United States Department of Labor
Employees' Compensation Appeals Board

M.L., Appellant	)	
and	)	**Docket No. 13-1602**
	)	**Issued: December 9, 2013**
DEPARTMENT OF THE AIR FORCE, AIR MOBILITY COMMAND, RANDOLPH AIR FORCE BASE, TX, 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, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 27, 2013 appellant, through his attorney, filed a timely appeal from the March 14, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 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 met his burden of proof to establish that he has more than 25 percent permanent impairment of his left leg, for which he received a schedule award.

FACTUAL HISTORY

OWCP accepted that on June 4, 2009 appellant, then a 56-year-old aircraft engine mechanic, sustained closed fractures of his left ribs and left tibia due to a work-related

[1] 5 U.S.C. §§ 8101-8193.

motorcycle accident.[2] On June 5, 2009 he underwent left leg surgery, including open reduction internal fixation and lateral meniscus repair. On January 6, 2010 appellant underwent arthroscopic surgery of his left knee in the form of a total left knee replacement. The procedures were authorized by OWCP.

In a July 15, 2010 report, Dr. Nicholas P. Diamond, an attending Board-certified orthopedic surgeon, determined that appellant had 31 percent permanent impairment of his left leg under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009). He rated appellant's left leg impairment for his total left knee replacement under Table 16-3 (Knee Regional Grid) on page 511 of the sixth edition. Dr. Diamond applied grade modifiers to the class 3 default value (fair result) for this rating, finding the following values: grade modifier 1 for Functional History (GMFH), grade modifier 2 for Physical Examination (GMPE) and grade modifier 4 for Clinical Studies (GMCS). He advised that appellant reached maximum medical improvement on the date of his examination, July 15, 2010.

On May 26, 2011 Dr. Robert Y. Pick, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, determined that appellant had 25 percent permanent impairment of his left leg under the standards of the sixth edition of the A.M.A., *Guides.* Based on Table 16-3, appellant's total left knee replacement fell under the class 2 default value (good result) rather than the class 3 default value indicated by Dr. Diamond. Dr. Pick found that appellant had a grade modifier 1 for functional history, grade modifier 2 for physical examination and grade modifier 4 for clinical studies and concluded that appellant had 25 percent left leg impairment. He agreed that appellant reached maximum medical improvement on July 15, 2010.

In a November 30, 2011 decision, OWCP granted appellant a schedule award for 25 percent permanent impairment of his left leg. The award ran for 72.0 weeks from July 15, 2010 to November 30, 2011 and was based on the opinion of Dr. Pick.

In a February 13, 2012 decision, OWCP's hearing representative determined that there was a conflict in the medical opinion as to the extent of appellant's left leg impairment between Dr. Diamond and Dr. Pick. She remanded the case for referral of appellant to an impartial medical specialist in order to resolve the conflict.

On remand, OWCP referred appellant to Dr. George P. Glenn, Jr., a Board-certified orthopedic surgeon, for an impartial medical examination and opinion on the extent of his left leg impairment.

In a June 14, 2012 report of his examination on that date, Dr. Glenn determined that appellant had a 21 percent permanent impairment of his left leg under the standards of the sixth edition of the A.M.A., *Guides.* He detailed appellant's medical history, including his diagnostic testing results and multiple surgeries. Dr. Glenn questioned appellant about his activities around the house in terms of the activities of daily living. Appellant acknowledged that he performed housework and laundry and that he was able to take care of his hygiene and dressing. He did comment that he had some difficulty going up and down stairs and that he could not run.

[2] Diagnostic testing revealed that appellant's left third through eighth ribs were fractured.

Dr. Glenn had appellant fill out a Pain Disability Questionnaire. In the course of filling out the form, appellant noted that he was able to do the work inside and outside his house and able to carry out his work activities which included climbing ladders.[3] He did not register any complaints about having difficulties with household duties or difficulties with standing, walking or sitting. Appellant lifted items overhead, grasped objects and could reach for things. Dr. Glenn stated that the Pain Disability Questionnaire appellant completed showed greater pain than his reported activity level suggested. He stated, "Under all of these circumstances, I cannot accept the Pain Disability Questionnaire as being valid." Dr. Glenn noted that appellant complained of pain to his low back and left ribcage. Appellant indicated that this left medial meniscectomy surgery had completely healed and that he no residuals of the surgery.

Dr. Glenn reported examination findings for appellant's left leg. Appellant showed no evidence of a limp and responded that he only limped on occasion. In the standing position, he showed a perfectly normal physiologic angle of the tibiofemoral joint without any evidence of varus or valgus either on the right or the left and it was noted that the left was equal and symmetrical to the right. Dr. Glenn found that appellant could perform about a third of a squat and that he could easily heel and toe walk and did so without any complaints of pain. Appellant had 140 degrees of active knee flexion on the right and approximately 110 degrees on the left. Extension was full and there was no longer any evidence of a left knee flexion contracture. Appellant had a very slight varus instability upon flexion on the left which was painless and not the least unusual with total knee anthroplasty. Dr. Glenn noted that, with the left knee in full extension, appellant had complete stability both medially and laterally. In the sitting position, hip flexion could be carried out to about 30 degrees bilaterally and with strength testing all of the muscles about the hip rated a 5/5. The quadriceps and hamstring muscle groups also rated a 5/5 and muscle strength testing of the ankles and feet again demonstrated a 5/5. Appellant's muscle tone and strength involving all muscles of both legs were excellent and rated a universal 5/5 and he failed to show any neurologic deficits. His patellar and Achilles reflexes were active and symmetrical and there were no areas of muscle atrophy. Dr. Glenn noted that appellant's left knee prosthetic device was in excellent position with absolutely no evidence of any loosening or abnormal bone wearing. Using Table 16-3 on page 511 of the sixth edition of the A.M.A., *Guides,* appellant's total left knee replacement fell under a class 2 value of 25 percent because the postsurgery knee was in good position, stable and functional as evidenced by the current examination and x-rays. Dr. Glenn found that, per Table 16-6 through Table 16-8 on pages 515 through 520, appellant had a grade modifier 1 for functional history, a grade modifier 1 for physical examination and a grade modifier 1 for clinical studies (due to the slight varus play with the left knee in flexion).[4] He found the Net Adjustment Formula on page 521 yield an adjustment modifier of minus 3. It was only possible to move two places to the left of the default value of Table 163, which meant that appellant had a total left leg impairment of 21 percent. Dr. Glenn advised that appellant reached maximum medical improvement on July 15, 2010.

On August 6, 2012 Dr. Henry J. Magliato, a Board-certified orthopedic surgeon serving as an OWCP referral physician, reviewed Dr. Glenn's impairment rating. He agreed that the

[3] A copy of the questionnaire is attached to Dr. Glenn's report.

[4] With respect to his modifier determinations, Dr. Glenn indicated that he was using the results of his interview with appellant rather than the Pain Disability Questionnaire.

June 14, 2012 evaluation showed that appellant had 21 percent permanent impairment of his left leg. Therefore, appellant did not have more than a 25 percent left impairment, for which he was previously rated.

In an August 27, 2012 decision, OWCP determined that appellant had not shown that he had more than 25 percent permanent impairment of his left leg. It found that the weight of the medical evidence rested with the well-rationalized opinion of Dr. Glenn, the impartial medical specialist.

Appellant requested a video hearing with an OWCP hearing representative. During the December 27, 2012 hearing, counsel argued that OWCP should ask Dr. Glenn to clarify his opinion. He contended that the physician did not adequately discuss how appellant's loss of motion, pain, instability or diminished ability to engage in daily living activities affected the impairment rating.

In a March 14, 2013 decision, OWCP's hearing representative affirmed the August 27, 2012 decision. She found that Dr. Glenn provided a proper rating of appellant's left leg impairment.

LEGAL PRECEDENT

The schedule award provision of FECA[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, FECA 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] For OWCP decisions issued on or after May 1, 2009, the sixth edition of the A.M.A., *Guides* (6th ed. 2009) is used for evaluating permanent impairment.[8]

In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the knee, the relevant portion of the leg for the present case, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[9] After the class of diagnosis (CDX) is determined from the Knee Regional Grid (including identification of a

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404 (1999).

[7] *Id*.

[8] *See* FECA Bulletin No. 9-03 (issued March 15, 2009). For OWCP decisions issued before May 1, 2009, the fifth edition of the A.M.A., *Guides* (5th ed. 2001) is used.

[9] *See* A.M.A., *Guides* 509-11 (6th ed. 2009).

default grade value), the Net Adjustment Formula is applied using the grade modifier for GMFH, GMPE and GMCS. The Net Adjustment Formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[11]

Section 8123(a) of FECA provides in pertinent part: "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."[12] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.[13] In situations where there exist opposing medical reports of virtually equal weight and rationale and 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 upon a proper factual background, must be given special weight.[14]

ANALYSIS

OWCP accepted that on June 4, 2009 appellant sustained closed fractures of his left ribs and left tibia due to a work-related motorcycle accident. On June 5, 2009 he underwent left leg surgery, including open reduction internal fixation and lateral meniscus repair. On January 6, 2010 appellant underwent arthroscopic surgery of his left knee in the form of a total left knee replacement. In a November 30, 2011 decision, OWCP granted him a schedule award for 25 percent permanent impairment of his left leg.

The Board finds that a conflict in the medical opinion arose regarding the extent of appellant's left leg impairment between Dr. Diamond, an attending Board-certified orthopedic surgeon, and Dr. Pick, a Board-certified orthopedic surgeon serving as an OWCP medical adviser.[15] OWCP properly referred appellant to Dr. George P. Glenn, Jr., a Board-certified orthopedic surgeon, for an impartial medical examination and opinion on the extent of his left leg impairment. In a June 14, 2012 report, Dr. Glenn determined that appellant had 21 percent permanent impairment of his left leg under the standards of the sixth edition of the A.M.A., *Guides.*

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[10] *Id.* at 515-22.

[11] *Id.* at 23-28.

[12] 5 U.S.C. § 8123(a).

[13] *William C. Bush*, 40 ECAB 1064, 1975 (1989).

[14] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

[15] *See supra* note 12. In a July 15, 2010 report, Dr. Diamond determined that appellant had a 31 percent permanent impairment of his left leg under the standards of the sixth edition of the A.M.A., *Guides.* In contrast, Dr. Pick determined on May 26, 2011 that appellant had a 25 percent permanent impairment of his left leg under the standards of the sixth edition of the A.M.A., *Guides.*

In a June 14, 2012 report, Dr. Glenn determined that appellant had 21 percent permanent impairment of his left leg under the standards of the sixth edition of the A.M.A., *Guides.* He detailed appellant's medical history including his diagnostic testing results and multiple surgeries. Dr. Glenn extensively questioned appellant about the level of his physical activities, including those of daily living. He properly considered the results of this interview over a Pain Disability Questionnaire which he stated showed greater pain than appellant's reported activity level suggested. Dr. Glenn listed the findings on examination which showed that appellant had no muscle strength loss or neurological deficits in his left leg. Appellant had good motion and stability in his left leg, except for slight varus instability upon flexion on the left which was painless and not the least unusual with total knee arthroplasty. Dr. Glenn indicated that, per Table 16-3 on page 511 of the sixth edition of the A.M.A., *Guides,* appellant's total left knee replacement fell under a Class 2 value of 25 percent because the postsurgery knee was in good position, stable and functional as evidence by the current examination and x-rays. He explained why he found that appellant had a grade modifier 1 for functional history, a grade modifier 1 for physical examination and a grade modifier 1 for clinical studies. Dr. Glenn properly applied the Net Adjustment Formula and concluded that appellant had a total left knee impairment of 21 percent.

The Board has carefully reviewed the June 14, 2012 impairment rating evaluation of Dr. Glenn and notes that it has reliability, probative value and convincing quality with respect to its conclusions regarding appellant's left leg impairment. Dr. Glenn provided a thorough factual and medical history and accurately summarized the relevant medical evidence.[16] He properly applied the standards of the sixth edition of the A.M.A., *Guides* to find that appellant had a 21 percent permanent impairment of his left leg, which meant that he had no more than the 25 percent impairment for which he had already been compensated. Dr. Glenn's opinion represents the weight of the medical evidence with respect to appellant's left leg impairment.[17]

On appeal, counsel argued that OWCP should have Dr. Glenn clarify his opinion as he did not adequately discuss how appellant's loss of motion, pain, instability and diminished ability to engage in daily living activities affected the impairment rating. The Board notes that Dr. Glenn fully considered all these matters in rendering his impairment rating.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he has more than 25 percent permanent impairment of his left leg, for which he received a schedule award.

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[16] *See Melvina Jackson*, 38 ECAB 443, 449-50 (1987); *Naomi Lilly*, 10 ECAB 560, 573 (1957).

[17] *See supra* note 14. Moreover, on August 6, 2012, Dr. Magliato, a Board-certified orthopedic surgeon serving as an OWCP referral physician, concurred that Dr. Glenn properly rated impairment under the A.M.A., *Guides*.

ORDER

IT IS HEREBY ORDERED THAT the March 14, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 9, 2013
Washington, DC

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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