# United States Department of Labor
# Employees' Compensation Appeals Board

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| **D.B., Appellant** | ) | |
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| **and** | ) | **Docket No. 10-2376** |
| | ) | **Issued: June 23, 2011** |
| **U.S. POSTAL SERVICE, SHARED SERVICE CENTER, Pittsburgh, PA, Employer** | ) | |

*Appearances:*
*Jeffrey P. Zeelander, Esq.*, for the appellant
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

### *JURISDICTION*

On September 26, 2010 appellant filed a timely appeal from the September 23, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP) concerning entitlement to schedule award compensation. Pursuant to the Federal Employees' Compensation Act (FECA)[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 more than a 10 percent permanent impairment of his left leg, for which he received a schedule award.

### *FACTUAL HISTORY*

In a prior appeal, the Board issued a decision on February 5, 2010 setting aside an April 22, 2009 OWCP decision and remanding the case to OWCP for further development of the

[1] 5 U.S.C. §§ 8101-8193.

medical evidence regarding appellant's entitlement to schedule award compensation.[2] The Board found that there was an outstanding conflict in the medical opinion regarding the extent of appellant's left leg impairment between Dr. Nicholas Diamond, an attending osteopath and Dr. Berman, the referral physician. In his February 12, 2009 report, Dr. Diamond determined that, under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001), appellant had a 30 percent impairment of his left leg due to motor strength deficits and pain. In contrast, he found, in his April 12, 2009 report, that appellant only had a 10 percent permanent impairment of his left leg under the fifth edition of the A.M.A., *Guides*. Dr. Diamond explained his disagreement with Dr. Diamond's impairment rating methods and found that appellant was entitled to a 10 percent impairment rating of his left leg due to his partial medial and lateral meniscectomies.

The Board remanded the case to OWCP for referral of appellant and the case record to an impartial medical specialist in order to resolve the conflict in the medical opinion between Dr. Diamond and Dr. Berman regarding the extent of appellant's left leg impairment. After such further development as it deemed necessary, OWCP was directed to issue an appropriate decision regarding appellant's entitlement to schedule award compensation. The facts and circumstances of the case up to that point are set forth in the Board's prior decision and are incorporated herein by reference.

On remand to OWCP, appellant was referred to Dr. Sanford H. Davne, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion on the extent of his left leg impairment.

In an August 16, 2010 report, Dr. Davne discussed appellant's medical history noting that he reported having constant pain in his left knee with popping, snapping and shifting of the joint. He indicated that, upon physical examination of the left knee, appellant had an obvious varus deformity and restricted motion of 0 to 100 degrees. There was tenderness along the medial and lateral joint lines and also along the patellar tendon and medial proximal tibial plateau. Appellant did not exhibit swelling or effusion of the left knee, but there was pain elicited with any movement of the knee. Dr. Davne stated that there was no weakness in appellant's quadriceps with knee extension or hamstrings with flexion and there was no atrophy noted of his thighs as they both measured 44 centimeters in circumference at 10 centimeters above the superior pole of the patella. There was a slight difference in the circumference of the left calf when measured 10 centimeters below the anterior tibial tubercle (the left leg was 37.5 centimeters whereas the right leg was 38 centimeters).

[2] Docket No. 09-1464 (issued February 5, 2010). On May 18, 2003 appellant, then a 52-year-old mail handler, sustained a work-related medial meniscus tear of his left knee due to pushing a heavy mail container. On June 16, 2003 he underwent OWCP authorized partial left medial and lateral meniscectomies with partial synovectomy of the patellofemoral joint. Appellant filed a claim alleging that he was entitled to a schedule award and, in an April 22, 2009 decision, OWCP granted him a schedule award for a 10 percent permanent impairment of his left leg based on an April 12, 2009 report of Dr. Arnold T. Berman, a Board-certified orthopedic surgeon serving as OWCP's medical adviser.

Dr. Davne indicated that he was applying the standards of the sixth edition of the A.M.A., *Guides* (6th ed. 2009). He concluded that appellant had a 10 percent permanent impairment of his left leg with a date of maximum medical improvement of February 12, 2009 (the date of Dr. Diamond's assessment). Dr. Davne stated:

> "Specifically I have referenced page 509, Table 16.3 for medial and lateral partial meniscal injury. The atrophy present is minimal and consistent with his degenerative arthritis and not as a result of specific neurologic or muscle weakness. There is no atrophy or weakness of his quadriceps. I do not agree with the determination of Dr. Diamond of 27 percent or 30 percent impairment as [appellant] does not suffer from motor strength impairment."

In a September 23, 2010 decision, OWCP determined that appellant was not entitled to schedule award compensation in addition to that received for a 10 percent permanent impairment of his left leg. It found that the opinion of Dr. Davne, the impartial medical specialist, showed that appellant only had a 10 percent permanent impairment of his left leg.

## ***LEGAL PRECEDENT***

The schedule award provision 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. 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.[5] For OWCP decisions issued on or after May 1, 2009, the sixth edition of the A.M.A., *Guides* (6th ed. 2009) is used for evaluating permanent impairment.[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 knee, the relevant portion of the leg for the present case, reference is made to Table 16-3 (knee regional grid) beginning on page 509.[7] After the Class of Diagnosis (CDX) is determined from the knee regional grid (including identification of a default grade value), the net adjustment formula is applied using the grade modifier for Functional History (GMFH), grade modifier for Physical Examination (GMPE) and grade modifier for

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

[5] *Id*.

[6] *See* FECA Bulletin No. 9-03 (issued March 15, 2009). For OWCP decisions issued before May 1, 2009, the fifth edition of the A.M.A., *Guides* (5th ed. 2001) is used.

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

Clinical Studies (GMCS). The net adjustment formula is GMFH - CDX + GMPE - CDX + GMCS - CDX.[8] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[9]

Section 8123(a) of FECA provides in pertinent part: "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."[10] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.[11] In a situation where OWCP secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from such specialist requires clarification or elaboration, OWCP has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original opinion.[12]

## ***ANALYSIS***

In the present case, OWCP accepted that appellant sustained a work-related medial meniscus tear of his left knee. On June 16, 2003 appellant underwent OWCP-authorized left medial and lateral meniscectomies with partial synovectomy of the patellofemoral joint. In an April 22, 2009 decision, OWCP granted him a schedule award for a 10 percent permanent impairment of his left leg. In a February 5, 2010 decision, the Board set aside OWCP's schedule award due to an existing conflict in the medical opinion regarding the extent of appellant's left leg impairment. The Board remanded the case to OWCP for further development.

On remand, OWCP properly referred appellant to Dr. Davne, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion on the extent of his left leg impairment. In a September 23, 2010 decision, OWCP found that the August 16, 2010 evaluation of Dr. Davne showed that appellant had no more than a 10 percent impairment of his left leg.

The Board notes that Dr. Davne correctly chose to apply the standards of the sixth edition of the A.M.A., *Guides* to evaluate appellant's impairment as this edition of the A.M.A., *Guides* was in effect at the time.[13] Given appellant's surgical history, Dr. Davne determined that, under Table 16-3 (knee regional grid), the most appropriate diagnostic classification (known as CDX was found under the "meniscal injury" category for both partial medial and lateral meniscectomies.

[8] *Id* at 515-22.

[9] *Id.* at 23-28.

[10] 5 U.S.C. § 8123(a).

[11] *William C. Bush*, 40 ECAB 1064, 1975 (1989).

[12] *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232, 238 (1988).

[13] *See supra* note 6.

Therefore, appellant fell under class 1, grade C, with a default impairment value of 10 percent. Dr. Davne concluded that appellant had a 10 percent permanent impairment of his left leg.[14]

The Board notes, however, that Dr. Davne's impairment evaluation was incomplete. As noted above, after the CDX is determined from the knee regional grid (including identification of a default grade value), the net adjustment formula is applied using the selected grade modifier for GMFH, grade modifier for GMPE and grade modifier for GMCS.[15] Dr. Davne did not select any grade modifiers and did not apply the net adjustment formula to determine whether these findings raised or lowered the impairment rating for appellant's left knee.

For the above-described reasons, the opinion of Dr. Davne is in need clarification and elaboration so that the appropriate standards of the sixth edition of the A.M.A., *Guides* can be fully applied. Therefore, in order to resolve the continuing conflict in the medical opinion, the case will be remanded to OWCP for referral of the case record, a statement of accepted facts, and, if necessary, appellant, to Dr. Davne for a supplemental report regarding the extent of his left leg impairment.[16] If Dr. Davne is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, OWCP must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[17] After such further development as OWCP deems necessary, an appropriate decision should be issued regarding the extent of appellant's left leg impairment.

## ***CONCLUSION***

The Board finds that the case is not in posture for decision regarding whether appellant has more than a 10 percent permanent impairment of his left leg. The case is remanded to OWCP for further development.

[14] *See* A.M.A., *Guides* 510.

[15] *Id* at 515-22. The net adjustment formula is GMFH - CDX + GMPE - CDX + GMCS - CDX. *See supra* note 8.

[16] *See supra* note 12. On appeal, counsel argued that Dr. Davne did not consider the effect of appellant's preexisting left knee arthritis on his impairment rating. It should be noted that, even when a meniscal injury is used as the primary diagnosis under Table 16-3, knee arthritis may be considered when choosing the GMCS under Table 16-8. *See* A.M.A., *Guides* 509, 516.

[17] *Harold Travis*, 30 ECAB 1071, 1078 (1979).

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the September 23, 2010 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: June 23, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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