United States Department of Labor
Employees' Compensation Appeals Board

N.M., Appellant	)	
and	)	**Docket No. 08-423**
	)	**Issued: July 7, 2008**
DEPARTMENT OF THE NAVY, PHILADELPHIA NAVAL SHIPYARD, 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:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 23, 2007 appellant filed a timely appeal from a July 20, 2007 merit decision of the Office of Workers' Compensation Programs' hearing representative who affirmed the January 4, 2007 denial of an additional schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award issue.

ISSUE

The issue is whether appellant has more than 14 percent impairment of the left lower extremity.

FACTUAL HISTORY

This case has previously been before the Board. Appellant, a 46-year-old pipe fitter, sustained a work-related torn left medial meniscus on January 12, 1994. He underwent an approved partial medial meniscectomy on March 28, 1994. On September 12, 2000 the Office issued a schedule award for two percent impairment of the left leg. In a March 8, 2002 decision,

the Board found a conflict in the medical evidence regarding the extent of appellant's permanent impairment. The conflict was between appellant's treating physician, Dr. Jack Haberman, a family practitioner, who found 21 percent impairment of the left leg, and Dr. Steven Valentino, an osteopath and Office referral physician, who found no ratable impairment. The findings of law and fact as set forth in the prior opinion are hereby incorporated by reference.[1]

On April 9, 2002 the Office referred appellant to Dr. Randall N. Smith, a Board-certified orthopedic surgeon, for an impartial medical examination. In a July 22, 2002 report, Dr. Smith noted appellant's history of knee injury on January 12, 1994 and his complaints of continuing left knee pain. Upon physical examination, he found tenderness over the posterior medial joint line, but noted normal quadricep size and strength. Although appellant complained of a limp, he was unable to replicate the limp in short distances in the office. Dr. Smith diagnosed status post tear of the posterior horn of the medial meniscus as well as pain and tenderness post meniscectomy. He found two percent impairment for the medial meniscectomy. In an October 29, 2002 note, the Office medical adviser concurred with Dr. Smith's findings and recommended that the Office grant appellant a schedule award for two percent impairment due to his medial meniscectomy.

By decision dated November 5, 2002, the Office granted appellant a schedule award for two percent impairment of the left lower extremity.

On November 14, 2002 appellant requested an oral hearing.

By decision dated January 8, 2004, a hearing representative vacated the November 5, 2002 schedule award decision and remanded the case, instructing the Office to refer appellant for a new impartial medical examination. The hearing representative found that Dr. Smith failed to identify any specific provision in the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[2] and that his report demonstrated questionable familiarity with the A.M.A., *Guides* and was of diminished credibility. He instructed the Office to refer appellant to a different specialist, "one with appropriate familiarity with the A.M.A., *Guides*," to determine his degree of impairment.

On February 12, 2004 the Office referred appellant to Dr. Herbert Stein, a Board-certified orthopedic surgeon, for an impartial medical examination to determine the extent of left leg impairment. In a March 18, 2004 report, Dr. Stein noted appellant's history of surgery on March 28, 1994, complaints of continuing knee pain on the medial and lateral aspects and problems with ambulation. He diagnosed a tear of the anterior horn of the left medial meniscus and status post left knee arthroscopy but found no loss of motion or measurable atrophy. Dr. Stein stated that appellant had no ratable impairment for loss of range of motion or atrophy and concluded that the only available impairment rating would be 10 percent impairment based on appellant's meniscectomy. He also noted that appellant may have some left knee arthritis, but that arthritis was not indicated at the time of his surgery in 1994 and therefore he did not rate impairment for arthritis.

[1] Docket No. 01-1499 (issued March 8, 2002).

[2] A.M.A., *Guides* (5th ed. 2001).

On April 29, 2004 the Office requested that Dr. Stein clarify his report to explain the method he used to rate 10 percent impairment as the A.M.A., *Guides* only provided for an award of two percent impairment for a medial meniscectomy. Dr. Stein did not reply to the Office's request for clarification.

On April 27, 2004 an Office medical adviser reviewed Dr. Stein's report, noting that the A.M.A., *Guides* provide only two percent impairment for a partial medial meniscectomy, rather than 10 percent impairment as Dr. Stein recommended. On May 20, 2004 the medical adviser recommended two percent impairment for the meniscectomy, three percent for pain, and seven percent for arthritis under Table 17-31 page 544 of the A.M.A., *Guides*.[3]

By decision dated May 26, 2004, the Office granted appellant a schedule award for 10 percent impairment of the left lower extremity. On June 14, 2004 appellant requested an oral hearing.

By decision dated January 11, 2005, a hearing representative vacated the Office's May 26, 2004 schedule award decision, directing the Office to seek clarification from Dr. Stein concerning his impairment rating method and the actual measurements made during his physical examination.

On February 1, 2005 the Office again requested clarification from Dr. Stein who did not reply.

On May 11, 2005 the Office referred appellant to Dr. Menachem M. Meller, a Board-certified orthopedic surgeon, for an impartial medical examination. In a June 1, 2005 report, Dr. Meller noted appellant's history of injury and complaints of continuing bilateral knee pain. On physical examination, he found that appellant had normal posture, flexion to 130 degrees, and full extension. Dr. Meller noted that appellant moved in a slow, deliberate manner consistent with his age and weight. He determined that appellant's symptoms were consistent with some degeneration of the left knee and diagnosed advanced long-standing bilateral osteoarthritis. Dr. Meller concluded that appellant's knee symptoms were entirely attributable to his arthritis, which he found to be preexisting and therefore not ratable. He advised that appellant had two percent impairment due to his partial medial meniscectomy, pursuant to the A.M.A., *Guides*, Table 17-33 on page 546.[4] However, Dr. Meller concluded that appellant's symptoms were imputable solely to his preexisting degenerative arthritis, which he determined was not work related and accordingly did not warrant any further impairment rating.

On August 23, 2005 the Office requested that Dr. Meller clarify his report to explain whether appellant's arthritis was caused by his January 12, 1994 injury, subsequent surgery, and the effects thereof, whether x-rays were required to document the presence of arthritis, and to provide measurements taken in connection with his impairment rating.

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

[4] *Id.* at 546, Table 17-33.

In an August 29, 2005 supplemental report, Dr. Meller opined that appellant's arthritis was caused by age, genetics, and wear and tear or stress on the knee joint. He stated that appellant's symptoms were not work related. Dr. Meller reasoned that there were no underlying structural abnormalities and no changes in the arthritic processes, other than normal degeneration. He concluded that appellant's arthritis was unrelated to his 1994 work injury. Dr. Meller also stated that x-ray testing was unnecessary because he had already documented the presence of arthritis.

In a November 22, 2005 report, an Office medical adviser opined that appellant's meniscectomy and patellofemoral arthritic changes were the factors that prevented his leg from functioning normally. He found two percent impairment due to the medial meniscectomy and five percent impairment for patellofemoral crepitation or arthritic changes based on Table 17-31 page 544 of the A.M.A., *Guides*,[5] or a total of seven percent impairment of the left leg. The medical adviser noted that appellant reached maximum medical impairment on June 1, 2005.

By decision dated December 13, 2005, the Office accepted the medical adviser's recommendations and found that appellant did not have more than 10 percent impairment, for which he had already received a schedule award.

Appellant requested an oral hearing on December 15, 2005. In a January 11, 2006 decision, the Office found that the weight of the medical evidence showed that appellant had no more than seven percent permanent impairment of the left leg.

An oral hearing was conducted on April 26, 2006. By decision dated July 11, 2006, the hearing representative set aside December 13, 2005 and January 11, 2006 decisions on the grounds that Dr. Meller's reports omitted discussion of appellant's arthritic changes and that the Office medical adviser improperly substituted his rating. She instructed the Office to request clarification from Dr. Meller. The hearing representative noted that the Office had paid schedule awards totaling 14 percent impairment of the left lower extremity.

On August 2, 2006 the Office referred appellant to Dr. Meller for another examination and an impairment rating taking into account appellant's work-related condition and preexisting arthritis.

In September 6, 2006 x-ray reports, Dr. Joan M. Mack, a radiologist, diagnosed mild osteoarthritic changes involving the right knee and minimal degenerative changes involving the left knee.

In a September 12, 2006 report, Dr. Meller noted that diagnostic testing revealed minimal changes in appellant's left knee, consistent with normal degenerative processes in an individual of appellant's age and weight. He stated that appellant's knee condition had returned to its baseline pathology following his meniscectomy. Dr. Meller explained that modern meniscectomy procedures had advanced so that "there is for all practical purposes no impairment as a result of this meniscectomy which would correspond to a zero percent impairment based on the range of motion model." He also stated that appellant's diagnostic testing did not evince

[5] *Id.* at 544, Table 17-31.

"any hastening or worsening of any preexisting or underlying osteoarthritis as a result of the meniscectomy."

On October 26, 2006 the Office requested that Dr. Meller clarify whether he performed strength testing and why he chose to utilize diagnosis-based estimates to rate appellant's impairment, rather than range of motion deficits. In a November 4, 2006 response, Dr. Meller stated that he had performed strength testing one year prior to his September 12, 2006 examination of appellant and found that he had normal strength and range of motion in both knees. He noted that appellant's quadriceps were symmetrical and his range of motion equal in both lower extremities. Dr. Meller stated that the A.M.A., *Guides* favors use of diagnosis-based estimates over the range of motion model noting that appellant would have two percent impairment using the diagnosis-based estimate method but zero percent impairment using the range of motion method.

In a December 22, 2006 report, the Office medical adviser noted that the diagnostic testing reports showed minimal joint space narrowing, so his previous recommendation of five percent impairment for patellofemoral crepitation was no longer appropriate. He also noted that Dr. Meller found normal strength and range of motion. Although Dr. Meller incorrectly stated that the A.M.A., *Guides* favor the diagnosis-based estimate impairment rating method, his use of the method was appropriate in this case. The medical adviser explained that, because Dr. Meller found normal motion, the only available impairment rating was two percent for appellant's meniscectomy, pursuant to the diagnosis-based estimate method. He also indicated that appellant was entitled to seven percent impairment for arthritis based on Table 17-31 on page 544 of the A.M.A., *Guides*,[6] which when combined with his two percent impairment for meniscectomy, totaled nine percent impairment of the left leg.

By decision dated January 4, 2007, the Office denied appellant's claim for an additional schedule award, finding that Dr. Meller and the Office medical adviser did not support that he had more than the 14 percent impairment. It found that the Office medical adviser represented the weight of the medical evidence.

On January 9, 2007 appellant requested an oral hearing, which was held on May 16, 2007.

By decision dated July 20, 2007, the hearing representative affirmed the January 4, 2007 decision denying appellant an additional schedule award, finding that Dr. Meller's report represented the weight of the medical evidence.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[7] and its implementing regulations[8] set forth the number of weeks of compensation payable to employees

[6] *Id.* at 544, Table 17-31.

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404 (1999).

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 regulation as the appropriate standard for evaluating schedule losses.[9]

It is well established that, in determining the amount of a schedule award for a member of the body that sustained an employment-related impairment, preexisting impairments are to be included.[10]

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.[11] When the case is referred to an impartial medical specialist for the purpose of resolving a conflict in medical evidence, the opinion of such specialist will be given special weight when based on a proper factual and medical background and sufficiently well rationalized on the issue presented.[12]

The Board has held that, when the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in his original report.[13] However, when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative, or lacking in rationale, the Office must submit the case record and a detailed statement of accepted facts to another impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[14]

Appellant's claim was accepted by the Office for a torn left medial meniscus for which he underwent surgical repair.

ANALYSIS

The Office referred appellant to Dr. Smith. However, Dr. Smith failed to resolve the conflict between Dr. Haberman and Dr. Valentino concerning the degree of permanent impairment. In a January 8, 2004 decision, a hearing representative found that Dr. Smith demonstrated unfamiliarity with the A.M.A., *Guides* and directed the Office to refer appellant to a different specialist to resolve the conflict. The Office referred appellant to Dr. Stein for an

[9] *See id.*

[10] *Carl J. Cleary*, 57 ECAB 563 (2006).

[11] 5 U.S.C. § 8123(a); *see Elsie L. Price*, 54 ECAB 734 (2003); *Raymond J. Brown*, 52 ECAB 192 (2001).

[12] *See Bernadine P. Taylor*, 54 ECAB 342 (2003); *Anna M. Delaney*, 53 ECAB 384 (2002).

[13] *Talmadge Miller*, 47 ECAB 673 (1996).

[14] *Id.*

impartial opinion. When Dr. Stein failed to resolve the conflict in the medical evidence, the Office requested a supplemental report but he did not reply. As Dr. Stein was nonresponsive to the Office's request for a supplemental report, the Office properly referred appellant to a third impartial medical examiner, Dr. Meller.[15]

On June 1, 2005 Dr. Meller opined that appellant had two percent impairment due to his meniscectomy but had no other work-related impairment. He stated that appellant's symptoms were exclusively caused by his nonwork-related arthritis. The Office requested that Dr. Meller clarify whether appellant's arthritis was related to his work injury and authorized meniscectomy and provide physical measurements and examination findings in support of his impairment rating. In an August 29, 2005 supplemental report, Dr. Meller stated that appellant's arthritis was not work related but rather was caused by normal degeneration commensurate with appellant's age and weight. He stated that x-rays were unnecessary and did not provide the requested measurements. Subsequently, an Office medical adviser recommended that the Office grant five percent impairment for patellofemoral crepitation or arthritic changes based on Table 17-31 of the A.M.A., *Guides*.[16] Using the medical adviser's recommendations, on December 13, 2005 and January 11, 2006, the Office found that appellant did not have greater impairment than that for which he had already received a schedule award. On July 11, 2006 a hearing representative found that Dr. Meller did not resolve the medical conflict and that the Office medical adviser improperly substituted his own judgment for that of the impartial specialist.[17] The hearing representative directed that the Office refer appellant back to Dr. Meller for examination and to rate impairment due to both his work-related condition and all preexisting conditions, including his arthritis.

On September 12, 2006 Dr. Meller declined to rate appellant's arthritis, stating that the arthritic changes were minimal and that appellant had no impairment resulting from the meniscectomy. Despite his prior diagnosis of advanced long-standing osteoarthritis and contrary to the Office's instruction that he should rate the preexisting arthritis, Dr. Meller failed to account for arthritis in his impairment rating. On October 26, 2006 the Office requested further clarification. In a November 4, 2006 report, Dr. Meller advised that he conducted strength testing when he examined appellant the previous year and stated that appellant had no impairment for range of motion but had two percent impairment under the diagnosis-based estimate method for his surgery. However, he did not provide any range of motion measurements to support his conclusion that appellant had no loss of motion and did not update his year-old strength testing measurements.

The Board finds that the reports of Dr. Meller do not resolve the conflict in medical evidence between Dr. Haberman and Dr. Valentino concerning the extent of appellant's

[15] *See id.*

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

[17] The Board notes that, as there was a conflict under section 8123(a) the conflict must be resolved by the impartial medical specialist. It is the impartial medical specialist who should provide a reasoned opinion as to a permanent impairment in accordance with the A.M.A., *Guides*. An Office medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist. *See Thomas J. Fragale*, 55 ECAB 619 (2004).

permanent impairment. Dr. Meller noted that appellant has advanced osteoarthritis but that his symptoms were not ratable because they were caused by a preexisting condition. However, after the Office instructed Dr. Meller to consider appellant's preexisting arthritis, he stated that appellant's degenerative changes and arthritis were minimal at most and that his meniscectomy surgery did not cause any acceleration or exacerbation of his arthritis. Dr. Meller disregarded the Office's instruction to rate the preexisting condition and failed to apply the A.M.A., *Guides* to appellant's arthritis. As noted, the Office must secure a supplemental report from an impartial specialist when the specialist's opinion requires clarification or elaboration. However, when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, the Office must refer appellant to another impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[18]

The Board finds that Dr. Meller's reports were vague and poorly rationalized and insufficient to resolve the conflict in the medical evidence. Upon return of the case record, the Office should refer appellant to a new impartial physician to resolve the medical conflict.

CONCLUSION

The Board finds that the case is not in posture for a decision, as there is an unresolved conflict in the medical evidence concerning appellant's degree of impairment of the left lower extremity.

[18] *See Miller, supra* note 13.

ORDER

IT IS HEREBY ORDERED THAT the July 20, 2007 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this decision.

Issued: July 7, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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