United States Department of Labor
Employees' Compensation Appeals Board

V.M., Appellant	)	
and	)	**Docket No. 16-1383**
	)	**Issued: December 13, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Grand Rapids, MI, Employer	)	

Appearances:
Alan J. Shapiro, for the appellant[1]
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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 21, 2016 appellant, through counsel, filed a timely appeal from a May 6, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant has met her burden of proof to establish ratable permanent impairment of the right lower extremity.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on September 1, 2001 appellant, then a 53-year-old casual clerk in a 90-day appointment, sustained sprains of the dorsum of her right foot and lateral malleolus when a bulk mail cart rolled over her foot. She stopped work that day and received wage-loss compensation on the daily rolls.

Immediately following the injury on September 1, 2001, appellant sought emergency room treatment. Dr. Teresa Baranowski, an osteopathic physician Board-certified in internal medicine, found mild deltoid ligament swelling. X-rays showed no acute fracture. Dr. Baranowski noted that appellant also had insulin-dependent diabetes mellitus. She diagnosed "[r]ight foot dorsum and lateral malleoli sprain."

October 1, 2001 x-rays of the right foot showed a possible avulsion fragment of bone anterior talus. October 17, 2001 nerve conduction velocity (NCV) and electromyography (EMG) studies demonstrated peripheral neuropathy of the right lower extremity. An October 23, 2001 bone scan showed abnormal activity in the right hindfoot in the superior aspect of the talar neck and the anterior calcaneus laterally. Appellant underwent a series of sympathetic nerve blocks from March to May 2002.

On January 12, 2004 appellant claimed a schedule award (Form CA-7). As the medical evidence did not indicate that she had reached maximum medical improvement, OWCP did not develop the schedule award claim at that time.

On May 7, 2004 Dr. Daniel Mankoff, an attending Board-certified anesthesiologist, opined that appellant had reached maximum medical improvement, with significant symptomatic improvement after a series of nerve blocks.

In a February 9, 2007 letter, OWCP advised appellant to obtain an impairment rating from her attending physician, confirming that she had attained maximum medical improvement, and rating any permanent impairment of the right lower extremity according to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*).

In response, appellant provided an April 19, 2007 report from Dr. Jeffrey F. Wirebaugh, a Board-certified family practitioner, who diagnosed complex regional pain syndrome. Dr. Wirebaugh assessed 11 percent permanent impairment of the right lower extremity due to restricted motion of the foot, according to the fifth edition of the A.M.A., *Guides*, then in effect.

On May 18, 2009 OWCP obtained a second opinion from Dr. Jeffrey Middledorf, an osteopathic physician Board-certified in physiatry, who found no basis for an impairment rating as there were no abnormal findings on examination. It found a conflict of medical opinion as to whether appellant continued to have residuals of the accepted occupational injuries. To resolve the conflict, OWCP selected Dr. Michael Holda, a Board-certified orthopedic surgeon to serve as an impartial medical examiner. Dr. Holda provided a September 18, 2009 report diagnosing chronic right foot pain that did not meet the criteria for complex regional pain syndrome. He found no ratable impairment of the right leg as there were no objective abnormalities.

On April 16, 2011 appellant filed a second schedule award claim (Form CA-7). In support of her claim, she provided an October 16, 2011 impairment rating by Dr. William Grant, a Board-certified orthopedic surgeon. On examination of the right foot, Dr. Grant found a fallen arch and thickening in the plantar aspect. He calculated 24 percent permanent impairment of the right lower extremity due to an open right foot fracture and sprain, according to Table 16-2 of the sixth edition of the A.M.A., *Guides*.[3]

An OWCP medical adviser reviewed Dr. Grant's report on April 19, 2012 and found it unreliable due to errors in history, examination, and impairment calculation. He recommended that OWCP obtain a second opinion.

On October 8, 2012 OWCP obtained a second opinion from Dr. Emmanuel Obianwu, a Board-certified orthopedic surgeon. Dr. Obianwu reviewed the medical record and statement of accepted facts. On examination, he noted no vascular impairment of either foot, normal arches bilaterally, and nearly full, identical motion in both feet and ankles. Dr. Obianwu obtained x-rays significant for degenerative changes in the calcaneocuboid and talonavicular joints, with narrowing of the joint spaces to two millimeters. He diagnosed a "[s]evere mid foot sprain with capsular avulsion injuries to the dorsal talonavicular joint and calcaneocuboid joint, August 25, 2001," a resolved sprain of the lateral ligament complex, and impingement of the right subtalar joint with a mild osteophyte and two-millimeter cartilage interval, and diabetic peripheral neuropathy of both feet. Dr. Obianwu opined that appellant had attained maximum medical improvement. He explained that imaging studies taken shortly after the September 1, 2001 injuries showed significant uptake in the area of the osteophytes and a reduced cartilage interval, demonstrating that the injuries caused those changes. Referring to Table 16-2 of the A.M.A., *Guides*, Dr. Obianwu found a class 1 for the Class of Diagnosis (CDX) impairment of subtalar arthritis with a two-millimeter cartilage interval, with a default value of five percent. In an attached worksheet, he assessed a plus two modifier for Clinical Studies (GMCS), a plus one modifier for Functional History (GMFH), and a plus one modifier for findings on Physical Examination (GMPE). Applying the net adjustment formula, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), (1-1) + (1-1) + (2-1), resulted in a net modifier of plus one, which moved the default five percent impairment upward to six percent. Dr. Obianwu therefore found six percent impairment of the right leg.

An OWCP medical adviser reviewed Dr. Obianwu's report on December 18, 2012. He explained that it was inappropriate to add a separate GMCS as it was included in the CDX. The appropriate net adjustment formula was (1-1) + (1-1) + (1-1), resulting in a net modifier of zero. Appellant, therefore, had five percent permanent impairment of the right leg.

OWCP then found a conflict of medical opinion between Dr. Grant, for appellant, and Dr. Obianwu, for the government, regarding the appropriate percentage of permanent impairment. To resolve the conflict, it selected Dr. David Frye, an osteopathic physician Board-certified in orthopedic surgery. Dr. Frye provided a March 26, 2014 report reviewing the medical record and statement of accepted facts. He found that appellant had attained maximum medical improvement. On examination of the right foot and ankle, Dr. Frye noted pain to

[3] Table 16-2, page 501 of the sixth edition of the A.M.A., *Guides* is titled "Foot and Ankle Regional Grid."

palpation of the right medial and lateral malleolar prominence, a normal vascular examination, and absent reflexes in both feet. He obtained x-rays of the right lower extremity showing a "bony prominence in the anterior talus neck and calcaneocuboid junction." Dr. Frye diagnosed a resolved right lateral ankle and forefoot contusion, idiopathic degenerative changes of the talonavicular and calcaneocuboid joints, and diabetic peripheral neuropathy. He opined that the diagnosed conditions were unrelated to the accepted injuries, because October 2001 imaging studies documented degenerative changes that could not have developed so soon after the September 1, 2001 injury. Dr. Frye explained that appellant had no permanent impairment related to the accepted right lower extremity injuries as they had resolved without objective residuals.

An OWCP medical adviser reviewed Dr. Frye's report on April 15, 2014 noting that, while OWCP had not accepted subtalar arthritis as work related, it should have been included in Dr. Frye's impairment rating as a preexisting condition. Based on this, OWCP requested a supplemental opinion from Dr. Frye on April 18, 2014.

In a May 6, 2014 supplemental report, Dr. Frye referred to Table 16-2 and found diagnosis-based impairment of subtalar arthritis with a two-millimeter cartilage interval, which provided a default rating of five percent. He found no modifiers for functional history or findings on physical examination. Dr. Frye, therefore, found five percent permanent impairment of the right lower extremity.

An OWCP medical adviser reviewed Dr. Frye's supplemental report on May 13, 2014. He disagreed with Dr. Frye's application of the net adjustment formula. The medical adviser opined that as applied to appellant's case, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (0-1) + (0-1), resulted in a net modifier of negative two, moving the default five percent for the CDX for subtalar arthritis downward two places to three percent. He therefore found three percent permanent impairment of the right lower extremity.[4]

By decision dated July 25, 2014, OWCP issued a schedule award for three percent impairment of the right foot. The period of the award, 6.15 weeks, ran from March 26 to May 8, 2014.

Appellant disagreed, and in an August 11, 2014 letter, through counsel, requested a telephonic hearing before an OWCP hearing representative, held on March 25, 2015. At the hearing, counsel asserted that OWCP mistakenly awarded 6.15 weeks of compensation for three percent impairment of the right foot only, whereas she was entitled to 8.64 weeks of compensation for three percent impairment of the right leg.

By decision dated July 7, 2015, an OWCP hearing representative set aside OWCP's July 25, 2014 schedule award determination, and remanded the case to OWCP for supplemental

[4] In a June 12, 2014 letter, OWCP advised appellant that it could not pay her the three percent schedule award as she was not "given due process rights or the ability to perfect [her] claim." It afforded appellant 30 days to submit new medical evidence supporting an impairment rating greater than the three percent determined by the medical adviser. Counsel responded by June 27, 2014 letter, requesting that OWCP issued the schedule award.

opinion from OWCP's medical examiner regarding the appropriate percentage of permanent impairment.

In a July 30, 2015 addendum report, OWCP's medical adviser opined that appellant had no residuals of the accepted September 1, 2001 injuries. Therefore, there was no ratable impairment of the right lower extremity for schedule award purposes.

By decision dated August 3, 2015, OWCP denied appellant's schedule award claim, finding that the medical evidence of record established that there were no injury-related residuals on which to base an impairment rating.

Counsel disagreed and, in an August 11, 2015 letter, requested a telephonic hearing, held on March 17, 2016. At the hearing, he argued that OWCP's medical adviser exceeded his authority by finding that there was no injury-related impairment after Dr. Frye had resolved the issue as impartial medical examiner. Appellant submitted an undated statement describing chronic right foot pain interfering with activities of daily living.

By decision dated May 6, 2016, an OWCP hearing representative affirmed OWCP's August 3, 2015 decision, finding that the July 25, 2014 schedule award was issued in error, as the weight of the medical evidence established that the accepted September 1, 2001 injuries resolved without residuals.

LEGAL PRECEDENT

The schedule award provisions of FECA[5] 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 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 a standard for evaluation of schedule losses and the Board has concurred in such adoption.[6] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[7]

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).[8] Under the sixth edition, the evaluator identifies the impairment CDX, which

[5] 5 U.S.C. § 8107.

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

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[8] A.M.A., *Guides* (6th ed. 2008), page 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[9] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

Section 8123(a) of FECA provides that when there is a disagreement between the physician making the examination for the United States and the physician of the employee, a third physician shall be appointed to make an examination to resolve the conflict.[10] When there are opposing medical reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a), to resolve the conflict in the medical evidence.[11] In situations where there are 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 on a proper factual background, must be given special weight.[12]

ANALYSIS

OWCP accepted that appellant sustained sprains of the dorsum of her right foot and lateral malleolus on September 1, 2011 when a bulk mail cart rolled over her foot. She claimed schedule awards on January 12, 2004 and April 16, 2011. Dr. Grant, an attending Board-certified orthopedic surgeon, assessed 24 percent permanent impairment rating based on diagnoses of an open fracture and sprain of the right foot. As his opinion was based on an inaccurate history, OWCP obtained a second opinion from Dr. Obianwu, who found six percent permanent impairment of the right lower extremity due to subtalar arthritis caused by the accepted injuries. It found a conflict of opinion between these two physicians, and selected Dr. Frye, a Board-certified orthopedic surgeon, to resolve it.

Dr. Frye opined on March 26, 2014 that, as the accepted injuries had resolved without residuals, appellant did not have a ratable impairment of the right leg. OWCP obtained a supplemental report from Dr. Frye on May 6, 2014, finding five percent impairment of the right leg due to preexisting subtalar arthritis.[13] An OWCP medical adviser reviewed Dr. Frye's mathematical calculation on May 13, 2014, resulting in three percent impairment. OWCP then issued a schedule award on July 25, 2014 for three percent impairment of the right foot.

Following a March 25, 2015 oral hearing, OWCP issued a July 7, 2015 decision setting aside the July 25, 2014 schedule award, and remanding the case for a supplemental opinion by OWCP's medical adviser regarding the appropriate percentage of permanent impairment, as

[9] A.M.A., *Guides* (6th ed. 2008), pp. 494-531.

[10] 5 U.S.C. § 8123(a); *Robert W. Blaine*, 42 ECAB 474 (1991).

[11] *Delphia Y. Jackson*, 55 ECAB 373 (2004).

[12] *Anna M. Delaney*, 53 ECAB 384 (2002).

[13] OWCP sought this supplemental report based on the opinion of its medical adviser, on April 15, 2014, that preexisting impairment must be rated. However, at this point, OWCP had not accepted any impairment as employment related. The Board has held that where the claimant did not demonstrate any permanent impairment caused by the accepted occupational exposure, the claim was not ripe for consideration of any preexisting impairment. *Thomas P. Lavin*, 57 ECAB 353 (2006).

Dr. Frye had made it clear that there were no injury-related residuals. As OWCP's medical adviser confirmed on July 30, 2015 that appellant did not have residuals of the accepted right foot and ankle injuries, OWCP denied the schedule award claim by decision issued August 3, 2015. Following a second oral hearing, OWCP issued a May 6, 2016 decision affirming the denial of the schedule award claim, as the medical evidence did not demonstrate any objective residuals of the accepted injuries.

The Board finds that appellant has not established ratable permanent impairment of the right lower extremity. Dr. Frye, the impartial medical examiner, provided detailed reports, based on the statement of accepted facts, the complete medical record, and a comprehensive clinical examination. He provided an extensive discussion of his medical reasoning, explaining that degenerative changes demonstrated on October 2001 imaging studies established that diagnosed subtalar arthritis could not have been related to the September 1, 2001 injuries as such changes would have taken much longer to develop. Dr. Frye observed no objective findings of the accepted right foot and lateral malleolus sprains. He therefore opined on May 6, 2014 that appellant had no ratable impairment of the right lower extremity attributable to the accepted injuries. OWCP properly accorded Dr. Frye's opinion the weight of the medical evidence.[14]

On appeal, counsel contends that OWCP's July 25, 2014 schedule award decision had not been rescinded and therefore remained valid and binding. However, as explained above, OWCP set aside the July 25, 2014 schedule award by July 7, 2015 and May 6, 2016 decisions, both predicated on Dr. Frye's well-reasoned opinion.

Appellant may request a schedule award or increased schedule award at any time, 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 met her burden of proof to establish ratable permanent impairment of the right lower extremity.

[14] *Supra* note 12.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 6, 2016 is affirmed.

Issued: December 13, 2016
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board