United States Department of Labor
Employees' Compensation Appeals Board

D.W., Appellant	)	
and	)	**Docket No. 21-0840**
	)	**Issued: November 30, 2021**
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, FEDERAL TRANSFER CENTER, Oklahoma City, OK, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On May 12, 2021 appellant filed a timely appeal from a February 1, 2021 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] and 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 met his burden of proof to establish greater than two percent permanent impairment of the right lower extremity for which he previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq*.

FACTUAL HISTORY

On January 10, 2018 appellant, then a 48-year-old material handler, filed a traumatic injury claim (Form CA-1) alleging that he injured his left ankle and right knee that day when he stepped on an uneven sidewalk, rolled his left ankle, and fell onto his right knee while in the performance of duty.

On April 10, 2018 OWCP accepted appellant's claim for right knee contusion, other internal derangements of right knee, right medial meniscus tear, and right knee lateral collateral ligament sprain.

On April 11, 2019 Dr. Brian Levings, an osteopathic physician Board-certified in orthopedic surgery, performed OWCP-authorized right knee arthroscopy with partial lateral meniscectomy, chondroplasty of the patella, and lateral retinacular release.

In a July 19, 2019 report, Dr. Levings noted arthritic changes of the right knee, which were not symptomatic prior to the January 10, 2018 employment injury. On examination he found full flexion, mild patellar crepitation, a positive patellofemoral grind test, grade 0 drawer and anterior drawer signs, and a negative McMurray test. Dr. Levings diagnosed right knee patellofemoral syndrome, right patella internal derangement, chondromalacia of the right patella, right lateral meniscus tear due to old injury, and right knee post-traumatic osteoarthritis. He released appellant to full duty effective July 19, 2019. Dr. Levings released appellant from care on August 30, 2019.

On October 31, 2019 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In support of his claim, appellant submitted an October 22, 2019 report by Dr. John W. Ellis, a Board-certified family practitioner. Dr. Ellis provided a history of injury and treatment, and noted that appellant had attained maximum medical improvement (MMI) as of that date. On examination of the right knee he noted arthroscopic scars, crepitation with movement of the patella, laxity of the medial collateral ligament with 6 degrees of movement, and laxity of the lateral collateral ligament with 8 degrees of movement, and flexion limited to 100 degrees based on three trials of range of motion. Dr. Ellis diagnosed right knee contusion, other internal derangements of right knee, other tear of right medial meniscus and sprain of lateral collateral ligament of right knee. He indicated that he would provide an impairment rating using the diagnosis-based impairment (DBI) method. Utilizing Table 16-3 (Knee Regional Grid), page 510, of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[2] Dr. Ellis determined that appellant's class of diagnosis (CDX) for mild lateral collateral ligament laxity resulted in a class 1 impairment with a default value of 10. He noted a grade modifier for functional history (GMFH) of 1, mild, and a grade modifier for physical examination (GMPE) of 1 due to a mild loss of flexion. Dr. Ellis noted no applicable grade modifier for clinical studies (GMCS). After applying the net adjustment formula (GMFH-CDX) + (GMPE-CDX), or (1-1) + (1-1), he determined that appellant had a net adjustment score of zero, which resulted in 10 percent permanent impairment of the right lower extremity due to lateral collateral ligament laxity. Referring to Table 16-3, page 509, of the A.M.A., *Guides*, Dr. Ellis

[2] A.M.A., *Guides* (6th ed. 2009).

determined that the CDX for lateral meniscectomy resulted in a class 1 impairment with a default value of 2. He noted a GMFH of 1 and GMPE of 1. Applying the net adjustment formula to calculate a net adjustment of zero, he found two percent permanent impairment of the right lower extremity due to lateral meniscectomy. Dr. Ellis noted that, using the range of motion (ROM) method, appellant had 10 percent permanent impairment of the right lower extremity according to Table 16-23 (Knee Motion Impairments). He explained that, according to Section 16-2 (Diagnosis-Based Impairment), page 497 of the A.M.A., *Guides*, only one diagnosis was appropriate. Dr. Ellis opined that, as the meniscectomy was a contributing factor to ligamentous laxity, the appropriate diagnosis was lateral collateral ligament laxity of the lateral retinacular release, equaling 10 percent permanent impairment of the right lower extremity.

On April 24, 2020 OWCP forwarded Dr. Ellis' report, the medical record, and statement of accepted facts (SOAF) to Dr. Morley Slutsky, a Board-certified orthopedic surgeon, to serve as a district medical adviser (DMA). In a May 10, 2020 report, Dr. Slutsky reviewed the SOAF and medical record. He opined that, according to the DBI rating method, appellant had two percent impairment of the right lower extremity for partial lateral meniscectomy according to Table 16-3. Dr. Slutsky noted that no other examiner had assessed lateral collateral ligament laxity, which was, therefore, an unreliable finding and would not be included in impairment calculations. He opined that the DBI method should be utilized as it appropriately described appellant's diagnosed condition, and the impairment did not meet the criteria under Section 16.7, page 543 to allow application of the ROM method. Additionally, Dr. Slutsky noted that Dr. Ellis "documented only one measurement per each joint motion" and, as such, the measurements were not valid for rating purposes.

OWCP, in a development letter dated September 1, 2020, requested that appellant ask Dr. Ellis to review Dr. Slutsky's May 10, 2020 report and submit an addendum/supplemental report addressing the differences between the impairment ratings.

In a September 24, 2020 letter, Dr. Ellis noted that he had reviewed Dr. Slutsky's impairment rating. He contended that Dr. Slutsky erred by noting that Dr. Ellis had performed only one measurement for each joint motion whereas he had provided three.

On December 3, 2020 OWCP forwarded Dr. Ellis' September 24, 2020 letter to Dr. Slutsky for review. It requested that Dr. Slutsky submit an addendum report addressing Dr. Ellis' contentions.

In a December 24, 2020 report, Dr. Slutsky acknowledged that Dr. Ellis had provided appropriate ROM measurements, but that the ROM rating method was inappropriate as ROM was used as a grade modifier. He reiterated that appellant had two percent permanent impairment of the right lower extremity for partial lateral meniscectomy.

By decision dated February 1, 2021, OWCP granted appellant a schedule award for two percent permanent impairment of the right lower extremity. The award ran for 5.76 weeks from October 22 through December 1, 2019. OWCP noted that the schedule award was based on the October 22, 2019 report of Dr. Ellis and the December 24, 2020 DMA report by Dr. Slutsky.

LEGAL PRECEDENT

The schedule award provisions of FECA[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. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants and the Board has concurred in such adoption.[5] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[6]

In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the right knee, the relevant position of the right leg for the present case, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[7] After CDX is determined from the Knee Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[8] Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnosis from regional grids and calculations of modifier scores.[9]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed through an OWCP medical adviser for an opinion concerning the nature and extent of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.[10]

Section 8123(a) of FECA, which 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 (known as a referee physician or impartial medical specialist) who shall make an examination.[11] This is called a referee examination and OWCP will

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Id.* at § 10.404 (a); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also* Chapter 3.700.2 and Exhibit 1 (January 2010).

[7] *See* A.M.A., *Guides* (6th ed. 2009) 509-11.

[8] *Id.* at 515-22.

[9] *Id.* at 23-28; *see R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[10] *See supra* note 6 at Chapter 2.808.6(f) (March 2017).

[11] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009); *M.S.*, 58 ECAB 328 (2007).

select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[12] When there exists opposing 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.[13]

ANALYSIS

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

OWCP accepted appellant's claim for right knee contusion, other internal derangements of the right knee, right medial meniscus tear, and right knee lateral collateral ligament sprain. On October 31, 2019 appellant filed a schedule award claim due to his accepted condition.

In support of his schedule award claim, appellant submitted a report from his physician, Dr. Ellis, dated October 22, 2019 utilizing both the DBI and ROM methods to calculate a right knee impairment. Utilizing Table 16-3, page 510, of the A.M.A., *Guides*,[14] Dr. Ellis determined a class 1 CDX for mild lateral collateral ligament laxity, a GMFH of 1, and a GMPE of 1. Application of the net adjustment formula resulted in a net adjustment score of zero, which resulted in 10 percent permanent impairment of the right lower extremity due to lateral collateral ligament laxity. Dr. Ellis also calculated 2 percent permanent impairment of the right lower extremity due to lateral meniscectomy, but explained that the 10 percent permanent impairment for ligamentous laxity better described appellant's impairment as the meniscectomy contributed to ligamentous laxity. He explained that, utilizing the ROM method, appellant also had 10 percent permanent impairment of the right lower extremity according to Table 16-23 (Knee Motion Impairments). However, Dr. Ellis found that, according to Section 16-2 of the A.M.A., *Guides*, which allowed for only one rating methodology, the DBI method rating for ligamentous laxity was the most appropriate for appellant's presentation. He ultimately concluded that appellant had 10 percent permanent impairment of the right lower extremity due to lateral collateral ligament laxity.

In reports dated May 10 and December 24, 2020, Dr. Slutsky, the DMA found appellant had two percent permanent impairment of the right lower extremity for status post lateral meniscectomy according to Table 16-3. He opined that Dr. Ellis' finding of lateral collateral ligament laxity was unreliable as it had not been observed by another clinician.

As Dr. Ellis, appellant's attending physician, and Dr. Slutsky, an OWCP DMA, disagree regarding the nature and extent of appellant's right lower extremity permanent impairment, the Board finds that a conflict in medical opinion exists.[15] As noted above, if there is a disagreement between an employee's physician and OWCP's physician, OWCP shall appoint a third physician,

[12] 20 C.F.R. § 10.321; *R.C.*, 58 ECAB 238 (2006).

[13] *See Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

[14] A.M.A., *Guides* (6th ed. 2009).

[15] *L.E.*, Docket No. 20-1505 (issued June 7, 2021); *C.B.*, Docket No. 20-0258 (issued November 2, 2020).

known as a referee physician or impartial medical specialist, who shall make an examination.[16] Because the reports of Dr. Ellis and Dr. Slutsky are virtually of equal weight, appellant must be referred to an impartial medical examiner to resolve the existing conflict in the medical opinion evidence regarding the extent of the permanent impairment of his right lower extremity.[17]

On remand OWCP shall refer appellant, along with the case record and SOAF, to a specialist in the appropriate field of medicine for an impartial medical evaluation and a rationalized opinion as to the extent of his right lower extremity permanent impairment. Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's schedule award claim.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the February 1, 2021 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: November 30, 2021
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

[16] 5 U.S.C. § 8123(a); *see R.S. and S.T., supra* note 11.

[17] *M.M.*, Docket No. 18-0235 (issued September 10, 2019); *L.W.*, Docket No. 19-1208 (issued July 19, 2019).