U S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs

DECISION OF THE HEARING REPRESENTATIVE

In the matter of the claim for compensation under Title 5, U S. Code 8101 et seq. of
Claimant; Employed by the
Case No.

Merit consideration of the case file was completed in Washington, D.C. Based on this review, the decision of the District Office dated is vacated for the reason(s) set forth below.

The claimant, (date of birth –), was employed as a sheet metal worker by the He filed timely written notice of injury on , stating that he injured his right knee at work on when he stepped on a tool.

The Office accepted the claim for right knee strain, internal derangement of the right knee, right knee surgeries performed on and , left knee patellofemoral syndrome, and left knee surgery performed on .

The claimant's right knee surgery o consisted of diagnostic arthroscopy of the right knee with arthroscopic medial plica resection. On , the claimant underwent right knee arthroscopic lateral release with open Fulkerson osteotomy.

In May of 1995, the claimant filed a claim for schedule award compensation for permanent impairment of his right lower extremity. In support of his claim, he submitted a report from Dr dated Dr , who is a physiatrist, computed an impairment rating of 27% of the claimant's right lower extremity using Table 17-33 in the 5th edition of the AMA Guides to the Evaluation of Permanent Impairment. In a supplemental report dated , he repeated his opinion that the claimant had a 2% impairment for a partial medial meniscectomy performed on [1] and a 25% lower extremity impairment for having undergone a proximal tibial osteotomy on .

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[1] The history given by Dr that the claimant underwent a partial medial meniscectomy of the right knee on is not supported by the operative report for the surgery performed on that date. The operative report does not describe any pathology of the medial meniscus of the claimant's right knee or state that a partial medial meniscectomy was performed.

Dr. , an orthopedic surgeon who is an Office District Medical Adviser, reviewed Dr. reports Dr. disagreed with Dr. s contention that the surgical procedure the claimant had undergone on (identified in the operative report as an open Fulkerson osteotomy) was equivalent to a proximal tibial osteotomy.

To resolve the conflict in medical opinion, the Office referred the claimant, Statement of Accepted Facts and case record to Dr. for an impartial medical evaluation. Dr. , who is a Board-certified orthopedic surgeon, examined the claimant on In his report, he described the claimant's history of injury and subsequent surgeries. He described the current examination findings and x-ray results. Dr. concluded:

> Mr. has apparently reached maximum improvement regarding his right lower extremity. By using the AMA Guide to the Evaluation of Permanent Impairment, fifth edition, two methods are available for assignment to a permanent partial impairment. Method one is the arthritis of the patellofemoral joint, found on page 544, table 17-31. A 2 mm patellofemoral cartilage interval indicates a 4% impairment of the whole person, and a 10% impairment of the right lower extremity. Table 17-2, on page 526, allows the use of the diagnosis based estimates in addition to DJD arthritis. On page 546, table 17-33, articular cartilage displaced more than 3 mm results in a 5% impairment of the lower extremity, and a 12% impairment of the whole person. This finding was indicated in the arthroscopic examination. Using the chart on page 604, the patient has a combined right lower extremity impairment of 9%.

By decision datec the Office paid the claimant 25.92 weeks of schedule award compensation for a 9% permanent impairment of the right lower extremity.[2]

The claimant disagreed with the decision and requested a hearing.

I find that the case is not in posture for a hearing, as the medical evidence requires further development on the issue of the percentage of the claimant's right lower extremity impairment under the standards in the AMA Guides.

The schedule award provisions of the Federal Employees' Compensation Act set forth the number of weeks of compensation to be paid for permanent loss or loss of use of the members or functions listed in the schedule. The Office evaluates the degree of impairment to schedule members according to the standards set forth in the American

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[2] 5 U.S.C. 8107(c) provides for payment of 288 weeks of schedule award compensation for 100% loss or loss of use of a leg. 9% of 288 weeks is 25.92 weeks.

Medical Association's Guides to the Evaluation of Permanent Impairment [3] The Office currently uses the 5th edition of the Guides in evaluating impairment for schedule award purposes.

A conflict in medical opinion occurred between Dr. and Dr. as to whether the claimant underwent a proximal tibial osteotomy on May 11, 2004 for which Table 17-33 (page 547) of the Guides assigns 25% lower extremity impairment for a "good" result. The Office referred the claimant to Dr for an impartial medical evaluation regarding the nature and extent of the claimant's right lower extremity impairment under the standards in the Guides. Dr. computed an impairment rating of 9% of the claimant's right lower extremity, but it is unclear how he computed that percentage from the described impairments, and it appears that the 9% may actually represent the whole person impairment rather than the lower extremity impairment. Dr. described the claimant as having impairment under the standards in Table 17-31 for patellofemoral arthritis, and under Table 17-33 for a diagnosis-based condition. It appears that under Table 17-33, he was referring to the knee condition "patellar fracture, articular surface displaced more than 3 mm", but he did not specifically explain how the surgery report supported the presence of that condition. He also appeared to transpose the lower extremity and whole person percentage values for the condition he was using from Table 17-33.[4] Moreover, Dr. did not provide a specific and rationalized opinion on the issue that was the primary area of conflict between Dr. and Dr i e , whether the surgical procedure of was in fact a proximal tibial osteotomy for which Table 17-33 allows 25% lower extremity impairment.

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.[5] On remand, the Office should refer the Statement of Accepted Facts and copies of the medical records back to Dr. and request that he provide a supplemental report containing rationalized opinion on the issues identified in the preceding paragraph. Dr. should provide an opinion, with supporting explanation, as to whether the claimant's surgical procedure of included a proximal tibial osteotomy. Dr. should explain the basis for his selection of a condition or conditions from Table 17-33 to combine with the arthritis impairment obtained under Table 17-31. He should perform any necessary re-

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[3] See 20 C.F.R. Section 10.404. See also Thomas P. Gauthier, 34 ECAB 1060

[4] Assuming that Dr. was referring to the condition "patellar fracture, articular surface displaced more than 3mm", Table 17-33 gives a rating of 12% lower extremity impairment and 5% whole person impairment, not 5% lower extremity impairment and 12% whole person impairment.

[5] April Ann Erickson, 28 ECAB 336.

computation of the claimant's right lower extremity impairment rating, fully explaining his calculations.

The case is remanded for further action, as described above, to be followed by a de novo decision on the issue of whether the claimant has greater than a 9% permanent impairment of the right lower extremity for the purpose of entitlement to schedule award compensation.

DATED: APR 20 2006
WASHINGTON, D.C.

Hearing Representative
for
Director, Office of
Workers' Compensation Programs