United States Department of Labor
Employees' Compensation Appeals Board

W.M., Appellant	)	
and	)	**Docket No. 10-605**
	)	**Issued: January 7, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Salem, 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 January 4, 2009 appellant, through counsel, filed a timely appeal from the Office of Workers' Compensation Programs' decision dated October 14, 2009, which affirmed the Office's March 5, 2009 schedule award decision. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this claim.

ISSUE

The issue is whether appellant met his burden of proof to establish that he sustained more than a 10 percent permanent impairment of his right lower extremity or more than a 10 percent permanent impairment of his left lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On March 15, 2005 appellant, then a 48-year-old letter carrier, filed an occupational disease claim alleging that he sustained bilateral knee conditions in the performance of duty. He

did not stop work. On September 7, 2006 the Office accepted the claim for acceleration of bilateral knee degenerative joint disease.[1]

In a November 9, 2006 report, Dr. Nicholas Diamond, an osteopath, noted appellant's history of injury and treatment and utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001) (hereinafter A.M.A., *Guides*). He determined that appellant had 30 percent permanent impairment of the right and left legs.

On February 6, 2007 appellant filed a (Form CA-7) claim for a schedule award.

In an October 15, 2007 report, an Office medical adviser noted the history of injury and treatment, reviewed Dr. Diamond's report and utilized the A.M.A., *Guides*. The Office medical adviser concluded that appellant had 27 percent permanent impairment of each leg.

On April 10, 2008 the Office referred appellant to Dr. George P. Glenn, Jr., a Board-certified orthopedic surgeon, to resolve the conflict in medical opinion.[2] In an April 29, 2008 report, Dr. Glenn noted appellant's history of injury and treatment. He referred to Table 17-1 and advised that atrophy and arthritis of the knee joint was the "pertinent subject with respect to knee problems."[3] Dr. Glenn explained that pursuant to Table 17-2, page 526, these two could not be combined and that range of motion and muscle strength could not be combined. Regarding arthritis, he utilized the roentgenographic grading method and determined that the tibiofemoral cartilage on the left measured nine millimeters medially and six millimeters laterally. For the right, appellant's cartilage measured eight millimeters medially and seven millimeters laterally. Dr. Glenn noted that for the upright position, the patellofemoral interval on the left measured three millimeters and on the right five millimeters. He referred to Table 17-31 at page 544 and explained that none of the intervals qualified for an impairment. Dr. Glenn also noted that while both Dr. Diamond and the Office medical adviser referred to muscle strength testing, his examination of all muscle groups revealed no gait abnormalities or zero percent under Table 17-7 at page 531. He also explained that muscle atrophy could not be utilized because it applied to unilateral involvement and both extremities were involved.[4] Dr. Glenn applied the range of motion method and noted that, while both Dr. Diamond and the Office medical adviser found no impairment, he found limited range of motion involving the right knee of 105 degrees and 3 to 5 degrees of flexion contracture in the left knee. Under Table 17-10 at page 537, flexion of less than 110 degrees resulted in a 10 percent permanent impairment of the right knee and flexion contracture was in the 5 to 9 degree range, which equated to 10 percent

[1] The record reflects that on June 20, 2003, appellant underwent arthroscopic debridement of the medial femoral condyle and partial lateral meniscectomy of the right knee.

[2] On January 22, 2008 the Office referred appellant to Dr. Gerald Packman, a Board-certified orthopedic surgeon, for an impartial medical evaluation to resolve the conflict in opinion between Dr. Diamond and the Office medical adviser regarding the extent of his permanent impairment. On April 1, 2008 it bypassed Dr. Packman as he required payment in advance. The Office also noted that he did not perform impartial medical examinations. The Office also bypassed Dr. Seth Silver, a Board-certified orthopedic surgeon, as an impartial specialist. On the bypass sheet, it noted that there was "[n]o phone number and 411 has no more information."

[3] A.M.A., *Guides* 525.

[4] *Id*. at 530.

impairment of the left knee. He explained that appellant exhibited nothing unusual in the pain presentation which would allow for consideration of the pain chapter.[5] Dr. Glenn noted that appellant had no evidence of weakness in any of the muscle groups in spite of the muscle atrophy. He opined that appellant's condition would have occurred at some point in time as the natural progression of the degenerative process without the added stimulus of his occupation. Dr. Glenn noted that the five percent impairment rating for both the right and left knees that the Office medical adviser included for patellofemoral compression producing pain and crepitus pursuant to Table 17-3[6] would not apply because there was no history of direct trauma.

In an August 20, 2008 report, an Office medical adviser concurred with Dr. Glenn. He advised that appellant reached maximum medical improvement on April 29, 2008.

On March 5, 2009 the Office granted appellant a schedule award for 10 percent permanent impairment of the right knee and 10 percent permanent impairment of the left knee. The award covered a period of 57.60 weeks from April 29, 2008 to June 6, 2009.

On March 10, 2009 counsel requested a hearing, which was held *via* video conference on July 29, 2009. During the hearing, he alleged that the Office improperly bypassed Dr. Silver before selecting Dr. Glenn. Counsel alleged that Dr. Silver was accessible and practiced medicine in the area for 22 years. He also alleged that Dr. Glenn's report was not entitled to special weight. In a letter dated July 31, 2009, counsel reiterated that Dr. Silver was improperly bypassed as he was readily available and had practiced medicine for over 22 years.

By decision dated October 14, 2009, the hearing representative affirmed the March 5, 2009 decision. She found that the Office properly selected Dr. Glenn as the impartial specialist and that his report was entitled to special weight.

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 sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[9] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[10]

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[5] *Id*. at 571.

[6] *Id*. at 544.

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404 (1999).

[9] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[10] *Supra* note 8.

The A.M.A., *Guides* provides for three separate methods for calculating the lower extremity permanent impairment of an individual: anatomic, functional and diagnosis based.[11] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[12] The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligamentous instability, bursitis and various surgical procedures, including joint replacements and meniscectomies.[13] The functional method is used for conditions when anatomic changes are difficult to categorize or when functional implications have been documented and includes range of motion, gait derangement and muscle strength.[14] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[15] When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.[16] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[17]

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.[18] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[19]

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.[20] 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 medical specialist designed to provide adequate safeguards against the

[11] *Supra* note 3.

[12] *Id.*

[13] *Id.*

[14] *Id.* at 525, Table 17-1.

[15] *Id.* at 548, 555.

[16] *Id.* at 526.

[17] *Id.* at 527, 555.

[18] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan*), 45 ECAB 207 (1993).

[19] *See Roger Dingess*, 47 ECAB 123 (1995); *Glenn C. Chasteen*, 42 ECAB 493 (1991).

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

appearance that the selected physician's opinion was biased or prejudiced.[21] 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.[22] Moreover, the reasons for the selection made must be documented in the case record.[23]

ANALYSIS

Dr. Diamond, the attending physician, found that appellant had 30 percent permanent impairment of the right and left legs. An Office medical adviser reviewed Dr. Diamond's report and determined that appellant had 27 percent impairment of each leg. As a conflict existed in the medical opinion evidence between Dr. Diamond and the Office medical adviser, the Office properly referred appellant to Dr. Glenn for an impartial medical examination.

The Board finds that the thorough and well-documented report of Dr. Glenn, the impartial medical specialist selected to resolve the conflict in the medical evidence, is based upon correct application of the A.M.A., *Guides* and is entitled to special weight. Dr. Glenn took measurements, referred to pages and tables in the A.M.A., *Guides* and explained his calculations.

In an April 29, 2008 report, Dr. Glenn noted appellant's history and utilized the A.M.A., *Guides.* He considered the various methods of assessment to determine appellant's impairment and explained which methods could not be combined. In particular Dr. Glenn properly noted that atrophy and arthritis of the knee joint could not be combined. He also explained that the A.M.A., *Guides* at Table 17-2 at page 526 precluded the combination of range of motion and muscle strength. For arthritis, Dr. Glenn appropriately utilized the roentgenographic grading method to measure the cartilage and joint spaces of the "medial and lateral tibiotalar joints in AP projection and the patellofemoral joint in lateral projection." He determined that the measurements of the left leg of nine millimeters medially and six millimeters laterally and the right leg of eight millimeters medially and seven millimeters laterally or the patellofemoral interval measurements on the left of three millimeters and the right of five millimeters, did not qualify for an impairment according to Table 17-31 of the A.M.A., *Guides*. Dr. Glenn advised that under Table 17-6 muscle atrophy could not be utilized because it was specifically intended for a unilateral involvement and both legs were involved in appellant's case. Regarding muscle strength, he noted that appellant had no gait abnormalities and thus, zero percent impairment according to Table 17-7. For range of motion, Dr. Glenn found limited range of motion involving the right knee of 105 degrees and 3 to 5 degrees of flexion contracture in the left knee. Dr. Glenn referred to Table 17-10 and explained that flexion of less than 110 degrees resulted in a 10 percent impairment of the right leg and that left leg flexion contracture was in the 5 to 9 degree range, resulting in 10 percent permanent impairment. He found no unusual pain presentation which would allow for consideration of the pain chapter.[24] Dr. Glenn also explained

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

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

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

[24] A.M.A., *Guides* 571.

that under Table 17-31, an additional impairment of five percent for both the right and left knees as a result patellofemoral compression producing pain and crepitus would not apply because there was no history of direct trauma.

The Board finds that Dr. Glenn's opinion is entitled to special weight as his reports are sufficiently well rationalized, based upon a proper factual background and properly apply the A.M.A, *Guides* to the facts. The Office properly relied upon his reports in finding that appellant had a permanent impairment of 10 percent of his right lower extremity and 10 percent of his left lower extremity. Therefore, Dr. Glenn's report resolved the medical conflict and establishes that, under the A.M.A., *Guides*, appellant has no more than 10 percent impairment of the right leg and 10 percent impairment of the left leg.

Counsel asserted during the hearing and on appeal that Dr. Silver was improperly bypassed during the selection of the impartial specialist such that Dr. Glenn was not chosen in accordance with proper procedures.[25] He argued that Dr. Silver was bypassed for no telephone number or further information. Counsel noted that Dr. Silver was available and had been a practicing physician for over 22 years. The Board notes that the Office properly documented its reason for bypassing Dr. Silver prior to selecting Dr. Glenn. The fact that appellant disagrees with the Office's reason is not sufficient to defeat the Office selection of Dr. Glenn.[26] There is no showing that the use of Dr. Glenn's medical opinion would undermine the appearance of impartiality or compromise the integrity of the system for selecting impartial medical specialists.

Consequently, the Office properly found that Dr. Glenn's opinion represented the special weight of the medical evidence and resolved the medical conflict regarding the extent of permanent impairment of appellant's lower extremities.

CONCLUSION

The Board finds that the evidence does not establish that appellant has more than 10 percent permanent impairment of his right lower extremity or more than 10 percent permanent impairment of his left lower extremity, for which he received a schedule award.

[25] To ensure the complete independence of physicians that are selected as impartial medical specialists, the Office developed specific procedures to safeguard against any possible appearance that the selected physician's opinion is biased or prejudiced. Impartial medical specialists are selected from the Board-certified specialists in the appropriate geographical area on a strict rotating basis to negate the appearance that any preferential treatment exists between a particular physician and the Office. Office procedures provide that the selection of an impartial medical specialist 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. *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4(b) (May 2003). *See also Willie M. Miller*, 53 ECAB 697 (2002).

[26] *G.E.*, Docket No. 10-81 (issued September 17, 2010); *see R.B.*, 61 ECAB ___ (Docket No. 09-1786, issued July 1, 2010).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated October 14, 2009 is affirmed.

Issued: January 7, 2011
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