United States Department of Labor
Employees' Compensation Appeals Board

K.E., Appellant	)	
	)	**Docket No. 07-130**
and	)	**Issued: July 25, 2007**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION HOSPITAL, Lyons, NJ, 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, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 18, 2006 appellant filed a timely appeal from Office of Workers' Compensation Programs' decisions dated April 28 and May 3, 2006, adjudicating her schedule award claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether appellant has more than a 14 percent permanent impairment of her left lower extremity; and (2) whether the Office properly denied her request to participate in the selection of the impartial medical specialist.

FACTUAL HISTORY

On April 9, 1998 appellant, then a 51-year-old psychiatric nurse assistant, filed a traumatic injury claim alleging that she sustained an injury when she slipped on a wet floor and fell to her knees. The Office accepted her claim for a lumbosacral sprain and a left knee sprain.

On July 10, 1998 appellant underwent a partial medial meniscectomy. She was released to return to work without restrictions as of October 22, 1998. On May 18, 2001 appellant filed a claim for a schedule award.

On March 7, 2001 Dr. David Weiss, an osteopathic specialist in orthopedic medicine, provided findings on physical examination and stated:

> "[Appellant] [has] left knee pain and stiffness daily in nature that waxes and wanes. She notes swelling of the left knee ….
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> "[Appellant] is unemployed. She notes [that] working increases the pain involving her left wrist and left knee. [Appellant] notes difficulty performing household duties of cooking, cleaning, vacuuming and shopping. Posturally, she notes difficulties with walking and climbing stairs. [Appellant] notes difficulties performing movements of kneeling and squatting….
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> "At present, [appellant] states the pain level on a scale of 0 to 10 is 5/10 in her left knee…. Prior to the date of the accident, [she] denies having any pain or difficulties with activities of daily living.
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> "Gastrocnemius circumference measures 42 cm [centimeters] on the right versus 43 cm on the left.
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> "Quadriceps circumference at 10 cm above the patella measures 62 cm on the right versus 60 cm on the left for a 2 cm differential.
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> "Isolated testing of the gastrocnemius musculature is graded at 4/5 on the left. Quadriceps testing is graded at 3+/5 on the left."
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> "Patellofemoral compression produces marked crepitance."

Dr. Weiss stated that appellant had a 34 percent combined impairment of the left lower extremity, including 5 percent for left patellofemoral pain and crepitation (arthritis),[1] based on Table 17-31 at page 544 of the A.M.A., *Guides*,[2] 17 percent for a Grade 4 motor strength deficit of the left quadriceps muscle (knee extension),[3] based on Table 17-8 at page 532 (muscle

[1] Dr. Weiss did not provide cartilage interval (joint space) measurements as shown on x-ray. Cartilage interval measurements are required for application of Table 17-31. *See* the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, 544, section 17.2h "[a]rthritis."

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

[3] A Grade 4 muscle weakness for knee extension equals a 12 percent impairment according to Table 17-8, not 17 percent. A.M.A., *Guides* 532, Table 17-8.

weakness) and 17 percent for a Grade 3 motor strength deficit of the left gastrocnemius muscle (ankle plantar flexion), based on Table 17-8 at page 532.[4]

In an August 6, 2001 report, Dr. David Rubinfeld, a Board-certified orthopedic surgeon and an Office referral physician, provided findings on physical examination and found that appellant had a two percent impairment of the left lower extremity for a partial meniscectomy.[5] He stated:

> "Examination of the left knee revealed an arthroscopic scar. Range of motion was from 0 to 140 degrees (normal). There was no tenderness on palpation. There was no effusion. No instability was noted."
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> "Examination of the left ankle revealed a range of motion as follows: dorsiflexion 20 degrees (normal), plantar flexion 40 degrees (normal), inversion 30 degrees (normal) and eversion 20 degrees (normal). There was no evidence of swelling or ecchymosis. There was no point tenderness on palpation."
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> "Motor strength was normal….
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> "Thigh and leg circumference measurements were equal bilaterally.
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> "Sensation was intact in the lower extremities bilaterally."

On December 11, 2001 Dr. Henry Magliato, the Office medical director stated that, based on the findings of Dr. Weiss and Dr. Rubinfeld, appellant had a 13 percent combined impairment of the left lower extremity, including 8 percent for 2 cm of quadriceps (thigh) muscle atrophy, according to Table 17-6 at page 530 of the A.M.A., *Guides*, 3 percent for 1 cm of gastrocnemius (calf) muscle atrophy, according to Table 17-6 and 2 percent for a partial medial meniscectomy, according to Table 17-33 at page 546 (diagnosis-based estimate).[6] He stated that Dr. Rubinfeld failed to include appellant's muscle atrophy in his impairment rating. The Office medical director noted that Dr. Weiss included five percent impairment for patella crepitus but only a knee sprain and meniscus tear were accepted by the Office.

[4] The Board notes that the rating methods used by Dr. Weiss in his March 7, 2001 report, muscle strength and arthritis, cannot be combined, according to Table 17-2, the cross-usage chart, at page 526 of the A.M.A., *Guides.*

[5] Dr. Rubinfeld referenced the fourth edition of the A.M.A., *Guides.* The applicable edition at the time of his evaluation was the fifth edition. However, both editions provide for two percent impairment for a partial meniscectomy. *See* A.M.A., *Guides* fifth edition 546, Table 17-33; A.M.A., *Guides* fourth edition 3/84, Table 64.

[6] The Board notes that the rating methods for muscle atrophy and a diagnosis-based estimate cannot be combined according to the cross-usage chart, Table 17-2 at page 526 of the A.M.A., *Guides.*

On March 23, 2002 the Office granted appellant a schedule award for 37.44 weeks based on a 13 percent impairment of the left lower extremity at the two-thirds pay rate for an employee without dependents.

Appellant requested an oral hearing that was held on August 27, 2003. On December 16, 2003 the Office hearing representative found a conflict in the medical opinion evidence between Dr. Weiss and Dr. Rubinfeld regarding appellant's left lower extremity impairment. She set aside the March 23, 2002 decision and remanded the case for referral to an impartial medical specialist.

On January 9, 2004 appellant asked to participate in the selection of an impartial medical specialist. She requested the names of three qualified physicians within his geographic area from which to choose. Appellant stated that the reason for the request was to attempt to assure that she received an impartial evaluation.

On March 10, 2004 the Office referred appellant to Dr. Robert Dennis, a Board-certified orthopedic surgeon, in order to resolve the conflict in medical opinion between Dr. Weiss and Dr. Rubinfeld as to her left lower extremity impairment. In a March 25, 2004 report, Dr. Dennis provided a review of the medical evidence and physical findings on examination. He diagnosed a left knee contusion, a left knee sprain with slight medial collateral ligament (MCL) and anterior cruciate ligament laxity, mild aggravation of degenerative changes in the left knee secondary to the ligamentous (ACL) laxity, status post partial medial meniscectomy and status post abrasion chondroplasty of the left knee. Dr. Dennis stated:

> "[Appellant] walked up and down the hallway … and pivoted normally. She did not list or limp in either direction. [Appellant's] knees were examined, both right and left, in comparison when she was standing…. When sitting, she easily flexed her left knee to 90 degrees.
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> "Examination of the left knee revealed [well-healed] arthroscopic scars. There was very slight effusion of the knee compared to the opposite side…. There was mild crepitus on the left knee…. The medial and lateral stability of the left knee was slightly diminished and there was a slight wobble compared to the other side…. [T]here was some slight laxity in forward drawer.
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> "Range of motion of the left knee revealed full extension equal to the opposite side. There was a slight extension lag and some very slight weakness of the left quadriceps [muscle], but this could be voluntary in nature. Flexion was possible 110 degrees on the left…. There was no difference in girth. Both quadriceps [muscles] measured the same. Obviously, found no evidence of gross atrophy that was definable on physical examination. Both [lower extremities] measured equally."
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> "The conditions found on my physical examination today showed slight minimal dysfunction. In summation, there is very slight loss of motion and some very slight swelling. Associated with this is the aggravation. There is some

> ligamentous laxity, which played a role in the acceleration of arthritic changes that have to be considered very mild, based on her clinical examination; but also the loss of the meniscus represents some degree of anatomical loss, which is described in the [A.M.A., *Guides*], under diagnosed based evaluation."
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> "[Appellant] has reached maximum … medical improvement. No further treatment is likely necessary. The arthritis that is noted in the knee is very mild. It does not functionally affect the range of motion and it does not cause a limp. The likelihood of requiring further treatment [of the] left knee is essentially nonexistent…."
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> "There is restriction of motion. About 15 degrees has a slight extension lag, but can get to full extension. [Appellant] lacks only a few degrees of flexion. She has a functional range of motion of the knee…."
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> * * *
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> "There is no definable atrophy of the quadriceps [muscle], but some very slight weakness. There is no sensory loss or ankylosis…."

Dr. Dennis determined that appellant had a 12 percent combined impairment of the left lower extremity, based on loss of strength of the quadriceps muscle, according to Table 17-8 at page 532 of the A.M.A., *Guides*, fifth edition (2 percent); ligamentous instability of the medial collateral and anterior cruciate ligaments of the left knee, according to Table 17-10 at page 537; loss of meniscus of the left knee and the associated arthritic acceleration of the left knee; and a total meniscectomy, according to Table 17-33 at page 546.[7] He did not provide impairment percentages for the various impairments, with the exception of two percent for quadriceps muscle weakness.

On April 5, 2004 Dr. Magliato, the Office medical director, stated that appellant had a 14 percent impairment of the left lower extremity, including 7 percent for slight (mild) laxity of the ACL and MCL ligaments, according to Table 17-33 at page 546[8] of the A.M.A., *Guides* (diagnosis-based estimate), 2 percent for a partial meniscectomy, according to Table 17-33 at page 546 (diagnosis-based estimate) and 5 percent for patellar crepitus, according to Table 17-31

[7] Dr. Dennis stated that appellant had undergone arthroscopy and probably a partial medial meniscectomy in 1978. He stated: "I, therefore, believe that accuracy requires that [she] be given credit for a total meniscectomy as a result of the 1998 surgery."

[8] Dr. Magliato noted that Dr. Dennis found a two percent impairment for ligament laxity but had used the wrong table in the A.M.A., *Guides*, Table 17-10 at page 537, rather than the correct Table 17-33 at page 546.

at page 544 (arthritis).[9] He stated that the slight weakness of appellant's quadriceps muscle was not ratable because Dr. Dennis found no atrophy and there was full extension on range of motion testing.

On April 21, 2004 the Office granted appellant a schedule award for 2.88 weeks based on an additional one percent impairment. The Office noted that Dr. Dennis found only a 12 percent impairment but the Office medical adviser calculated a 14 percent impairment using the applicable tables from the A.M.A., *Guides*.

On March 22, 2005 Dr. Weiss stated that, at the time of his March 7, 2001 examination of appellant, she had a 27 percent combined impairment of the left lower extremity, including 12 percent for a Grade 4 motor strength deficit of the left quadriceps muscle and 17 percent for a Grade 3 motor strength deficit of the left gastrocnemius muscle, according to Table 17-8 at page 532 of the A.M.A., *Guides*.

On May 20, 2005 an Office hearing representative remanded the case for further development of the medical evidence. On July 5, 2005 the Office asked Dr. Dennis to review the March 22, 2005 report of Dr. Weiss and Dr. Magliato's April 5, 2004 report. The Office asked Dr. Dennis to indicate whether he wished to amend his rating of appellant's left lower extremity impairment after reviewing this medical evidence. On July 14, 2005 Dr. Dennis stated:

> "[M]y physical examination of [appellant] on March 25, 2004 revealed little significant findings. Based on my March 25, 2004 examination, I came to the determination, using what I felt were appropriate charts and tables, of the [fifth] [e]dition of the A.M.A., *Guides*, that [appellant] had … a 12 [percent] permanent impairment of the [left] lower extremity."
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> "[H]aving taken all things into consideration, [appellant] has … a 13 percent permanent impairment of the left lower extremity. To the extent of this 1 [percent] difference between 12 and 13 percent, I have indeed, modified my opinion."
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> "I have reconsidered [my] calculations and believe the appropriate percentage is 13 percent.
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> "I have considered the report of Dr. Weiss … and cannot find … support for his conclusions….
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> "The recent final report of Dr. Weiss does not alter my opinion."

[9] It is unclear how Dr. Magliato found a five percent impairment for patellar (knee) crepitus based on Table 17-31 at page 544 as the only provisions for a five percent impairment of the lower extremity in that table are for the ankle and foot. Additionally, Dr. Dennis did not provide cartilage interval measurements as shown on x-ray.

On August 29, 2005 the Office denied appellant's claim for more than a 14 percent impairment of her left lower extremity.

On September 7, 2005 appellant requested a hearing that was held on February 24, 2006. On November 17, 2005 appellant advised that she had been married since 1976 and was entitled to the three-fourths pay rate for employees with dependents.

By decision dated April 28, 2006, an Office hearing representative affirmed the August 29, 2005 decision denying appellant's claim for more than a 14 percent impairment of her left lower extremity. He also found that there was no evidence of improper selection of the impartial medical specialist.

By decision dated May 3, 2006, the Office amended its March 23, 2002 and April 21, 2004 schedule award decisions to correct appellant's pay rate from two-thirds to the three-fourths rate of pay for employees with dependents.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[10] and its implementing regulation[11] 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 regulation as the appropriate standard for evaluating schedule losses.[12]

The A.M.A., *Guides* provides for three separate methods for calculating the lower extremity permanent impairment of an individual: anatomic, functional and diagnosis based.[13] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[14] The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligamentous instability, bursitis and various surgical procedures, including joint replacements and meniscectomies.[15] The functional method is used for conditions when anatomic changes are difficult to categorize or when functional implications have been documented and includes range of motion, gait derangement and muscle strength.[16] The evaluating physician must determine

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

[12] *Id*.

[13] A.M.A., *Guides* 525.

[14] *Id.*

[15] *Id.*

[16] *Id*. at 525, Table 17-1.

which method best describes the impairment of a specific individual based on patient history and physical examination.[17] When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.[18] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[19]

Section 8123(a) 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 [of Labor] shall appoint a third physician who shall make an examination."[20] Where 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 on a proper factual and medical background, must be given special weight.[21]

When the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in his original report.[22] However, when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, the Office must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[23] Unless this procedure is carried out by the Office, the intent of section 8123(a) of the Act will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.[24]

ANALYSIS

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

On March 7, 2001 Dr. Weiss determined that appellant had a 34 percent combined impairment of the left lower extremity. On August 6, 2001 Dr. Rubinfeld found a two percent impairment. Dr. Magliato applied the findings of Dr. Weiss and Dr. Rubinfeld to the A.M.A, *Guides* and found a 13 percent combined impairment of the left lower extremity based on a diagnosis-based estimate for a partial medial meniscectomy (2 percent) and muscle atrophy of

[17] *Id*. at 548, 555.

[18] *Id*. at 526.

[19] *Id*. at 527, 555.

[20] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

[21] *See Roger Dingess*, 47 ECAB 123 (1995); *Glenn C. Chasteen*, 42 ECAB 493 (1991).

[22] *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232 (1988); *Ramon K. Ferrin, Jr.*, 39 ECAB 736 (1988).

[23] *Roger W. Griffith*, 51 ECAB 491 (2000); *Talmadge Miller*, 47 ECAB 673 (1996).

[24] *Roger W. Griffith*, *supra* note 23; *Harold Travis*, 30 ECAB 1071 (1979).

the quadriceps and gastrocnemius muscles (8 percent and 3 percent, respectively).[25] The Office granted appellant a schedule award based on a 13 percent impairment. Subsequently, the Office found a conflict in the medical evidence and referred appellant to Dr. Dennis for an independent medical examination.

On March 25, 2004 Dr. Dennis provided findings on physical examination and determined that appellant had a 12 percent combined impairment of the left lower extremity, based on weakness of the quadriceps muscle, according to Table 17-8 at page 532 of the A.M.A., *Guides*; laxity of the medial collateral and ACL of the left knee, according to Table 17-10 at page 537[26]; loss of meniscus of the left knee and associated arthritis; and a total meniscectomy,[27] according to Table 17-33 at page 546. Dr. Dennis did not provide impairment percentages for the various impairments, with the exception of two percent for quadriceps muscle weakness.[28] Dr. Magliato applied the physical findings of Dr. Dennis to the A.M.A., *Guides* and stated that appellant had a 14 percent impairment of the left lower extremity, including 7 percent for mild laxity of the ACL and MCL ligaments, according to Table 17-33 at page 546 of the A.M.A., *Guides*, 2 percent for a partial meniscectomy, according to Table 17-33 at page 546 and 5 percent for patellar crepitus, according to Table 17-31 at page 544. He stated that the slight weakness of appellant's quadriceps muscle was not ratable because Dr. Dennis found no atrophy and there was full extension on range of motion testing. The Office granted appellant a schedule award based on an additional one percent impairment.

On March 22, 2005 Dr. Weiss stated that, at the time of his March 7, 2001 examination, appellant had a 27 percent combined impairment of the left lower extremity, including 12 percent for a Grade 4 muscle weakness of the left quadriceps muscle[29] and 17 percent for a Grade 3 muscle weakness of the left gastrocnemius muscle, based on Table 17-8 at page 532 of the A.M.A., *Guides.*

The Office asked Dr. Dennis to review the March 22, 2005 report of Dr. Weiss and April 5, 2004 report of Dr. Magliato and determine whether he wished to amend his previous impairment rating. On July 14, 2005 Dr. Dennis stated that his examination of appellant on March 25, 2004 revealed few significant findings. He used appropriate tables of the fifth edition of the A.M.A., *Guides* and found that appellant had a 12 percent impairment of the left lower extremity. Dr. Dennis stated: "[H]aving taken all things into consideration, [appellant] has … a

[25] As noted, the A.M.A., *Guides* precludes the combination of muscle atrophy and diagnosis-based estimate rating methods. A.M.A., *Guides* 526, Table 17-2.

[26] As noted, Dr. Dennis should have used Table 17-33 at page 546 for ligament laxity.

[27] The Office has accepted only a partial meniscectomy as related to the accepted employment injury.

[28] It is unclear how Dr. Dennis determined that appellant had a two percent impairment for quadriceps weakness based on Table 17-8 at page 532 as there is no provision in that table for a two percent impairment of the lower extremity, except for extension weakness of the great toe. Impairments for the knee in Table 17-8 range from 12 to 25 percent, depending on the grade of impairment, ranging from Grade 0 to Grade 4. A.M.A., *Guides* 532, Table 17-8.

[29] This is a correction from his earlier statement that a Grade 4 muscle weakness equaled a 17 percent impairment according to Table 17-8.

13 percent permanent impairment of the left lower extremity. To the extent of this 1 percent difference between 12 and 13 percent, I have indeed, modified my opinion."

The Board finds that the reports of Dr. Dennis are not entitled to special weight and are not sufficient to resolve the conflict in the medical opinion evidence as to appellant's left lower extremity impairment. In his first impairment rating on March 25, 2004, Dr. Dennis found that appellant had a 12 percent combined impairment due to muscle weakness of the left quadriceps muscle, according to Table 17-8 at page 532 of the A.M.A., *Guides.* Dr. Weiss also noted quadriceps muscle weakness in his March 7, 2001 and March 22, 2005 reports and referenced Table 17-8. In his July 5, 2005 report, Dr. Dennis did not address the fact that both he and Dr. Weiss (in Dr. Weiss' March 22, 2005 report) determined that appellant had a 12 percent combined impairment due to left quadriceps muscle weakness according to Table 17-8. He did not address the fact that Dr. Magliato, in his April 5, 2004 report, dismissed Dr. Dennis' finding of impairment due to muscle weakness and did not include this impairment in his determination that appellant had a 14 percent combined impairment. Dr. Dennis noted in his March 25, 2004 report that appellant had impairment due to arthritis but he did not provide cartilage interval measurements as shown on an x-ray. He did not address the fact that his March 25, 2004 impairment rating combined impairment due to loss of muscle strength and impairment due to a diagnosis-based estimate which is not permitted according to the cross-usage chart, Table 17-2 at page 526 of the A.M.A., *Guides.*[30] Dr. Dennis stated that he had increased his rating of appellant's left lower extremity impairment from 12 to 13 percent but he did not provide sufficient explanation for his change in rating. Due to these deficiencies, Dr. Dennis' opinion regarding appellant's left lower extremity impairment is not entitled to special weight. Therefore, the conflict in the medical evidence has not been resolved.[31]

CONCLUSION

The Board finds that this case is not in posture for a decision as to appellant's left lower extremity impairment rating. On remand, the Office should refer appellant, together with the case record and statement of accepted facts, to another Board-certified specialist for an evaluation of her impairment due to her accepted left knee sprain and partial medial meniscectomy. After such further development as the Office deems necessary, it should issue an appropriate decision. Due to the Board's resolution of the first issue in this case, the second issue is rendered moot.

[30] As noted, Dr. Magliato also erred in his December 11, 2001 report when he combined impairment due to muscle atrophy and impairment due to a diagnosis-based estimate, which is precluded by Table 17-2.

[31] The Board notes that four different impairment rating methods have been used by Drs. Weiss, Rubinfeld, Magliato, and Dennis: arthritis (Table 17-31), muscle weakness (Table 17-8), diagnosis-based estimates (a partial medial meniscectomy and ligament laxity) (Table 17-33) and muscle atrophy (Table 17-6). As noted, the A.M.A., *Guides* provides that, if more than one rating method can be used, the method that provides the higher rating should be adopted. There is no medical report of record that correctly applies the A.M.A., *Guides* to physical findings on examination of appellant and explains the choice of rating method(s) with thorough medical rationale.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated May 3 and April 28, 2006 are set aside and the case remanded for further action consistent with this decision.

Issued: July 25, 2007
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

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