

right knee injury and appellant did not stop work due to the May 23, 2002 injury. A May 9, 2002 magnetic resonance imaging (MRI) scan of the left knee demonstrated “prepatellar and superficial infrapatellar bursitis and degenerative changes of the patellofemoral compartment and lateral hemijoint.”

On November 18, 2004 appellant filed a schedule award claim and submitted an August 2, 2004 report in which Dr. David Weiss, an osteopath, provided physical examination findings and advised that appellant had reached maximum medical improvement. Dr. Weiss provided an impairment rating in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),¹ concluding that, in accordance with Table 17-6, left calf atrophy yielded an 8 percent impairment and that, under Table 18-1, appellant had a 3 percent impairment for pain, for a total 11 percent left lower extremity impairment.² On March 8, 2005 the Office accepted that appellant sustained a left knee internal derangement.

By letter dated June 26, 2007, the Office asked that appellant secure a report from her physician to determine the extent of permanent impairment to the left knee. In reports dated July 23 and 25, 2007, Dr. Frederick G. Dalzell, a Board-certified orthopedic surgeon, noted appellant’s complaint of significant left knee pain. He advised that range of motion of the left knee was 15 degrees to 120 degrees with moderate effusion and tenderness over the medial joint line and the patellofemoral joint and noted that appellant walked with a cane. Dr. Dalzell diagnosed significant degenerative changes of the knee and advised that the date of maximum medical improvement was unknown, that she had diffuse lower extremity weakness and post-traumatic arthritis and concluded that she would require prosthetic replacement if her weight could be reduced.

In a December 4, 2007 report, Dr. Arnold T. Berman, a Board-certified orthopedic surgeon and Office medical adviser reviewed Dr. Weiss’ report and advised that, based on his finding of one centimeter of left calf atrophy, under Table 17-6 of the fifth edition of the A.M.A., *Guides*, appellant would be entitled to a three percent impairment. He further found a three percent award for pain in accordance with Figure 18-1, as recommended by Dr. Weiss, for a total left lower extremity impairment of six percent.

The Office determined that a conflict in medical evidence existed between the opinions of Dr. Weiss and the Office medical adviser. A memorandum in the record indicated that Dr. Joseph Harhay was bypassed for selection because he could not give an appointment in a reasonable amount of time and appellant was referred to Dr. O’Dowd for an impartial evaluation. By report dated April 22, 2008, Dr. O’Dowd noted the history of injury and appellant’s complaint of left knee pain. He reported that appellant was morbidly obese and advised that it was virtually impossible to measure any muscle mass of the thighs and calves because it was too far buried beneath adipose tissue. Dr. O’Dowd advised that she had very clear-cut valgus

¹ A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

² Dr. Weiss also provided an impairment analyses for the right upper and lower extremities. The record indicates that appellant has a separate accepted claim for neck, right shoulder and right knee injuries and has been paid schedule awards for right upper and lower extremity impairments.

deformity of both knees and was tender medially, laterally and in the patellofemoral joint, and that she had stable-appearing knees with a little bit of a lateral laxity consistent with a valgus deformity. He indicated that, although the left knee was a little bit warmer than the right, he could not palpate or feel an effusion of either knee. Dr. O'Dowd reviewed the statement of accepted facts and medical record including the May 2002 MRI scan of the left knee and opined that this, together with his physical findings, indicated that appellant had a contusion to her left knee as evidenced by the prepatellar bursitis on the MRI scan, which did not show other traumatic abnormalities. He opined that appellant did not sustain ligamentous injuries in her knee and that the degenerative joint disease (DJD) found was clearly preexisting and due to her morbid obesity and was not employment related, stating that the employment-related injury merely resulted in prepatellar bursitis that had long since resolved. Dr. O'Dowd concluded that the only internal derangement of appellant's left knee was the DJD but that, since the statement of accepted facts indicated that internal derangement was accepted, he would agree with Dr. Berman's conclusion that appellant had a six percent left lower extremity impairment.

The Office referred the medical evidence, including Dr. O'Dowd's report, to Dr. Morley Slutsky, Board-certified in occupational medicine and an Office medical adviser, for review. In a September 15, 2008 report, Dr. Slutsky noted his review of the record and advised that the date of maximum medical improvement was April 22, 2008, the date of Dr. O'Dowd's report. He stated that he agreed with Dr. O'Dowd's assertion that the left knee MRI scan revealed prepatellar bursitis that had long resolved and that the pain appellant had was secondary to the underlying DJD, which was not an accepted condition. Dr. Slutsky also agreed with Dr. O'Dowd's finding that it was impossible to measure muscle mass in a patient with morbid obesity, noting that the measurements would not reflect actual muscle mass differences and would thus not be valid for impairment rating purposes. He concluded that, based on Dr. O'Dowd's finding of no other left lower extremity ratable impairments, if the Office did not accept the left knee DJD condition, the final left lower extremity impairment was zero percent.

By decision dated October 23, 2008, the Office denied appellant's claim for a schedule award for her accepted left lower extremity condition, finding the evidence insufficient to establish permanent impairment to a scheduled member. On November 3, 2008 appellant, through her attorney, requested a hearing that was held on March 17, 2009. At the hearing, appellant described her medical condition and testified that she had a work-related right knee injury, and that on the day she had surgery on her right knee, fluid was drained from her left knee. Her attorney asserted that the reasoning for bypassing Dr. Harhay was vague and argued that, since Dr. O'Dowd changed the accepted condition, did not provide calf measurements and did not discuss appellant's preexisting conditions, his report was insufficient to carry special weight.

In a May 21, 2009 decision, an Office hearing representative found that the fact that Dr. Harhay was bypassed because he could not give an appointment in a reasonable amount of time was not vague reasoning and noted that the acceptance of internal derangement of the left knee as causally related to the April 9, 2002 work injury had not been based on reasoned medical evidence. He credited the opinion of Dr. O'Dowd that appellant did not have this condition, based on the MRI scan findings and concluded that, as appellant had no work-related impairment, she was not entitled to a schedule award for a preexisting impairment due to her diagnosed DJD.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,³ and its implementing federal 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, 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 for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.⁵ For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.⁶ For decisions issued after May 1, 2009, the sixth edition will be used.⁷

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.⁸ When the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.⁹ A physician selected by the Office to serve as an impartial medical examiner should be free to exercise his judgment independently.¹⁰ The Office developed procedures for selecting impartial medical examiners that were designed to provide safeguards against any possible appearance that the selected physician's opinion is biased.¹¹ The procedures contemplate that an impartial medical examiner will be selected from Board-certified specialists in the appropriate geographical area on a strict rotating basis in order to negate any appearance of preferential treatment between a particular physician and the Office.¹²

The Federal (FECA) Procedure Manual provides that the selection of referee physicians (impartial medical examiners) is made through a strict rotational system using appropriate medical directories.¹³ According to the procedure manual, the Physicians Directory System

³ 5 U.S.C. § 8107.

⁴ 20 C.F.R. § 10.404.

⁵ *Id.* at § 10.404(a).

⁶ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

⁷ FECA Bulletin No. 09-03 (issued March 15, 2008).

⁸ 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

⁹ *Manuel Gill*, 52 ECAB 282 (2001).

¹⁰ *T.P.*, 58 ECAB 524 (2007).

¹¹ *Id.*

¹² Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4b (May 2003).

¹³ *Id.*

(PDS) should be used for selecting impartial medical examiners wherever possible.¹⁴ The PDS is a set of stand-alone software programs designed to support the scheduling of second opinion and referee examinations.¹⁵ The PDS database of physicians is based in large part on the Directory of Medical Specialists compiled by the American Board of Medical Specialties. The directory contains the names of physicians who are Board-certified in certain specialties as recognized by the American Medical Association. The PDS database also includes Board-certified osteopathic physicians recognized by the American Osteopathic Association.¹⁶

When the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist requires clarification or elaboration, it has the responsibility to secure a supplemental report from the specialist for the purpose of correcting a defect in the original report.¹⁷ When the impartial medical specialist's statement of clarification or elaboration is not forthcoming, or if the specialist is unable to clarify or elaborate on the original report or if the specialist's supplemental report is also vague, speculative or lacks rationale, the Office must submit the case record together with a detailed statement of accepted facts to a second impartial specialist for a rationalized medical opinion on the issue in question. Unless this procedure is carried out by the Office, the intent of section 8123(a) of the Act will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.¹⁸

ANALYSIS

The Board finds that there is no evidence of record to show that the Office did not properly select Dr. O'Dowd to serve as impartial examiner. The record contains a memorandum advising that Dr. Harhay was bypassed for selection because he could not schedule an appointment in a reasonable amount of time. The Board finds this to be sufficient justification for bypassing the physician and does not constitute evidence of bias.

The Board, however, finds this case is not in posture for decision because a conflict remains regarding whether appellant is entitled to a schedule award. The Office determined that a conflict existed between the opinions of Dr. Weiss, an attending osteopath, who advised that appellant had an 11 percent left lower extremity impairment, and that of Dr. Berman, an Office medical adviser, who advised that appellant's impairment equaled 6 percent. The Office then appropriately referred her to Dr. O'Dowd for an impartial medical opinion regarding the degree of impairment due to the accepted condition of internal derangement of the left knee. In his April 22, 2008 report, Dr. O'Dowd opined that the evidence, particularly a May 2002 MRI scan of the left lower extremity, did not demonstrate a knee internal derangement, rather the evidence supported that appellant sustained a contusion leading to bursitis which had since resolved. He

¹⁴ *Id.*

¹⁵ *Id.* at Chapter 3.500.7 (May 2003).

¹⁶ *Id.*

¹⁷ *Nancy Keenan*, 56 ECAB 687 (2005).

¹⁸ *I.H.*, 60 ECAB ____ (Docket No. 08-1352, issued December 24, 2008).

found that appellant had painful DJD of the left knee, but advised that this was a preexisting condition and not employment related. Dr. O'Dowd, however, concluded that, if there had been internal derangement of the left knee, he agreed with Dr. Berman's logic that appellant would have a six percent left lower extremity impairment. As he did not agree with the finding of internal derangement, he found no permanent impairment. Dr. Slutsky, an Office medical adviser, reviewed Dr. O'Dowd's report and agreed that, if appellant did not have an internal derangement of the left knee, there was no employment-related impairment. Appellant's only impairment would be due to DJD which had not been accepted as employment related. The Office denied her claim for a schedule award for her left lower extremity condition.

The Office has not rescinded acceptance of left knee internal derangement, and Dr. O'Dowd concluded, without further explanation or reference to the A.M.A., *Guides*, that, if there were an internal derangement, he would agree with Dr. Berman's conclusion that appellant had a six percent left lower extremity impairment. In attempting to rescind acceptance of internal derangement, it found that appellant was not entitled to a schedule award. Once the Office accepts a claim, it has the burden of justifying the termination or modification of compensation benefits. This holds true where the Office later decides that it erroneously accepted a claim. *V.C.*, 59 ECAB ____ (Docket No. 07-642, issued October 18, 2007). Although in the May 21, 2009 decision, the hearing representative appeared to rescind acceptance of internal derangement of the left knee, the Office did not inform appellant that it was contemplating rescission nor did it actually rescind acceptance of the internal derangement of the left knee.

It is well established that, when a referee examination is arranged to resolve a conflict in medical opinion, the physician must follow the statement of accepted facts.¹⁹ The Office had accepted internal derangement of the left knee.²⁰

When the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist does not follow the statement of accepted facts as the framework for his opinion, the probative value of the opinion is severely diminished or negated altogether. The case will therefore be remanded for the Office to secure clarification from Dr. O'Dowd regarding the degree of impairment utilizing the A.M.A., *Guides* and the accepted statement of facts. If Dr. O'Dowd is unable to clarify his opinion, the Office shall refer appellant to a second impartial medical specialist to resolve the issue of permanent impairment.²¹

CONCLUSION

The Board finds this case is not in posture for decision because a conflict remains.

¹⁹ *Willa M. Frazier*, 55 ECAB 379, 385 (2004). See also Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3(10) (October 1990).

²⁰ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.5(c) (May 2003).

²¹ *I.H.*, *supra* note 18.

ORDER

IT IS HEREBY ORDERED THAT the May 21, 2009 decision of the Office of Workers' Compensation Programs be set aside and the case remanded to the Office for further proceedings consistent with this opinion of the Board.

Issued: August 10, 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