

for a torn meniscus in his right knee and an aggravation of degenerative joint disease in his left knee. Appellant underwent arthroscopic surgery on his right knee.¹

Appellant filed a claim for a schedule award. To resolve a conflict in medical opinion on the extent of his permanent impairment, the Office referred him, together with the case record and a statement of accepted facts, to Dr. Herbert Stein, a Board-certified orthopedic surgeon.

On June 4, 2008 Dr. Stein related appellant's history and complaints and reviewed the medical record. His findings on examination included 125 degrees flexion and a lack of 5 degrees extension on the right. Range of motion was 0 to 135 on the left. There was no joint instability. Appellant's quadriceps were symmetrical, but the right calf was approximately one-half inch smaller than the left. Dr. Stein noted "excellent" strength, particularly in the quadriceps and hamstrings. He did not think there was any significant joint space narrowing on weight-bearing films, but he did not feel he could adequately evaluate the degree of cartilage loss "if I do not have a normal knee to compare with." Dr. Stein concluded that appellant had a 10 percent impairment of the right lower extremity due to medial and lateral partial meniscectomies and an additional 5 percent impairment due to loss of knee extension. He recommended a three percent pain-related impairment for the left lower extremity due to exacerbation of degenerative knee arthritis.

On July 1, 2008 the Office issued schedule awards for a 15 percent impairment of the right lower extremity and a 3 percent impairment of the left. On February 26, 2009, however, an Office hearing representative set aside the awards and remanded the case for a supplemental report from Dr. Stein providing "the specific manual muscle testing performed, as well as any other strength testing that was done to determine that the claimant did not have weakness or atrophy."

On March 11, 2009 Dr. Stein explained that he performed manual muscle testing against manual resistance. "[Appellant] had good strength when I tested him manually." He also explained that he measured calf atrophy but that appellant's quadriceps were symmetrical. There was no sign of atrophy on visual evaluation or actual measurement. "Therefore, my conclusion is that I found no evidence of weakness in either lower extremity to manual testing and as far as showing any signs of atrophy, it was slight in the right calf; none in the quadriceps related to his knees, specifically the left knee."

In a decision dated April 20, 2009, the Office found that appellant had no more than 15 percent impairment on the right or 3 percent impairment on the left. On October 15, 2009 an Office hearing representative affirmed.

On appeal, appellant's attorney contends that, while Dr. Stein explained that appellant had "good" strength when tested manually, he did not provide any results of that testing or a rating in accordance with Office guidelines. Counsel suggests that, because both lower extremities are involved, it is difficult to measure atrophy.

¹ In 1994 appellant underwent right medial and lateral meniscectomies with chondral shaving.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act² authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.³

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.⁴ When 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.⁵ 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. When the impartial medical specialist's statement of clarification or elaboration is not forthcoming or if the specialist is unable to clarify or elaborate on the original report or if the specialist's supplemental report is also vague, speculative or lacks rationale, the Office must submit the case record together with a detailed statement of accepted facts to a second impartial specialist for a rationalized medical opinion on the issue in question.⁶ Unless this procedure is carried out by the Office, the intent of section 8123(a) will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.⁷

ANALYSIS

Dr. Stein, the Board-certified orthopedic surgeon and impartial medical specialist, rated a 15 percent impairment of the right lower extremity by combining a 10 percent diagnosis-based estimate with a 5 percent range of motion estimate. Such a combination is permissible under Table 17-2, page 526 of the A.M.A., *Guides* (5th ed.).

Appellant had medial and lateral partial meniscectomies on the right. According to Table 17-33, page 546 of the A.M.A., *Guides*, this represents a 10 percent diagnosis-based impairment of the right lower extremity. Appellant also had five degrees lack of right knee extension.

² 5 U.S.C. § 8107.

³ 20 C.F.R. § 10.404.

⁴ 5 U.S.C. § 8123(a).

⁵ *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

⁶ *See Nathan L. Harrell*, 41 ECAB 402 (1990).

⁷ *Harold Travis*, 30 ECAB 1071 (1979).

According to Table 17-10, page 537, this represents a 10 percent range of motion impairment of the right lower extremity. Dr. Stein incorrectly read five percent impairment from this table.

When more than one rating method is used to evaluate impairment, the individual impairment ratings are combined using the Combined Values Chart on page 604.⁸ Appellant's 10 percent diagnosis-based impairment combines with his 10 percent range of motion impairment for a 19 percent total impairment of the right lower extremity. The Board will therefore modify the Office's October 15, 2009 decision accordingly.⁹

On the left Dr. Stein found range of motion from 0 to 135 degrees, representing no impairment under Table 17-10, page 537. He did not think there was any significant joint space narrowing on weight-bearing films but did not feel he could adequately evaluate the degree of cartilage loss without a normal knee for comparison. Such a comparison is unnecessary under the A.M.A., *Guides*. Table 17-31, page 544, provides a grading system for evaluating impairment due to inflammatory and degenerative arthritis based on Roentgenographically determined cartilage intervals. Dr. Stein reviewed weight-bearing films and could have evaluated the degree of cartilage loss by simply measuring the cartilage interval in millimeters. The thinner the articular cartilage, the greater the impairment.

Because Dr. Stein did not follow the procedure in the A.M.A., *Guides* for determining lower extremity impairment due to primary knee joint arthritis, the Board will set aside the Office's October 15, 2009 decision with respect to the left lower extremity. The Board will remand the case for a supplemental report from Dr. Stein who shall provide the Roentgenographically determined cartilage interval that was demonstrated in appellant's left primary knee joint and the resulting impairment estimate from the appropriate edition of the A.M.A., *Guides*.¹⁰ Following such further development as may be necessary, the Office shall issue an appropriate final decision on appellant's entitlement to a schedule award for his left lower extremity.

On appeal, appellant's representative confines his argument to manual muscle testing and atrophy. According to Table 17-2, page 526 of the A.M.A., *Guides*, those two methods of evaluating impairment may not be combined. Moreover, neither method may be combined with a diagnosis-based or range of motion estimate. Dr. Stein found excellent strength and no evidence of weakness against resistance. That represents no impairment to either extremity under Table 17-7, page 531 and Table 17-8, page 532. Right calf atrophy of one-half inch (1.27 centimeters) extrapolates -- assuming it is a permanent condition -- to a lower extremity impairment of approximately 4.5 percent under Table 17-6, page 530, which is considerably less than the 19 percent rating appellant receives from diagnosis-based and range of motion

⁸ A.M.A., *Guides* 527.

⁹ The Office medical adviser noted that lack of extension was not present in a 2007 examination, but the Board notes that the examining physician at that time did not address lack of extension.

¹⁰ In neither the fifth nor the sixth edition may pain-related impairment be considered as an add-on to impairment determinations derived from other chapters.

estimates. If more than one method can be used, the method that provides the higher rating should be adopted.¹¹

CONCLUSION

The Board finds that appellant has a 19 percent impairment of his right leg. The Board finds that this case is not in posture with respect to impairment of the left leg due to the accepted aggravation of degenerative joint disease. Clarification from the impartial medical specialist is warranted on the cartilage interval that was demonstrated in the left primary knee joint and the resulting impairment estimate.

ORDER

IT IS HEREBY ORDERED THAT the October 15, 2009 decision of the Office of Workers' Compensation Programs is affirmed, as modified, with respect to the right lower extremity and is set aside with respect to the left lower extremity. The case is remanded for further action consistent with this opinion.

Issued: October 12, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

¹¹ *Supra* note 8.