United States Department of Labor
Employees' Compensation Appeals Board

J.C., Appellant	)	
and	)	**Docket No. 08-1833**
	)	**Issued: March 23, 2009**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, New Castle, 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:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 17, 2008 appellant filed a timely appeal from an October 18, 2007 decision of the Office of Workers' Compensation Programs adjudicating his schedule award claim. Pursuant to 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 13 percent permanent impairment of his left lower extremity.

FACTUAL HISTORY

This is the second appeal in this case.[1] By decision dated January 30, 2007, the Board set aside a January 17, 2006 Office decision granting appellant a schedule award based on 13 percent left lower extremity impairment. The Board remanded the case for further development of the medical evidence. The facts of the previous Board decision are incorporated herein by reference.

On August 15, 2007 the Office referred appellant, together with a statement of accepted facts and a list of questions, to Dr. Stephen R. Bailey, a Board-certified orthopedic surgeon, for an impairment rating of his left lower extremity.[2]

In a September 14, 2007 report, Dr. Bailey reviewed the medical history and provided findings on physical examination. He noted that appellant walked with a slight limp favoring his left leg and used a cane. Appellant appeared to be in no acute distress. Dr. Bailey found no evidence of a left knee sprain on physical examination. There was no difference in the circumference of his thighs which indicated normal usage of the left knee. If appellant was not using his left knee normally, there would have been significant left thigh atrophy. Manual motor testing of both lower extremities was normal. Dr. Bailey asked him to flex his left knee back as far as he could. At first, appellant went from full extension of his left lower extremity to approximately 105 degrees, complaining of back pain. Dr. Bailey examined his right knee and then reexamined his left knee. Appellant was then able to actively flex his left knee to 120 degrees. Dr. Bailey noted that the American Medical Association, *Guides to the Evaluation of Permanent Impairment* provides for knee impairment based on decreased extension of five degrees or more. However, appellant's left knee extension was normal. There was no varus or valgus deformity. There was no effusion, heat or joint laxity. Appellant reported diffuse medial joint discomfort to palpation. McMurray's testing for a meniscal tear was negative. No surgical scars were visible on the left knee and there was no discoloration of the knee or leg. Reflexes at the knee and ankle were 2+ and equal bilaterally. Calf girth was 13 inches bilaterally. Appellant had an extensor hallucis longus muscle of 5/5 and could perform three repetitions of heel raise which showed equal strength bilaterally. There was no dermatomal sensory loss. Sensation was intact to pin and light touch. Appellant's knee quadriceps muscle strength was normal compared to the right. There was no joint instability, effusion or any evidence of internal derangement. Dr. Bailey did not correlate appellant's complaints of knee pain with any objective impairment. He noted that an accepted condition was a herniated disc at L5-S1 but there was no evidence of radiculopathy into the left lower extremity. Dr. Bailey indicated that if appellant had

[1] *See* Docket No. 06-1865 (issued January 30, 2007). On March 31, 1998 appellant, then a 42-year-old custodial group leader, filed a traumatic injury claim alleging that he injured his back and left knee when he slipped in mud and fell. The Office accepted his claim for a left knee strain and sprain and a lumbar sprain and strain. On May 17, 2005 appellant filed a claim for a schedule award for his left lower extremity. Appellant has two other back injury claims filed with the Office. In OWCP File No. xxxxxx397, the Office accepted that appellant sustained a lumbar strain and a herniated disc at L5-S1 on May 24, 1999. A schedule award based on a six percent impairment of the right lower extremity was granted on May 11, 2005. Appellant also has a claim based on accepted thoracic and lumbar strains sustained on July 22, 1998 in OWCP File No. xxxxxx543.

[2] The Office first referred appellant to Dr. Gerald Pifer. However, the Office found that the impairment rating from this referral physician was not sufficient to establish appellant's left lower extremity impairment.

experienced a partial torn medial meniscus and undergone a meniscectomy, he would have two percent impairment of the left lower extremity, based on Table 17-33 at page 546 of the A.M.A., *Guides*. However, he found no evidence of record that appellant had undergone a meniscectomy. Dr. Bailey concluded that appellant had no impairment of his left lower extremity causally related to his March 31, 1998 work-related left knee sprain and lumbar sprain.

In reports dated September 14 and October 5, 2007, Dr. Morley Slutsky, a Board-certified specialist in preventive medicine and an Office medical adviser, stated that there was no evidence to support that appellant underwent a meniscectomy to repair a left knee meniscus tear. He stated that the A.M.A., *Guides* provides for impairment based on a meniscectomy, not for a meniscal tear.[3] Dr. Slutsky agreed that appellant had no ratable impairment of the left lower extremity based on the findings in Dr. Bailey's report.[4]

By decision dated October 18, 2007, the Office denied appellant's claim for more than 13 percent impairment of his left lower extremity on the grounds that the medical evidence did not establish additional impairment.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[5] and its implementing regulations[6] 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, 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 regulations as the appropriate standard for evaluating schedule losses.[7]

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.[8] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[9] The diagnosis-based method may

[3] *See* A.M.A., *Guides* 546, Table 17-33.

[4] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] 20 C.F.R. § 10.404.

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

[9] *Id.*

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.[10] 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.[11] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[12] 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.[13] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[14]

ANALYSIS

Dr. Bailey reviewed appellant's medical history and provided findings on physical examination. There was no evidence of a left knee sprain. There was no difference in the circumference of his thighs which indicated normal usage of the left knee. Manual motor testing of both lower extremities was normal. Appellant's knee quadriceps muscle strength was normal compared to the right. There was no joint instability, effusion or any evidence of internal derangement. There was no effusion, heat or joint laxity. McMurray's testing for a meniscal tear was negative. No surgical scars were visible on the left knee and there was no discoloration of the knee or leg. Reflexes at the knee and ankle were 2+ and equal bilaterally. Calf girth was 13 inches bilaterally. Appellant's extensor hallucis longus was 5/5 and three repetitions of heel raise showed equal strength bilaterally. Regarding range of motion, appellant was able to actively flex his left knee to 120 degrees which demonstrated no impairment based on Table 17-10 at page 537 of the A.M.A., *Guides*. Dr. Bailey noted that the A.M.A., *Guides* provides for range of motion knee impairment based on decreased extension of five degrees or more; however, appellant's left knee extension was normal. There was no range of motion varus or valgus deformity. Regarding sensory loss or pain, appellant had no dermatomal sensory loss. Sensation was intact to pin and light touch. Although appellant reported diffuse medial joint discomfort to palpation, Dr. Bailey did not correlate his complaints of knee pain with any objective impairment. He noted that a herniated disc at L5-S1 was an accepted condition but there was no evidence of radiculopathy into the left lower extremity. Dr. Bailey advised that if appellant had undergone a meniscectomy, he would have two percent impairment of the left lower extremity, based on Table 17-33 at page 546 of the A.M.A., *Guides*. However, the record did not establish that appellant had undergone a meniscectomy. Dr. Bailey stated that appellant had no impairment of his left lower extremity causally related to his March 31, 1998 work-related left knee sprain and lumbar sprain. Dr. Slutsky concurred that appellant had no

[10] *Id.*

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

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

[13] *Id*. at 526.

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

impairment of the left lower extremity based on the findings in Dr. Bailey's report. He stated that there was no evidence of record that appellant had undergone a meniscectomy to repair a left knee meniscus tear and, as Dr. Bailey noted, the A.M.A., *Guides* provides for impairment based on a meniscectomy, not for a meniscal tear. The Board finds that Dr. Bailey's impairment rating conforms to Office procedures and the procedures in the A.M.A., *Guides* for determining impairment. His report establishes that appellant has more than 13 percent impairment of his left lower extremity.

On appeal, appellant asserts that the Office erred in not combining this case with appellant's two separate accepted back injury cases. He stated that the Board should have all three case records, not just the documents added by the Office, from one of the other files, to the file on appeal. However, appellant provided insufficient explanation as to why combining these three cases is necessary in order to evaluate any impairment to his left lower extremity.

On appeal, appellant asserts that Dr. Bailey's opinion regarding his left lower extremity impairment is of diminished probative value because he is mentioned as a referral physician in 11 Board decisions regarding other individuals and is not listed as a treating physician in any Board decisions. However, the Office's procedure manual provides that "[s]econd opinion [referral] examinations are generally conducted by a doctor selected by a medical referral group that has contracted with [the Office] to provide second opinion medical referrals."[15] Appellant asserts that in these 11 cases Dr. Bailey found that the injured worker was less seriously injured or not injured, as compared to treating physicians, and this shows a predictable pattern of bias. However, appellant provided no evidence to establish bias on the part of Dr. Bailey.[16] Mere allegations are not sufficient to establish bias.[17] There must be evidence in the record of actual bias or unfairness on the part of the physician used by the Office as a referral physician in an employee's case.[18] There is no evidence of bias in Dr. Bailey's rating of appellant's left lower extremity impairment. The Board finds that Dr. Bailey's medical opinion is sufficient to establish that appellant has no more than 13 percent impairment of the left lower extremity.

CONCLUSION

The Board finds that appellant failed to establish that he has more than 13 percent impairment of the left lower extremity.

[15] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.7 (May 2003).

[16] *See Atanacio G. Sambrano*, 51 ECAB 557, 560 (2000).

[17] *See James F. Weikel*, 54 ECAB 660, 663 (2003); *Willie M. Miller*, 53 ECAB 697, 699-700 (2002).

[18] *Anthony La-Grutta*, 37 ECAB 602, 607-08 (1986).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated October 18, 2007 is affirmed.

Issued: March 23, 2009
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