United States Department of Labor
Employees' Compensation Appeals Board

R.B., Appellant	)	
and	)	**Docket No. 09-1786**
DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF INVESTIGATION, Quantico, VA, Employer	)	**Issued: July 1, 2010**

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
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On July 8, 2009 appellant, through counsel, timely appealed the April 9, 2009 merit decision of the Office of Workers' Compensation Programs, which affirmed a September 16, 2008 schedule award. Pursuant to 20 C.F.R. §§ 501.2 and 501.3, the Board has jurisdiction over the merits of the schedule award claim.

ISSUE

The issue is whether appellant has greater than 12 percent impairment of the right lower extremity.

FACTUAL HISTORY

Appellant, a 38-year-old special agent, has an accepted claim for right anterior cruciate ligament (ACL) tear. He twisted his right knee on March 30, 2004 while participating in defensive tactics training/boxing. Appellant had right ACL reconstructive surgery on June 30, 2004.

On March 14, 2007 the Office granted a schedule award for nine percent impairment of the right lower extremity, which amounted to 25.9 weeks' compensation.[1] It based the award on the February 3, 2007 report of its district medical adviser (DMA), Dr. Morley Slutsky.[2] The DMA disagreed in part with the July 13, 2006 impairment rating provided by Dr. George P. Glenn, Jr., a Board-certified orthopedic surgeon and impartial medical examiner (IME),[3] who found a combined five percent impairment for calf one centimeter (cm) and thigh one cm atrophy. Dr. Glenn believed that a separate rating for pain was unwarranted. He explained that the impairment rating already included an allowance for pain and, therefore, an additional three percent was "inappropriate." In contrast, Dr. Slutsky found six percent impairment for right thigh and calf atrophy, plus three percent impairment for pain, for a combined right lower extremity rating of nine percent. He explained that the impairment rating for thigh and calf atrophy did not address pain at all and appellant's pain-related impairment substantially increased the burden of his condition. Dr. Slutsky noted that appellant was limited in jogging, and there was increased pain/limitation with prolonged driving, and difficulty with kneeling and squatting. The Office accepted the DMA's explanation regarding the appropriateness of a pain-related impairment over the IME's objection to such an award.

By decision dated October 3, 2007, the Branch of Hearings and Review vacated the March 14, 2007 schedule award and remanded the case for clarification of whether the Office properly selected Dr. Glenn to serve as the IME. In a decision dated November 15, 2007, the Office found that the IME selection process was properly administered and, therefore, the previous schedule award for nine percent impairment of the right lower extremity was affirmed.

By decision dated June 2, 2008, the Branch of Hearings and Review vacated the November 15, 2007 Office decision. The hearing representative found that a true conflict had not existed between Dr. Weiss and Dr. Magliato, the DMA. He noted that Dr. Weiss' pain-related impairment lacked adequate explanation and Dr. Magliato had merely highlighted this fact. The hearing representative stated that because Dr. Weiss' three percent award for pain did not conform to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001), a true conflict in medical opinion did not exist. Absent a true conflict, Dr. Glenn's July 13, 2006 impairment rating was relegated from IME status to "second opinion" status. The hearing representative further found that Dr. Glenn's and Dr. Weiss' differing atrophy-based impairment ratings represented a conflict in medical opinion. Accordingly, the case was remanded to the Office for referral to an IME to address the extent of appellant's impairment due to atrophy, as well as the appropriateness of any pain-related impairment.

[1] The award covered a period of 25.9 weeks from July 14, 2005 through January 11, 2006.

[2] Dr. Slutsky is Board-certified in occupational medicine.

[3] The Office selected Dr. Glenn to resolve a perceived conflict in medical opinion between its DMA, Dr. Henry J. Magliato, and appellant's physician, Dr. David Weiss, a Board-certified orthopedist. Dr. Magliato and Dr. Weiss agreed there was at least 13 percent lower extremity impairment due to right thigh (2.5cm) atrophy. However, Dr. Magliato disagreed with Dr. Weiss' inclusion of an additional three percent impairment for pain. Dr. Magliato noted that pain had not been quantified or documented with the appropriate questionnaire.

Dr. Jatin D. Gandhi, a Board-certified orthopedic surgeon and IME, examined appellant on July 22, 2008 and diagnosed status post operative ACL reconstruction. Appellant's complaints included intermittent -- "off and on" -- right knee pain, difficulty kneeling, some leg weakness, pain after jogging and pain after sitting for long periods. On physical examination the IME noted there was no laxity of the collateral and cruciate ligaments. Knee range of motion (ROM) was 0 to 130 degrees on the right compared to 0 to 145 on the left, without any associated pain. Thigh circumference on the right side was 52 cm compared to 53.5 cm on left. Appellant's right calf diameter was 43 cm compared to 44 cm on the left side. Based on the reported thigh and calf measurements, the IME found 1.5 cm atrophy of the right quadriceps and 1 cm atrophy of the right calf muscle. The IME explained that appellant's current disability consisted of pain in the knee, mild stiffness and atrophy of the quadriceps and calf muscles. In calculating appellant's impairment, the IME factored in a 20 degree loss of flexion (0 percent), 1 cm calf muscle atrophy (3 percent), 1.5 cm quadriceps muscle atrophy (6 percent) and right knee pain (3 percent), for an overall right lower extremity impairment of 12 percent. He justified including a separate pain-related impairment because appellant's pain was reportedly not addressed by the atrophy method of rating impairment.

On August 15, 2008 Dr. Magliato reviewed the IME's July 22, 2008 report and concurred with his finding of 12 percent impairment of the right lower extremity.

On September 16, 2008 the Office awarded an additional three percent impairment of the right lower extremity.[4] By decision dated April 9, 2009, the Branch of Hearings and Review affirmed the Office's September 16, 2008 schedule award.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[5] 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 under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[6] Effective February 1, 2001, schedule awards are determined in accordance with the A.M.A., *Guides* (5th ed. 2001).[7]

The Act and implementing regulations provide for the reduction of compensation for subsequent injury to the same scheduled member.[8] Benefits payable under 5 U.S.C. § 8107(c)

[4] The award covered a period of 8.6 weeks.

[5] For a total loss of use of a leg, an employee shall receive 288 weeks' compensation. 5 U.S.C. § 8107(c)(2) (2006).

[6] 20 C.F.R. § 10.404.

[7] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003).

[8] 5 U.S.C. § 8108; *see* 20 C.F.R. § 10.404(c).

shall be reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[9]

The Act further provides that, if there is disagreement between the physician making the examination for the Office and the employee's physician, the Office shall appoint a third physician who shall make an examination.[10] A physician selected by the Office to serve as an impartial medical examiner should be free to exercise his or her judgment independently.[11] The Office's procedures for selecting impartial medical examiners were designed to provide safeguards against any possible appearance that the selected physician's opinion is biased.[12]

The Federal (FECA) Procedure Manual provides that the selection of referee physicians (IMEs) is made through a "strict rotational system" using appropriate medical directories.[13] According to the procedure manual, the Physicians' Directory System (PDS) should be used for selecting IMEs 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]

The procedure manual provides that the services of all available and qualified Board-certified specialists will be used as far as possible to eliminate any inference of bias or partiality.[17] This is accomplished by selecting specialists in "alphabetical order" as listed in the roster chosen under the specialty and/or subspecialty heading in the appropriate geographic area, and repeating the process when the list is exhausted.[18]

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[9] *Id*. at § 10.404(c)(1), (2).

[10] 5 U.S.C. § 8123(a); *Shirley L. Steib*, 46 ECAB 309, 317 (1994). Where the Office has referred the claimant to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight. *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

[11] *T.P.*, 58 ECAB 524, 526-27 (2007).

[12] *Id.*

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

[14] *Id.*

[15] *Id.* at Chapter 3.500.7.

[16] *Id*.

[17] *Id.* at Chapter 3.500.4(b)(1).

[18] *Id.*

ANALYSIS

The Office hearing representative properly found there was a conflict of medical opinion between appellant's physician, Dr. Weiss, and the Office referral physician, Dr. Glenn. Because of this conflict, the Office referred appellant to an IME to resolve the issue of the extent of his right lower extremity permanent impairment.[19]

On appeal, counsel challenges the Office's selection of Dr. Gandhi as the IME. The Office selected Dr. Gandhi after bypassing another Board-certified orthopedic surgeon, Dr. "W. [Scott] Williams." When a physician is bypassed, the Office is required to provide a reason.[20] The Office contacted Dr. Williams' office on June 26, 2008 and apparently he was unable to schedule appellant in a timely fashion. The Office's reported reason for bypassing Dr. Williams was because "the earliest [appointment was] too far into the future."[21] Within a matter of minutes after bypassing Dr. Williams, the Office contacted Dr. Gandhi's office and was able to schedule an appointment for July 22, 2008. The procedure manual provides that, if an appointment with the physician identified by PDS cannot be scheduled within 60 days, due to the physician's schedule or seasonal travel conditions, the Office may select another physician within the same or a nearby geographical area.[22]

Counsel argued that the Office's "too far into the future" rationale for bypassing Dr. Williams was inappropriate because it left too much discretion to the Office in determining whether an appointment could be scheduled quickly enough. The Board notes that the Office is not divested of all discretionary authority when selecting an IME. In fact, the procedure manual recognizes that the Office's "guidelines allow for discretion in arranging referee examinations...."[23] While utilizing the PDS on a strictly rotational basis is the ideal method for selecting an IME, the procedure manual indicates that in certain situations the Office may need to use a modified means of selecting an IME.[24]

The record includes an internal Office memorandum -- IME referral form -- with the following notation: "<u>REMAND</u> [PLEASE] EXPEDITE."[25] As noted, the Office bypassed Dr. Williams on June 26, 2008 because his earliest available appointment was "too far into the future." It has the discretion to select another physician when the PDS-identified physician cannot schedule the employee in a timely fashion. Whether Dr. Williams' first available

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[19] 5 U.S.C. § 8123(a); *Shirley L. Steib*, *supra* note 10.

[20] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations,* Chapter 3.500.7(d)(4).

[21] The record does not indicate the precise date when Dr. Williams would have been available to examine appellant.

[22] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations,* Chapter 3.500.7(d)(3)(b).

[23] *Id.* at Chapter 3.500.7(d)(4).

[24] *Id.* at Chapter 3.500.7(d).

[25] The decision to expedite appellant's case was likely in response to counsel's June 10, 2008 letter reminding the Office that the case had been remanded by the hearing representative for further medical development.

appointment was more than 60 days from the June 26, 2008 request is unclear. However, what is clear is that the Office chose to expedite appellant's case, and Dr. Gandhi was able to see him within four weeks' time.

Appellant's counsel believed the decision to bypass Dr. Williams was "inappropriate" because the Office exercised "too much discretion." The question is not whether the Office has "too much discretion," but whether the Office abused its discretion in this instance.[26] Counsel has not argued, nor does the record establish that the Office abused its discretion when it bypassed Dr. Williams because of his limited availability.[27] The Board notes that the Office properly documented its reason for bypassing Dr. Williams and then proceeded to select Dr. Gandhi through the PDS. Accordingly, the Board finds no reversible error with respect to the Office's designation of Dr. Gandhi as the IME. In addition to challenging Dr. Gandhi's selection as the IME, counsel also challenged the substance of his July 22, 2008 impairment rating. Before addressing these specific arguments, the Board will focus its immediate attention on another one of counsel's procedural arguments.

Appellant's counsel took exception to the Office's August 2008 referral of the case to Dr. Magliato. As previously noted, Dr. Magliato reviewed the IME's July 22, 2008 report and concurred with the 12 percent impairment rating. Counsel argued that because Dr. Magliato had previously reviewed the case and "was part of the medical opinion that established the initial conflict," he should not be part of the resolution of the conflict. Appellant's counsel is correct that a DMA who played a role in creating a conflict in medical opinion should not subsequently review the findings of the IME assigned to resolve that same conflict.[28] However, in this particular instance, Dr. Magliato was not part of the medical conflict that Dr. Gandhi was assigned to resolve. The Office initially declared a conflict in medical opinion between appellant's physician, Dr. Weiss and Dr. Magliato in his capacity as DMA. However, the hearing representative subsequently found that there was no true conflict between these two physicians. Instead, the hearing representative determined there was an unresolved conflict between Dr. Weiss and Dr. Glenn, who the Office initially assigned to resolve the purported conflict between Dr. Weiss and Dr. Magliato. Thus, contrary to counsel's argument Dr. Magliato was not "part of the medical opinion that established the initial conflict in medical

[26] Abuse of discretion is generally shown through proof of manifest error, a clearly unreasonable exercise of judgment, or actions taken which are clearly contrary to logic and probable deductions from established facts. *J.C.* 58 ECAB 594, 606 (2007).

[27] However, even if Dr. Williams was able to see appellant within 60 days of the Office's June 26, 2008 request, there is nothing inherently unreasonable with the Office's decision to expedite the processing of appellant's case on remand.

[28] The procedure manual provides that after an Office-directed medical examination the reports should be routinely referred to the DMA for review only where determination of a schedule award is involved. The DMA should note any medical errors found, such as improper application of the A.M.A., *Guides*. Where a conflict in medical evidence is involved, the case should be referred to the DMA only if a medical interpretation is required. The procedure manual further provides that "[n]o report which addresses a conflict should be reviewed by a DMA who was involved in creating the conflict [because] bias might be inferred from this action." Arrangements must be made to have another DMA or a physician acting as a consultant to the Office review the file. Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations,* Chapter 3.500.5(c)(1).

evidence." Because Dr. Gandhi did not resolve a conflict involving Dr. Magliato, the Office was free to assign the case to Dr. Magliato for purposes of reviewing the IME's July 22, 2008 report.

Returning to Dr. Gandhi's 12 percent impairment rating, appellant's counsel argued that the IME failed to provide medical reasons for his atrophy ratings of the right calf (3 percent) and right quadriceps (6 percent). Counsel also argued that Dr. Gandhi did not provide any ROM ratings despite the fact that there was loss of motion in the right leg. With respect to loss of right knee flexion, Dr. Gandhi noted that appellant had a restriction of 20 degrees. Although the IME recognized appellant's limited ROM, the 20 degree loss was insufficient to warrant a separate impairment rating. For appellant to have received a rating for loss of knee flexion, he would have had to have exhibited less than 110 degrees of flexion.[29] According to Dr. Gandhi, appellant's right knee ROM was 0 to 130 degrees. Consequently, appellant is not entitled to an additional rating for loss of right knee flexion.

As to Dr. Gandhi's award of three percent impairment for right calf atrophy, he clearly explained that there was a 1 cm difference between appellant's right and left calf (43 cm vs. 44 cm). Under Table 17-6, A.M.A., *Guides* 530, a 1 to 1.9 cm difference in calf circumference represents a mild impairment, with a corresponding lower extremity rating of three to eight percent. Because appellant's 1 cm difference was at the low end of the spectrum (1 to 1.9 cm), it represented only three percent impairment. Table 17-6 also applies to muscle atrophy involving the thigh or quadriceps. Dr. Gandhi found a 1.5 cm difference between the right and left quadriceps (52 cm vs. 53.5 cm). Similar to calf atrophy, a 1 to 1.9 cm difference in thigh circumference represents a mild impairment, and a corresponding lower extremity rating of three to eight percent. Appellant had a 1.5 cm difference, which fell in the middle of the 1 to 1.9 cm range for a mild impairment. According to Dr. Gandhi, the 1.5 cm difference was mathematically proportionate to a six percent impairment of the right lower extremity.[30] Contrary to counsel's argument on appeal, Dr. Gandhi provided adequate reasoning for his atrophy-based impairment ratings. He identified the relevant findings on physical examination, referenced the applicable section of the A.M.A., *Guides* and explained how he apportioned the individual calf and quadriceps ratings based on the measurements obtained.

Appellant does not take issue with the Office's decision to include a separate award for pain (three percent). Dr. Weiss included a similar rating in his July 14, 2005 report, but neglected to explain why it was appropriate. The A.M.A., *Guides* limit the circumstances under which a pain-related impairment may be assessed under Chapter 18. If an impairment can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*, such as Chapters 13, 16 and 17, then pain-related impairments should not be assessed using Chapter 18.[31] The A.M.A., *Guides* provide for an incremental adjustment of

[29] A.M.A., *Guides* 537, Table 17-10.

[30] Comparing the 0.9 cm range in atrophy (1 to 1.9 cm) with the five degree range of impairment (three to eight percent), Dr. Gandhi calculated that for every 0.1 cm increase in atrophy there was a corresponding 0.56 percent increase ($5 \div 9 = .555$) in impairment above the base rating of 3 percent. Appellant's 1.5 cm atrophy was an additional 0.5 cm above the base impairment of three percent. This increase represented an additional 2.8 percent impairment ($5 \times .56$), which Dr. Gandhi rounded-up to 3 percent, for a total right thigh atrophy impairment of 6 percent.

[31] A.M.A., *Guides* 571-72, Section 18.3b.

up to three percent for pain when the conventional rating system does not adequately encompass the burden of the individual's condition. Where the pain-related impairment appears to increase the burden of the individual's condition "slightly," the physician can increase the percentage found under the conventional rating system by up to three percent.[32] Dr. Gandhi and Dr. Slutsky both explained that an additional three percent for pain-related impairment was justified because the atrophy-based rating under Chapter 17 did not account for appellant's right knee pain.

The IME's July 22, 2008 impairment rating conforms to the A.M.A., *Guides* (5th ed. 2001). The Office properly accorded determinative weight to Dr. Gandhi's findings, as he was the IME.[33] As outlined above, Dr. Gandhi's opinion is sufficiently well reasoned and based upon a proper factual background. Accordingly, Dr. Gandhi's impairment rating represents the weight of the medical evidence regarding the extent of appellant's right lower extremity impairment. Appellant has not submitted any credible medical evidence indicating he has greater than 12 percent impairment of the right lower extremity. The Board finds that the Office properly awarded appellant an additional three percent impairment of the right lower extremity.[34]

CONCLUSION

Appellant has not demonstrated that he has greater than 12 percent impairment of the right lower extremity.

[32] *Id.* at 573, Section 18.3d; *Id*. at 574, Figure 18-1.

[33] *Gary R. Sieber*, *supra* note 10.

[34] The Office correctly reduced the latest award by nine percent to reflect appellant's March 14, 2007 schedule award. *See* 5 U.S.C. § 8108; 20 C.F.R. § 10.404(c). Although the March 14, 2007 decision was later set aside, the Office had already paid appellant 25.9 weeks' compensation.

ORDER

IT IS HEREBY ORDERED THAT the April 9, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 1, 2010
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board