United States Department of Labor
Employees' Compensation Appeals Board

R.S., Appellant	)	
and	)	**Docket No. 09-1331**
	)	**Issued: April 5, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Dayton, OH, Employer	)	

Appearances:
Alan J. Shapiro, 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 April 27, 2009 appellant filed a timely appeal from the September 26, 2008 and April 3, 2009 decisions of the Office of Workers' Compensation Programs denying his claim for an increased schedule award. 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 10 percent impairment of the right lower extremity for which he received a schedule award.

FACTUAL HISTORY

On July 26, 2004 appellant, then a 44-year-old letter carrier, filed a traumatic injury claim alleging that on July 24, 2004 he heard and felt a pop in his right knee while walking and fingering mail.[1] He stopped work on July 24, 2004 and returned on July 26, 2004. The Office

[1] Appellant originally filed this as a recurrence claim from a November 24, 2003 traumatic injury claim, adjudicated under claim number xxxxxx468 and was accepted for right medial collateral knee strain. The Office subsequently combined both claims.

accepted appellant's claim for right knee sprain/strain of the medial collateral ligament and medial meniscus tear.

Dr. Edward Robert Wanat, an osteopath Board-certified in occupational medicine, diagnosed right knee medial collateral ligament sprain with evidence of medial meniscal tear. Reports from Dr. Jonathan Paley, a Board-certified orthopedic surgeon, diagnosed right knee sprain, acute right knee medial meniscal tear and aggravated preexisting arthritis.

On June 28, 2006 appellant filed a schedule award claim. He submitted a February 27, 2006 operative report from Dr. Paley who performed a right knee arthroscopy with chondroplasty, medial femoral condyle and debridement of the posterior horn medial meniscal tear. In his December 8, 2006 report, Dr. Paley found that appellant's range of motion was normal with no impairment based on 0 degrees extension and 135 degrees flexion. He noted that appellant had significant pain that was ratable between Class II and III for pain disorder impairment. Dr. Paley advised that appellant required ongoing treatment. Due to appellant's damaged articular medial femoral condyle, he would require future partial knee replacement surgery and therefore was not at maximum medical improvement. Dr. Paley determined that, as appellant's pain level was between Class II and III, he had 20 percent whole person impairment. On May 22, 2007 he noted that appellant had technically reached maximum medical improvement as he did not want further right knee surgery. Dr. Paley also noted that appellant had not actually reached maximum medical improvement as he needed a knee replacement without which he could not significantly improve.

On October 11, 2007 Dr. Martin Fritzhand, a Board-certified urologist, examined appellant and performed an impairment evaluation. He found right knee flexion at 90 degrees and flexion contracture of the knee to 5 degrees. Dr. Fritzhand also found synovial thickening over the right knee joint, atrophy over the right lower extremity and diminished muscle strength. He disagreed with Dr. Paley's impairment rating. Dr. Fritzhand found 10 percent right lower extremity impairment secondary to flexion deformity and 10 percent impairment for flexion contracture, citing Table 17-10 on page 537 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*). He also determined that Table 17-6a and 17-6b on page 530 of the A.M.A., *Guides* showed 13 and 8 percent impairment respectively of the right lower extremity. Dr. Fritzhand further found seven percent pain impairment, citing Figure 18-1 on page 574 of the A.M.A., *Guides*. He utilized the Combined Values Chart to find 41 percent total right leg impairment.

On November 29, 2007 an Office medical adviser reviewed the medical evidence of record and determined that he could not provide a definitive impairment rating as the reports from Drs. Paley and Fritzhand were too disparate. The medical adviser recommended a second opinion evaluation.

On December 5, 2007 the Office referred appellant to Dr. Rudolf Hofmann, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a January 8, 2008 report, Dr. Hofmann reviewed appellant's medical records and summarized the history of injury and treatment. Upon examination, he found that appellant walked with a limp on the right and he had no unilateral muscular atrophy of the lower extremity. Dr. Hofmann also found both knees extended fully and the right knee flexed to 85 degrees. Appellant had painfully limited range of motion which was inconsistently documented in the medical records. Therefore this was not an objective finding allowing an impairment rating according to the A.M.A., *Guides*. Dr. Hofmann

determined that appellant had two percent impairment for a partial medial meniscectomy, citing Table 17-33 on page 546 of A.M.A., *Guides*. Citing Table 17-31 on page 544 of the A.M.A., *Guides*, he opined that appellant had 20 percent impairment of the right leg based on the rate of damage to the cartilage of the medial femoral condyle, analogous with an arthritic rating of two millimeters joint space, based on a review of magnetic resonance imaging (MRI) films, video arthroscopy pictures and Dr. Paley's operative report. Dr. Hofmann noted that there were no standing x-rays of appellant's right knee in accordance with the A.M.A., *Guides,* allowing for an objective measurement of cartilage thickness of the medial joint space. He utilized the Combined Values Chart on page 604 of the A.M.A., *Guides* to find a total 22 percent right leg impairment.

On February 13, 2008 an Office medical adviser reviewed Dr. Hofmann's report and determined that appellant had two percent right lower extremity impairment for partial medial meniscectomy, citing Table 17-33 on page 546 of the A.M.A., *Guides*. The medical adviser opined that Dr. Hofmann improperly provided an additional impairment for arthritis, as the required standardized x-rays were not of record.

On April 22, 2008 the Office referred appellant to Dr. Pietro Seni, a Board-certified orthopedic surgeon, for an impartial referee evaluation to resolve a conflict in medical opinion between the Office medical adviser and Dr. Hofmann. In a May 28, 2008 report, Dr. Seni noted that appellant's claim had been accepted for sprained right medial collateral ligament and right torn medial meniscus and repair. He reviewed the statement of accepted facts and the medical evidence of record. Upon examination, Dr. Seni found 90 degrees flexion, 3 degrees of full extension, bilaterally invarus alignment of the knees and no effusion. He noted pain on palpation over the medial and lateral compartments and no medial or lateral instability at 30 degrees. Dr. Seni determined that impairment must be based on appellant's partial medial meniscectomy, and rated two percent impairment citing Table 17-13 on page 548 of the A.M.A., *Guides*.[2] He indicated that weight-bearing x-ray views of the knee showed that medial joint space was 4.5-5 millimeters, which was not a ratable impairment according to Table 17-31 on page 544 of the A.M.A., *Guides*. Dr. Seni also indicated that a mild degree of flexion contracture equaled zero percent impairment and flexion to 90 degrees equaled 10 percent impairment, citing Table 17-10 on page 537 of the A.M.A., *Guides* for a total impairment rating of 12 percent. He noted that diagnostic and operative reports were not valid to rate arthritic impairment according to the A.M.A., *Guides*.

On July 18, 2008 an Office medical adviser determined that appellant had 10 percent permanent impairment based on 90 degrees flexion and 0 percent impairment for extension lacking three degrees according to Table 17-10 on page 537 of the A.M.A., *Guides*. The medical adviser noted that his impairment rating differed from Dr. Seni's because the medical adviser based his rating on range of motion deficit of flexion, not partial medial meniscectomy which cannot be combined with range of motion under the cross-usage chart at Table 17-2 on page 526 of the A.M.A., *Guides*. He also found that appellant reached maximum medical improvement on February 27, 2007, one year after undergoing knee arthroscopy.

[2] Dr. Seni's page citation appears to be a transcription error as the impairment rating of two percent for partial medial meniscectomy is on Table 17-33 on page 546, not page 548.

In a September 26, 2008 decision, the Office granted appellant a schedule award for 10 percent impairment of the right lower extremity. Appellant received 28.8 weeks of compensation from February 27 to September 16, 2007.

On October 1, 2008 appellant, through his representative, requested a telephone hearing which was held on January 14, 2009. In a February 10, 2009 report, Dr. Paley noted that appellant's right knee was grossly inflamed and swollen with an uncomfortable range of motion. He further noted that appellant ambulated with antalgic gait and utilized a cane for assistance. Dr. Paley found good stability of the knee with crepitations present and possible fixed varus deformity. He opined that appellant would benefit from a total knee replacement but did not have osteoarthrosis.

In an April 3, 2009 decision, an Office hearing representative affirmed the Office's September 26, 2008 decision finding that the Office medical adviser properly reviewed the case and the impartial specialist's report and explained the basis for his impairment rating according to the A.M.A., *Guides*.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulations 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. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of the Office. For consistent results and to ensure equal justice, the Board has authorized 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 Office for evaluating schedule losses and the Board has concurred in such adoption.[4]

ANALYSIS

Appellant received a schedule award for 10 percent impairment of his right lower extremity due to his accepted right knee sprain/strain of the medial collateral ligament and medial meniscus tear.

On December 5, 2007 the Office referred appellant to Dr. Hofmann for a second opinion evaluation due to the disparate findings of appellant's treating physicians Drs. Paley and Fritzhand. It found that a conflict in medical opinion existed between Dr. Hofmann and an Office medical adviser that reviewed Dr. Hofmann's findings. 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 shall appoint a third physician who shall make an examination.[5] A conflict under section 8123(a) cannot exist unless there is a

[3] 5 U.S.C. §§ 8101-8193. *See* 5 U.S.C. § 8107.

[4] *See* 20 C.F.R. § 10.404; *R.D.*, 59 ECAB ___ (Docket No. 07-379, issued October 2, 2007).

[5] 5 U.S.C. § 8123(a).

conflict between an attending physician and an Office physician.[6] The Board notes that, although there was a discrepancy between the impairment ratings calculated by Dr. Hofmann and the Office medical adviser, this did not create a conflict in medical opinion as the second opinion physician Dr. Hofmann and the Office medical adviser were both acting as physicians of the Federal Government. Therefore, the Office improperly designated Dr. Seni as an impartial medical specialist.[7]

Although Dr. Seni's report is not entitled to the special weight afforded to the opinion of an impartial medical specialist resolving a conflict in medical opinion, his report can still be considered for its own intrinsic value and can still constitute the weight of the medical evidence.[8] His May 28, 2008 report constitutes the most reliable and probative evidence regarding whether appellant has more than 10 percent impairment of the right lower extremity. It is also the most recent report from an examining physician that purports to rate impairment under the A.M.A., *Guides.* Dr. Seni reviewed the medical evidence and provided detailed findings on examination in accordance with the A.M.A., *Guides*. He found that appellant's range of motion consisted of 90 degrees flexion equaling 10 percent impairment and 3 degrees flexion contracture equaling 0 percent impairment, citing Table 17-10 on page 537 of the A.M.A., *Guides*. Dr. Seni also found two percent impairment for a partial medial meniscectomy according to Table 17-13 on page 546 of the A.M.A., *Guides*. He concluded 12 percent total impairment of the right lower extremity.

An Office medical adviser found that appellant had 10 percent impairment of the right lower extremity, relying on Dr. Seni's finding of 90 degrees flexion. This is 10 percent impairment, under Table 17-10 on page 537 of the A.M.A., *Guides*. The medical adviser disagreed with Dr. Seni rating an additional two percent impairment for the partial medial meniscectomy. The Office's procedure manual states that an Office medical adviser must review the report to verify correct application of the A.M.A., *Guides* and confirm the percentage of permanent impairment as well as specify his reasons for assigning a certain percentage of loss of use to the measurements or factors provided by the examining physician.[9] In the present case, the medical adviser properly noted that impairment for range of motion or flexion deficit may not be combined with the diagnosis-based partial medial meniscectomy impairment, citing Table 17-2 on page 526 of the A.M.A., *Guides*.[10] He utilized Dr. Seni's objective clinical findings to compare them with impairment criteria listed in the A.M.A., *Guides*.[11]

In contrast to Dr. Seni's report, Dr. Hofmann's report did not properly calculate appellant's impairment rating. Dr. Hofmann determined that appellant had two percent

[6] *Delphia Y. Jackson*, 55 ECAB 373 (2004).

[7] *See S.G.*, 58 ECAB 383 (2007).

[8] *See Cleopatra McDougal-Saddler*, 47 ECAB 480 (1996); *see also Rosa Whitfield Swain*, 38 ECAB 368 (1987).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.7(c) (April 1993).

[10] Table 17-2 indicates that a meniscectomy, which is a diagnosis-based estimate, cannot be combined with gait derangement, muscle atrophy, muscle strength or range of motion ankylosis to evaluate a single impairment.

[11] If the clinical findings are fully described, any knowledgeable observer may check the findings with the A.M.A., *Guides* criteria. A.M.A., *Guides* 17. *See also I.H.*, 60 ECAB ___ (Docket No. 08-1352, issued December 24, 2008).

impairment for partial medial meniscectomy. He also calculated 20 percent impairment for arthritis based on cartilage damage to appellant's medial femoral condyle despite noting the record contained no standing x-rays of appellant's right knee as required under the A.M.A., *Guides* for impairment rating purposes. Dr. Hofmann combined the impairment values to derive 22 percent right lower extremity impairment. He stated that he based the arthritis finding on review of MRI scan films, video arthroscopy pictures and Dr. Paley's operative report; however, the A.M.A., *Guides* clearly provide that the arthritis finding must be based on x-rays.[12] Dr. Hofmann improperly assigned an impairment rating for arthritis as the physician did not obtain the requisite x-rays in accordance with the A.M.A., *Guides*.

Additionally, appellant's treating physicians Drs. Fritzhand and Paley did not accurately determine appellant's right lower extremity impairment pursuant to the A.M.A., *Guides*. Dr. Fritzhand determined that appellant had 41 percent right lower extremity impairment based on his findings of 20 percent range of motion impairment citing Table 17-10 on page 537 of the A.M.A., *Guides*, 13 percent impairment of thigh atrophy, 8 percent impairment of calf atrophy citing Table 17-6a and 17-6b respectively on page 530 of the A.M.A., *Guides* and 7 percent pain impairment citing Figure 18-1 on page 574 of the A.M.A., *Guides*. The cross-usage chart at Table 17-2 on page 526 of the A.M.A., *Guides*, provides that range of motion deficit cannot be evaluated with muscle atrophy for a single impairment. Furthermore, Dr. Fritzhand's range of motion findings, are at odds with those of Dr. Paley and the more recent findings of Dr. Seni. Dr. Hofmann noted that the range of motion findings in the record were inconsistently documented. Dr. Fritzhand's atrophy findings were not noted in subsequent examinations by Dr. Hofmann and Dr. Seni. The A.M.A., *Guides* warns that examiners should not use Chapter 18 to rate pain-related impairment for any condition that can be adequately rated on the basis of the body and organ impairment rating systems given in other chapters.[13] The A.M.A., *Guides* also explain that the impairment ratings in the body organ system chapters make allowance for expected accompanying pain.[14]

Dr. Paley determined that, although appellant had zero percent range of motion impairment, his pain level derived 20 percent whole person impairment. The Act, though, does not authorize schedule awards for permanent impairment of the whole person.[15] Also, Dr. Paley did not explain how he applied the tables and pages of the A.M.A., *Guides* to his findings or otherwise explain how he calculated impairment pursuant to the A.M.A., *Guides*.[16]

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[12] Impairment estimates for knee arthritis are based on standard x-rays taken with the individual standing with the joint in neutral flexion-extension position. A.M.A., *Guides* 544. A footnote to Table 17-31, at page 544, allows for five percent impairment for patellofemoral pain without joint-space narrowing on x-rays where there is a history of direct trauma and crepitation on examination. However, Dr. Hofmann did not indicate that this provision applied to appellant and he also noted no crepitus on examination. Furthermore, Table 17-2, page 526, of the A.M.A., *Guides* precludes combining arthritis and range of motion impairments.

[13] *B.P.*, 60 ECAB ___ (Docket No. 08-1457, issued February 2, 2009); *see also* A.M.A., *Guides* 571.

[14] A.M.A., *Guides* 20.

[15] *See D.J.*, 59 ECAB ___ (Docket No. 08-725, issued July 9, 2008).

[16] *See Tonya D. Bell*, 43 ECAB 845 (1992) (where the Board held that an opinion is of little probative value where the physician does not explain how he derived such an impairment rating or whether it was ascertained by using the appropriate standards of the A.M.A., *Guides*).

For these reasons, the evidence does not support that appellant has more than 10 percent impairment of the right lower extremity pursuant to the A.M.A., *Guides*.

CONCLUSION

The Board finds that appellant did not establish that he has more than 10 percent permanent impairment of the right lower extremity for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decisions dated April 3, 2009 and September 26, 2008 are affirmed, as modified.

Issued: April 5, 2010
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