United States Department of Labor
Employees' Compensation Appeals Board

GEORGE K. MILLER,	)	
and	)	**Docket No. 05-1024**
	)	**Issued: February 13, 2006**
DEPARTMENT OF THE AIR FORCE, TINKER AIR FORCE BASE, Oklahoma City, OK, Employer	)	

Appearances:
James Linehan, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On March 29, 2005 appellant filed a timely appeal from the Office of Workers' Compensation Programs' schedule award decision dated February 10, 2005. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination.

ISSUE

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

FACTUAL HISTORY

On September 6, 2000 appellant, then a 56-year-old air craft mechanic, filed a traumatic injury claim alleging that on August 3, 2000 he sustained an injury to his left knee as a result of frequently getting in and out of his vehicle while in the performance of duty. Appellant did not

stop work.[1] On May 16, 2001 appellant underwent a partial medial meniscectomy, chondroplasty of the medial femoral condyle and chondroplasty of the patellofemoral joint. On April 19, 2002 an Office hearing representative accepted appellant's claim for left knee sprain. Appellant received appropriate compensation benefits.[2]

In an October 18, 2002 report, appellant's treating physician, Dr. Richard J. Langerman, an osteopath and Board-certified orthopedic surgeon, determined that appellant had marked medial as well as lateral joint pain with a positive Appley's and McMurray's test. He also noted that appellant had negative instability, drawer's and Lachman's and diagnosed degenerative joint disease of the left knee.

In a July 16, 2003 report, Dr. John W. Ellis, Board-certified in family medicine and a treating physician, noted the history of injury and treatment. He reported current complaints of left knee pain and listed findings on examination, including decreased flexion, extension and strength of the left leg. He also indicated that there was slight laxity of the medial collateral and anterior cruciate ligaments as compared to the right knee, marked crepitation with range of motion and a positive McMurray's click along the posterior lateral joint line. He diagnosed internal derangement of the left knee requiring arthroscopy and meniscectomy, repeat tear of the posterior horn of the lateral meniscus, left knee laxity, anterior cruciate and medial collateral ligaments of the left knee and opined that these were causally related to factors of appellant's federal employment. Dr. Ellis recommended that appellant avoid climbing ladders or steps. He utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A., *Guides*) (5th ed. 2001) and provided an impairment rating for the left lower extremity of 33 percent and opined that appellant had reached maximum medical improvement. He explained these calculations and referred to Table 17-33.[3] He allowed 10 percent for the partial meniscectomy and 25 percent for the anterior cruciate and medial collateral ligament laxity. He combined these two figures to arrive at an impairment of 33 percent to the left lower extremity.

On August 6, 2003 appellant completed a Form CA-7 for compensation for a schedule award.

On December 19, 2003 an Office medical adviser determined that there was insufficient medical evidence to support permanent impairment as the evidence did not establish whether appellant had instability of the left knee.

By letter dated March 17, 2004, the Office informed appellant's representative that the impairment of Dr. Ellis included internal derangement requiring an arthroscopy and meniscectomy, repeat tear of the posterior horn of the lateral meniscus and laxity of the anterior cruciate and medial collateral ligaments, all of the left knee; however, there was no record of these conditions or procedures being performed.

[1] Appellant also filed an occupational disease claim. Both claims were combined into file No. 16-2008190. The occupational disease claim was denied on February 21, 2003.

[2] Appellant retired on July 1, 2003.

[3] A.M.A., *Guides* 546, Table 17-33.

By letter dated April 6, 2004, the Office requested that appellant provide a rationalized report from a physician establishing a relationship between his employment duties and the need for surgical treatment.

In an April 12, 2004 report, Dr. Ellis noted that appellant was initially diagnosed with a knee sprain and was later diagnosed with internal derangement/medial meniscal tear, which required surgery. Dr. Ellis explained that the original diagnosis started out with a left knee strain; however, once appellant was examined, it was determined that he had internal derangement and a medial meniscal tear. He opined that these conditions were related to the left knee injury of March 8, 2000, which caused a strain injury as well as a medial meniscal tear.

On May 24, 2004 the Office expanded appellant's claim and accepted a tear of the medial cartilage or meniscus of the knee, left chondromalacia of the patella and partial meniscectomy and chondroplasty.

In a memorandum dated May 25, 2004, the Office determined that there remained a conflict with respect to whether appellant had laxity of the medial collateral and anterior cruciate ligaments based on a partial meniscectomy.

On July 8, 2004 the Office referred appellant to Dr. Sami Framjee, a Board-certified orthopedic surgeon, to resolve the conflict regarding whether appellant had laxity of the medial collateral and anterior cruciate ligaments based on a partial meniscectomy.

In a July 28, 2004 report, Dr. Framjee noted appellant's history of injury and treatment. He conducted an examination of the left knee and indicated that appellant related that he had "constant pain and stiffness." Dr. Framjee advised that no other complaints were "volunteered by the patient." On physical examination, appellant had residuals of "old Osgood-Schlatter's disease." However, he indicated that there was no point tenderness on palpation and that the patellar crunch and inhibition tests were negative. He also noted that the Appley's and McMurray's tests were negative and that range of motion of the left knee was from full extension to 120 degrees of flexion with very mild anteromedial instability. Dr. Framjee also reviewed diagnostic tests and noted that there were no fractures and no gross degenerative changes. He explained that appellant's primary pathology in the left knee was a partial medial meniscal tear, which resulted in a partial medial meniscectomy. He determined that appellant had reached maximum medical improvement. He utilized the A.M.A., *Guides* and determined that appellant had five percent impairment for the partial left medial meniscectomy. Dr. Framjee further noted that arthroscopy did not indicate any evidence of trauma to the cruciate ligaments. He determined that appellant could return to regular duty.

On September 28, 2004 the Office requested that an Office medical adviser review Dr. Framjee's July 28, 2004 report and provide an impairment rating.[4]

[4] In a September 13, 2004 report, the Office medical adviser reviewed Dr. Framjee's July 28, 2004 report and indicated that Table 17-33, of page 546 of the A.M.A., *Guides* only provided an impairment of two percent for a medial or lateral meniscectomy.

In a January 31, 2005 report, an Office medical adviser reviewed Dr. Framjee's July 28, 2004 report and determined that appellant had a five percent impairment of his left lower extremity based on the A.M.A., *Guides*. He noted that appellant was entitled to two percent for a partial medial meniscectomy pursuant to Table 17-33.[5] He also referred to Chapter 18.3d(C) and indicated that appellant was entitled to an additional impairment of three percent for his pain. The Office medical adviser indicated that, although Dr. Framjee awarded appellant five percent for his partial meniscectomy, he chose a different method which resulted in the "same final figure." He determined that appellant reached maximum medical improvement on July 28, 2004.

By decision dated February 10, 2005, the Office awarded appellant compensation for 14.4 weeks from July 28 to November 5, 2004, based upon a 5 percent permanent impairment of the left lower extremity.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[6] and its implementing regulation[7] sets 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 regulation as the appropriate standard for evaluating schedule losses.[8]

Section 8123(a) of the Act provides: if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary of Labor shall appoint a third physician, who shall make an examination.[9] When a case is 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.[10]

ANALYSIS

To resolve the conflict between appellant's treating physician, Dr. Ellis, who advised that appellant had laxity in the left lower extremity and the Office medical adviser who found that this was not established, the Office referred appellant to Dr. Framjee, who was selected as the impartial medical specialist. Dr. Framjee examined appellant and reported findings. He utilized

[5] A.M.A., *Guides* 546, Table 17-33.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] A.M.A., *Guides* (5th ed. 2001).

[9] *Richard L. Rhodes*, 50 ECAB 259 (1999); *Noah Ooten*, 50 ECAB 283 (1999).

[10] *James R. Driscoll*, 50 ECAB 146 (1998).

the A.M.A., *Guides* and determined that appellant was entitled to an impairment of five percent for the partial left medial meniscectomy. However, he did not explain how this figure was derived. The Board notes that the A.M.A., *Guides* provide an impairment of two percent for a medial or lateral meniscectomy.[11] Dr. Framjee did not explain how he used Table 17-33 of the A.M.A., *Guides* to determine the five percent impairment rating of appellant's left lower extremity. The impartial medical examiner did not explain how the other three percent was derived. Therefore, the Board finds that Dr. Framjee's report is not sufficiently rationalized to resolve the conflict.

An Office medical adviser subsequently reviewed his report and attempted to explain Dr. Framjee's findings. In his January 31, 2005 report, the Office medical adviser concurred with the findings of the impartial medical examiner but explained that he chose a different method to arrive at his findings. While an Office medical adviser may review the opinion of an impartial specialist, but the resolution of the conflict is the responsibility of the impartial medical specialist. Should the impartial specialist's opinion require clarification, the Office should request a supplemental opinion.[12] The medical adviser correctly noted that appellant was only entitled to two percent for a partial medial meniscectomy pursuant to Table 17-33. He also referred to Chapter 18.3d(C) and indicated that appellant was entitled to an additional impairment of three percent for his pain. However, the impartial specialist did not attribute any impairment to pain. Furthermore, according to section 18.3(b) of the A.M.A., *Guides*, "examiners should not use this chapter to rate pain[-]related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*."[13] Office procedures provide that Chapter 18 is not to be used in combination with other methods to measure impairment due to sensory pain (Chapters 13, 16 and 17).[14] The medical adviser's report was therefore insufficient to clarify the impartial medical examiner's findings.

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.[15] As noted above, Dr. Framjee's report is insufficient to resolve the matter and the Office did not seek clarification from him. Therefore, the Office should request clarification of Dr. Framjee's opinion on the issue of impairment. Following this and such other development as deemed necessary, the Office will issue an appropriate merit decision regarding appellant's permanent impairment.

[11] A.M.A., *Guides* 546, Table 17-33.

[12] *See Richard R. LeMay*, 56 ECAB ___ (Docket No. 04-1652, issued February 16, 2005).

[13] Section 18.3b, page 571, A.M.A., *Guides* (5th ed. 2001).

[14] *See* FECA Bulletin 01-05 (issued January 31, 2001); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003).

[15] *Phillip H. Conte*, 56 ECAB ___ (Docket No. 04-1524, issued December 22, 2004).

CONCLUSION

The Board finds that this case is not in posture for decision on the issue of whether appellant has more than a five percent permanent impairment of the left lower extremity, for which he received a schedule award, due to an unresolved conflict in medical opinion evidence.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 10, 2005 is set aside and the case is remanded to the Office for further development in accordance with this decision.

Issued: February 13, 2006
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