United States Department of Labor
Employees' Compensation Appeals Board

R.T., Appellant	)	
and	)	**Docket No. 08-2495**
	)	**Issued: September 23, 2009**
DEPARTMENT OF THE ARMY, MATERIAL COMMAND, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 19, 2008 appellant filed a timely appeal from the November 19, 2007 and May 19, 2008 schedule award decisions of the Office of Workers' Compensation Programs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than 18 percent impairment of her left arm, 5 percent permanent impairment of her left leg and 1 percent impairment of her right foot, for which she received schedule awards.

FACTUAL HISTORY

The Office accepted that on July 24, 2001 appellant, then a manager, sustained sprains of her left shoulder, left knee and right foot and a fracture of the right fifth metatarsal. On

March 10, 2003 she underwent a left knee arthroscopy with lateral release and a postoperative diagnosis of internal derangement the left knee, patella subluxation and patella chondromalacia.[1]

On December 1, 2004 appellant filed a claim for a schedule award. In a September 13, 2004 report, Dr. David Weiss, an attending osteopath, opined that she had an 18 percent impairment of her left leg (8 percent for left thigh atrophy, 8 percent for left calf atrophy and 3 percent for pain), a 3 percent impairment of her right foot (for right foot pain) and a 14 percent impairment of her left arm (1 percent for loss of flexion, 10 percent for resection arthroplasty and 3 percent for pain).

In a September 5, 2005 report, an Office medical adviser found 15 percent impairment for left leg thigh and calf atrophy but that 3 percent should not be allowed for pain. He similarly disallowed three percent for pain in the right leg. The Office medical adviser noted that appellant's left shoulder flexion was 1 percent impairment and her arthroplasty was a 10 percent impairment.

The Office determined that a conflict in medical opinion arose between Dr. Weiss and the Office medical adviser regarding the extent of appellant's impairment. To resolve the conflict, it referred her to Dr. Michael Sclafani, a Board-certified orthopedic surgeon, for an impartial medical examination. However, Dr. Sclafani's office advised that the physician did not evaluate ankles. The Office subsequently referred appellant to David A. Bundens, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a March 14, 2006 report, Dr. Bundens reviewed the evidence of record, described his findings on examination and opined that appellant has a 1 percent impairment of the right foot due to pain, a 7 percent impairment of her left leg due to arthritis (which incorporates the assumption of pain) and a 10 percent impairment of her left arm due to loss of motion and pain.[2]

In a report dated May 4, 2006, Dr. Henry Magliato, a Board-certified orthopedic surgeon and Office medical adviser, reviewed the medical evidence. He opined that appellant had 1 percent impairment of her right leg, a 5 percent impairment of her left leg and a 10 percent impairment of her left arm. In a follow-up report dated June 6, 2006, Dr. Magliato stated that Dr. Bundens did not find any measurable joint space narrowing on x-ray so he used the minimal amount of seven percent. He indicated, however, that he chose five percent for patellofemoral pain and crepitation due to chondromalacia as he felt that a five percent rating was more accurate based on the physical findings and use of Table 17-31 on page 544 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001).

[1] The record shows that appellant had a motor vehicle accident in 1998 in which she injured her neck and left shoulder and for which she underwent left shoulder surgery, including subacromial decompression and distal clavicular resection. She also had a fall in September 2001 that resulted in two surgical procedures on her right shoulder, a work-related mid-back injury in 1980 and another motor vehicle accident in 2000.

[2] Dr. Bundens indicated that appellant's 110 degrees of left shoulder flexion warranted a five percent rating and that her 100 degrees of abduction warranted a four percent rating.

In a June 23, 2006 decision, the Office granted appellant a schedule award for 5 percent impairment to her left leg, 1 percent impairment of her right foot and 10 percent impairment of her left arm.

Appellant requested a hearing before an Office hearing representative, which was held on October 25, 2006. In a January 8, 2007 decision, the Office hearing representative set aside the June 23, 2006 schedule awards and remanded the case for further development. She found that appellant was properly referred to Dr. Bundens; however, his report was not sufficiently detailed in that he should have taken x-rays to quantify appellant's left knee arthritis. The hearing representative instructed the Office to obtain further opinion on the permanent impairment of appellant's left leg due to arthritis.

The Office referred appellant back to Dr. Bundens. X-rays of the knees were taken on April 24, 2007 and showed minimal spurring on the left with no significant joint space narrowing. In an April 27, 2007 report, Dr. Bundens opined that appellant did have traumatic arthritis of the left knee, but did not have joint space narrowing. He noted that Table 17-31 on page 544 of the A.M.A., *Guides* states, "[I]f an individual with a history of direct trauma has a complaint of patellofemoral pain and crepitation but without joint space narrowing x-rays, a [two] percent whole person or [five] percent lower extremity impairment is given." Dr. Bundens opined that appellant fit into the category, *i.e.*, no joint space narrowing but with traumatic arthritis and that her left knee condition warranted a five percent rating. The case was reviewed by Dr. Morley Slutsky, a Board-certified orthopedic surgeon and Office medical adviser, who concurred with Dr. Bundens' impairment rating.

In a June 22, 2007 decision, the Office determined that appellant was not entitled to additional schedule compensation.

In a September 6, 2007 decision, an Office hearing representative found that the case was not in posture for decision. The hearing representative determined that appellant was properly referred to Dr. Bundens but noted that there were several defects in his reports. He remanded the case to obtain a supplemental report from Dr. Bundens to address the following issues: (1) whether appellant has permanent impairment for left thigh and calf atrophy and, if so, whether this rating method was preferred to the diagnosis-based method found in Table 17-31; (2) whether it was appropriate to rate pain in the right foot and left shoulder under Chapter 18 given that the A.M.A., *Guides* provide that physicians should not use that chapter when such impairment can be rated on the basis of the body and organ impairment systems from other chapters; and (3) whether appellant had any impairment based on resection arthroplasty of the left knee and, if so, whether this constituted a rating that should be added or combined with range of motion ratings or a rating that should be used instead of range of motion ratings in light of the cross-usage chart.

On September 20, 2007 Dr. Bundens addressed the rating by Dr. Weiss concerning left calf and thigh atrophy, noting that these conditions should not be considered in the award. He stated:

> "I believe the problem is within the knee joint proper. I think that any calf and thigh atrophy is secondary to the knee joint proper and for this reason I would not

attribute any findings for disability to the calf and thigh atrophy. I do not think that the atrophy is the disabling issue….

"As far as your questions in paragraph four relative to evaluation for pain, you are indeed correct to correct me as far as pain to the left shoulder. I did review Chapter 18.3b of the [fifth edition of the A.M.A., *Guides*] and it states that pain does not need to be included when there is a body system impairment. I think that the pain is appropriate for the foot; but as far as the shoulder is concerned, this would not need to be included. For this reason I would not add the one percent for pain in the left shoulder.

"As questioned in paragraph five, [Dr.] Weiss gave an additional percent for resection arthroplasty of the shoulder. I did review the A.M.A., *Guides* and he is correct; *i.e.*, Table 16-27 on [p]age 506 indicates that distal clavicle resection arthroplasty is a 10 percent upper extremity impairment and this can be added to the range of motion impairments as noted in paragraph 16.7b.

"For this reason, as far as the shoulder is concerned, for the upper extremity this would be 10 percent for resection arthroplasty of the distal clavicle and 9 percent for loss of motion. This would result in 18 percent using the Combined Values Chart on [p]age 604."

By letter dated October 5, 2007, Dr. Bundens was asked to review the September 5, 2005 report of the medical adviser and further clarify his opinion. In a response dated October 16, 2007, he stated:

"In response to your questions, it is my opinion that [appellant's] left shoulder warrants 10 percent of resection arthroplasty of the distal clavicle and 9 percent for loss of motion resulting in 18 percent using the Combined Values Chart on [p]age 604.

"As far as the left knee is concerned, I believe she deserves five percent of the left lower extremity for traumatic arthritis. I think that the traumatic arthritis is the primary problem and, therefore, I think that the atrophy in the thigh and calf is secondary; therefore, I would not include those as separate percentages. I believe the total for the left lower extremity would be five percent.

"As far as the right foot is concerned, I believe [that appellant] should be considered Class I as denoted on Table 18-3, [p]age 575; and I would award her one percent for the right foot. I would not give an additional rating for pain in the left lower extremity because we have a joint impairment rating. This also applies for the left shoulder; *i.e.*, no additional percentage for pain."

In a report dated October 30, 2007, Dr. Magliato concurred with the impairment rating estimates provided by Dr. Bundens.

On November 19, 2007 the Office issued a schedule award for an additional 8 percent impairment of the left arm (for a total 18 percent impairment of the arm) but found no additional impairment of her left leg or right foot.

Appellant disagreed with the decision and requested a hearing before an Office hearing representative, which was held on March 25, 2008. At the hearing, counsel for appellant did not contest the impairment rating by Dr. Bundens of appellant's left arm. However, it was argued that, since the physician provided an initial and a supplement report, it was improper to ask him to provide further reports explaining the impairment rating. With regard to the left leg, counsel indicated that Dr. Bundens did not measure for atrophy and did not provide a rating for this condition. She noted that an Office medical adviser had given an impairment rating based on atrophy. Counsel contended that Dr. Bundens erred in stating that arthritis is the primary problem and calf and thigh atrophy was secondary. She noted that the A.M.A., *Guides* state that if a claimant can be rated by different categories (anatomical, functional and diagnosis-based), the physician must use the category that provides the highest rating for the claimant. Counsel argued that the impairment rating provided by the Office medical adviser for atrophy was more appropriate than the diagnosis-based rating provided by Dr. Bundens. She contended that appellant's injury to the right foot affected her lower extremity rather than just the foot and that therefore the impairment rating should be for the entire extremity. For these reasons, appellant should be referred for a new impartial medical examination to measure the atrophy-related impairment due to the left knee injury and to evaluate the pain-related impairment to the right lower extremity.

In a May 19, 2008 decision, the Office hearing representative affirmed the November 19, 2007 schedule award decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulations[4] 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.[5]

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."[6] When there are

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

[5] *Id*.

[6] 5 U.S.C. § 8123(a).

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 where there exist 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 upon a proper factual background, must be given special weight.[8] In a situation where the Office secures an opinion from an impartial medical examiner for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[9]

ANALYSIS

The Office accepted that appellant sustained sprains of her left shoulder, left knee and right foot and a fracture of the right fifth metatarsal. It granted her schedule awards for an 18 percent impairment of her left arm, 5 percent permanent impairment of her left leg and a 1 percent impairment of her right foot based on the report of the impartial medical specialist, Dr. Bundens the impartial medical specialist.

Dr. Bundens properly found that appellant had an 18 percent impairment of her left arm. He noted that Table 16-27 on page 506 of the A.M.A., *Guides* provides that distal clavicle resection arthroplasty is a 10 percent upper extremity impairment and that this may be added to the range of motion impairment as noted under paragraph 16.7b. Therefore, the left arm warranted a 10 percent rating for resection arthroplasty of the distal clavicle and a 9 percent rating for loss of left shoulder motion.[10] This totals 18 percent rating using the Combined Values Chart on page 604. On appeal, counsel for appellant did not contest this aspect of the schedule award decision.

As to the left leg impairment, Dr. Bundens determined that appellant had five percent impairment. He found that she had traumatic arthritis of the left knee, but did not have joint space narrowing on x-ray. Table 17-31 on page 544 of the A.M.A., *Guides* states, "[I]f an individual with a history of direct trauma has a complaint of patellofemoral pain and crepitation but without joint space narrowing x-rays, a two percent whole person or five percent lower extremity impairment is given." Dr. Bundens opined that appellant fit into that category, *i.e.*, no joint space narrowing but with traumatic arthritis and that her left knee condition warranted a five percent rating to the left leg.[11]

[7] *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] *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232, 238 (1988).

[10] Dr. Bundens correctly indicated that appellant's 110 degrees of left shoulder flexion warranted a five percent rating and that her 100 degrees of abduction warranted a four percent rating. *See* A.M.A., *Guides* 476-77, Tables 16-40 and 16-43.

[11] *See* A.M.A., *Guides* 544, Table 17-31.

Dr. Weiss, an attending osteopath, based his impairment left leg impairment rating on atrophy to the thigh and calf. Dr. Bundens provided a diagnosis-based impairment rating for arthritis without evidence of joint space narrowing. The cross-usage chart of Table 17-2 on page 526 of the A.M.A., *Guides* lists which methods of evaluating impairment to the lower extremity may be combined. The chart provides that impairment ratings for atrophy and diagnosis-based estimates may not be combined and are, in fact, mutually exclusive. The A.M.A., *Guides* at section 17.2 on page 526 further states that it is the responsibility of the evaluating physician to explain in writing why a particular method to assign the impairment rating was chosen. The evaluator should choose the method "that gives the most clinically accurate impairment rating." Dr. Bundens, in his capacity as the impartial medical specialist, advised that atrophy should not be considered as the basis for rating impairment in this case because appellant's problem was due to arthritis within the knee joint. He evaluated the alternative methods for rating impairment and determined that the diagnosis-based estimate for arthritis was most appropriate. Dr. Bundens' reports advised that this was the most clinically accurate basis for rating impairment.

Dr. Bundens also determined that appellant had a one percent impairment of her right foot. It is accepted that, as a result of her injury, appellant sustained a right foot sprain and fracture of the right fifth metatarsal. Dr. Weiss and Dr. Bundens agreed that, since pain to the right foot could not be adequately rated on the basis the rating systems provided under Chapter 17 of the A.M.A. *Guides*, they rating pain under Chapter 18. The reports differ in that Dr. Weiss provided a rating for the entire lower extremity; however, he offered no explanation as to how the right toe fracture and ankle sprain extended into the larger member and resulted in permanent impairment of the right leg. Dr. Bundens provided a rating for the foot based on the accepted toe fracture and ankle sprain.

The Office properly referred appellant to Dr. Bundens, a Board-certified orthopedic surgeon, due to a conflict in the medical evidence and his well-rationalized reports constitute the weight of the medical evidence with regard to her permanent impairment. Appellant contended before the Office that once it obtains a single supplemental report from a referee physician it cannot request further clarification from the physician but must refer the employee for a new impartial medical examination. The Office's procedure manual and Board precedent does not so limit the clarification that may be sought from an impartial medical specialist.[12]

CONCLUSION

The Board finds that appellant did not meet her burden of proof to establish that she has more than an 18 percent permanent impairment of her left arm, a 5 percent permanent impairment of her left leg and a 1 percent permanent impairment of her right foot, for which she received a schedule award.

[12] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.5(b)(2) (March 1994). *See, e.g., B.P.*, 60 ECAB ___ (Docket No. 08-1457, issued February 2, 2009); *I.H.*, 60 ECAB ___ (Docket No. 08-1332, issued December 24, 2008) and Docket No. 07-1348 (issued October 23, 2007).

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' May 19, 2008 and November 19, 2007 decisions are affirmed.

Issued: September 23, 2009
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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