U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JOHN J. CLEAVER and DEPARTMENT OF THE NAVY, PHILADELPHIA NAVAL SHIPYARD, Philadelphia, PA

Docket No. 00-2562; Submitted on the Record;
Issued August 6, 2001

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
A. PETER KANJORSKI

The issue is whether appellant met his burden of proof to establish that he sustained greater than a 50 percent permanent impairment of his right lower extremity, for which he received a schedule award.

On February 12, 1993 appellant, then a 58-year-old rigger supervisor, filed a claim for traumatic injury alleging that on that date he injured his right knee when he slipped on the ice while in the performance of duty. The Office of Workers' Compensation Programs accepted his claim on March 17, 1999 for a right knee sprain. Appellant subsequently filed a claim for a schedule award, and on September 20, 1993 the Office awarded appellant a schedule award for a 25 percent permanent impairment of his right lower extremity. On June 17, 1997 the Office approved surgery for a total right knee replacement. Surgery was performed on September 22, 1997.

In a medical report dated November 25, 1997, Dr. Gregory S. Maslow, appellant's treating Board-certified orthopedic surgeon, stated that appellant had an excellent surgical result, and had a 50 percent permanent impairment of both lower extremities, as a result of his knee injuries, degenerative joint disease and resultant total knee arthroplasties.[1]

On February 6, 1998 an Office medical adviser found that, using Dr. Maslow's physical findings and assessment on examination, pursuant to Table 64, page 85, of the A.M.A., *Guides*, fourth edition, a total knee replacement with an excellent result equated to a 37 percent permanent impairment.

By decision dated June 15, 1998, the Office granted appellant a schedule award for an additional 12 percent impairment of the right lower extremity.

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[1] The record reflects that appellant also underwent a left total knee arthroplasty which is not part of the instant claim.

Appellant then requested an oral hearing by letter dated July 9, 1998, and submitted a medical report from Dr. Ronald J. Potash, a Board-certified surgeon, in support of his claim. In his report dated January 21, 1999, Dr. Potash reported his findings on physical examination and review of the file and concluded that, pursuant to Table 66, page 88 and Table 64, page 85, of the A.M.A., *Guides*, appellant had a 75 percent permanent impairment of his right lower extremity.

A hearing was held on February 23, 1999, and the hearing representative issued a decision on April 22, 1999, in which he found the newly submitted evidence sufficient to require further medical development of the claim. The hearing representative therefore vacated and remanded the Office's June 15, 1998 decision and ordered a referral to a second opinion physician.

On May 13, 1999 the Office referred appellant to Dr. Frank A. Mattei, a second opinion physician and Board-certified orthopedic surgeon. In a report dated June 2, 1999, Dr. Mattei stated that appellant had a 37 percent permanent impairment of the right lower extremity, pursuant to Table 64, page 85 and Table 66, page 88, of the A.M.A., *Guides*.

On July 7, 1999 the Office found a conflict in medical opinion existed between appellant's physician, Dr. Potash, and the Office referral physician, Dr. Mattei, and, therefore, referred appellant to Dr. Edward J. Resnick, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve this conflict.

In a medical report dated August 3, 1999, Dr. Resnick noted his findings on physical examination, and concluded that appellant had a 90 percent permanent impairment of the right lower extremity, pursuant to the A.M.A., *Guides*.

In a medical report dated August 24, 1999, the Office medical adviser reviewed the range of motion data and other physical findings from Dr. Resnick and determined that appellant had a 50 percent permanent impairment of the right lower extremity.

By decision dated August 30, 1999, the Office awarded appellant an additional 13 percent permanent impairment of his right lower extremity, for a total of 50 percent.

On September 1, 1999 appellant requested an oral hearing.

By decision dated April 24, 2000, the hearing representative affirmed the Office's August 30, 1999 decision.

The Board finds that the case is not in posture for decision regarding whether appellant sustained more than a 50 percent permanent impairment of his right lower extremity, for which he received a schedule award.

An employee seeking compensation under the Federal Employees' Compensation Act[2] has the burden of establishing the essential elements of his claim by the weight of the reliable,

[2] 5 U.S.C. §§ 8101-8193.

probative and substantial evidence,[3] including that he sustained an injury in the performance of duty as alleged and that his disability, if any, was causally related to the employment injury.[4] Section 8107 of the Act provides that if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[5] Neither the Act nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants, the Office has adopted the American Medical Association, (A.M.A.,) *Guides to the Evaluation of Permanent Impairment* (4th ed. 1993) as a standard for evaluating schedule losses and the Board has concurred in such adoption.[6]

After finding that a conflict in medical opinion existed between Drs. Potash and Mattei, the Office referred appellant and the case record to Dr. Resnick for an impartial medical examination and an opinion regarding the degree of permanent impairment in his right lower extremity for which he would be entitled to a schedule award. Following the receipt of Dr. Resnick's report, the Office referred the claim to an Office medical adviser for application of Dr. Resnick's findings to the appropriate provisions of the A.M.A., *Guides*. By decision dated August 30, 1999, the Office granted appellant an award for an additional 13 percent permanent impairment, for a total of 50 percent. Following a hearing held at appellant's request, in a decision dated April 24, 2000, an Office hearing representative affirmed the Office's August 30, 1999 decision.

Section 8123(a) of the Act provides in pertinent part: "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." When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of the Act, to resolve the conflict in the medical evidence.[7] In situations were a case is properly referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[8] In addition, where the Office requested that a physician evaluate permanent impairment pursuant to the A.M.A., *Guides*, and the doctor reported findings but made no specific references to the A.M.A., *Guides*, it is proper for an Office medical adviser to apply the A.M.A., *Guides* to the findings reported by the physician on examination.[9] In order for the A.M.A., *Guides* to be utilized, however, the examining physician's description of the impairment must be in sufficient detail so that others

[3] *Donna L. Miller*, 40 ECAB 492, 494 (1989); *Nathaniel Milton*, 37 ECAB 712, 722 (1986).

[4] *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[5] 5 U.S.C. § 8107(a).

[6] *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989); *Charles Dionne*, 38 ECAB 306, 308 (1986).

[7] 5 U.S.C. § 8123(a); *William C. Bush*, 40 ECAB 1064, 1975 (1989).

[8] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

[9] *John L. McClenic*, 48 ECAB 552 (1997).

reviewing the file will be able to clearly visualize the impairment with its restrictions and limitations.[10]

The Board notes that the Office properly referred appellant to Dr. Resnick in that there was a conflict in the medical evidence regarding the extent of the permanent impairment of appellant's right lower extremity.

In his report dated August 3, 1999, Dr. Resnick reported the findings of his examination, noting that appellant reported feeling occasional pain, soreness and tenderness of his knees, with painless clicking of the knees when he is walking. Appellant also reported that he must stop walking after he has walked about 100 yards, that he cannot stand for very long, and that his knees bother him during intercourse. Dr. Resnick further noted, in relevant part:

> "Knee flexion is 10 to 95/10 to 95. There is no synovial thickening or effusion in either knee. The expected amount of mediolateral and anteroposterior instability with total knee replacement is noted in each knee. This amount is considered as normal and acceptable as a result of total knee replacement. Tenderness is present over the left and right medial femoral condyles. Hypesthesia to pinprick is present over a strip of skin inferior and lateral to each skin incision and is considered as associated with the skin incisions. Quadriceps and hamstring muscles bilaterally rate 4/5. The peripheral pulses are palpable and equal. Deep tendon reflexes are normal and symmetrical. Leg lengths are 37/37. Thigh circumferences are 20/20. Knee circumferences are 17/17. Calf circumferences are 16/16."

Dr. Resnick concluded his report, stating:

> "With regard to the right knee, there has been a quite satisfactory total knee replacement. In the right knee there are expected minor residuals even in the presence of the quite satisfactory result of surgery. These include the residual limitation of motion, the muscular weakness, the pain and tenderness and the minimal sensory change. In my opinion, based upon consultation with [G]uides to the [E]valuation of [P]ermanent [I]mpairment of the A.M.A., there is permanent partial physical impairment amounting to 90 percent of the right knee, equivalent to 36 percent of the whole man. I feel that maximum medical improvement has been obtained by approximately January 1998."

Table 64, page 85, of the fourth edition of the A.M.A., *Guides* provides a point rating system for knee replacement results. Under this system, 85 to 100 points represents a good result and equates to a 37 percent impairment, 50 to 84 points represents a fair result and equates to a 50 percent impairment, and less than 50 points represents a poor result, and equates to a 75 percent impairment. The points themselves are obtained by comparing specific measurements in the categories of pain, range of motion, stability, flexion contracture, extension lag and alignment, to the figures set forth in Table 66, page 88, of the A.M.A., *Guides*. The Board finds that Dr. Resnick's findings on physical examination are not described in sufficient detail such

[10] *See Noe L. Flores*, 49 ECAB 344 (1998).

that it was appropriate to apply the standards of the A.M.A., *Guides* relating to knee replacement results. For example, with respect to stability, Dr. Resnick noted only that "the expected amount of mediolateral and anteroposterior instability with total knee replacement" was noted in each knee, and that "this amount is considered as normal and acceptable as a result of total knee replacement." Table 66, page 88, of the A.M.A., *Guides*, however, specifically requires that both anteroposterior and mediolateral stability be measured in millimeters. Therefore, Dr. Resnick has not fully explained how his assessment of permanent impairment was derived in accordance with the standards adopted by the Office and approved by the Board as appropriate for evaluating schedule losses.[11]

In a situation where 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 such specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original opinion.[12] For the reasons discussed above, the opinion of Dr. Resnick is in need of clarification and elaboration.

Therefore, in order to resolve the continuing conflict in the medical opinion, the case will be remanded to the Office for referral of the case record, a statement of accepted facts and, if necessary, appellant, to Dr. Resnick for a supplemental report regarding the degree of permanent impairment of his right lower extremity, with specific attention to the categories set forth in Table 64, page 85 and Table 66, page 88, of the A.M.A., *Guides*. If Dr. Resnick is unwilling or unable to clarify and elaborate on his opinion, the case should be referred to another appropriate impartial medical specialist.[13] After such further development as the Office deems necessary, an appropriate decision should be issued regarding the degree of impairment of appellant's right lower extremity.

[11] *See James Kennedy, Jr.*, 40 ECAB 620, 626 (1989) (finding that an opinion, which is not based upon the standards adopted by the Office and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's permanent impairment).

[12] *Nancy Lackner (Jack D. Lackner),* 40 ECAB 232, 238 (1988); *Harold Travis,* 30 ECAB 1071, 1078 (1979).

[13] *See Harold Travis*, 30 ECAB 1071, 1078-79 (1979).

The decisions of the Office of Workers' Compensation Programs dated April 24, 2000 and August 30, 1999 are set aside and the case remanded to the Office for further proceedings consistent with this decision of the Board.

Dated, Washington, DC
August 6, 2001

Michael J. Walsh
Chairman

David S. Gerson
Member

A. Peter Kanjorski
Alternate Member