

torn lateral meniscus of the left knee, chondromalacia of the left patella, and loose body in the knee. Appellant received compensation benefits on the short-term rolls as of February 20, 2009 and benefits on the periodic rolls as of July 5, 2009.²

On June 4, 2009 OWCP expanded the claim to accept the consequential conditions of torn medial meniscus of the right knee and chondromalacia of the right patella.

By decision dated May 13, 2010, OWCP granted appellant a schedule award for 10 percent permanent impairment of the right lower extremity, paid during the period November 3, 2009 to May 23, 2010, for a total of 28.8 weeks of compensation.

On January 12, 2011 appellant underwent authorized surgery for right patellofemoral joint replacement.

By decision dated January 12, 2011, OWCP granted appellant a schedule award for an additional one percent permanent impairment of the right lower extremity for the period May 24 to June 13, 2012, for an additional 2.88 weeks of compensation.

On April 25, 2012 appellant underwent authorized surgery for right diagnostic arthroscopy; extensive synovectomy, right knee; removal heterotopic ossifications/bony loose bodies, right knee; and partial meniscectomy.

On September 9, 2014 appellant filed a claim for an additional schedule award (Form CA-7) based on a partial loss of use of his right lower extremity.

In an October 27, 2014 report, Dr. Stephen W. Dailey, Board-certified in orthopedic surgery, found that appellant had 31 percent right lower extremity impairment pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009) (A.M.A., *Guides*). He advised that appellant had undergone multiple surgical procedures, including a right total knee arthroplasty, and partial meniscectomy of both his lateral and medial meniscus of the right knee due to his accepted osteoarthritis condition. Dr. Dailey reported that appellant had continued mild pain with walking and stairs, with a range of motion of his right knee of 80 degrees. He advised that appellant's right knee was stable with normal alignment. Dr. Dailey reported that he calculated his impairment rating using Table 16-3 at page 511; Table 16-6 at page 516; and Table 16-23 at page 519. In an October 27, 2014 impairment worksheet, he found that appellant had a class 3 impairment; he reported that he had a functional history grade modifier 1 and a physical examination grade modifier 1, which yielded a grade A impairment.

In a November 19, 2014 report, Dr. Morley Slutsky, Board-certified in occupational medicine and an OWCP medical adviser, reviewed Dr. Dailey's October 27, 2014 report and found that appellant had 23 percent right lower extremity impairment in conformance with the

² Appellant had a prior January 4, 2005 claim for left leg injury under OWCP file number xxxxxx087, which was accepted for fracture of the medial malleolus, contusion of the left lower leg, nonunion fracture of the left ankle, and left ankle post-traumatic arthritis. He received a schedule award for 49 percent permanent impairment of the left lower extremity on October 26, 2006. Appellant's degree of permanent impairment of the left lower extremity continued to be assessed under OWCP file number xxxxxx087.

A.M.A., *Guides*. He used a diagnosis-based impairment method, finding that under Table 16-3, pages 509 and 511, Knee Regional Grid, Lower Extremity Impairments, appellant's right knee replacement yielded a class 2 impairment; good result and position, stable and functional, with a default value of grade C for stable to good result.³ Dr. Slutsky noted that Dr. Dailey documented continuing symptoms in appellant's knee joint, including possible antalgic gait which did not require use of a single gait/external orthotic device for stabilization; he did not document a positive Trendelenburg. Based on these factors he found a grade modifier 1 for functional history for pursuant to the Adjustment Grid, Functional History, at Table 16-6, page 516 of the A.M.A., *Guides*.⁴ Dr. Slutsky advised that appellant had a one plus effusion and retropatellar crepitation on examination and therefore rated a grade modifier 2 pursuant to the Adjustment Grid, Physical Examination, at Table 16-7, page 517 of the A.M.A., *Guides*. Using the net adjustment formula at page 521,⁵ he subtracted the diagnostic class grade modifier 2 from the functional history and physical examination grade modifiers for a net adjustment of minus 1; using Table 16-3, page 511, he found that this moved the initial default impairment of grade C to grade B, for 23 percent right lower extremity permanent impairment at Table 16-3, page 509, 511.

In a January 8, 2015 report, Dr. Dailey reiterated that appellant had 31 percent right lower extremity permanent impairment. He expounded on his previous calculations. Using a diagnosis-based impairment method, Dr. Dailey found that under Table 16-3, appellant's right knee replacement yielded a class 3 rating for fair result (fair position, mild instability and/or mild motion deficit). He advised that appellant was at status post patellar arthroplasty at maximum medical improvement and noted that he had instability with ambulation, with his knee giving way, and that his range of motion was 0 to 90 degrees.⁶ Dr. Dailey found a grade modifier 1 for functional history at Table 16-6, for antalgic gait; he found a grade modifier 3 for physical examination, pursuant to Table 16-7, based on retropatellar crepitation, effusion and moderate laxity of patellar mechanism. He did not assign a grade modifier for clinical studies, as these were used to place appellant into the correct diagnostic class. Dr. Dailey found that appellant had a final, net adjusted impairment of A, which yielded 31 percent right lower extremity permanent impairment.

OWCP found that there was a conflict in the medical evidence between Dr. Dailey, appellant's treating physician, and Dr. Slutsky, the OWCP medical adviser, regarding the extent of impairment stemming from appellant's accepted right knee condition. It referred appellant for an impartial medical examination with Dr. Thomas A. Bender, Board-certified in orthopedic surgery. In a report dated July 29, 2015, Dr. Bender found that appellant had 31 percent right lower extremity impairment pursuant to the A.M.A., *Guides*. On examination, he noted that appellant was able to symmetrically bear weight on both of his lower extremities, with excellent alignment in terms of the hips to the ankles. Appellant showed no exaggerated varus or valgus at the levels of knees and no postsurgical malalignment; in terms of leg lengths, his knees were

³ A.M.A., *Guides* 509, 511.

⁴ *Id.* at 516.

⁵ *Id.* at 521.

⁶ *Id.* at 509, 511.

symmetrical left to right. Dr. Bender reported that thigh circumference measurements were symmetrical at 55 centimeters; knee circumferences were asymmetrical, measuring 44 centimeters on the right compared with 46 centimeters on the left; calf circumferences were symmetrical at 41 centimeters. With regard to range of motion of the right knee, he noted that appellant had full extension to 110 degrees of knee flexion, with no evidence of instability of the collateral ligaments to the right knee and no medial joint line McMurray's sign. Dr. Bender advised that appellant was subjectively tender on palpation along the medial aspect of the right knee and showed no evidence of patellofemoral instability in either knee. He noted that he had reviewed all of appellant's medical records and that based upon the record and his physical examination he concurred with Dr. Dailey's finding that appellant's right knee replacement surgery only yielded a fair result and a class 3 impairment. Dr. Bender noted that this contrasted with the finding by Dr. Slutsky that the procedure produced a good result.

In an August 12, 2015 report, Dr. Daniel Zimmerman, a Board-certified in orthopedic surgery and an OWCP medical adviser, reviewed Dr. Bender's July 29, 2015 report and found that appellant had 23 percent right lower extremity impairment in conformance with the sixth edition of the A.M.A., *Guides*. He disagreed with the opinion of Drs. Dailey and Bender that appellant's knee replacement surgery had yielded a fair result. He asserted that a good result from class 2 with a rating range from 21 to 25 percent required a good result, good position, stable, functional under Table 16-3, page 511 and that a fair result from class 3 with a rating range from 31 to 43 percent required fair position, mild instability and/or mild motion deficit. Dr. Zimmerman advised that Dr. Bender's July 29, 2015 examination findings placed the knee replacement results in the class 2 category; he opined that his range of motion measurements were inconsistent with a mild motion deficit at Table 16-23, page 549⁷ and noted that the positioning of the hardware was not abnormal. He further noted that Dr. Bender specifically reported that there was no instability on examination. In addition, Dr. Zimmerman opined that Dr. Bender demonstrated no knowledge as to how the grade modifier tables and net adjustment formula were used to move a rating from class A to class E. He further advised that neither Dr. Bender nor Dr. Dailey offered an explanation of how the grade modifier tables and net adjustment formula were used.

Dr. Zimmerman noted that Dr. Bender's examination findings showed that appellant symmetrically bore weight on both lower extremities, had mild asymmetry of the knee circumferences and, with regard to range of motion, had full extension to 110 degrees of knee flexion, with no evidence of instability of the collateral ligaments of the right knee. Appellant also underwent a cruciate test which was negative. Based on these factors, Dr. Zimmerman rated a grade modifier of two for functional history under Table 16-6, noting that appellant required single gait aid. He found that appellant rated a grade modifier of one for physical examination under Table 16-7, based on palpatory pain.⁸ Using the net adjustment formula at page 521, Dr. Zimmerman subtracted the functional history grade modifier of two from the diagnosed based class 2, then subtracted the physical examination grade modifier of one for a net

⁷ *Id.* at 549.

⁸ Dr. Zimmerman advised that palpatory pain was not reported but would be expected; the Board notes that in his July 29, 2015 report Dr. Bender did report that appellant was subjectively tender on palpation along the medial aspect of the right knee.

adjustment of minus 1; using Table 16-3, page 511, he found that this moved the default impairment to class B, which yielded 23 percent right lower extremity impairment based on a range between 21 and 25 percent. He further found that the date of maximum medical improvement was July 29, 2015, the date of Dr. Bender's examination.

By decision dated September 9, 2015, OWCP granted appellant schedule award for an additional 12 percent permanent impairment of the right lower extremity for the period July 29, 2015 to March 26, 2016, for a total of 34.56 weeks of compensation, for a total of 23 percent permanent impairment, based on the August 10, 2015 report of its medical adviser, Dr. Zimmerman.

LEGAL PRECEDENT

The schedule award provision of FECA⁹ and its implementing regulations¹⁰ 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, FECA 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.¹¹ The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.¹²

FECA provides that, if there is a 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 the examination.¹³ The implementing regulations state that if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee or impartial examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.¹⁴

⁹ 5 U.S.C. § 8107.

¹⁰ 20 C.F.R. § 10.404.

¹¹ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *see also* Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

¹² *Veronica Williams*, 56 ECAB 367, 370 (2005).

¹³ 5 U.S.C. § 8123(a).

¹⁴ 20 C.F.R. § 10.321. *See also B.T.*, Docket No. 14-1609 (issued December 28, 2015).

ANALYSIS

In the instant case, OWCP accepted the conditions of torn medial meniscus of the right knee and chondromalacia of the right patella and authorized surgery for right knee replacement. Regarding the degree of impairment stemming from his accepted conditions, there was a conflict in the medical evidence. Dr. Dailey, appellant's treating physician, rated 31 percent right lower extremity impairment pursuant to the sixth edition of the A.M.A., *Guides* based on a class 3 postoperative rating based on a fair result, fair position, mild instability and/or mild motion deficit under Table 16-3, page 511. This contrasted with the opinion of Dr. Slutsky, OWCP's medical adviser, who found that appellant had 23 percent impairment based on a good result, stable and functional, for knee replacement, a class 2 impairment pursuant to Table 16-3, page 511. In order to resolve the conflict, OWCP referred appellant to Dr. Bender, an impartial medical examiner, who in a July 29, 2015 report essentially concurred with Dr. Dailey's findings and his rating of 31 percent right lower extremity impairment for fair result from knee replacement surgery. Dr. Bender's impartial report was subsequently reviewed by OWCP's medical adviser, Dr. Zimmerman, who determined that Dr. Bender's impairment rating was not rendered in conformance with the applicable protocols and tables of the A.M.A., *Guides* and calculated 23 percent right lower extremity based on a good result from right knee replacement.

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

OWCP referred the case to Dr. Bender, an impartial medical specialist, because a conflict existed in the medical opinion evidence as to whether appellant had a class 2 good result from his total knee replacement, or a class 3 fair result from the surgery. Dr. Bender found that appellant had a class 3, fair result from the surgery, resulting in 31 percent permanent impairment of the right lower extremity.

Since Dr. Zimmerman questioned Dr. Bender's opinion regarding his ultimate finding that appellant had only a fair result from his total knee replacement, and that appellant in fact had mild motion deficit of the knee, OWCP had the responsibility to secure a supplemental report from Dr. Bender, the impartial medical specialist for the purpose of correcting a defect in the original report.¹⁵

In order to properly resolve the conflict created, it is the impartial medical specialist, Dr. Bender, who should provide a reasoned opinion as to the extent of permanent impairment in accordance with the A.M.A., *Guides*. An OWCP medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.¹⁶ The case will be remanded to OWCP to seek clarification from Dr. Bender for clarification as to why appellant's total knee replacement had only a fair result.¹⁷ Following such further development as is necessary, OWCP shall issue a *de novo* decision on the schedule award issue.

¹⁵ See Nancy Keenan, 56 ECAB 687 (2005).

¹⁶ Richard R. Lemay, 56 ECAB 341 (2005); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808(g)(1) (February 2013).

¹⁷ See Harry T. Mosier, 49 ECAB 688 (1998).

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the September 9, 2015 decision of the Office of Workers' Compensation Programs is set aside and this case is remanded to OWCP for further proceedings consistent with this opinion.

Issued: March 4, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board