U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

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In the Matter of MARY L. ELLENBURG and DEPARTENT OF DEFENSE, NATIONAL SECURITY AGENCY, Fort Meade, MD

*Docket No. 02-2240; Submitted on the Record;*
*Issued May 13, 2003*

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DECISION and ORDER

Before DAVID S. GERSON, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether appellant sustained greater than a 17 percent impairment to her left lower extremity.

This case has previously been before the Board. On January 6, 1993 appellant, then a 49-year-old executive secretary, filed a traumatic injury claim alleging that on December 15, 1992 the heel of her shoe slipped on a tile floor causing her to fall and injure her right ankle. On February 4, 1993 the Office of Workers' Compensation Programs accepted appellant's claim for a right ankle sprain. She sustained a consequential injury to her left knee on October 29, 1994, which the Office accepted as related to her federal employment by letter dated April 27, 1995.

On December 16, 1997 appellant filed a claim for a schedule award for impairment to her left lower extremity. In a medical report dated November 17, 1997, Dr. Thomas J. Harries, appellant's treating Board-certified orthopedic surgeon, stated that appellant reached maximum medical improvement on November 17, 1997. He noted that appellant's range of flexion-extension was 150 degrees and that she had retained active flexion of 120 degrees. Dr. Harries noted that there was an additional impairment of function due to weakness, atrophy, pain or discomfort which he estimated at 30 percent of the lower extremity. He recommended an impairment rating of 47 percent of the left lower extremity.

The Office forwarded this report to an Office medical adviser. On March 10, 1998 Dr. W. Thompson reviewed Dr. Harries' examination findings and used those findings to compute an impairment rating of 19 percent for claimant's left lower extremity. Dr. Thompson noted that knee joint crepitation from arthritis was 5 percent pursuant to Table 62 page 83, 5 percent for atrophy pursuant to Table 37 page 77 and 10 percent for flexion contracture pursuant to Table 41 page 78. He utilized the Combined Values Chart to determine that appellant had a 19 percent impairment of the left lower extremity.

A different Office medical adviser, Dr. Thomas Grant, reviewed the medical evidence on March 10, 1998 and concluded that appellant had a 31 percent impairment of the left lower extremity based on the (4th ed. 1993) of the American Medical Association, (A.M.A., *Guides*)

*Guides to the Evaluation of Permanent Impairment*. Dr. Grant estimated a rating for weakness, atrophy and pain as 5 percent pursuant to pages 303-314 of the A.M.A., *Guides*, 17 percent for "[anterior cruciate ligament] tear left knee" pursuant to Table 64, page 85, 7 percent of medial compartment osteoarthritis pursuant to Table 62, page 83 and 2 percent for lateral meniscus tear pursuant to Table 64, page 85.

By decision dated May 26, 1998, the Office awarded a 31 percent permanent impairment of the left lower extremity. By letter dated June 10, 1998, appellant requested a review of the written record.

By letter to the Office medical adviser dated October 7, 1998, the hearing representative expressed concerns about whether the Office medical advisers calculated impairment on tables that were duplicative in nature. The hearing representative requested that the Office medical adviser determine if either calculation was proper and if not, determine the permanent impairment of appellant's left lower extremity explaining calculations and citing specific tables and sections in the A.M.A., *Guides*. On October 20, 1998 a third Office medical adviser, Dr. Neven A. Popovic, noted that the estimates of Drs. Grant and Harries contained duplications. He noted that appellant's total rating should be 19 percent based on a 10 percent impairment for knee flexion contracture pursuant to Table 41, page 78, 5 percent based on atrophy pursuant to Table 37, page 77 and 5 percent impairment for knee joint crepitation pursuant to Table 62, page 83. He noted: "Pain, per say is not ratable as 'it' is included in ratings based on other factors such as range of motion."

The hearing representative referred the case to Dr. Virginia Miller, the Office medical director. In a report dated December 10, 1998, Dr. Miller concluded that none of the medical advisers calculated the degree of physical impairment properly, although Dr. Popovic's opinion was the most accurate. Applying the fourth edition of the A.M.A., *Guides*, Dr. Miller agreed with Dr. Popovic that there was a 10 percent impairment due to a flexion contracture of the knee pursuant to Table 41, page 78 of the A.M.A., *Guides* as well as 5 percent impairment due to atrophy of the thigh, pursuant to Table 37, page 77 of the A.M.A., *Guides*. However, Dr. Miller did not agree with the use of Table 62 in this case. She noted:

> "Using Table 62, Dr. Harries assigned 7 percent impairment based on an unspecified type of x-ray. But it is obvious that [appellant's] knee osteoarthritis is the cause of the atrophy and the range of motion abnormalities, therefore, using this table would duplicate the impairment estimates. In addition, Dr. Popovic assigns five percent for crepitus. This is a misuse of the table which is based on the cartilage intervals in the knee joint."
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> "Finally, I would use Table 64 (page 85) in this case to assign a 2 percent impairment based on the fact that [appellant] underwent a partial lateral meniscectomy and suffered a loss of tissue. This level of impairment is assigned only for the loss of tissue and minimal if any physical findings. However, [appellant] demonstrates significant physical findings. In such a case, the use of this table can be accompanied by range of motion measurements, etc."

Dr. Miller concluded that appellant sustained a 17 percent impairment of the left knee based on 10 percent range of motion impairment, 5 percent impairment for atrophy and 2 percent loss of tissue.

By decision dated December 11, 1998, the hearing representative determined that the weight of the medical evidence establishes that appellant had no more than a 17 percent permanent impairment of the left lower extremity.

By letter dated February 13, 1999, appellant requested reconsideration.

In a report dated January 25, 1999, Dr. Harries noted that he disagreed with Dr. Miller's lower extremity rating. He stated:

> "In referring to Dr. Miller's calculations of an impairment rating of 17 percent of the lower extremity of [appellant], I find some contradictions. She awarded [him] 10 percent for loss of motion, 5 percent for impairment from atrophy and 2 percent for loss of tissue from the lateral meniscectomy. She then went on to assume that the impairment was due to arthritis. I think that is a faulty assumption. The loss of motion and the atrophy are, in my opinion, a direct result of her anterior cruciate reconstruction and not a result of her arthritis. The calculation of Dr. Miller does not take into account what so ever, pain associated with her arthritis. [Appellant] could have a 17 percent impairment rating and have a painless, full functional knee. This is not the case, however, as she suffers from significant degenerative arthritis and has a fairly painful knee. There has got to be some mechanism to compensate [appellant] for her arthritis and her pain and it [is] certainly not taken into account with Dr. Miller's method. I would suggest that the pain is an instigating factor and my experience with the A.M.A., [*Guides*] has allowed treating physician's latitude in applying an increased percentage to account for that. There also should be some accountability for the amount of arthritis that [appellant] has. We took a standing x-ray back in November 1997 and measured the joint space. [Appellant], at that time, has a one mm loss of joint space, which would increase her impairment by at least seven percent.
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> "In conclusion, I would state that Dr. Miller's impairment does not account for pain and arthritis, which she assumes that the tables do. I would submit that [appellant's] loss of motion and atrophy are a direct result of her successful anterior cruciate reconstruction, rather than her arthritis. Please reconsider [appellant's] impairment rating...."

In a December 10, 1999 decision, the Office denied reconsideration.

Appellant filed an appeal to the Board.[1] In a May 1, 2001 decision, the Board remanded the case for further merit review. The Board noted that Dr. Harries provided a new and relevant medical report regarding the extent of appellant's impairment and this report constituted new and relevant evidence.

[1] Docket No. 00-1391 (issued May 1, 2001).

By decision dated September 22, 2001, the Office reviewed appellant's case on the merits and determined that Dr. Harries opinion was insufficient to warrant modification of the decision dated December 11, 1998, as it was devoid of references to the A.M.A., *Guides*.

The Board finds that this case is not in posture for a decision.

The schedule award provisions of the Federal Employees' Compensation Act[2] and its implementing regulation[3] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use of schedule 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 regulation as the appropriate standard for evaluating schedule losses.

In the instant case, appellant's treating physician, Dr. Harries, recommended an impairment rating of 47 percent of the left lower extremity. The Office medical director, Dr. Miller, found that appellant had a 17 percent impairment of the left knee. Dr. Harries then reviewed Dr. Miller's report, noting specific disagreement with how she rated appellant's impairment under the A.M.A., *Guides*. He provided further medical opinion discussing pain and atrophy as impairment factors.

Section 8123(a) of the Act provides that, when there is a disagreement between a physician making the examination for the United States and the physician of the employee, a third physician shall be appointed to make an examination to resolve the conflict.[4] The Board finds that there is a conflict with regard to the extent of permanent impairment of appellant's left lower extremity between appellant's treating physician, Dr. Harries, and the Office medical director, Dr. Miller. Accordingly, the case will be remanded to the Office for resolution of the conflict. The Office should refer appellant, together with the case record and a statement of accepted facts, to an appropriate medical specialist for a rationalized opinion on the degree of impairment to appellant's left lower extremity. The physician should be asked to apply the fifth edition of the A.M.A., *Guides*, with citation to applicable pages, tables and figures, in reaching his or her conclusion.[5] After such further development as the Office deems necessary, it should issue an appropriate decision.

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

[4] *Lawrence C. Parr*, 48 ECAB 445, 453 (1997).

[5] Although the Office properly used the fourth edition of the A.M.A., *Guides* to calculate the awards, which are recalculated as a result of hearings, reconsideration or appeals should be based on the fifth edition of the A.M.A., *Guides* effective February 1, 2001. *See* FECA Bulletin 01-05 (issued January 29, 2001).

The September 22, 2001 decision of the Office of Workers' Compensation Programs is vacated and this case remanded to the Office for further development of the record in accordance with this opinion.

Dated, Washington, DC
May 13, 2003

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member