and perhaps without complete relaxation there was no evidence of pathologic laxity on varus stress testing of the LCL, the site of the accepted work injury. When appellant relaxed there was significant laxity of the LCL some of which may have been pseudolaxity as a result of the prior partial

meniscectomies. Dr. Meller stated that this corresponded with her complaint that the knee locked and gave out. Appellant's sharp pain improved to some degree with a knee brace. Dr. Meller stated that the knee demonstrated some limitation in ROM for testing. He stated that there was no additional impairment for using the ROM method. Dr. Meller agreed with Dr. Berman's finding that appellant had 10 percent impairment due to a meniscectomy and 7 percent impairment due to cruciate repair based on Table 17-33 at page 546 of the fifth edition of the A.M.A., *Guides*. He disagreed with Dr. Weiss' 34 percent right lower extremity impairment rating, noting that it was based on weakness without accompanying atrophy.

By decision dated February 27, 2009, the Office granted appellant a schedule award for 16 percent impairment of the right lower extremity for the period November 6, 2007 to September 23, 2008.[4]

On March 6, 2009 appellant, through counsel, requested an oral hearing before an Office hearing representative.

In a June 3, 2009 decision, an Office hearing representative set aside the February 27, 2009 decision and remanded the case to the Office. She found that the Office failed to refer Dr. Meller's February 17, 2009 report to an Office medical adviser for review prior to the issuance of its schedule award decision. The hearing representative instructed the Office to refer all pertinent evidence, including Dr. Meller's report to a new Office medical adviser who was not involved in the medical conflict for review. She directed the Office to combine all of appellant's claims related to the right knee as these injuries were being considered for impairment assessment.

On June 4, 2009 the Office requested that an Office medical adviser review Dr. Meller's February 17, 2009 report under the standards of the sixth edition of the A.M.A., *Guides*.[5] In a June 5, 2009 report, Dr. Slutsky, an Office medical adviser, reviewed the medical evidence, including Dr. Meller's February 17, 2009 findings. He advised that appellant had LCL laxity of the right knee. Dr. Slutsky utilized the adjustment grid and grade modifiers at page 516, Table 16-6, Functional History Adjustment, Lower Extremities and advised that a Grade 1 modifier was appropriate, with mild deficit. He noted that appellant was able to stand and walk with a slight limitation and exhibited a limp. According to page 517, Table 16-7, Physical Examination Adjustment, Lower Extremities, under knee, Grade 1 Lachman's test, slight laxity patellar mechanism represented a Grade 1 modifier due to crepitation and synovitis. Dr. Slutsky pointed out that appellant had 12 degrees of valgus alignment to the right knee and 10 degrees on the left. Under Table 16-8 on page 519, Clinical Studies Adjustment, Lower Extremities, a Grade 0 modifier was appropriate as there were no diagnostic tests present at the date of maximum medical improvement. Dr. Slutsky advised that the grade modifiers represented a net adjustment of one. He noted that the net adjustment formula was (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) and found a Class 1, Grade B impairment for the right knee, incorporating a net

[4] On March 9, 2009 the Office reissued the February 27, 2009 schedule award for 16 percent impairment to the right lower extremity.

[5] A.M.A., *Guides* (6th ed. 2009).

adjustment of one, which represented an eight percent impairment of the right lower extremity (A.M.A., *Guides* 521).

In a June 10, 2009 decision, the Office found that appellant had no more than 16 percent impairment of the right upper extremity based on Dr. Slutsky's June 5, 2009 report.[6]

On June 15, 2009 appellant, through counsel, requested an oral hearing.

In a December 9, 2009 decision, an Office hearing representative found that appellant had no more than 16 percent impairment of the right lower extremity based on the reports of Dr. Meller and Dr. Slutsky.[7]

LEGAL PRECEDENT

The schedule award provision of the Act[8] and its implementing regulations[9] set forth the number of weeks of compensation to be paid for permanent loss or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[10] However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[11]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[12] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE) and clinical

[6] The record reflects that the Office previously paid appellant from November 6, 2007 to September 23, 2008 for the 16 percent schedule award.

[7] Following the issuance of the Office hearing representative's December 9, 2009 decision, the Office received additional evidence. The Board may not consider evidence for the first time on appeal which was not before the Office at the time it issued the final decision in the case. 20 C.F.R. § 501.2(c)(1). Appellant can submit this evidence and legal contentions to the Office with a formal written request for reconsideration. 5 U.S.C. § 8128; 20 C.F.R. § 10.606.

[8] *Supra* note 1 at § 8107.

[9] 20 C.F.R. § 10.404.

[10] 5 U.S.C. § 8107(c)(19).

[11] 20 C.F.R. § 10.404.

[12] *Supra* note 4 at 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

studies (GMCS).[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14]

Section 8123 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.[15] In situations where 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.[16]

In some instances, an Office medical adviser's opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the A.M.A., *Guides*. In this instance, a detailed opinion by the Office medical adviser which gives a percentage based on reported findings and the A.M.A., *Guides* may constitute the weight of the medical evidence.[17]

ANALYSIS

Appellant contends on appeal that she has more than 16 percent impairment of the right lower extremity. The Office accepted her claim for sprain/strain and internal derangement of the right knee. Appellant underwent anterior cruciate ligament repair with partial medial meniscectomy. By decision dated June 10, 2009, the Office granted her a schedule award for 16 percent impairment of the right lower extremity. In a December 9, 2009 decision, it found that appellant was not entitled to any additional schedule award. The Board finds that she has not met her burden of proof to establish that she has impairment greater than the 16 percent already awarded.

The Board notes that a conflict in the medical opinion evidence arose between Dr. Weiss, an attending physician, on the one hand, Dr. Berman, an Office medical adviser, and Dr. Valentino, an Office referral physician, regarding the extent of impairment to appellant's right lower extremity. Dr. Weiss opined that appellant had 34 percent impairment of the right lower extremity. Dr. Berman opined that she had 16 percent impairment of the right lower extremity. Dr. Valentino found that appellant had no impairment of the right lower extremity. The Office properly referred her to Dr. Meller, selected as the impartial medical examiner to resolve the conflict.

[13] *Id.* at 494-531.

[14] *Id.* at 521.

[15] 5 U.S.C. § 8123; *see Charles S. Hamilton*, 52 ECAB 110 (2000).

[16] *Gloria J. Godfrey*, 52 ECAB 486 (2001); *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

[17] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.7(h) (April 1993).

In a February 17, 2009 report, Dr. Meller found that, based on the fifth edition of the A.M.A., *Guides*, appellant had 10 percent impairment due to a meniscectomy and 7 percent impairment due to cruciate repair, resulting in 16 percent impairment of the right lower extremity (A.M.A., *Guides* 547, 604, Table 17-33, Combined Values Chart). The Office correctly requested that the Office medical adviser review Dr. Meller's February 17, 2009 report under the standards of the sixth edition of the A.M.A., *Guides*.[18]

In a June 5, 2009 report, Dr. Slutsky, an Office medical adviser, discussed his review of the medical records and provided an opinion that appellant had an eight percent impairment of right lower extremity under the standards of the sixth edition of the A.M.A., *Guides*. The Board finds that he properly applied these standards to reach his conclusion about appellant's permanent right knee impairment.

Dr. Slutsky found that appellant had LCL laxity of the right knee. He choose grade modifiers from the table for the various categories, including history, physical findings and test findings, based on Dr. Meller's findings. Dr. Slutsky then correctly averaged the grade modifiers and choose the default value of one for the Grade 3 modifier categories to conclude that appellant had an eight percent impairment of the right lower extremity (A.M.A., *Guides* 516-518, 521, Table 16-6, Table 16-7 and Table 16-8). The Board notes that there is no medical evidence of record showing that appellant has more than 16 percent permanent impairment of the right knee, for which she already received a schedule award. For these reasons, the Board finds that the evidence does not establish entitlement to additional schedule award compensation.

Appellant's contention on appeal that the Office improperly relied on Dr. Slutsky to resolve the conflict in the medical evidence instead of Dr. Meller has not been established. Dr. Meller's 16 percent impairment rating was based on the fifth edition of the A.M.A., *Guides* then in use. However, Dr. Slutsky found eight percent impairment according to the appropriate tables and grading schemes of the sixth edition of the A.M.A., *Guides* currently in use by the Office. Moreover, it is well established that the Office may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the clinical findings reported by an examining physician.[19]

CONCLUSION

The Board finds that appellant has failed to establish that she has more than 16 percent impairment of the right lower extremity, for which she received a schedule award.

[18] The Office's decision regarding impairment was not issued until after May 1, 2009 and, therefore, its use of the sixth edition of the A.M.A., *Guides* was appropriate. *See supra* note 5.

[19] *J.Q.*, 59 ECAB 366 (2008); *Linda Beale*, 57 ECAB 429 (2006).

ORDER

IT IS HEREBY ORDERED THAT the December 9, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 6, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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