United States Department of Labor
Employees' Compensation Appeals Board

R.R., Appellant	)	
and	)	**Docket No. 14-998**
	)	**Issued: August 26, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Oklahoma City, OK, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 20, 2014 appellant filed a timely appeal from a February 24, 2014 decision of the Office of Workers' Compensation Programs (OWCP) regarding a schedule award. 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.[2]

ISSUE

The issue is whether appellant established that she sustained more than a seven percent permanent impairment of the left lower extremity, for which she received a schedule award.

On appeal, appellant contends that a third-party reviewed her doctor's impairment rating and found it to be correct. She further contends that OWCP's referral physician only saw her for

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the issuance of the February 24, 2014 OWCP decision, appellant submitted new evidence. The Board is precluded from reviewing evidence which was not before OWCP at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c)(1).

15 minutes and hardly assessed her physically and requests a third opinion or a referee examination.

FACTUAL HISTORY

OWCP accepted that appellant, then a 55-year-old customer services supervisor, sustained a left knee and leg sprain and a fracture of the left ankle while ascending stairs to deliver a parcel on April 7, 2012. Appellant was placed on the periodic rolls and returned to full-time, light-duty work with restrictions effective June 4, 2012.

On November 15, 2013 appellant filed a claim for a schedule award and submitted an October 21, 2013 report from Dr. J. Arden Blough, a Board-certified family practitioner, who found that appellant had a 13 percent permanent impairment of the left lower extremity "due to chronic recurrent foot pain with weakness noted throughout range of motion" based on Table 16-2[3] of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). Dr. Blough placed her in class 1 based on his diagnosis of fracture of fibula with mild motion deficits impairment with a mid-range default value of nine percent impairment. He assigned a grade modifier of 2 for Functional History (GMFH), Clinical Studies (GMCS) and Physical Examination (GMPE) for moderate and consistent palpatory findings. Using the net adjustment formula of (GMFH - diagnosed condition (CDX)) + (GMPE - CDX) + (GMCS - CDX), Dr. Blough found that (2-1) + (2-1) + (2-1) resulted in a net grade modifier of 3, resulting in an impairment class 1, grade E, equaling a 13 percent permanent impairment of the left foot/ankle. He further opined that appellant had a seven percent permanent impairment of the left lower extremity "due to chronic recurrent foot pain with weakness noted throughout range of motion" based on Table 16-2[4] of the A.M.A., *Guides*. Dr. Blough placed her in class 1 based on his diagnosis of tear of the anterior talofibular ligament with mild motion deficits impairment with a mid-range default value of two percent impairment. He assigned a grade modifier of 2 for physical examination for moderate and consistent palpatory findings and a grade modifier of 3 for clinical studies. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), Dr. Blough found that (n/a) + (2-1) + (3-1) resulted in a net grade modifier of 3, resulting in an impairment class 1, grade E, equaling a seven percent permanent impairment of the left foot/ankle. He determined that appellant had a three percent permanent impairment to the left lower extremity "due to chronic recurrent foot pain with weakness noted throughout range of motion" based on Table 16-2[5] of the A.M.A., *Guides*. Dr. Blough placed her in class 1 based on his diagnosis of "'all other tendon tear' (split tear of the peroneus brevis tendon)" with mild motion deficits impairment with a mid-range default value of two percent impairment. He assigned a grade modifier of 2 for physical examination for moderate and consistent palpatory findings and a grade modifier of 2 for clinical studies. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), Dr. Blough found that (n/a) + (2-1) + (2-1) resulted in a net grade modifier of 2,

[3] Table 16-2, pages 501-08 of the sixth edition of the A.M.A., *Guides* is entitled *Foot and Ankle Regional Grid -- Lower Extremity Impairments.*

[4] *Id.*

[5] *Id.*

resulting in an impairment class 1, grade E, equaling a three percent permanent impairment of the left foot/ankle. He combined the total left lower extremity impairments using the Combined Values Chart on page 604 of the A.M.A., *Guides* yielding a 21 percent permanent impairment of the left lower extremity.[6] Dr. Blough determined that appellant had reached maximum medical improvement.

On November 27, 2013 Dr. Ronald Blum, a Board-certified orthopedic surgeon and OWCP medical adviser, reviewed the medical evidence of record and a statement of accepted facts. He reviewed Dr. Blough's October 21, 2013 report and explained that he described a fibular fracture but used tibial fracture as it was near the site of the fibular fracture and opined that "the impairment following a healed fracture of the fibula and a healed fracture of the tibia cannot be equated." Therefore the use of tibial fracture to determine impairment in appellant's case was erroneous. Regarding the diagnosis of tear of the anterior talofibular ligament, Dr. Blum stated that Dr. Blough recommended a seven percent permanent impairment but was not clear as to how he arrived at that figure. Regarding Dr. Blough's diagnosis of other torn tendons, he explained that OWCP had not accepted this condition in appellant's case. Dr. Blum concluded that Dr. Blough's report was insufficient to determine appellant's permanent impairment and recommended a second opinion evaluation to obtain an impairment evaluation from an appropriate Board-certified specialist.

OWCP referred appellant, together with a statement of accepted facts and medical records, to Dr. Michael Shawn Smith, a Board-certified physiatrist, for a second opinion evaluation. In a January 8, 2014 report, Dr. Smith diagnosed left mid-shaft fibular fracture and distal fibular nondisplaced fracture near the malleolus, peroneus brevis tendon tear, peroneus longus tendinitis and anterior talofibular ligament rupture with residual pain. He indicated that Table 16-2,[7] page 501, of the A.M.A., *Guides* provided for strain tendinitis and ruptured tendons of the ankle. Appellant did not have significant motion deficits and as a result Dr. Smith placed her in a class 1, default grade C and assigned a grade modifier of 1 for functional history and clinical studies. Dr. Smith opined that she had a one percent permanent impairment of the anterior talofibular ligament which was completely ruptured and a one percent permanent impairment for the peroneus brevis tendon which remained tender with some weakness. Regarding the fibular fracture, he found that the closest diagnosis was a malleolar ankle fracture as it best described the fibular fracture near the ankle and was consistent with the type of injuries and trauma to the surrounding ligaments, as well. Dr. Smith indicated that it was nondisplaced which provided for a range of three to seven percent impairment. He assigned a grade modifier of 1 for functional history and clinical studies and indicated that physical examination was not scored due to classifications under class 1 impairments. Dr. Smith found that, based on Table 16-2,[8] page 503, this resulted in five percent impairment and combining all of appellant's injuries resulted in a seven percent permanent impairment of the left lower extremity. He noted that no additional impairment was provided for nerve damage as there was no evidence of nerve injury and there were no significant range of motion scores that would lift the impairment rating

[6] Appendix A, pages 604-06 of the sixth edition of the A.M.A., *Guides* is entitled *Combined Values Chart.*

[7] *Supra* note 3.

[8] *Id.*

above the current level described. Dr. Smith concluded that appellant had reached maximum medical improvement in October 2013, one year following her initial release.

On January 27, 2014 Dr. Michael M. Katz, a Board-certified orthopedic surgeon and OWCP medical adviser, reviewed the medical record and determined that the date of maximum medical improvement was January 8, 2014, the date of Dr. Smith's second opinion examination. He explained that Dr. Smith's use of three separate diagnoses was not consistent with the methodology set forth in the A.M.A., *Guides*, which states on page 497 that "If a patient has two significant diagnoses, for instance, ankle instability and posterior tibial tendinitis, the examiner should use the diagnosis with the highest impairment rating in that region that is causally related for the impairment calculation."[9] Dr. Katz noted that in using a single grid, however, grade modifiers may be adjusted to account for the added complexity of the impairment. He recalculated Dr. Smith's impairment rating and found that, according to Table 16-2,[10] page 503, appellant's "fracture, malleolar, palpatory findings with normal motion" placed him in class 1 with a default value of five percent impairment. Dr. Katz assigned a grade modifier of 1 for functional history and 3 for clinical studies for ligament and tendon injuries based on a September 25, 2012 magnetic resonance imaging (MRI) scan. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), OWCP's medical adviser found that (1-1) + (n/a) + (3-1) resulted in a net grade modifier of 2, resulting in an impairment class 1, grade E, equaling a seven percent permanent impairment of the left lower extremity.

By decision dated February 24, 2014, OWCP granted appellant a schedule award for seven percent permanent impairment of the left lower extremity. The award ran for 20.16 weeks for the period January 8 through May 29, 2014.

LEGAL PRECEDENT

The schedule award provisions of FECA[11] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a mater 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 a standard for evaluation of schedule losses and the Board has concurred in such adoption.[12] For schedule awards after

[9] *See* Section 16.2, *Diagnosis-Based Impairment*, page 497 of the sixth edition of the A.M.A., *Guides.*

[10] *Supra* note 3.

[11] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[12] *See Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[13]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[14] Under the sixth edition, the evaluator identifies the impairment class for the CDX, which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[15] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX). Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[16]

ANALYSIS

OWCP accepted that appellant sustained a left knee and leg sprain and a fracture of the left ankle on April 7, 2012. Appellant claimed a schedule award on November 15, 2013. Appellant's attending physician, Dr. Blough, relied upon three different diagnoses to determine his impairment rating under Table 16-2 of the sixth edition of the A.M.A., *Guides*. OWCP's medical adviser, Dr. Blum, explained that Dr. Blough's calculations did not conform to the A.M.A., *Guides* and, thus, concluded that his report could not be used as a basis for an impairment rating.

In order to determine the extent and degree of any employment-related impairment of appellant's left lower extremity, OWCP properly referred appellant to Dr. Smith for a second opinion evaluation. Dr. Smith examined appellant on January 8, 2014 and concluded that she had a seven percent permanent impairment of the left lower extremity. He diagnosed left mid-shaft fibular fracture and distal fibular nondisplaced fracture near the malleolus, peroneus brevis tendon tear, peroneus longus tendinitis and anterior talofibular ligament rupture with residual pain. Dr. Smith indicated that Table 16-2,[17] page 501, of the A.M.A., *Guides* provided for strain tendinitis and ruptured tendons of the ankle. Appellant did not have significant motion deficits and as a result he placed her in a class 1, default grade C and assigned a grade modifier of 1 for functional history and clinical studies. Dr. Smith opined that she had a one percent permanent impairment of the anterior talofibular ligament which was completely ruptured and a one percent permanent impairment for the peroneus brevis tendon which remained tender with some weakness. Regarding the fibular fracture, he found that the closest diagnosis was a malleolar ankle fracture as it best described the fibular fracture near the ankle and was consistent with the type of injuries and trauma to the surrounding ligaments, as well. Dr. Smith indicated that it was

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[14] A.M.A., *Guides* (6th ed., 2009), page 3, section 1.3, The of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[15] *Id*. at 494-531.

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

[17] *Supra* note 3.

nondisplaced which provided for a range of three to seven percent impairment. He assigned a grade modifier of 1 for functional history and clinical studies and indicated that physical examination was not scored due to classifications under class 1 impairments. Dr. Smith found that, based on Table 16-2,[18] page 503, this resulted in five percent impairment and combining all of appellant's injuries resulted in a seven percent permanent impairment of the left lower extremity. He noted that no additional impairment was provided for nerve damage as there was no evidence of nerve injury and there were no significant range of motion scores that would lift the impairment rating above the current level described. Dr. Smith concluded that appellant had reached maximum medical improvement in October of 2013, one year following her initial release.

In accordance with its procedures, OWCP properly referred the evidence of record to its medical adviser, Dr. Katz, who reviewed the clinical findings of Dr. Smith on January 27, 2014 and determined that the date of maximum medical improvement was January 8, 2014. Dr. Katz explained that Dr. Smith's use of three separate diagnoses was not consistent with the methodology set forth in the A.M.A., *Guides*, which states on page 497 that "If a patient has 2 significant diagnoses, for instance, ankle instability and posterior tibial tendinitis, the examiner should use the diagnosis with the highest impairment rating in that region that is causally related for the impairment calculation."[19] He noted that in using a single grid, however, grade modifiers may be adjusted to account for the added complexity of the impairment. Dr. Katz recalculated Dr. Smith's impairment rating and found that, according to Table 16-2,[20] page 503, appellant's "fracture, malleolar, palpatory findings with normal motion" placed him in class 1 with a default value of five percent impairment. He assigned a grade modifier of 1 for functional history and 3 for clinical studies for ligament and tendon injuries based on a September 25, 2012 MRI scan. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), Dr. Katz found that (1-1) + (n/a) + (3-1) resulted in a net grade modifier of 2, resulting in an impairment class 1, grade E, equaling a seven percent permanent impairment of the left lower extremity.

The Board finds that Dr. Katz applied the appropriate tables and grading schemes of the sixth edition of the A.M.A., *Guides* to Dr. Smith's clinical findings. Dr. Katz' calculations were mathematically accurate. There is no medical evidence of record utilizing the appropriate tables of the sixth edition of the A.M.A., *Guides* demonstrating a greater percentage of permanent impairment. Dr. Katz' report explained that Dr. Blough's 21 percent impairment rating for the left lower extremity was erroneous as it relied upon three different diagnoses instead of using the diagnosis with the highest causally-related impairment rating in that region. Therefore, OWCP properly relied on the medical adviser's assessment of a seven percent permanent impairment of the left lower extremity.[21]

[18] *Id.*

[19] *See supra* note 9.

[20] *Supra* note 3.

[21] *See M.T.*, Docket No. 11-1244 (issued January 3, 2012).

On appeal, appellant contends that a third-party reviewed her doctor's impairment rating and they could not see where he failed to do it correctly. She further contends that the referral physician only saw her for 15 minutes and hardly assessed her physically and requests a third opinion or a referee examination. Based on the findings and reasons stated above, the Board finds appellant's arguments are not substantiated.

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 that she sustained more than a seven percent permanent impairment of the left lower extremity, for which she received a schedule award.

ORDER

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

Issued: August 26, 2014
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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