United States Department of Labor
Employees' Compensation Appeals Board

M.D., Appellant	)	
and	)	**Docket No. 16-0207**
	)	**Issued: June 3, 2016**
DEPARTMENT OF HOMELAND SECURITY, IMMIGRATION & CUSTOMS ENFORCEMENT, New York, NY, Employer	)	

Appearances:
Lenin V. Perez, for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On November 16, 2015 appellant, through her representative, filed a timely appeal from June 8 and September 24, 2015 merit decisions 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 the case.

ISSUE

The issue is whether appellant is entitled to an additional schedule award.

On appeal, appellant's representative contends that the impairment rating based on range of motion, which was more favorable to appellant, should be the basis for the schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On April 22, 2009 appellant, then a 40-year-old immigration enforcement agent, filed a traumatic injury claim (Form CA-1) alleging that on that date, during training, her instructor told her to jump on a 20-inch high box jump. She was instructed that she could not do so with both feet. In her attempt, appellant subsequently missed the box and hit her shin and calf on the metal box. She listed the nature of her injury as scrape and bruise of right lower leg. Appellant initially received continuation of pay benefits and then received compensation benefits on the supplemental rolls as of June 8, 2009. She returned to modified work on April 12, 2010.

OWCP accepted appellant's claim for bilateral sprain of foot; contusion of right knee; closed second metatarsal fracture of left foot; abrasion or friction burn of right leg, localized of ankle, calcaneal ligament; osteoarthritis of bilateral lower legs; enthesopathy of ankle and tarsus, unspecified left; sprain open wound of right leg, right contusion of the left foot; and sprain of left tarsometatarasal. Appellant underwent authorized surgery on her left ankle on November 23, 2009, *i.e.*, a left ankle modified Brostom lateral reconstruction with extensor retinacular graft, arthroscopic debridement of the talar dome chondral fraying, and arthroscopic synovectomy. An authorized right knee arthroscopy with excision of medical plica and chondroplasty was performed on February 3, 2012, and she underwent an authorized left ankle arthroscopy on March 19, 2013.

On May 28, 2014 Dr. Kevin E. McGovern, a Board-certified orthopedic surgeon and appellant's treating physician, conducted an impairment evaluation of appellant. He reviewed appellant's medical history, conducted a physical examination, and listed his impression as left ankle sprain with osteochondral lesion of talus, status post left ankle reconstruction with osteochondral debridement and drilling and surgery times two; internal derangement of the right knee; and status post arthroscopic surgery of the right knee. Dr. McGovern noted that the motion in appellant's left ankle was moderately decreased, noting that appellant could dorsiflex to neutral and plantar flex to 30 degrees. He also noted 0 degrees of inversion and 0 degrees of eversion. Dr. McGovern noted minimal swelling, no instability. He found that examination of appellant's right knee revealed no effusion, with some medial and lateral joint line tenderness. Dr. McGovern noted mild patellofemoral tenderness with crepitus, and no instability or effusion. He opined that, based on the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (2009) (A.M.A., *Guides*), Table 16-3, page 509, for a soft tissue injury to the knee, including a plica, one percent impairment of her right lower extremity was allowed. For appellant's ankle injury, from Table 16-2, page 503, for the talus with a nondisplaced tibial dome lesion with mild motion deficits without talar body collapse, an additional 10 percent impairment of her lower extremity was allowed.

On June 20, 2014 appellant filed a claim for a schedule award (Form CA-1).

On July 5, 2014 appellant's schedule award claim was reviewed by an OWCP medical adviser, Dr. Lawrence A. Manning, a Board-certified orthopedic surgeon, who reviewed Dr. McGovern's report and agreed with Dr. McGovern's calculation that appellant was entitled to one percent impairment due to a soft tissue injury of the knee. With regard to the 10 percent impairment, for appellant's ankle injury, Dr. Manning noted that, although Dr. McGovern utilized an appropriate diagnosis-based method, there was greater impairment using the range of

motion results submitted by Dr. McGovern. He noted that the sixth edition of the A.M.A., *Guides*, Table 16-20 and Table 16-23 on page 549, appellant's impairment was 14 percent left lower extremity impairment based on ankle dorsi flexion to neutral, eversion to zero degrees, and inversion to zero degrees. Dr. Manning added seven percent impairment for dorsiflexion, five percent impairment for inversion, and two percent for eversion. He noted that this superseded the impairment using the diagnosis-based method. Dr. Manning concluded that appellant had 14 percent left lower extremity impairment and 1 percent right lower extremity impairment. He listed the date of maximum medical improvement as March 19, 2014, one year after the date of the second left ankle surgery.

By decision dated July 24, 2014, OWCP issued a schedule award for 14 percent impairment of appellant's left lower extremity and 1 percent impairment of the right lower extremity.

On August 18, 2014 appellant requested an oral telephonic hearing before an OWCP Branch of Hearings and Review hearing representative. At the hearing held on March 20, 2015 appellant's representative initially argued that he would like the record to be held open for 30 additional days to submit a new impairment rating. He also contended that the effective pay rate was wrong for the calculation and did not allow a cost-of-living increase. Appellant testified that she was afraid of having any further surgery. She testified that she has always gone back to work after her surgeries.

By decision dated June 8, 2015, the hearing representative affirmed the determination that appellant had 14 percent impairment of her left lower extremity and 1 percent impairment of the right lower extremity. He noted that there was no medical report in the record showing that appellant was entitled to a greater schedule award, and that the OWCP medical adviser actually calculated a higher impairment rating than did appellant's physician. The hearing representative did modify appellant's pay rate date based on her argument that she was entitled to a recurrent pay rate when she stopped work due to her left ankle surgery.

On August 29, 2015 appellant, through her representative, requested reconsideration. In support of her request, appellant submitted a March 10, 2015 medical report from Dr. Samy F. Bishai, a physician Board-certified in emergency medicine, who reviewed appellant's medical history, conducted a physical examination, and listed the medical diagnoses as: (1) internal derangement of the right knee joint; (2) status postoperative arthroscopic surgery on the right knee joint; (3) tricompartmental osteoarthritis of the right knee joint; (4) internal derangement of the left ankle and foot; (5) status postoperative surgery on the left ankle joint with reconstruction of the lateral ligament; and (6) internal derangement of the right ankle and foot. Dr. Bishai applied the sixth edition of the A.M.A., *Guides* and determined that appellant had an impairment of her left lower extremity of 21 percent and of the right lower extremity of 20 percent. For the left ankle and foot, he chose the stand-alone range of motion method over the diagnosis-based method to calculate the impairment rating as this was the most disabling part of her injuries and it affected all of the activities at work as well as her activities of daily living. Dr. Bishai used Table 16-22 on page 549 and Table 16-20 on page 494 to calculate an impairment rating of the left ankle and foot. He noted that appellant had dorsiflexion of 10 degrees which gave her 7 degrees lower extremity impairment, plantar flexion was 20 degrees which gave her 7 percent lower extremity impairment, inversion was 5 degrees which gave her 5 percent lower extremity

impairment, and eversion was 5 degrees which gave her 2 percent lower extremity impairment. Adding these figures together, Dr. Bishai determined that appellant had 21 percent lower extremity impairment because of the residual loss of range of motion in her left foot and ankle from the injury of April 22, 2009. He also used the stand alone range of motion method for calculating the impairment rating for the injury to the right knee joint as the range of motion constituted a major disability for appellant. Dr. Bishai noted that these calculations were based on Table 16-23 on page 549 of the A.M.A., *Guides,* and that the calculations were as follows: appellant had an extension lag of -5 degrees due to the presence of flexion contracture of the right knee joint and flexion of 105 degrees. The extension deficit gave appellant 10 percent lower extremity impairment and the loss of flexion in the range of motion gave appellant 10 percent lower extremity impairment. The total impairment rating was obtained by adding the two values for extension and flexion which is 10 plus 10 which equaled 20 percent lower extremity impairment for the right lower extremity. Accordingly, Dr. Bishai determined that appellant was entitled to an impairment rating for the left lower extremity of 21 percent and the right lower extremity of 20 percent.

OWCP referred the case to the OWCP medical adviser on September 9, 2015. In a response dated September 13, 2015, Dr. Arnold T. Berman, a Board-certified orthopedic surgeon, noted that Dr. McGovern's evaluation had credibility because he was a Board-certified orthopedic surgeon and appellant's treating physician and he found no reduction in range of motion of the knee. Therefore, he concluded that it would not have been appropriate for Dr. Bishai to make a calculation based upon range of motion. Dr. Berman also noted that the preferred methodology, wherever possible, should be the diagnosis-based method, and that therefore, he was in agreement with Dr. McGovern's calculations. He noted that, pursuant to Table 16-3, *Soft Tissue Injury Including Plica*, resulted in class 1 with no motion deficit, one percent impairment, default value with a range of zero to two percent. Dr. Berman then made adjustments for a grade modifier for functional history of 1, clinical studies 1, and physical examination of 1, and determined that this resulted in a net adjustment of 0 and that one percent was appellant's impairment based on the right knee disorder. He then referred to page 503 of the A.M.A., *Guides*, and noted that nondisplaced tibial dome lesion with mild motion deficit without tear or body collapse equaled a default value of 10 percent with the range of 7 to 13 percent under class 1. Dr. Berman noted grade modifiers identical to above, and that the default value became grade C, for 10 percent impairment. He therefore concluded that the most accurate calculations were Dr. McGovern's calculations that appellant had 1 percent impairment of the right lower extremity and 10 percent impairment of the left lower extremity. Therefore Dr. Berman opined that no further schedule award was merited.

By decision dated September 24, 2015, OWCP denied modification of the prior decision. It found that the examination by Dr. McGovern had more credibility because he was a Board-certified orthopedic surgeon and appellant's treating physician. As Dr. McGovern found no reduction in range of motion in the knee, OWCP determined that it would not be appropriate for Dr. Bishai to make a calculation based upon range of motion.

LEGAL PRECEDENT

Section 8107 of FECA provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for

the permanent impairment of the scheduled member or function.[2] Neither FECA nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants OWCP has adopted the A.M.A., *Guides*, as the uniform standard applicable to all claimants.[3] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition.[4]

The sixth edition requires identifying the impairment Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[5] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[6]

Chapter 16 of the sixth edition of the A.M.A., *Guides*, pertaining to the lower extremities, provides that diagnosis-based impairment is the primary method of calculation for the lower limb and that most impairments are based on the diagnosis-based impairment where impairment class is determined by the diagnosis and specific criteria as adjusted by the grade modifiers for functional history, physical examination, and clinical studies. It further provides that alternative approaches are also provided for calculating impairment for peripheral nerve deficits, complex regional pain syndrome, amputation, and range of motion. Range of motion is primarily used as a physical examination adjustment factor.[7] The A.M.A., *Guides*, however also explain that some of the diagnosis-based grids refer to the range of motion section when that is the most appropriate mechanism for grading the impairment. This section is to be used as a stand-alone rating when other grids refer to this section or no other diagnosis-based sections of the chapter are applicable for impairment rating of a condition.[8]

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 specified.[9]

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[2] 5 U.S.C. § 8107. This section enumerates specific members or functions of the body for which a schedule award is payable and the maximum number of weeks of compensation to be paid; additional members of the body are found.

[3] 20 C.F.R. § 10.404(a).

[4] *See* 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, Exhibit 1 (January 2010).

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

[6] *Id.* at 521.

[7] *Id.* at 497, section 16.2.

[8] *Id*. at 543; *see also D.F.*, Docket No. 15-0664 (issued January 8, 2016).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

ANALYSIS

The Board finds that this case is not in posture for decision.

Appellant received a schedule award for 14 percent impairment to her left lower extremity and 1 percent impairment to her right lower extremity. She now contends that she is entitled to an additional schedule award. Specifically, appellant contends that she is entitled to an award based on 21 percent left lower extremity impairment and 20 percent right lower extremity impairment pursuant to the report of Dr. Bishai.

On July 24, 2014 OWCP issued a schedule award for 14 percent impairment of appellant's left lower extremity and 1 percent impairment of her right lower extremity. In reaching this conclusion, it noted that Dr. McGovern and the initial OWCP medical adviser, Dr. Manning, both agreed that appellant was entitled to one percent impairment of her right lower extremity. However, Dr. Manning, in reviewing Dr. McGovern's report, noted that although 10 percent impairment for the left lower extremity was appropriate using the diagnosis-based method as set forth by Dr. McGovern, appellant would receive a greater impairment, *i.e.*, 14 percent, when based on ankle dorsi flexion to neutral, eversion to 0 degrees and inversion to 0 degrees. He concluded that appellant's left lower impairment rating was 14 percent. OWCP issued its schedule award based on 1 percent impairment of the right lower extremity and 14 percent impairment of the left lower extremity, and the hearing representative affirmed this conclusion.

However, on reconsideration, appellant submitted a new medical report by Dr. Bishai. Dr. Bishai also applied the sixth edition of the A.M.A., *Guides* and rated appellant using range of motion findings after explaining why a diagnosis-based impairment evaluation was not preferred in this case. He calculated that appellant was entitled to 20 percent impairment of her right lower extremity and 21 percent impairment of her left lower extremity. Dr. Berman, an OWCP medical adviser, disagreed, and noted that the preferred methodology was the diagnosis-based method. He indicated that Dr. Bishai's findings were in conflict with those of Dr. McGovern and lacked the credibility of the earlier report of Dr. McGovern as he is a Board-certified orthopedic surgeon. Dr. Berman determined that appellant's impairment was 10 percent of the left lower extremity and 1 percent of the right lower extremity as found by Dr. McGovern, and that as OWCP had already awarded a schedule award based on a left lower extremity impairment of 14 percent and 1 percent impairment of the right lower extremity, appellant was not entitled to a greater award.

OWCP based its September 24, 2015 decision on the opinion of Dr. Berman, OWCP's medical adviser.

A reasoned opinion by an OWCP medical adviser will not usually constitute the weight of the medical evidence in an accepted disability case, even if the medical adviser is a Board-certified specialist in the appropriate field of medicine and the attending physician is not a specialist and offers no rationale. This is because the medical adviser has not examined the claimant while the attending physician has.[10] As the medical adviser found that the opinions of

[10] *A.A.*, Docket No. 15-0898 (issued July 28, 2015).

treating physicians Dr. Bishai and Dr. McGovern differed he should have referred appellant for a second opinion examination.[11] It is not the role of the medical adviser to act in an adjudicatory manner and grant more weight to a report of one treating physician over the other based upon credibility.[12] The Board also notes that while Dr. Berman stated that appellant's impairment should be evaluated using the diagnosis-based method, previously OWCP's medical adviser Dr. Manning had opined that the range of motion method should be used to more accurately assess appellant's degree of permanent impairment. On remand the second opinion physician should explain, with rationale, which method for rating permanent impairment is most appropriate in this case.

The Board will remand the case for a second opinion referral to determine the extent and degree of appellant's permanent impairment of the lower extremities. After such further development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision.

[11] *See D.F.*, Docket No. 15-0664 (issued January 8, 2016).

[12] *See* Federal (FECA) Procedure Manual, Part 3 -- *Function of the Medical Unit*, Chapter 3.200.4 (October 1990); *see also Carlton L. Owens*, 36 ECAB 608 (1985).

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated September 24 and June 8, 2015 are set aside, and the case is remanded for further consideration consistent with this opinion.

Issued: June 3, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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