United States Department of Labor
Employees' Compensation Appeals Board

J.M., Appellant	)	
and	)	**Docket No. 09-2230**
	)	**Issued: August 11, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Newark, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 8, 2009 appellant, through her attorney, filed a timely appeal of the Office of Workers' Compensation Programs' merit decisions dated October 9, 2008 and June 1, 2009. Pursuant to 20 C.F.R. §§ 501.2 and 501.3, the Board has jurisdiction over the merits of this case.[1]

ISSUE

The issue is whether appellant had more than 18 percent impairment of her right lower extremity for which she has received schedule awards.

FACTUAL HISTORY

This case has previously been before the Board on appeal. On November 9, 1999 appellant, then a 37-year-old mail carrier filed a traumatic injury claim alleging that she was

[1] For Office decisions issued prior to November 19, 2008, a claimant had one year to file an appeal. An appeal of Office decisions issued on or after November 19, 2008 must be filed within 180 days of the decision. 20 C.F.R. § 501.3(e) (2008).

struck by an automobile during the performance of duty injuring her right knee. The Office accepted the claim for contusion and tear of the meniscus of the right knee and left knee strain. Appellant underwent right knee surgeries on March 2 and December 6, 2000 to repair her anterior cruciate ligament and a partial synovectomy, respectively. She requested a schedule award and submitted a report from Dr. David Weiss, an osteopath and a Board-certified orthopedic surgeon, finding that she had 8 percent impairment due to quadriceps atrophy, 17 percent impairment due loss of motor strength and 3 percent due to pain for 27 percent impairment of the right lower extremity.

The Office referred appellant for a second opinion evaluation with Dr. Kenneth Flavo, a Board-certified orthopedic surgeon, who found only loss of flexion entitling appellant to five percent impairment. Due to the conflict of medical opinion evidence, it referred appellant to Dr. Howard, Blank, a Board-certified orthopedic surgeon, for an impartial medical examination. Dr. Blank found ½ inch visible atrophy of the right quadriceps, 125 degrees of flexion and concluded that appellant had 10 percent impairment of her right lower extremity. The Office medical adviser reviewed the medical evidence and concluded that appellant had five percent impairment due to loss of flexion and five percent impairment due loss of cartilage space. It granted appellant a schedule award for 10 percent impairment of her right lower extremity. The Board reviewed the Office's decision on appeal and found that the case should be remanded for the Office to secure a supplemental report from Dr. Blank providing a reasoned opinion explaining how he reached his impairment rating applying the protocols of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001).[2] The facts and the circumstances of the case as set out in the Board's prior decision are adopted herein by reference.

On remand from the Board, the Office requested a supplemental report from Dr. Blank on August 23 and October 13, 2005. As there was no response, the Office then referred appellant to Dr. Todd Krell, a Board-certified orthopedic surgeon, for a second impartial medical examination. Dr. Krell examined appellant on December 20, 2005 and provided a proper history of injury. He found that appellant's gait was normal and limited flexion of 125 degrees on the right. Dr. Krell found thigh circumference was 45.5 centimeters on the right and 46.5 on the right.[3] He noted only 4/5 strength in right hip forward flexion and performed x-rays including bilateral skyline views. Dr. Krell assigned three percent impairment due to one centimeter of atrophy on the right. He noted that leg forward flexors included knee extensors and that appellant had 12 percent impairment of the lower extremity due to this condition as a whole with 8.5 percent impairment allowing for the contribution of hip forward flexors and knee extensors to the clinically measured loss of strength.[4]

Dr. Krell found that appellant had a difference in side-to-side range of motion of the right knee as compared to the left. The right knee reached full extension with flexion of 125 degrees. The left, unaffected knee, reached full extension with flexion of 140 degrees, yielding a side-to-

[2] Docket No. 05-697 (issued July 20, 2005).

[3] A.M.A., *Guides*, Table 17-6.

[4] *Id.* at Table 17-8.

side difference of 15 degrees. Dr. Krell noted that, based strictly on Table 17-10, only ranges of motion less than 110 degrees are assigned ratings. He found, however, that appellant's loss of motion of 15 degrees did interfere with the performance of certain functional tasks such as squatting. Dr. Krell concluded, "The loss of 15 degrees by comparison to the normal of 140 degrees represents approximately a 103 percent change in the range of motion as compared to the unaffected side. The patient is therefore assigned 10 percent lower extremity impairment for loss of range of motion with a subsequent effect on functional ability." He also found that appellant had pain in accordance with Chapter 18 of the A.M.A., *Guides*, noting that she completed a rating scale in this chapter which placed her in mild pain impairment of two percent of the lower extremity.[5] Dr. Krell found appellant had 24 percent impairment of the right lower extremity.

The district medical adviser reviewed this report on January 12, 2006 and found that Dr. Krell used the wrong tables for range of motion and incorrectly used the muscle strength tables. He stated that appellant had no impairment due to loss of range of motion and five percent impairment due to loss of hip flexor strength on the right. The district medical adviser stated that as appellant received impairment due to loss of motor strength she was not also entitled to receive impairment for atrophy. He concluded that appellant had eight percent impairment of the right lower extremity.

The Office denied appellant's claim for an additional schedule award by decision dated January 17, 2006. Appellant, through her attorney, requested an oral hearing on January 23, 2006. By decision dated July 31, 2006, the Branch of Hearings and Review found that a new district medical adviser should review the medical evidence as the previous reviewing district medical adviser created the conflict regarding appellant's permanent impairment.

On remand, a second district medical adviser, Dr. Andrew Merola, a Board-certified orthopedic surgeon, reviewed the case and determined that only 10 percent for loss of range of motion and 3 percent for pain could be combined.[6] The Office then requested a supplemental report from Dr. Krell who responded and argued that, as both the thigh and knee joints were involved, it was appropriate to combine thigh atrophy and strength resulting in 22 percent impairment.

The Office referred Dr. Krell's report back to Dr. Merola who again stated that strength, atrophy and loss of motion could not be combined. Dr. Merola concluded that appellant had 9 percent impairment due to loss of strength combined with 2 percent for pain resulting in 11 percent impairment. By decision dated January 19, 2007, the Office granted appellant an additional 1 percent impairment for a total of 11 percent impairment of her right lower extremity. Appellant, through her attorney, again requested an oral hearing. By decision dated April 11, 2007, the Branch of Hearings and Review found that there was a conflict of medical opinion evidence between Dr. Krell and the district medical adviser regarding the interpretation of the A.M.A., *Guides* and remanded the case for an additional impartial medical examination.

[5] *Id.* at Chapter 18, Tables 18-3 through 18-7.

[6] *Id.* at 526, Table 17-2.

The Office referred appellant to Dr. Robert Dennis, a Board-certified orthopedic surgeon, on May 24, 2007. In his report dated June 14, 2007, Dr. Dennis noted appellant's history of injury and medical history and provided findings on physical examination. He found that appellant exhibited a normal gait, limited range of motion with only 100 degrees of flexion. Dr. Dennis did not find effusion or patellar crepitus but noted that appellant's surgery scars were still tender. He found that appellant's anterior cruciate ligament was stable. Dr. Dennis concluded that appellant had weakness of the quadriceps and stated, "[W]e felt [this] would be more accurately measured by measuring the girth." He noted that the A.M.A., *Guides* advocated the anatomic method and he chose atrophy as the appropriate method to determine appellant's permanent impairment due to quadriceps weakness as it could be measured with great accuracy. Dr. Dennis found that appellant's left leg measured 18 inches in circumference at 10 centimeters above the patella, while her right leg measured 17¼ inches. He opined that appellant had 11/16 of an inch of atrophy or 1.7 centimeters atrophy of the right thigh which correlated to mild atrophy or seven percent impairment of the lower extremity.[7] Dr. Dennis concluded that appellant had two percent impairment due to pain as the result of her hyperesthesia with pain associated with her surgical scars. He then noted that appellant could also receive an impairment rating for loss of motion and that 100 degrees of flexion was 10 percent impairment of the right lower extremity.[8] Dr. Dennis noted that appellant did not provide any objective studies for him to review. He stated that he found no evidence on post-traumatic arthritis on clinical examination. Dr. Dennis stated, "[W]e doubt if x-rays would show joint narrowing since the patient is so very functional without crepitus." He addressed the specific questions formulated by the Office and found that appellant had 18 percent impairment of her right lower extremity utilizing the Combined Values Chart. The district medical adviser reviewed this report on July 6, 2007 and agreed with Dr. Dennis' impairment rating. By decision dated July 20, 2007, the Office awarded appellant a schedule award for an additional 7 percent impairment of her right lower extremity for a total impairment rating of 18 percent.

Appellant, through her attorney, requested an oral hearing on July 25, 2007. Counsel stated that he could not tell if Dr. Dennis was selected through the Physicians Directory System, (PDS), he argued that Dr. Dennis' report did not appropriately apply the A.M.A., *Guides* as he compared appellant's legs to determine atrophy and appellant had injured both legs on November 9, 1999, that he used inches instead of centimeters and because he did not test for motor strength deficits. He also asserted that Dr. Dennis should have provided a rating for arthritis and failed to adequately explain his pain rating. Counsel noted that atrophy and range of motion deficits could not be combined under the A.M.A., *Guides*. By decision dated June 13, 2008, the hearing representative concluded that appellant's arguments should be addressed and the case remanded so that Dr. Dennis could provide additional clarification of his opinion regarding the extent of appellant's atrophy and any arthritis resulting from her accepted conditions. The hearing representative also directed the Office to explain the selection method utilized to select Dr. Dennis as the impartial medical examiner.

The Office provided appellant's attorney with a letter dated August 14, 2008 which explained the reasons behind the use of the PDS. It also requested a supplemental report from

[7] *Id.* at 530, Table 17-6.

[8] *Id.* at 337, Table 17-10.

Dr. Dennis on August 14, 2008. Dr. Dennis responded on August 19, 2008 and agreed that under the A.M.A., *Guides*, range of motion and muscle atrophy should not be combined. He found that appellant demonstrated 100 degrees of flexion on the right, 10 percent impairment under the A.M.A., *Guides* and also found that appellant had additional impairment due to sensory loss from her scars which he concluded was two percent impairment of the right lower extremity. Dr. Dennis stated that in deference to appellant's attorney he was excluding atrophy from the rating as it could not be combined with range of motion impairments.

By decision dated October 9, 2008, the Office found that appellant had no more than 12 percent impairment of her right lower extremity for which she had received schedule awards.

Appellant, through her attorney, requested an oral hearing on October 15, 2008. Counsel alleged that the Office had not provided sufficient information to establish that Dr. Dennis was appropriately selected, instead providing general information. He alleged that Dr. Dennis should have chosen the method of impairment rating that was most favorable to appellant rather than choosing the method that he felt was "more easily measured" and that rather than discounting appellant's strength deficits entirely, Dr. Dennis should have utilized another method other than atrophy to determine the impairment due to loss of quadriceps strength. Counsel also stated that Dr. Dennis should have included any impairment to appellant's calf strength. Appellant testified that her right leg was weak and that she believed that she had arthritis.

By decision dated June 1, 2009, the hearing representative found that the Office had selected Dr. Dennis through the PDS and that appellant had not established any error or irregularity in his selection. The hearing representative further found that Dr. Dennis followed the A.M.A., *Guides* by selecting the most appropriate method to calculate appellant's impairment. He further noted that, as arthritis cannot be combined with loss of range of motion, there was at most harmless error in failing to calculate this impairment rating. The hearing representative affirmed the Office's October 9, 2008 decision.

LEGAL PRECEDENT

A physician selected by the Office to serve as an impartial medical specialist should be wholly free to make a completely independent evaluation and judgment. To achieve this, the Office has developed specific procedures for the selection of impartial medical specialists designed to provide safeguards against any possible appearance that the selected physician's opinion is biased or prejudiced. The procedures contemplate that impartial medical specialists will be selected from Board-certified specialists in the appropriate geographical area on a strict rotating basis in order to negate any appearance that preferential treatment exists between a particular physician and the Office.[9] The Federal (FECA) Procedure Manual (the procedure manual) provides that the selection of referee physicians (impartial medical specialists) is made through a strict rotational system using appropriate medical directories. The procedure manual provides that the PDS should be used for this purpose wherever possible.[10] The PDS is a set of stand-alone software programs designed to support the scheduling of second opinion and referee

[9] *B.P.*, 60 ECAB ___ (Docket No. 08-1457, issued February 2, 2009).

[10] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4(b) (May 2003).

examinations.[11] The PDS database of physicians is obtained from the American Board of Medical Specialties (ABMS) which contains the names of physicians who are Board-certified in certain specialties. The Board has held that an appropriate notation should be made in the directory when a specialist indicates his or her unwillingness to accept a case or when, for other valid reasons it is not advisable or practicable to use his or her services.[12]

ANALYSIS

The Board finds that this case is not in posture for decision. The Office accepted appellant's claim for contusion and tear of the meniscus of the right knee and left knee strain as well as surgery on March 2, 2000 for an anterior cruciate ligament repair and December 6, 2000 for a partial synovectomy. The most recent conflict of medical opinion arose because Dr. Krell, a Board-certified orthopedic surgeon and impartial medical examiner, found that appellant had 22 percent impairment and offered his medical reasoning for finding this impairment rating. The district medical adviser, Dr. Merola, a Board-certified orthopedic surgeon, disagreed with Dr. Krell's application of the A.M.A., *Guides* and found only 11 percent impairment. The Branch of Hearings and Review found that this constituted a conflict of medical opinion evidence and remanded for referral to an additional impartial medical examiner.

The Office selected Dr. Dennis, a Board-certified orthopedic surgeon to serve as the impartial medical specialist. It is well established that Office procedures provide that an impartial medical specialist must be selected from a rotational list of qualified Board-certified specialists, including those certified by the American Medical Association and American Osteopathic Association.[13] The physician selected as the impartial specialist must be one wholly free to make an independent evaluation and judgment. To achieve this end, the Office has developed procedures for the selection of the impartial physician designed to provide adequate safeguards against the appearance that the selected physician's opinion was biased or prejudiced.[14] These procedures contemplate selection on a strict rotating basis in order to negate any appearance that preferential treatment exists between a physician and the Office.[15] Moreover, the reasons for the selection made must be documented in the case record.[16]

The case record before the Board does not contain any documentation from the PDS explaining how the Office selected Dr. Dennis. The Board has found that the Office has an obligation to ensure that the record reflects proper selection of the impartial medical examiner.[17] As this record does not contain the necessary documentation, the Board finds that Dr. Dennis

[11] *Id.* at Chapter 3.500.7 (May 2003).

[12] *David Peisner*, 39 ECAB 1167 (1988).

[13] *See LaDonna M. Andrews*, 55 ECAB 301 (2004).

[14] *See Raymond J. Brown*, 52 ECAB 192 (2001).

[15] *See also Miguel A. Muniz*, 54 ECAB 217 (2002).

[16] *See* Federal FECA Procedure Manual, *supra* note 10.

[17] *Asghar Rowshandel*, 61 ECAB ___ (Docket No 09-1566, issued June 1, 2010).

cannot serve as the impartial medical examiner and the case must be remanded for referral to a new properly selected physician designated to serve as the impartial medical examiner and to resolve the existing conflict of medical opinion evidence.

On remand, the Office should request a detailed report with specific findings on every aspect of appellant's lower extremity previously implicated including loss of range of motion, loss of strength, pain and loss of cartilage interval. The physician designated as the impartial medical examiner should be properly selected through the PDS and such selection should be properly documented. The physician should provide figures for the various methods of evaluating appellant's impairments including loss of strength and select the method or combination of methods which is most favorable to appellant. After this and such other development as the Office deems necessary, the Office should issue an appropriate decision.

On appeal appellant's attorney alleged that the Office must prove that Dr. Dennis was properly selected as the impartial medical adviser through the PDS. He further alleged that Dr. Dennis' report was not sufficiently detailed to constitute the weight of the medical opinion evidence. Appellant's attorney also stated that Dr. Magliato should not have reviewed Dr. Dennis' report as he had previously created a conflict in the record. As found in the preceding paragraphs, the Board agrees that the proper selection of Dr. Dennis was not adequately documented in the record to serve as the impartial medical examiner and is remanding the case for an appropriate referral.

CONCLUSION

The Board finds that this case is not in posture for decision due to an existing conflict of medical opinion evidence which must be resolved through a referral to a new impartial medical examiner.

ORDER

IT IS HEREBY ORDERED THAT the June 1, 2009 decision of Office of Workers' Compensation Programs must be set aside and the case remanded for further development consistent with this decision of the Board.

Issued: August 11, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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