

¹ 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On August 15, 2002 appellant, then a 44-year-old tow boat pilot, filed a traumatic injury claim alleging that, on August 14, 2002, while landing a pump, he became entangled in a coil of cable on the barge deck and fell, thereby sustaining a fracture to his lower leg above the ankle. On August 15, 2002 he underwent an open reduction-internal fixation left tibia and fibula. OWCP accepted appellant's claim for fractures in left tibia and fibula with postoperative infection. On January 13, 2005 it had surgery to remove the hardware in the left tibia and fibula. Appellant's claim for a recurrence on January 13, 2005 was accepted by OWCP on March 28, 2005.

In a March 22, 2012 report, Dr. Michael J. Platto, a Board-certified physiatrist, conducted an impairment rating evaluation pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009). He indicated that two models could be used to perform this evaluation. Dr. Platto stated that, in Table 16-2, the closest diagnosis would be fracture dislocation of the tibia extra articular on page 502. However, he concluded that his diagnosis did not fit because appellant not only had a fracture of the tibia, but also of the fibula and there is a diagnosis listed in Table 16-2 which includes a comminuted distal tibia fibular fracture. Dr. Platto then noted that, according to page 543, the Range of Motion Impairment Model is to be used as a stand alone rating when other grids refer one to this section or no other diagnosis-based sections of this chapter are applicable for impairment rating of condition. He believed that this was the appropriate way to evaluate appellant's impairment and therefore used the range of motion model. Dr. Platto found that appellant had 20 degrees flexion contracture of the left ankle of neutral, which according to Table 16-22, page 549, would be a severe 30 percent lower extremity impairment. He also noted that according to Table 16-20, page 549, hind foot motion impairment inversion of 11 degrees would be a mild two percent lower extremity impairment. Accordingly, Dr. Platto found that appellant had a 32 percent left lower extremity impairment rating. He then applied the grade modifiers and determined that they would not alter his finding. Dr. Platto noted that, in terms of Functional History Adjustment Table 16-6 at page 516 of the A.M.A., *Guides*, appellant had a mild problem antalgic limp with asymmetric shortened stance, which corrects with footwear modifications and orthotics, which appellant does wear. He indicated that this would be a grade modifier 1. In the case of functional history, Dr. Platto determined that grade adjustment was actually less than the range of motion ICF class, so no additional impairment was given. Therefore, he concluded that the impairment rating remained at 32 percent of the left lower extremity.

On April 5, 2012 appellant filed a claim for a schedule award.

On April 10, 2012 OWCP asked its medical adviser to evaluate appellant's claim with regard to impairment to the left lower extremity. An OWCP medical adviser responded in a report dated April 19, 2012. He also noted that the method of calculation could be based on diagnosis of fractured tibia, which would be appropriate by utilizing Table 16-2, page 502. The medical adviser noted that the fibula is considered part and parcel of the tibial fracture and therefore does not require a separate calculation. Accordingly, he indicated that Dr. Platto's description of the diagnosis was not appropriate. The medical adviser further noted that Dr. Platto's examination was not consistent with the examination of the treating surgeons. He stated that Dr. Platto's calculation was based on a 20-degree flexion contracture which was

calculated as part of ankle range of motion. The medical adviser found that if appellant had a 20-degree flexion contracture as well as other contractures, he would be nonambulatory and this would not be consistent with an ambulating patient. He concluded that there were two alternatives. One could utilize the standard calculation utilizing the diagnosis with moderate motion deficit or mild motion deficit as defined by the A.M.A., *Guides* or alternatively, a second opinion should be obtained prior to consideration of awarding a schedule award because the range of motions proposed by Dr. Platto did not appear to be consistent with the treating physician's examination or with the clinical circumstances and functional levels described. The medical adviser noted that in the operative note the fracture was described as extra-articular but low to the joint which means it is not an intra-articular pylong fracture. Therefore, he concluded that the diagnosis of tibial fracture as listed on page 502 would be the optimal diagnostic category and not the intra-articular pylong fracture which would not be the diagnosis according to the operative note described. The medical adviser then calculated appellant's impairment as follows. Utilizing page 502, Table 16-2, he found that appellant's tibial fracture diagnosis class 2, moderate-to-severe deficit on range of motion and/or moderate malignment, class, 1 equaled a 19 percent impairment, default value grade C, with a range of 14 to 25 percent. Utilizing the adjustment grid or grade modifiers, the medical adviser found that, for Functional History, appellant had a mild problem with antalgic limp, which corrects with footwear modification for a grade modifier 1; for Physical Examination Adjustment, Table 16-7 on p. 517, he noted a moderate motion loss, for grade 2. For Clinical Studies Adjustment, Table 16-8 on page 518, the medical adviser found a grade modifier 1. Utilizing the net adjustment formula, he noted that the net adjustment was minus 1. Therefore, utilizing Table 16-2, class 2, the grade is moved from grade C to grade B for a 17 percent impairment. The medical adviser therefore concluded that appellant should receive a schedule award for a 17 percent impairment of the left lower extremity.

On June 7, 2012 OWCP issued a schedule award for a 17 percent lower extremity impairment.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations² set forth the number of weeks of compensation payable to employee sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. FECA, however, 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 that rests within the sound discretion of OWCP.³ For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates 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 the implementing

² 20 C.F.R. § 10.404.

³ *Linda R. Sherman*, 56 ECAB 127 (2004); *Daniel C. Goings*, 37 ECAB 781 (1986).

regulations as the appropriate standard for evaluating schedule losses.⁴ As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.⁵

The sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.⁶ The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).⁷ The sixth edition of the A.M.A., *Guides* also provides that range of motion may be selected as an alternative approach in rating impairment under certain circumstances. A rating that is calculated using range of motion may not be combined with a diagnosis-based impairment and stands alone as a rating.⁸

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the percentage of impairment using the A.M.A., *Guides*.⁹

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.¹⁰

ANALYSIS

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

The sixth edition of the A.M.A., *Guides* states that diagnosis-based impairment is the primary method of evaluation for the upper limb and method of choice for calculating impairment.¹¹ On the other hand, range-of-motion based impairment may be used as a stand-alone rating when other grids refer the evaluator to this method or when no other diagnosis-based

⁴ Ronald R. Kraynak, 53 ECAB 130 (2001).

⁵ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

⁶ A.M.A., *Guides* 494-531.

⁷ *Id.* at 521.

⁸ *L.B.*, Docket No. 12-910 (issued October 5, 2012).

⁹ Federal (FECA) Procedure Manual, *supra* note 5 at Chapter 2.808.6(d) (August 2002).

¹⁰ *R.C.*, Docket No. 12-437 (issued October 23, 2012).

¹¹ A.M.A., *Guides*, 387, 461.

sections are applicable for impairment rating of a condition.¹² A range of motion impairment stands alone and is not combined with diagnosis impairment.¹³

Both Dr. Platto and the medical adviser contend that there are two ways to determine appellant's impairment rating. The medical adviser opined that the best way was by utilizing Table 16-2. There is a conflict between he and Dr. Platto with regard to the best way to calculate impairment under this table. Dr. Platto reported that there was a category for fracture of the tibia, but that this was not appropriate because appellant's diagnoses included a comminuted distal fibular fracture. Accordingly, he determined that using this table was not the best way to evaluate appellant's impairment and evaluated appellant based on range of motion. The medical adviser disagreed and opined that applying Table 16-2 was the best way to determine appellant's impairment. He noted that the fibula was considered part and parcel of the tibial fracture and therefore did not require a separate calculation. Therefore, the Board finds that a conflict in medical opinion exists between Dr. Platto and the medical adviser with regard to the best method by which to rate appellant's left lower extremity impairment. The Board has long held that an OWCP medical adviser may create a conflict in medical opinion with an examining physician.¹⁴ Accordingly, the Board remands this case for referral of appellant to an impartial medical examiner to resolve the conflict between Dr. Platto and the medical adviser with regard to the proper way to evaluate appellant's impairment.

With regard to range of motion findings, both physicians appear to indicate that this may be a possible way to evaluate appellant's impairment. However, the medical adviser finds that Dr. Platto's findings are in conflict with prior examinations. Furthermore, he indicated that if appellant had a 20-degree flexion contracture, he would not be ambulatory. The medical adviser recommended a second opinion because the range of motions proposed by Dr. Platto did not appear to be consistent with earlier reports. He did not examine appellant. Accordingly, remand is also necessary so that a new physician can conduct an examination and make findings on physical examination with regard to appellant's range of motion.

CONCLUSION

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

¹² *Id.* at 461. See also *id.* at 387 (“[r]ange of motion is used primarily as a physical examination adjustment factor and only to determine actual impairment values when a grid permits its use as an option ...”). (Emphasis omitted.)

¹³ *Id.* at 405.

¹⁴ T.S., Docket No. 08-470 (issued September 24, 2008).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 7, 2012 is set aside and the case is remanded for further proceedings consistent with this opinion.

Issued: February 26, 2013
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