United States Department of Labor
Employees' Compensation Appeals Board

T.G., Appellant	)	
and	)	**Docket No. 09-1856**
	)	**Issued: August 24, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Rochester, NY, Employer	)	

Appearances:
David W. Covino, for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 13, 2009 appellant filed a timely appeal from the Office of Workers' Compensation Programs' schedule award decision dated April 30, 2009. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination.

ISSUE

The issue is whether appellant has more than a 10 percent impairment of her right leg and more than a 15 percent impairment of her right eye, for which she received schedule awards.

FACTUAL HISTORY

On January 24, 1998 appellant, then a 28-year-old rural carrier, sustained injury in a head-on collision while in the performance of duty. She stopped work. The Office accepted appellant's claim for fractured pelvis, fractured ankle, eye and facial trauma. Appellant underwent eye surgery on June 10, 1996 to repair a detached retina and additional eye surgery on January 4, 1999 for a corneal transplant and implementation of a secondary intraocular lens and lysis of peripheral anterior synechia. She underwent multiple scar revisions, including the right cheek and left eyebrow, reconstruction and repair of the right upper and lower eyelid, as well as

scar revision of the right cheek and dermabrasion of the forehead on October 10, 2000. On February 22, 2001 appellant underwent a hard palate graft to the right lower lid and right lower lid scar revision, including a cicatricial ectropian of the right eye and revision of the scar of the right lower lid. She received wage-loss compensation benefits.

In a report dated March 21, 2005, Dr. Linda Karbonit, an osteopath, noted appellant's history of injury and treatment. She utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (5th ed. 2001) (A.M.A., *Guides)*. Dr. Karbonit advised that appellant had a right corneal transplant and lens implant, which required the continued use of eye drops for elevated pressures. Appellant had limited vision and an irregular pupil on that side. Regarding the right pupil, Dr. Karbonit explained that records from an ophthalmologist suggested that she had no visual field defects; however, she noted that the best vision improvement was 20/150 in the right eye. For vision, she referred to Tables 12-2, 12-3, 12-4[1] and indicated that appellant had vision of OU 20/30, vision OD 20/150 (corrected), vision OS 20/20 or 15 percent whole person impairment.

Dr. Karbonit noted that appellant had significant facial scarring that included several revisions to the eyelids and a fracture to the right frontal sinus with residual scarring that caused puffiness around the side of the face. The face had a 22 centimeter laceration that started over the right forehead, continued through the medial aspect of the right eye, along the nose and then curled back upward behind the cheek. Dr. Karbonit advised that the scar was flat with minimal pigment change to it and minimal width. She explained that appellant had a red area over the right cheek which was about 8 x 5.5 centimeters as well as a scar including and over the left eyebrow which measured about 1.5 centimeters in diameter. Dr. Karbonit advised that the edges of the scar were slightly retracted. She referred to Table 11-5, and noted that, with facial scars, sinus fracture, and pulling of the mouth to right, appellant would fall into a Class 2 or six percent whole person impairment.[2]

Regarding the right foot, Dr. Karbonit noted that appellant's range of motion was good, and lacked only about 10 degrees of dorsiflexion in the ankle and minimal loss of eversion. She referred to Table 17-11[3] and advised that, based on 10 degrees loss of extension of right ankle, appellant had three percent whole person impairment. Regarding the paresthesia in the right leg, she referred to Table 15-3: category II -- bilateral tenderness LS, uneven sacrum, nonverifiable paresthesia into right leg; five percent whole person impairment.[4] For the pelvis, Dr. Karbonit noted that it was fairly even with good range of motion in the hip, despite being able to reach 90 degrees of flexion on the left side and only 60 degrees of flexion on the right side. She advised that appellant was able to reach 60 degrees of extension and she had full abduction and adduction without pain. Dr. Karbonit referred to Table 17-9 for hip flexion and advised that 80 degrees would warrant four percent whole person impairment.[5] She also noted six percent whole person

[1] A.M.A., *Guides* 284-85.

[2] *Id*. at 256.

[3] *Id*. at 537.

[4] *Id*. at 384.

[5] *Id*. at 537.

impairment for in the right arm, under Table 15-5, tightness in right-sided musculature with nonverifiable paresthesia.[6] Dr. Karbonit referred to the Combined Values Chart and determined that appellant had 38 percent whole person impairment.[7]

On October 12, 2005 appellant requested schedule awards.[8]

In a report dated August 31, 2006, the Office medical adviser noted that appellant's physician mixed whole person impairment with foot and lower extremity impairments and used the ankle table incorrectly. He found that appellant had a 10 percent impairment for flexion of 60 degrees. The Office medical adviser referred to Table 17-12.[9] He concluded that appellant had 10 percent impairment of the right leg.

On October 31, 2006 the Office determined that a conflict had arisen between the Office medical adviser and Dr. Karbonit regarding the extent of appellant's impairment. It requested a comprehensive report and opinion regarding the extent of impairment, if any, due to the accepted conditions which included: contusion of the face, scalp and neck, except eyes, right corneal opacity, fracture of the pelvis and a fracture of the medial malleolus of the ankle, closed.

On December 4, 2006 the Office referred appellant together with a statement of accepted facts and the medical record to Dr. Charles E. Jordan, a Board-certified orthopedic surgeon, for an impartial medical evaluation. However, in a letter dated December 7, 2006, the Office advised appellant that the appointment was cancelled and she would be notified of a new appointment, once scheduling issues were resolved.

In a letter dated December 13, 2006, the Office advised appellant that her impartial medical examination was cancelled due to scheduling problems. It noted that it might be able to circumvent the examination if her doctor provided clarification on the extent of her condition. The Office provided appellant with a copy of the medical adviser's report and requested that she obtain clarifying information from her physician. On that same date, it also sent a letter to Dr. Karbonit, requesting that she provide additional information in relation to appellant's schedule award. The Office requested an opinion on impairment for the right lower extremity.

In a December 20, 2006 report, Dr. William S. Beckett, Board-certified in internal medicine, noted that Dr. Karbonit was on medical leave. He provided an opinion based on his review of Dr. Karbonit's records from her March 21, 2005 examination. Dr. Beckett utilized the A.M.A., *Guides* and advised that, for the lower extremity, pursuant to Table 17-11[10] ankle dorsiflexion of 45 degrees and full plantar flexion would warrant zero percent impairment. He

[6] *Id*. at 392.

[7] *Id*. at 604.

[8] The record reflects that appellant received a third-party settlement in the amount of $30,513.51. Appellant had also requested a schedule award on June 20, 2003 for her facial scar.

[9] A.M.A., *Guides* 537.

[10] *Id*. at 537.

noted that pursuant to Table 17-12[11] eversion of 40 degrees and full inversion would also warrant zero percent impairment. Dr. Beckett referred to Table 17-9[12] and advised that right hip flexion of 70 degrees was 10 percent impairment. He also noted that full abduction/adduction would equal zero percent impairment. Dr. Beckett opined that appellant had 10 percent impairment to the right leg.

Appellant submitted several requests regarding the status of her schedule award. On February 5, 2008 the Office requested that the Office medical adviser provide a rating for appellant's eye loss. Appellant noted that "[u]unfortunately, no one ever rated the eye loss" along with other ratable body parts.

In a February 15, 2008 report, the Office medical adviser noted appellant's history, stating that on March 21, 2005 she was examined for her eyes and on December 20, 2006 she was examined for the right leg. He referred to Table 17-11 and 12[13] and advised that, for the ankle, dorsiflexion of 45 degrees would result in zero percent impairment and full plantar flexion was equal to zero percent impairment. For the hindfoot, full inversion would result in a zero percent impairment and eversion of 40 degrees would also result in zero percent impairment. The Office medical adviser referred to Table 17-9,[14] and advised that 70 degrees of flexion would result in 10 percent impairment. He noted that appellant had full abduction and adduction and found total right leg impairment of 10 percent. The medical adviser advised that appellant reached maximum medical improvement on December 20, 2006. In regard to the right eye, he referred to Table 12-2, Impairment of Visual Acuity, and Table 12-3: Calculation Of Acuity-Related Impairment Rating and Table 12-4: Classification Of Visual Acuity Impairment.[15] The Office medical adviser determined that appellant's vision was "OU 20/30, vision OD 20/150, corrected vision OS 20/20, which was a 15 percent whole person impairment."

In a January 7, 2009 report, Dr. Ronald Plotnik, a Board-certified ophthalmologist, noted that he originally saw appellant on November 9, 2008 after a motor vehicle accident with facial trauma to the right side of her face and damage to the eye. Appellant's history included a retinal repair and a dense corneal scar which required that she receive a corneal transplant with a secondary intraocular lens. Dr. Plotnik explained that appellant had decreased vision due to healing problems due to her lagophthalmos and lid and orbital abnormalities in terms of surfacing the eye. Appellant had an irregular pupil due to the injury, which limited her vision as well. Dr. Plotnik explained that the visual acuity was limited in the eye due to the initial trauma but that it had improved to a reasonable level to improve her depth perception. He advised that appellant had intraocular inflammation, iritis and iridocyclitis, along with glaucoma with elevated pressures in the eye requiring topical medications, surface abnormalities and some issues with irregular corneal astigmatism. Dr. Plotnik opined that her visual acuity was limited

[11] *Id*.

[12] *Id*. at 537.

[13] *Id.*

[14] *Id.*

[15] *Id.* at 284-85.

to 20/60 and the intraocular pressure was elevated (glaucoma) despite the use of topical medication. He explained that she was being followed closely for her intraocular pressure along with her transplants. Dr. Plotnik advised that appellant had a history of astigmatism within the corneal transplant, which required corneal relaxing incisions. He noted that her initial surgery was January 4, 1999.

On April 30, 2009 the Office granted appellant schedule awards for 10 percent permanent impairment of the right lower extremity and 15 percent of the right eye. The award covered a period of 28.80 weeks from December 20, 2006 to July 9, 2007.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[16] sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[17] The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[18] The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[19]

ANALYSIS

The Board finds that this case is not in posture for a decision. The Board finds that further development of the medical evidence is needed.

Initially, the Board notes that the Office's apparent finding of a medical conflict[20] in 2006 between Dr. Karbonit and an Office medical adviser was in error.[21] Appellant's physician, Dr. Karbonit, did not rate impairment of scheduled body members pursuant to the A.M.A., *Guides* but instead rated whole person impairment. She found that appellant had whole person impairment of 38 percent for loss of vision, facial injuries and right arm and leg injuries. The Act, however, does not provide a schedule award based on whole person impairments.[22]

[16] 5 U.S.C. §§ 8101-8193.

[17] *Id.* at § 8107.

[18] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[19] 20 C.F.R. § 10.404.

[20] *See* 5 U.S.C. § 8123(a).

[21] As noted, appellant was never examined by a physician due to this conflict finding as the appointment was cancelled by the Office.

[22] *See Tania R. Keka*, 55 ECAB 354 (2004); *James E. Mills*, 43 ECAB 215 (1991) (neither the Act, nor its implementing regulations provide for a schedule award for impairment to the body as a whole).

Dr. Karbonit did not otherwise provide a reasoned opinion explaining the extent of appellant's impairment to scheduled members pursuant to the A.M.A., *Guides*.[23] As she did not provide appropriate ratings for scheduled members of the body, her report did not create a conflict in the medical evidence. Thus, a medical conflict necessitating referral to an impartial specialist did not exist.

While a medical conflict did not exist, the Office did undertake further development of the medical evidence. It arranged but then cancelled an appointment with Dr. Jordan in 2006 due to scheduling issues and informed appellant that she would later be notified of a new appointment. However, the Office requested an updated opinion from Dr. Karbonit, a treating physician, who was unavailable. Instead, Dr. Beckett, on December 20, 2006, provided a rating for the right leg based on the records of Dr. Karbonit's March 21, 2005 examination. He did not conduct an examination and he did not address impairment of appellant's right eye. On February 15, 2008 an Office medical adviser provided ratings based on the reports of Drs. Karbonit and Beckett. Consequently, the April 30, 2009 schedule award decision was based on findings from Dr. Karbonit's March 21, 2005 examination.

The Board finds that, under the circumstances presented, the Office should have conducted further medical development of the claim and obtained a current medical opinion. It is well established that once the Office undertakes development of the medical evidence, it has the responsibility to do so in a proper manner.[24] The Office should have continued developing the claim after 2006 and secured a second opinion examination to determine the extent of appellant's impairment due to her accepted conditions which included contusion of the face, scalp and neck, the right cornea, fracture of the pelvis and the medial malleolus of the ankle. Proceedings under the Act are not adversarial in nature nor is the Office a disinterested arbiter.[25] While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence to see that justice is done.[26]

The case will be remanded to the Office to refer appellant for appropriate Board-certified specialists for an opinion on the nature and extent of her permanent impairment. After such further development as it deems necessary, the Office should issue an appropriate decision on appellant's claim for a schedule award.

On appeal, appellant's representative disagreed with the schedule award and asserted that the medical evidence warranted higher impairment ratings and a rating for facial disfigurement. As noted, the medical evidence requires further development to determine the extent of

[23] *See I.F.*, 60 ECAB ___ (Docket No. 08-2321, issued May 21, 2009) (an opinion which is not based upon the standards adopted by the Office and approved by the Board as appropriate for evaluating schedule losses is of diminished probative value in determining the extent of permanent impairment).

[24] *Melvin James*, 55 ECAB 406 (2004).

[25] *Phillip L. Barnes*, 55 ECAB 426 (2004).

[26] *Donald R. Gervasi*, 57 ECAB 281 (2005); *William B. Webb*, 56 ECAB 156 (2004).

appellant's permanent impairment. Following such development, the Office will issue an appropriate decision regarding appellant's permanent impairment.[27]

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 30, 2009 is set aside. The case is remanded for further action consistent with this decision.

Issued: August 24, 2010
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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

[27] The April 30, 2009 decision addressed only impairment of the right leg and right eye. The record also indicates that appellant filed a schedule award claim for facial disfigurement in 2003. As the Office has not yet issued a decision on this claim, the Board does not have jurisdiction to consider it on this appeal. *See* 20 C.F.R. § 501.2(c).