United States Department of Labor
Employees' Compensation Appeals Board

R.S., Appellant	)	
and	)	**Docket No. 14-138**
	)	**Issued: June 12, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Richmond, VA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 22, 2013 appellant, through his attorney, filed a timely appeal from an August 1, 2013 merit decision 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 this case.

ISSUE

The issue is whether appellant has more than a one percent impairment of his left lower extremity and whether he is entitled to an additional award for impairment of the right lower extremity.

FACTUAL HISTORY

On April 29, 2002 appellant, then a 52-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that he developed a bilateral foot condition as a result of

[1] 5 U.S.C. § 8101 *et seq.*

walking several miles a day and standing on concrete floors during his federal employment. OWCP accepted the claim for bilateral calcaneal spurs and bilateral plantar fibromatosis. On July 30, 2004 appellant underwent a left heel spur excision and plantar fasciectomy. On February 16, 2007 he underwent the same procedure on the right side.

The Board notes that appellant has a separate occupational disease claim for a right knee injury, which was accepted by OWCP on February 26, 2007 for right derangement of anterior horn of lateral meniscus, Claim No. xxxxxx268.[2] On June 17, 2008 appellant received a schedule award for eight percent right lower extremity impairment under that file.

On February 28, 2011 appellant filed a claim for a schedule award under this Claim No. xxxxxx692.

Appellant submitted a February 15, 2011 impairment evaluation summary from Dr. Limor Glazer, a treating physician,[3] who reported that, in 2007, appellant underwent additional surgeries on both feet that included bone spur removal and plantar fascial release. A functional capacity evaluation was obtained on December 28, 2010. Appellant complained of continued bilateral foot pain and noted that he had other medical issues involving multiple herniated discs in his neck and right knee osteoarthritis. Dr. Glazer utilized the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (2001) to determine appellant's impairment rating. He noted objective findings of the thigh at 44 centimeters (cm) on the right and 43.5 cm on the left. The calf was marked as 36 cm on the right and 37 cm on the left. These figures were used to calculate three percent lower extremity impairment. Dr. Glazer then noted range of motion figures for the right ankle, right toe, left ankle and left toe. Based on appellant's range of motion, he concluded that appellant had 13 percent right ankle impairment and 11 percent left ankle impairment. Dr. Glazer further noted five percent right whole person impairment and four percent left whole person impairment for a total whole person impairment of nine percent.

On May 16, 2011 OWCP routed Dr. Glazer's report, a statement of accepted facts and the case file to a district medical adviser (DMA), Dr. Christopher R. Brigham, Board-certified in occupational medicine, for review and a determination on whether appellant sustained a permanent partial impairment and the date of maximum medical improvement.

In a May 26, 2011 report, the DMA reported that he reviewed Dr. Glazer's February 15, 2011 report to determine the proper impairment rating. He stated that Dr. Glazer improperly used the fifth edition of the A.M.A., *Guides.* Using the sixth edition of the A.M.A., *Guides*, the DMA calculated one percent permanent impairment of the left ankle and one percent permanent impairment of the right ankle.[4] He noted that, under Table 16-2, Foot and Ankle Regional Grid, the diagnosis of bilateral plantar fasciitis had a class 1 rating with a default score of one percent

[2] This Claim No. xxxxxx692, was administratively combined with Claim No. xxxxxx268. Claim No. xxxxxx692 is the master claim file.

[3] The Board notes that the impairment evaluation was performed and signed by a physical therapist and cosigned by Dr. Glazer.

[4] A.M.A., *Guides* (2009).

lower extremity impairment.[5] The DMA further noted that appellant was assigned a grade modifier 0 for functional history because there was no evidence that he walked with a gait.[6] Appellant was assigned a grade modifier 1 for physical examination, which revealed mild ankle motion deficits bilaterally and a grade modifier 1 for clinical studies which confirmed the diagnosis.[7] The net adjustment of the three modifiers compared to diagnosis class 1 was negative 1; grade B, one percent lower extremity impairment bilaterally.

The DMA further noted that appellant was previously awarded eight percent lower extremity impairment for the right knee. He stated that the medical records showed that appellant had an arthroscopic debridement of the lateral femoral cartilage defect followed by osteochondral autograft transplantation of lateral femoral condyle with bone plug. The DMA recalculated appellant's right knee impairment for arthritis pathology and determined that he sustained a six percent permanent impairment of the right knee. Using Table 16-3, Knee Regional Grid, of the A.M.A., *Guides*, he placed appellant in the diagnostic category of "primary knee joint arthritis" under class 1 based on full thickness articular cartilage defect for a default score of seven percent.[8] According to Table 16-6 functional history adjustment, appellant was assigned a grade modifier of 0 as functional history was consistent with "no problems."[9] The DMA found a physical examination grade modifier of 1 as appellant still had some symptoms[10] and did not utilize a grade modifier for clinical studies as clinical studies were not used to confirm the diagnosis.[11] Based on a functional history grade modifier of 0 and physical examination grade modifier of 1 with no applicable clinical studies, the net adjustment of -1 equaled 1 position to the left of class 1 default grade C resulting in grade B.[12] Thus, appellant had six percent lower extremity impairment.[13]

The DMA combined the one percent impairment for the right ankle/foot with the six percent impairment of the right knee to reach a total of seven percent right lower extremity impairment. He noted that, because appellant received a previously awarded eight percent right lower extremity impairment, he was not afforded an additional impairment and would be awarded zero percent for the right lower extremity. The DMA further found that appellant sustained a one percent permanent impairment of the left lower extremity. The date of maximum medical improvement was noted as February 15, 2011, the date of Dr. Glazer's initial examination.

[5] *Id.* at 511.

[6] *Id.* at 516, Table 16-6.

[7] *Id.* at 517-18.

[8] *Id.* at 509, Table 16-3.

[9] *Id.* at 516.

[10] *Id.* at 517, Table 16-7.

[11] *Id.* at 518.

[12] *Id.* at 520, Table 16-9.

[13] *Supra* note 5.

By decision dated August 29, 2011, OWCP granted appellant a schedule award claim for one percent permanent impairment of the left lower extremity. It provided no additional impairment for the right lower extremity, noting that he had previously received an eight percent right lower extremity impairment and the DMA calculated a lower seven percent right lower extremity impairment.

Appellant, through counsel, requested a hearing before the Branch of Hearings and Review, which was held on January 11, 2011.

By decision dated March 15, 2012, the Branch of Hearings and Review affirmed the August 29, 2011 schedule award decision.

By letter dated February 27, 2013 appellant, through counsel, requested reconsideration of the March 15, 2012 decision.

By decision dated August 1, 2013, OWCP affirmed the August 29, 2011 schedule award decision.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations 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.[14] However, FECA does not specify the manner in which the percentage of loss shall be determined. 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 regulations as the appropriate standard for evaluating schedule losses.[15]

The A.M.A., *Guides* provide a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health. For lower extremity impairments, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[16] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[17] Evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[18]

[14] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[15] *K.H.*, Docket No. 09-341 (issued December 30, 2011). For decisions issued after May 1, 2009, the sixth edition will be applied. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

[16] *Supra* note 4 at 493-531.

[17] *Id*. at 521.

[18] *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

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 nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[19]

ANALYSIS

OWCP accepted appellant's claim for bilateral calcaneal spurs and bilateral plantar fibromatosis. In a separate claim, it accepted his claim for right derangement of anterior horn of lateral meniscus for which he had received a schedule award for eight percent permanent impairment of the right lower extremity. The issue is whether appellant sustained more than a one percent impairment of the left lower extremity and more than eight percent impairment award of the right lower extremity. The Board finds that he has not met his burden of proof to establish increased impairment of the lower extremities.

Dr. Glazer's February 15, 2011 report utilized the fifth edition of the A.M.A., *Guides* to calculate 13 percent right ankle impairment, 11 percent left ankle impairment, 5 percent right whole person impairment and 4 percent left whole person impairment for a total whole person impairment of 9 percent. The Board notes that there is no statutory basis for the payment of a schedule award for whole body impairment under FECA.[20] Payment is authorized only for the permanent impairment of specified members, organs or functions of the body. Moreover, Dr. Glazer incorrectly utilized the fifth edition of the A.M.A., *Guides* as schedule awards are to be calculated under the sixth edition effective May 1, 2009.[21]

Dr. Glazer's report was routed to the DMA who noted the above defects. The DMA's May 26, 2011 report provided calculations, under the sixth edition of the A.M.A., *Guides*, establishing a one percent permanent impairment of the left ankle and one percent permanent impairment of the right ankle based on Dr. Glazer's February 15, 2011 report. The DMA also noted that the medical records showed that appellant had an arthroscopic debridement of the lateral femoral cartilage defect followed by osteochondral autograft transplantation of lateral femoral condyle with bone plug. He recalculated appellant's right knee for arthritis pathology and determined that he sustained a six percent permanent impairment of the right knee. The DMA combined the one percent impairment for the right ankle/foot with the six percent impairment of the right knee to arrive at a total of seven percent right lower extremity impairment. He noted that, because appellant had previously been awarded a schedule award for eight percent permanent impairment of the right lower extremity, he was not entitled to an increased right lower extremity schedule award. Thus, the DMA found that appellant was only entitled to one percent permanent impairment of the left lower extremity. The date of maximum medical improvement was noted as February 15, 2011.

[19] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

[20] *N.M.*, 58 ECAB 273 (2007).

[21] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 (January 2010).

The Board notes that the DMA properly utilized the A.M.A., *Guides* with reference to the appropriate tables and specific grade modifiers to calculate the impairment ratings based on the report referenced.

The DMA noted that, under Table 16-2, Foot and Ankle Regional Grid, the diagnosis of plantar fasciitis had a class 1 rating with a default score of one percent lower extremity impairment.[22] He further noted that appellant was assigned a grade modifier 0 for functional history because there was no evidence that he walked with a gait.[23] Appellant was assigned a grade modifier 1 for physical examination, which revealed mild ankle motion deficits bilaterally and a grade modifier 1 for clinical studies which confirmed the diagnosis.[24] Applying the net adjustment formula, the DMA properly subtracted 1, the numerical value of the class, from the numerical value of the grade modifier for each component (functional history, physical examination and clinical studies) and then added those values, resulting in a net adjustment of -1 ((0-1) + (1-1) + (1-1)).[25] This resulted in a class 1 adjustment negative 1, which equaled class 1 grade B, resulting in a one percent lower extremity impairment for each side.

The DMA also properly evaluated appellant's right knee impairment under the relevant standards of the sixth edition of the A.M.A., *Guides*. He provided a detailed pre and postoperative history, examination findings and clinical studies to calculate an impairment rating for permanent residuals of the lower left extremity. The DMA indicated that, according to Table 16-3, Knee Regional Grid, appellant fell under the diagnosis-based category of "primary knee joint arthritis" under class 1 based on full thickness articular cartilage defect for a default score of seven percent.[26] Appellant was assigned a grade modifier of 0 as functional history was consistent with "no problems,"[27] A grade modifier of 1 for physical examination because he still had some symptoms[28] and did not assign a grade modifier for clinical studies as none were used to confirm the diagnosis.[29] Applying the net adjustment formula, the DMA properly subtracted 1, the numerical value of the class, from the numerical value of the grade modifier for each component (functional history and physical examination) and then added those values, resulting in a net adjustment of -1 ((0-1) + (1-1) + (n/a)).[30] He properly found that the net adjustment of -1

[22] *Supra* note 4 at 501.

[23] *Id.* at 516, Table 16-6.

[24] *Id.* at 517-18.

[25] *Id.* at 521.

[26] *Id.* at 509, Table 16-3.

[27] *Id.* at 516, Table 16-6.

[28] *Id*. at 517, Table 16-7.

[29] *Id.* at 519.

[30] *Id.* at 520.

equaled 1 position to the left of class 1 default grade C resulting in grade B.[31] Thus, appellant had six percent lower extremity impairment based on his right knee arthritis pathology.[32]

The Board finds that OWCP properly awarded appellant a schedule award for one percent permanent impairment of the left lower extremity. The Board further finds that OWCP properly determined that he was not entitled to additional schedule award compensation beyond the eight percent right lower extremity impairment previously awarded. The date of maximum medical improvement was correctly noted as February 15, 2011, the date of appellant's evaluation with Dr. Glazer, as the determination of the date ultimately rests with the medical evidence[33] and is usually considered to be the date of the evaluation by the physician which is accepted as definitive by OWCP.[34]

Appellant did not submit any additional medical evidence on appeal which would establish that he has more than one percent impairment to the left lower extremity or entitled to an additional award for permanent impairment of the right lower extremity. On appeal, counsel argued that OWCP's methodology amounts to junk science. The Board notes, however, that the A.M.A., *Guides* have been adopted as the uniform standard applicable to all claimants for the determination of permanent impairment under FECA.[35]

CONCLUSION

The Board finds that appellant has not established that he has more than a one percent impairment of his left lower extremity for which he received schedule awards and is also not entitled to an additional award for impairment of the right lower extremity.

[31] *Id.* at 520, Table 16-9.

[32] *Id.* at 511.

[33] *L.H.*, 58 ECAB 561 (2007).

[34] *Mark Holloway*, 55 ECAB 321, 325 (2004).

[35] *See D.S.*, Docket No. 13-2011 (issued February 18, 2014). *See also J.C.*, Docket No. 11-241 (issued September 22, 2011); *M.R.*, Docket No. 11-84 (issued September 21, 2011).

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated August 1, 2013 is affirmed.

Issued: June 12, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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