United States Department of Labor
Employees Compensation Appeals Board

K.D., Appellant	)	
and	)	**Docket No. 19-0281**
	)	**Issued: June 30, 2020**
U.S. POSTAL SERVICE, CHICAGO METRO SURFACE TRANSFER CENTER, Elk Grove, IL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On November 19, 2018 appellant, through counsel, filed a timely appeal from a September 20, 2018 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 this case.

[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.*

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than six percent permanent impairment of the right lower extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On January 27, 2013 appellant, then a 37-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that she developed a heel condition as a result of factors of her federal employment, including constant walking on a concrete floor, and pushing, pulling and loading bulk mail containers. On February 22, 2013 OWCP accepted her claim for right acute plantar fibromatosis. It paid retroactive wage-loss compensation on the supplemental rolls commencing February 9, 2013 and on the periodic rolls effective October 20, 2013. OWCP later expanded the acceptance of appellant's claim to include bilateral plantar fibromatosis, right tarsal tunnel syndrome, bilateral calcaneal spurs, bilateral open wounds of the toes without complications, right tendon sheath contracture, and bilateral phlebitis/thrombophlebitis of the lower extremities. Appellant underwent right foot surgery on April 9, 2013, August 14, 2014, and January 6, 2015.[3] She retired on disability effective September 4, 2015 and continued to receive compensation benefits through April 30, 2016 when she elected Civil Service Retirement System benefits, effective May 1, 2016.

On June 2, 2016 appellant filed a claim for a schedule award (Form CA-7). With her claim, appellant submitted a letter from Dr. Whitney Castle, a podiatric surgeon, who indicated that she had reached maximum medical improvement (MMI).[4]

By letter dated June 16, 2016, OWCP requested that appellant submit an impairment evaluation from her attending physician in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5] It afforded her 30 days to submit additional evidence. No additional evidence was received.

By decision dated September 15, 2016, OWCP denied appellant's schedule award claim. It noted that she had not submitted evidence in response to its June 16, 2016 letter, and that the medical evidence of record was insufficient to establish permanent impairment.

In correspondence dated September 5, 2016, received by OWCP on September 19, 2016, counsel forwarded a July 20, 2016 medical report from Dr. Neil Allen, Board-certified in internal medicine and neurology. Dr. Allen described appellant's job duties as a mail handler and her

[3] An operative report for the January 6, 2015 procedure is not found in the case record before the Board.

[4] OWCP referred appellant for a second-opinion evaluation with Dr. Allan M. Brecher, a Board-certified orthopedic surgeon, on September 25, 2015. The statement of accepted facts (SOAF) provided to Dr. Brecher indicated that bilateral plantar fasciitis was accepted. After his evaluation, Dr. Brecher advised that appellant had ongoing right plantar fasciitis, that she could not work as a mail handler, and provided permanent physical restrictions. He did not provide an impairment rating.

[5] A.M.A., *Guides* (6th ed. 2009).

medical and surgical history, and her current symptoms of bilateral foot pain, stiffness, numbness, tingling, and instability with difficulty standing, walking, and climbing stairs. He noted that she had an American Association of Orthopedic Surgeons (AAOS) Lower Limb Questionnaire score of 45 and described lower extremity physical examination findings. Soft touch and sharp/dull discrimination were intact, and her Achilles reflexes were rated at 0/5 bilaterally. On examination of the right foot, Dr. Allen observed an altered gait with cane assistance. Well-healed surgical scars were present, and he found global tenderness on palpation. Muscle strength on the right was 4/5 for dorsiflexion and 5/5 for plantar flexion, inversion, and eversion. Dr. Allen reported right foot range of motion as 20 degrees (20 degrees, 20 degrees) of dorsiflexion, 40 degrees (38 degrees, 37 degrees) of plantar flexion, 20 degrees (15 degrees, 15 degrees) of inversion and 10 degrees (5 degrees, 5 degrees) of eversion. He indicated that appellant had right ankle magnetic resonance imaging (MRI) scans done on December 3, 2012, August 8 and October 9, 2014, with the latter demonstrating previous Achilles tendon surgery and very mild focal and distal tenosynovitis of the posterior tibial tendon, somewhat resolved when compared to previous MRI scans. Dr. Allen also noted that a June 11, 2015 electromyogram and nerve conduction velocity (EMG/NCV) study demonstrated lumbar compression irritation resulting in active radiculopathy and mild sensory nerve action potential abnormalities. He utilized the diagnosis-based impairment (DBI) rating method of the sixth edition of the A.M.A., *Guides* to calculate appellant's right foot permanent impairment. Dr. Allen found that, under Table 16-2, Foot and Ankle Regional Grid, the medical records and physical examination findings of a moderate dorsiflexion deficit represented a class one impairment with a default value of 10 percent. He found a functional history modifier of 2, noting qualifiers of the AAOS score of 45, altered gait, and regular use of a cane and brace. Dr. Allen found a physical examination modifier of 1, noting mild palpatory findings with observed abnormalities, negative for instability, no alteration in alignment/deformity when compared to the unaffected side, mild motion deficit in eversion and inversion, and negative for muscle atrophy. He also found a grade modifier of 2 for clinical studies, based on the MRI scan findings. Dr. Allen applied the net adjustment formula and concluded that appellant had 13 percent permanent impairment of the right lower extremity.

On September 21, 2016 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

On September 28, 2016 OWCP routed Dr. Allen's report, a SOAF, and the case record to Dr. Jovito Estaris, who is Board-certified in occupational medicine, acting as a district medical adviser (DMA), for review and a determination of permanent impairment of appellant's lower extremities, and her date of MMI.

In an October 18, 2016 report, Dr. Estaris indicated that he had reviewed the SOAF and medical record. He noted appellant's medical and surgical history and her continued complaint of pain over the foot and ankle. Dr. Estaris reviewed the August 26, 2015 right ankle MRI scan and agreed that appellant's impairment should be rated in accordance with Table 16-2. He opined that for a diagnosis of right plantar fibromatosis with Achilles tendinitis, appellant had a class 1 impairment with a default value of 5. Dr. Estaris assigned a grade modifier for functional history (GMFH) of 2, based on antalgic gait and use of a cane, and a grade modifier for physical examination (GMPE) of 1, based on a mild motion deficit with no instability. He advised that a grade modifier for clinical studies (GMCS) was not applicable because it was used for proper classification in the DBI grid. Dr. Estaris applied the net adjustment formula and calculated a net

adjustment of +1, for a class 1, grade D right lower extremity impairment of six percent. He found that appellant had reached MMI on July 20, 2016. Dr. Estaris explained that his impairment rating of six percent permanent impairment of the right lower extremity differed from Dr. Allen's because, while Dr. Allen chose the third level in the DBI grade for moderate motion deficits, his physical examination only found mild motion deficits in eversion and inversion, and no ankle motion impairments in dorsiflexion and plantar flexion.[6]

After a preliminary review, by decision dated December 19, 2016, OWCP's hearing representative noted that the DMA explained how he determined appellant's percentage of impairment, based upon Dr. Allen's examination findings and the sixth edition of the A.M.A., *Guides*. She found no evidence of error in the DMA's report and found that appellant had met her burden of proof to establish her schedule award claim. The hearing representative indicated that, upon return of the record, OWCP should issue a schedule award.

On March 1, 2017 OWCP granted appellant a schedule award for six percent permanent impairment of the right lower extremity.[7] It based the award on the opinion of its DMA, Dr. Estaris. The award ran for 20.16 weeks from July 20 through December 8, 2016.

On March 6, 2017 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative. Counsel also forwarded a May 9, 2017 addendum report in which Dr. Allen disagreed with Dr. Estaris' application of the A.M.A., *Guides* with regard to the calculation of appellant's right lower extremity impairment. Dr. Allen noted that page 549 of the A.M.A., *Guides* indicated that dorsiflexion measurements of the ankle extending beyond neutral were indicated as "(-)" whereas flexion contractures were documented as "(+)." He explained that appellant was found to have mild deficits in inversion and eversion, as well as a moderate deficit in dorsiflexion, as the measurement recorded was a flexion contracture, which indicated that she had a moderate deficit and, therefore, her impairment had been accurately calculated in his July 20, 2016 report.

In a record of a conversation with an OWCP representative dated August 15, 2017, counsel agreed to convert the hearing request to a review of the written record.

[6] Dr. Allen also provided left lower extremity examination findings and impairment analysis, and the DMA reviewed Dr. Allen's left lower extremity findings. Left lower extremity impairment is not at issue in the present appeal.

[7] OWCP also awarded one percent permanent impairment of the left lower extremity.

By decision dated October 18, 2017, a hearing representative affirmed the March 1, 2017 decision with regard to the degree of appellant's left lower extremity impairment.[8] She remanded the case for further medical development regarding appellant's right lower extremity impairment.

On October 31, 2017 OWCP forwarded Dr. Allen's addendum report, a SOAF, and the case record to Dr. Estaris for review and determination of permanent impairment of appellant's right lower extremity and for a date of MMI.

In a report dated November 5, 2017, Dr. Estaris indicated that he had reviewed the SOAF and medical record, including Dr. Allen's addendum report dated May 9, 2017. He maintained that Dr. Allen's report included no mention of flexion contracture. Dr. Estaris noted that dorsiflexion was reported at 20 degrees and plantar flexion at 40 degrees, neither of which rated a motion impairment. He indicated that Dr. Allen's explanation that ankle plantar flexion was not impaired and ankle dorsiflexion was moderately impaired was inconsistent, as it was difficult to understand how plantar flexion could be normal while dorsiflexion would be abnormal. Dr. Estaris indicated that his opinion was further supported by measurements of ankle inversion and eversion, which demonstrated mild impairments. He advised that his impairment rating remained the same, noting that only ankle inversion and eversion showed mild range of motion deficits whereas ankle dorsiflexion and plantar flexion range of motion showed no deficits.

By decision dated February 15, 2018, OWCP found the weight of the medical evidence rested with the opinion of its DMA and, thus, appellant had not established right lower extremity impairment greater than the six percent previously awarded.

On February 23, 2018 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. At a July 31, 2018 hearing, counsel argued that Dr. Allen's report was not inconsistent, noting that he found an abnormal gait and use of a cane, which indicated instability. Counsel also asserted that the DMA should have included a grade modifier for clinical studies The hearing representative held the record open for 30 days for the submission of additional evidence.

By letter dated August 8, 2018, counsel maintained that, while the DMA indicated that there was no mention of flexion contracture in Dr. Allen's report, the addendum report dated July 20, 2016 clearly indicated that a flexion contracture was found and was defined as a moderate deficit. He further argued that Dr. Allen found loss of range of motion in both dorsiflexion and plantar flexion in his original report.

By decision dated September 20, 2018, a hearing representative affirmed the February 15, 2018 decision. She found that the DMA correctly applied the A.M.A., *Guides* to the measurements

[8] The March 1, 2017 schedule award was based on the basic compensation rate of 66-2/3 percent. Counsel forwarded information indicating that appellant had a qualifying dependent, and on October 3, 2017, OWCP adjusted appellant's schedule award compensation to the augmented compensation rate of 75 percent and paid additional schedule award compensation. In the October 18, 2017 decision, the hearing representative noted that this adjustment had been made. By that decision, the hearing representative also set aside the schedule award with regard to whether appellant had been compensated at the correct pay rate. In an e-mail dated February 2, 2018, the employing establishment confirmed that appellant's pay rate and premium pay were the same on February 3 and 9, 2013, the date disability began.

reported by Dr. Allen and that Dr. Allen's addendum report was insufficient to refute the opinion of the DMA.

LEGAL PRECEDENT

The schedule award provisions of FECA,[9] and its implementing federal regulation,[10] 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. The method used in making such a determination is a matter which rests in the 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. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 2009.[11] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[12]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[13] Under the sixth edition, the evaluator identifies the impairment class of diagnosis (CDX), which is then adjusted by the GMFH, GMPE, and GMCS.[14] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[15]

With respect to the foot/ankle, reference is made to Table 16-2 (Foot and Ankle Regional Grid) of the A.M.A., *Guides*.[16] After the CDX is determined from the Foot and Ankle Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX)

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

[11] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides* (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5 (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[12] *See K.J.*, Docket No. 19-1492 (issued February 26, 2020); *Isidoro Rivera*, 12 ECAB 348 (1961).

[13] A.M.A., *Guides*, *supra* note 5 at 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[14] *Id*. at 495-531.

[15] *Id.* at 411.

[16] *Id*. at 501-08.

+ (GMCS-CDX).[17] Table 16-20, Table 16-21, and Table 16-22 describe motion impairments of the mid foot and ankle.[18]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and extent of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[19]

Section 8123(a) provides that, if there is a 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.[20] The implementing regulations state that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[21] 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 rationale and based upon a proper factual background, must be given special weight.[22]

ANALYSIS

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

Both Dr. Allen and Dr. Estaris based their analysis on Table 16-2, the Foot and Ankle Regional Grid. This table indicates that for a muscle/tendon impairment, a mild motion deficit has a default value of 5, and that a moderate motion deficit and/or significant weakness has a default value of 10.[23] Table 16-20, Table 16-21, and Table 16-22 identify specific motion impairments.[24]

In a report dated July 20, 2016, Dr. Allen described physical examination findings, including three range of motion measurements. He found a moderate impairment under Table 16-2. After applying the net adjustment formula, Dr. Allen concluded that appellant had 13 percent permanent impairment of the right lower extremity. In a report dated October 18, 2016,

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

[18] *Id*. at 549.

[19] Federal (FECA) Procedure Manual, *supra* note 11 at Chapter 2.808.6(f) (March 2017).

[20] 5 U.S.C. § 8123(a); *M.G.*, Docket No. 19-1627 (issued April 17, 2020); *R.C.*, Docket No. 12-0437 (issued October 23, 2012).

[21] 20 C.F.R. § 10.321.

[22] *J.W.*, Docket No. 19-1271 (issued February 14, 2020); *F.C.*, Docket No. 14-0560 (issued November 12, 2015).

[23] *Supra* note 17.

[24] *Supra* note 19.

Dr. Estaris, the DMA, disagreed with Dr. Allen's analysis. He maintained that Dr. Allen's physical examination findings demonstrated only a mild deficit and no instability. After applying the net adjustment formula, Dr. Estaris concluded that appellant had six percent right lower extremity impairment. In his May 9, 2017 supplemental report, Dr. Allen referenced the tables found on page 549 of the A.M.A., *Guides* and indicated that appellant had mild deficits in inversion and eversion and a moderate deficit in dorsiflexion, as the measurement recorded a flexion contracture. In a November 5, 2017 report, Dr. Estaris reiterated his conclusions.

For a conflict to arise, the opposing physician's opinions must be of equal weight.[25] The Board finds that the opinions of Drs. Allen and Estaris are of equal weight regarding their interpretation of the A.M.A., *Guides*. While an OWCP medical adviser may create a conflict in medical opinion, he or she may generally not resolve it.[26] Thus, due to this discrepancy between the interpretation of physical examination finding in accordance with the A.M.A., *Guides*, resulting in a variance in the impairment rating, the Board finds a conflict in medical opinion evidence has been created regarding the extent of appellant's right lower extremity impairment.[27]

Therefore, the case must be remanded for referral to an impartial medical examiner in accordance with section 8123(a) of FECA for resolution of this conflict in the medical opinion evidence.[28] After this and other such further development as OWCP deems necessary, it shall issue a *de novo* decision on the percentage of impairment for appellant's right lower extremity.

CONCLUSION

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

[25] *See M.G., supra* note 20; *Darlene R. Kennedy*, 57 ECAB 414 (2006).

[26] *See A.D.*, Docket No. 16-0841 (issue February 16, 2017); *L.S.*, Docket No. 15-1564 (issued March 4, 2016).

[27] *See S.S.*, Docket No. 19-0766 (issued December 23, 2019); *S.W.*, Docket No. 15-1740 (issued January 28, 2016).

[28] *See M.G., supra* note 20; *A.D., supra* note 26.

ORDER

IT IS HEREBY ORDERED THAT the September 20, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: June 30, 2020
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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