U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of HARRY JONES and U.S. POSTAL SERVICE,
POST OFFICE, Princeton, NJ

Docket No. 00-2509; Submitted on the Record;
Issued July 6, 2001

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether appellant has greater than a 12 percent permanent loss of use of the left leg.

On January 31, 1997 appellant, then a 33-year-old letter carrier, filed a claim for a twisted left knee sustained on January 30, 1997 while coming down stairs. The Office of Workers' Compensation Programs accepted that appellant sustained a tear of the lateral meniscus of his left knee, and authorized an arthroscopy and meniscectomy. On March 5, 1997 Dr. Mark Pressman, a Board-certified orthopedic surgeon, performed a repair of the torn lateral meniscus of appellant's left knee.

On December 9, 1997 appellant filed a claim for a schedule award of the left leg and submitted a report dated October 29, 1997 from Dr. Ronald J. Potash, a Board-certified surgeon, who concluded that appellant had a 19 percent permanent impairment of the left leg: 5 percent for left knee crepitance, 5 percent for 4/5 motor strength weakness and 10 percent for loss of knee flexion. An Office medical adviser reviewed Dr. Potash's report on December 17, 1997 and concluded that appellant had an 8 percent permanent loss of use of the left leg: 0 percent for flexion to 110 degrees and 8 percent for 3/4 of an inch of quadriceps atrophy. This Office medical adviser noted that FECA Bulletin No. 96-17 indicated that the table for crepitance may be used only if no other abnormality was present, with the exception of joint fractures.

By decision dated December 18, 1997, the Office issued appellant a schedule award for an eight percent permanent loss of use of his left leg.

Appellant requested a hearing, which was held on July 16, 1998. By decision dated September 3, 1998, an Office hearing representative found that an Office medical adviser should again review Dr. Potash's report, comment on weakness reported by Dr. Potash and use the correct table for knee flexion. On September 23, 1998 the same Office medical adviser again reviewed Dr. Potash's October 29, 1997 report and noted that use of the correct table still resulted in 0 percent impairment for 110 degrees of knee flexion. The Office medical adviser

then stated that appellant's impairment was either 8 percent for quadriceps atrophy or 12 percent for knee flexion muscle weakness.

By decision dated September 29, 1998, the Office issued appellant a schedule award for an additional 4 percent permanent loss of use of the left leg, for a total of 12 percent.

Appellant requested a hearing, which was held on March 31, 1999. By decision dated July 6, 1999, an Office hearing representative found that there was a conflict of medical opinion between Dr. Potash and the Office medical adviser who reviewed his reports. To resolve this conflict, the Office referred appellant to Dr. Robert Bachman, a Board-certified orthopedic surgeon. In a report dated August 31, 1999 he, after reviewing appellant's history and the prior medical reports, stated:

> "Today's orthopedic examination revealed the following objective abnormalities regarding the left lower extremity: antalgic gait mild, decrease in vastus medialis oblique muscle volume, equivocal effusion, 1+ Lachman test left knee compared to 1 Lachman test [right] knee not significantly different, a positive patella inhibition sign on the left, 1/2 inch atrophy left thigh three inches above the patella and a very minimal decrease in range of motion left knee 0 to 130 degrees compared to 0 to 135 degrees right and three arthroscopic portals all well[-]healed left knee.
>
> "X-rays of the left knee performed today did not reveal any significant narrowing of the joint spaces when left knee was compared to the right knee. There was only an equivocal effusion left knee joint. The strength was considered to be normal. There were no neurological deficits. Normal pulses were present.
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> "Reference was then made to the A[merican] M[edical]A[ssociation], *Guides to the Evaluation of Permanent Impairment*, fourth edition beginning in section 3, page 75, the lower extremity 3.2. I think it is important to acknowledge the introductory paragraph on page 75, which states that 'while some impairments may be evaluated appropriately by determining the range of motion, others are <u>better</u> evaluated by the use of diagnostic categories or according to test criteria. In general, only one evaluation method should be used to evaluate a specific impairment.' The exception discussed on page 77, in my opinion, does not pertain to [appellant's] left knee. It discusses different areas of the lower extremity. It is my opinion that the diagnosis based estimate therefore is the most appropriate means of evaluating [his] impairment. This is found on page 85 of section 3 [T]able 64 called Impairment Estimates for Certain Lower Extremity Impairments. There is no specific reference to meniscal repair, which actually should provide a better result than meniscectomy. If lateral meniscectomy is chose, partial meniscectomy results in a 2 [percent] impairment … for the lower extremity and a 7 [percent] impairment for total meniscectomy. Furthermore, with regard to Dr. Potash's evaluation regarding range of motion deficit left knee, today's examination revealed a range of motion from 0 to 130 degrees, for which there is no percentage of impairment, according to [T]able 41. As stated above, Dr. Potash's percentages given for left knee crepitus and 4/5 strength are not the

> desired way of rating, if one refers again to the first paragraph on page 75. Even if one accepts his method of rating, it would amount to 10 [percent], which is not very different from the award which already had been given according to the records that I reviewed. Initially 8 [percent] and then an extension to 12 [percent]. In my opinion, however, if one adheres strictly to the guidelines, the percentage of impairment of the left lower extremity is no more than 7 [percent] which is awarded in the diagnostic category for total lateral meniscectomy. As stated above, it is my opinion to be no more than 7 [percent] for total lateral meniscectomy. It is only 2 [percent] for partial lateral meniscectomy and it should be kept in mind that when the meniscus is preserved as it was in this case by surgical repair, the percentage of permanent impairment is no greater than that of excision. Therefore, I continue to be of the opinion that 7 [percent] permanent impairment of the left lower extremity is the appropriate figure. I did note the postoperative infection, but in my opinion, this was treated quite well with resolution and does not add anything to the percentage of impairment as judged by today's orthopedic examination." (Emphasis in the original.)

The same Office medical adviser reviewed Dr. Bachman's report and stated that he concurred with his calculations.

By decision dated October 26, 1999, the Office found that appellant had no greater than a 12 percent permanent loss of use of his left leg. He requested a hearing, which was held on February 29, 2000. By decision dated April 20, 2000, an Office hearing representative found that the report of Dr. Bachman constituted the weight of the medical evidence and established that appellant had no greater than a 12 percent permanent loss of use of the left leg.

The Board finds that appellant has no greater than a 12 percent permanent loss of use of the left leg.

The schedule award provision of the Act[1] and its implementing regulation[2] 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. However, the Act does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.

In situations where there are 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 on a proper factual background, must be given special weight.[3] There was a conflict of medical opinion

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404 (1999).

[3] *James P. Roberts*, 31 ECAB 1010 (1980).

between Dr. Potash and an Office medical adviser on the percentage of permanent impairment reflected by Dr. Potash's examination of appellant.[4] To resolve this conflict, the Office, pursuant to section 8123(a) of the Act,[5] referred appellant to Dr. Bachman, a Board-certified orthopedic surgeon.

In his August 31, 1999 report, Dr. Bachman stated that he considered the use of the diagnosis based estimate from the A.M.A., *Guides* to be the most appropriate means of evaluating appellant's impairment. Using Table 64 of Chapter 3, Dr. Bachman assigned seven percent, the amount allowed for a total lateral meniscectomy. He noted that appellant's range of motion on his examination -- flexion to 130 degrees -- resulted in 0 percent impairment. Dr. Bachman reported no significant narrowing of the joint spaces of appellant's left knee on x-rays and also reported normal strength. He noted one-half inch of thigh atrophy, but this would result in no more than an eight percent impairment of appellant's leg, according to Table 37 of Chapter 3 of the A.M.A., *Guides*. Section 3.2i of the fourth edition of the A.M.A., *Guides* provides: "The evaluating physician must determine whether diagnostic or examination criteria best describe the impairment of a specific patient. *The physician, in general, should decide which estimate best describes the situation and should use only one approach for each anatomic part.*" (Emphasis in the original.) Thus either the atrophy and the meniscectomy, but not both, can be used to rate the permanent impairment of appellant's left leg.

The report of Dr. Bachman, as that of an impartial medical specialist resolving a conflict of medical opinion, constitutes the weight of the medical evidence. His report shows that he correctly applied the tables of the A.M.A., *Guides* to the impairments he found on examination of appellant's left knee and establishes that appellant has no greater than a 12 percent permanent loss of use of his left leg.

[4] *See Chester E. Menter*, 38 ECAB 697 (1987) (conflict between attending physician and Office medical adviser on percentage of impairment).

[5] 5 U.S.C. § 8123(a) states 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."

The decisions of the Office of Workers' Compensation Programs dated April 20, 2000 and October 26, 1999 are affirmed.

Dated, Washington, DC
July 6, 2001

Michael J. Walsh
Chairman

David S. Gerson
Member

Willie T.C. Thomas
Member