United States Department of Labor
Employees' Compensation Appeals Board

W.M., Appellant	)	
and	)	**Docket No. 15-342**
	)	**Issued: April 6, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Richmond, VA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 26, 2014 appellant filed a timely appeal from a September 24, 2014 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 has a ratable impairment of the right lower extremity due to his accepted right metatarsal injury.

FACTUAL HISTORY

OWCP accepted that on December 6, 2010 appellant, then a 53-year-old city letter carrier, sustained a right foot injury in the performance of duty. Appellant stopped work on December 7, 2010. OWCP accepted appellant's claim for right foot fracture of the fifth

[1] 5 U.S.C. § 8101 *et seq.*

metatarsal and paid wage-loss and medical benefits.[2] Appellant returned to full duty on March 28, 2011.

By letters dated August 31, September 18, and December 18, 2012, appellant requested a second opinion examination and functional capacity examination in order to obtain an impairment rating for his accepted right foot injury. He stated that he could not find a physician to accept his case.

On January 17, 2013 OWCP referred the case, along with a statement of accepted facts, to Dr. Vipool Goradia, a Board-certified orthopedic surgeon, for a second opinion examination in order to determine whether appellant sustained a permanent impairment of his accepted right metatarsal fracture in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) and the date of maximum medical improvement.

In a February 7, 2013 report, Dr. Goradia reviewed appellant's history, including the statement of accepted facts, and noted that appellant sustained a right fifth metatarsal fracture on December 6, 2012. He related appellant's history of bilateral cavus feet, ankle instability, and left foot cyst and noted that appellant continued to complain of pain in both feet related to the chronic problems but not directly related to the healed right fifth metatarsal fracture. Upon examination, Dr. Goradia observed severe fixed cavus deformity of both feet with resultant callus formation and instability of both ankles. He found no tenderness to palpation over the right fifth metatarsal. Dr. Goradia opined that appellant did not have any impairment of the right lower extremity secondary to the previous right fifth metatarsal fracture. He reported that according to the sixth edition of the A.M.A., *Guides*, Chapter 16, page 504, Table 16-2, class 0 (healed without residual) appellant had no ratable impairment. Dr. Goradia stated that appellant reached maximum medical improvement at the time he was cleared to return to full duty on March 28, 2011.

In an April 22, 2013 progress note, Dr. Rodney Harris, a podiatrist, examined appellant for history of chronic bilateral foot and ankle pain related to constant stress on his feet while on active duty causing difficulty walking over the past six years. Upon examination, Dr. Harris observed bilateral palpable posterior tibial pulses and left foot dorsal edema secondary to a sizable ganglionic cyst. He also reported restricted range of motion of both ankles, left greater than right. Muscle strength was normal. Dr. Harris diagnosed pes cavus, hammertoe deformity, and lateral deviation of toes at metatarsalphalangeal joint two to four. He recommended heel lifts bilaterally, physical therapy, steroid injections, and orthotics.

In an April 29, 2013 x-ray report of both feet, Dr. Bruce Sandow, a Board-certified diagnostic radiologist, noted appellant's history of foot fractures. He reported that the x-ray was negative for acute fracture or dislocation. Dr. Sandow observed mild tibiotalar degenerative changes bilaterally and callus formation at the base of the right fifth metatarsal consistent with healed fracture. He diagnosed mild bilateral tibiotalar degenerative changes.

[2] The record reveals that appellant also has an accepted traumatic injury claim for an August 3, 2011 left foot injury (File No. xxxxxx079). The left foot injury is not a subject of this appeal.

In a June 13, 2013 report, Dr. Lawrence A. Manning, an OWCP medical adviser and Board-certified orthopedic surgeon, noted that appellant's claim was accepted for fracture of the fifth metatarsal right foot as a result of a December 6, 2010 employment injury. He reviewed appellant's history, including Dr. Goradia's February 7, 2013 second opinion report. Dr. Manning noted that appellant complained of pain in both feet related to chronic foot and ankle problems but not directly related to his healed right fifth metatarsal fracture. He also reported that appellant had no complaints of pain and no tenderness at the fracture site. Dr. Manning related that medical reports over the months showed a delayed union of appellant's right foot fracture and that a May 12, 2011 x-ray revealed that the fracture was in a healing stage. He stated that, based on the medical records, he concurred that appellant had zero percent partial impairment of the right lower extremity based on the condition of the right fifth metatarsal fracture. Dr. Manning reported a date of maximum medical improvement of March 28, 2011.

In a December 16, 2013 functional capacity evaluation (FCE) form, Wayne MacMasters, a physical therapist, related that appellant worked as a mail carrier and demonstrated the ability to perform the physical demands of the full-duty job with no restrictions. He reported that, according to the sixth edition of the A.M.A., *Guides*, appellant had 16 percent lower extremity impairment and 6 percent whole person impairment.

In a December 16, 2013 impairment rating report, Lisa Brewer, a certified family nurse practitioner, noted that appellant had injuries of the right and left foot. She provided range of motion findings and observed essentially normal motion and strength of the right foot fifth metatarsal. Ms. Brewer reported that according to Table 16-2 of the sixth edition of the A.M.A., *Guides* appellant was class 0 impairment for healed right foot fifth metatarsal with no residual impairment. She opined that there was no objective basis for a permanent impairment rating of the right foot.

On January 7, 2014 appellant filed a claim for a schedule award for his right foot. In a statement, he noted that he was enclosing medical documentation, MRI scans, and x-rays that proved that he had been receiving ongoing medical treatment on his bilateral foot condition throughout the past year. Appellant reported that from August 2012 to May 2013 he was treated by a Dr. Morgan and that he was currently receiving treatment from Dr. Sara Bouraee, a podiatrist who specializes in foot and ankle surgery. He questioned why his claim for his left foot injury was closed and why OWCP was not responding to his written requests and telephone messages.

Appellant submitted an August 8, 2011 x-ray report by Dr. Sandow, who observed a transverse fracture at the base of the fifth metatarsal of the right foot which was consistent with an old ununited fracture. Dr. Sandow also noted preserved joint spaces and pes planus of the right foot. X-ray of the left foot revealed slightly comminuted oblique fracture of the proximal shaft of the fifth metatarsal and mild hallux valgus. Dr. Sandow diagnosed ununited fracture at the base of the right fifth metatarsal and slightly comminuted fracture of proximal left metatarsal.

In a January 17, 2014 decision, OWCP denied appellant's schedule award claim. It found that the medical evidence was insufficient to establish that he sustained any permanent impairment to the right lower extremity causally related to his accepted right fifth metatarsal fracture.

On February 11, 2014 OWCP received appellant's request for a review of the written record. In a February 6, 2014 statement, he noted that Dr. Goradia incorrectly stated that his date of injury was December 6, 2012 when it was December 6, 2010. Appellant also pointed out that he was not treated by a Dr. Roach as Dr. Goradia stated. He further alleged that Dr. Goradia misread his medical records. Appellant submitted various medical records regarding treatment for his left foot and Dr. Goradia's February 7, 2013 report.

Appellant submitted a June 17, 2013 report by Dr. Bouraee who related appellant's history of bilateral foot conditions including ples cavus or club foot, a large soft tissue mass on the dorsal aspect of his left foot, and bilateral fifth metatarsal fractures. Examination of appellant's feet demonstrated pain on range of motion and instability at the lateral subtalar joint. Dr. Bouraee also observed a soft tissue mass over the dorsal medial foot/first metatarsal and second metatarsal approximately. She diagnosed nonunion fracture of fifth metatarsal, foot pain, and cavus deformity of the foot.

In an April 4, 2014 report, Dr. Bouraee related appellant's concerns regarding his bilateral cavus deformity. She noted that he currently denied any pain and had resumed all normal activities. Upon examination, Dr. Bouraee observed painful exotosis on palpation and pain with Chopart's range of motion. She also noted that appellant could bear weight on the lateral border of the foot and that there was a slight limp present.

In a May 15, 2014 neurological report, Dr. Adel A. Boulos-Mikhaiel, a Board-certified neurologist, noted that appellant was referred for evaluation of charcot marie tooth. She related that appellant had a history of feet problems since he was in the military. Dr. Boulos-Mikhaiel stated that appellant worked as a mailman for 15 years and retired due to cavus feet and multiple fractures in his feet and ankles. She reported that appellant had three surgeries to fix a ganglion cyst of the left foot and had two surgeries with screws on the left ankle and foot. Dr. Boulos-Mikhaiel noted that appellant also had a right side fracture that healed without the need for surgery. Upon examination she observed no joint deformities or edema of the extremities.

In a July 2, 2014 progress note, Dr. Bouraee noted appellant's history of chronic bilateral foot pain. She related his complaints of pain on the lateral aspect of the left foot when he walked and hyperkeratotic lesion difficulty wearing shoes. Dr. Bouraee noted that appellant had resumed all normal activities and now complained of back pain which radiated down his leg. Upon examination, she observed nonreducible, cavus foot and hammertoes. Dr. Bouraee reported that appellant's left foot surgical site was stable and nontender.

By decision dated September 24, 2014, an OWCP hearing representative affirmed the January 17, 2014 decision denying appellant's schedule award claim for his right foot metatarsal fracture.

LEGAL PRECEDENT

The schedule award provision of FECA[3] and its implementing regulations set forth the number of weeks of compensation payable to employees sustaining permanent impairment from

[3] 5 U.S.C. §§ 8101-8193.

loss or loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized 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 OWCP as the appropriate standards for evaluating schedule losses.[4]

The sixth edition requires identifying the impairment Class of Diagnosis condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[5] Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[6]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the medical adviser for an opinion concerning the nature and percentage in accordance with the A.M.A., *Guides* with the medical adviser providing rationale for the percentage of impairment.[7]

ANALYSIS

OWCP accepted that appellant sustained a fifth metatarsal fracture of the right foot on December 6, 2010. On January 7, 2014 appellant requested a schedule award for the right foot. In decisions dated January 23 and September 24, 2014, OWCP denied appellant's schedule award claim finding that the medical evidence did not establish permanent impairment of his right foot in accordance with the sixth edition of the A.M.A., *Guides.* The Board affirms this finding.

In order to determine the extent and degree of any employment-related impairment of appellant's right lower extremity, at appellant's request, OWCP referred him to Dr. Goradia for a second opinion evaluation. Dr. Goradia examined him on February 7, 2013 and concluded that he did not have a ratable impairment of the right lower extremity. He reviewed appellant's history and noted a chronic history of bilateral cavus feet, chronic ankle instability, and left foot cyst. Dr. Goradia also noted that on December 6, 2012 appellant sustained a right fifth metatarsal fracture, which subsequently healed.[8] Upon examination, he observed that the right foot had no surgical incisions and was nontender to palpation over the right fifth metatarsal.

[4] 20 C.F.R. § 10.404 (1999); *see also Jacqueline S. Harris,* 54 ECAB 139 (2002).

[5] A.M.A., *Guides* 494-531.

[6] *See R.V.,* Docket No. 10-1827 (issued April 1, 2011).

[7] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Payment of Compensation and Schedule Awards,* Chapter 2.808.6 (February 2013).

[8] The Board notes that, although Dr. Goradia incorrectly referenced a December 6, 2012 right foot injury instead of a December 6, 2010 right foot injury, this mistake appears to be a minor typographical error.

Dr. Goradia indicated that according to Table 16-2, page 504, of the A.M.A., *Guides* appellant was classified as class 0 for a healed metatarsal fracture without residual. He reported that appellant reached maximum medical improvement on March 28, 2011, the date that he was cleared to return to work.

In accordance with its procedures, OWCP referred the evidence of record to its medical adviser, Dr. Manning, who reviewed Dr. Goradia's February 7, 2013 report and agreed that appellant had no ratable impairment of the right lower extremity based on the accepted condition of fifth metatarsal fracture of the right foot. He noted that appellant walked with an antalgic gait and had no tenderness about the right fifth metatarsal.

The Board notes that appellant submitted additional medical reports to OWCP in support of his schedule award claim following Dr. Goradia's evaluation. While the reports from Drs. Harris, Sandow, Bouraee, and Boulos-Mikhaiel discuss apppellant's chronic bilateral foot conditions, none of these physicians provided an evaluation of appellant's permanent impairment for the accepted right foot metatarsal fracture, pursuant to the A.M.A., *Guides*.

The only other evaluations of appellant's permanent impairment came from physical therapist, Mr. MacMasters, in his report dated December 16, 2013, and from Nurse Practitioner Brewer in her December 16, 2013 report. Certain healthcare providers, such as physician assistants, nurse practitioners, physical therapists, and social workers are not considered physicians as defined under FECA, pursuant to 5 U.S.C. § 8101(2). Consequently, their medical findings and/or opinions are insufficient for purposes of establishing entitlement under FECA.

To support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred (date of maximum medical improvement), describes the impairment in sufficient detail so that it can be visualized on review and computes the percentage of impairment in accordance with the A.M.A., *Guides*.[9] The only medical report that meets these requirements is the report from Dr. Goradia and establishes that appellant does not have a permanent impairment of the right lower extremity caused by the accepted injury. Therefore, appellant has not established a permanent impairment of his right lower extremity for which he should receive a schedule award.

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 has not established a permanent impairment of his right lower extremity for which he should receive a schedule award.

[9] *See J.L.*, Docket No 13-2124 (issued April 21, 2014).

ORDER

IT IS HEREBY ORDERED THAT the September 24, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 6, 2015
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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