

multiple preexisting medical problems including diabetes and cerebral palsy. He stated that she presented with pain in her left shoulder, left trapezius and left cervical spine and reported blurred vision in her left eye resulting from a fall at work.

In a December 29, 2000 report, Dr. Hernando Zegarra, an attending Board-certified ophthalmologist, wrote that within two hours of her fall appellant noticed blurred vision in her left eye. He indicated her visual acuity in her left eye was 20/400 compared to 20/20 in her right eye. An ophthalmoscopy revealed a dense vitreous hemorrhage with poor visualization of the retina and a localized detachment with retinal break. He diagnosed proliferative diabetic retinopathy with active disc neovascularization and mild macular edema of the right eye, vitreous hemorrhage and localized retinal detachment of the left eye and a history of a head injury. Dr. Zegarra recommended surgery and on January 12, 2001 Dr. David Miller, an attending Board-certified ophthalmologist, performed eye surgery on appellant's left eye. His postoperative diagnosis was vitreous hemorrhage secondary to proliferative diabetic retinopathy and tractional retinal detachment.

On February 27, 2001 the Office accepted appellant's claim for cervical sprain, left shoulder sprain, left retinal detachment, left vitreous hemorrhage and left round hole of retina. Eye surgery was authorized and appellant received total temporary disability compensation.

Appellant had a subsequent surgery on her left eye in March 2001 for diabetic traction retinal detachment and in June 2001 she underwent cataract surgery with an implant. On July 6, 2001 Dr. Miller performed his fourth surgical procedure on appellant's left eye. His diagnosis was traction retinal detachment secondary to proliferative diabetic retinopathy, proliferative vitreoretinopathy, anterior fibrovascular hyaloid proliferation and rhegmatogenous retinal detachment of the left eye. In an October 25, 2001 report, Dr. Miller wrote that appellant has developed anterior hyaloid proliferation in the left eye. He indicated that appellant presented with visual acuity in her right eye of 20/20 but her left eye could only see a hand motion at one foot. Dr. Miller noted that there was very little hope of her regaining useful vision in her left eye.

On November 5, 2001 appellant requested a schedule award. In a December 8, 2001 report, Dr. Miller stated, "[Appellant] has undergone multiple surgeries to her left eye. Due to the underlying condition of proliferative diabetic retinopathy, the vision has not improved in spite of the surgeries. She has reached maximum level of vision in the left eye at hands motion."

In a January 21, 2002 report, Dr. Miller noted that appellant was under his treatment for diabetic retinopathy in both eyes complicated by retinal detachment in the left eye. He stated that appellant had a long history of diabetes mellitus and developed proliferative diabetic retinopathy sometime in the past year or two. Dr. Miller indicated that appellant had a fall at work which precipitated the retinal detachment and bleeding in the left eye. He stated, "Although she did indeed have the underlying condition of the proliferative diabetic retinopathy, it is the fall that started the sequence of events leading to the loss of vision in the left eye." In a February 5, 2002 report, Dr. Miller wrote that appellant was completely blind in her left eye.

On February 22, 2002 the Office referred appellant for a second opinion evaluation. In a March 4, 2002 report, Dr. Howard Siegel, a Board-certified ophthalmologist, wrote that

appellant had no vision in her left eye and there was no further treatment possible. Dr. Siegel indicated that appellant's best corrected vision in the right eye was 20/20 for vision but that she had some peripheral loss of vision. He noted that there was no expected change in her eye condition in the immediate future. Using the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), he provided the following results of his calculations:¹ functional acuity score 80; functional visual field score 50; functional vision score 40; impairment 60; impairment class 4.

By award of compensation dated March 29, 2002 decision, the Office granted appellant a schedule award for a 60 percent permanent impairment of her left eye.

In an October 4, 2002 report, Dr. Richard Statesir, an attending Board-certified eye surgeon, stated that appellant suffered a left eye trauma in December 2000 and ultimately developed both a cataract and retinal detachment in her left eye. He indicated that appellant's general course was a downhill deterioration of the left eye with resultant loss of vision and noted that ultimately her left eye might have to be removed.

Appellant requested a hearing before an Office hearing representative which was held on October 23, 2002. Appellant's representative emphasized that appellant had no vision in her left eye and therefore should be entitled to compensation for a 100 percent impairment, not for the 60 percent she was awarded. In a decision dated and finalized January 8, 2003, the Office hearing representative affirmed the Office's March 29, 2002 decision. The Office hearing representative indicated that the weight of the medical evidence was properly given to Dr. Siegel and stated that the A.M.A., *Guides* determines visual impairment by calculating both eyes together, not individually.

LEGAL PRECEDENT

Section 8107(c)(19) of the Federal Employees' Compensation Act provides that "[t]he degree of loss of vision or hearing under this schedule is determined without regard to correction."² The A.M.A., *Guides* defines a permanent visual impairment as a permanent loss of vision that remains after maximal medical improvement of the underlying medical condition has been reached.³ The A.M.A., *Guides* indicates that the evaluation of visual impairment is based on the functional vision score (FVS), which is the combination of an assessment of visual acuity, the ability of the eye to perceive details, necessary for activities such as reading; and an assessment of visual field, the ability of the eye to detect objects in the periphery of the visual environment, which relates to orientation and mobility.⁴ The A.M.A., *Guides* also allows for

¹ Dr. Siegel also included a visual disability worksheet that showed how he reached his impairment rating.

² 5 U.S.C. § 8107(c)(19).

³ A.M.A., *Guides* 278 (5th ed. 2001). The fifth edition of the A.M.A., *Guides*, applicable in the present case, became effective February 1, 2001. See FECA Transmittal No. 02-12 (issued August 30, 2002).

⁴ *Id.* at 278, 280, 296. This represents a change from the visual efficiency scale that was used up to the fourth edition of the A.M.A., *Guides*, as the extra scale and losses for diplopia and aphasia have been removed. The current edition of the A.M.A., *Guides* also utilizes a different formula for calculating visual impairment ratings to better account for situations where the binocular function is not identical to the function of the better eye.

individual adjustments for other functional deficits, such as contrast and glare sensitivity, color vision defects and binocularity, stereopsis, suppression and diplopia, only if these deficits are not reflected in a visual acuity or visual field loss.⁵ However, the A.M.A., *Guides* specifically limits adjustment of the impairment rating for these deficits to cases which are well documented and states, “The adjustment should be limited to an increase in the impairment rating of the visual system (reduction of the FVS) by, at most, 15 points.”⁶

Visual acuity is usually measured with symbols on a letter chart and recorded as a fraction comparing the individual’s performance to a performance standard.⁷ In the United States, it is customary to standardize the numerator at 20. Thus, a visual acuity of ½ is recorded as 20/40 and one of 1/5 is recorded as 20/100.⁸ Table 12-2, *Impairment of Visual Acuity*, is used to convert these readings to visual acuity scores (VAS).⁹ The formula which yields the functional acuity score (FAS) is $(3 \times VAS_{OU} + VAS_{OD} + VAS_{OS})/5$ where OU is binocular vision, OD is vision in the right eye and OS is vision in the left eye.¹⁰

Visual fields can be measured through three means: the confrontation visual field, used to confirm a normal vision field only when the individual has not claimed a vision field loss; Goldmann visual field equipment; and automated perimetry. In measuring visual fields, the number of points seen on a standardized visual field grid is counted. The average normal field is 100 points.¹¹ Table 12-5, *Impairment of the Visual Field*, is used to convert these readings to visual field scores (VFS).¹² The formula which yields the functional field score (FFS) is $(3 \times VFS_{OU} + VFS_{OD} + VFS_{OS})/5$.¹³ The FVS is reached by multiplying the FAS times the FFS and dividing that figure by 100. Subtracting the FVS from 100 provides the visual impairment rating.¹⁴

ANALYSIS

In the present case, Dr. Siegel, a Board-certified ophthalmologist who served as an Office referral physician, properly applied the relevant standards of A.M.A., *Guides* to determine that

⁵ A.M.A., *Guides* 297.

⁶ *Id.*

⁷ *Id.* at 281.

⁸ *Id.*

⁹ *Id.* at 284, Table 12-2.

¹⁰ *Id.*

¹¹ A.M.A., *Guides* 287-88. The A.M.A., *Guides* specifically finds that tangent screen testing is not an acceptable method to determine visual field for accurate assessment of permanent impairment.

¹² A.M.A., *Guides* 289, Table 12-5.

¹³ *Id.* at 289, Table 12-6.

¹⁴ *Id.* at 296.

appellant had a permanent visual impairment which would entitle her to a schedule award for a 60 percent impairment of her left eye. Dr. Siegel used Table 12-2 of the fifth edition of the A.M.A., *Guides* to convert the findings derived from appellant's reading of symbols on a letter chart to VAS.¹⁵ He then took the VAS for left eye vision (0), right eye vision (100), and binocular vision (100) and applied the formula for deriving the FAS. As noted above, this formula is $(3 \times VAS_{OU} + VAS_{OD} + VAS_{OS})/5$ where OU is binocular vision, OD is vision in the right eye and OS is vision in the left eye.¹⁶ This calculation yielded an FAS of 80.

Dr. Siegel then used Table 12-5 to convert the readings from visual field testing to VFS.¹⁷ He took the VFS for left eye vision (0), right eye vision (62), and binocular vision (186) and applied the formula for deriving the FFS. This formula is $(3 \times VFS_{OU} + VFS_{OD} + VFS_{OS})/5$ and the calculation yielded a FFS of 50.¹⁸ Dr. Siegel then calculated the functional vision score by multiplying the FAS, 80, times the FFS, 50, and dividing that figure by 100.¹⁹ He subtracted the result of this calculation, 40, from 100 to provide the visual impairment rating of 60 percent.²⁰

Appellant's representative argued that appellant had no vision in her left eye and therefore should be entitled to compensation for a 100 percent impairment, not for the 60 percent she was awarded. However, as explained above, the relevant standards of the fifth edition of the A.M.A., *Guides* provide that visual impairment is determined by measuring the functional acuity and field vision of both eyes together. On appeal, appellant's attorney cited a Board case, *Arnold J. Giannini*, 31 ECAB 931 (1980), which he felt showed that appellant was entitled to a schedule award for 100 percent impairment. However, the schedule award granted for visual impairment in *Giannini* was calculated under the standards of the first edition of the A.M.A., *Guides*; the relevant standards for calculating the schedule award in the present case, are found in the fifth edition of the A.M.A., *Guides*. The standards for evaluating visual impairment under the fifth edition of the A.M.A., *Guides* are substantially different from those of earlier editions.

The record contains a January 22, 2002 report in which Dr. Miller, an attending Board-certified ophthalmologist, stated that appellant had a 50 to 61 percent impairment of her whole person. However, the Board has found that a schedule award is not payable under section 8107 of the Act for an impairment of the whole person.²¹ Moreover, the opinion of Dr. Miller is of limited probative value in that he did not clearly specify the precise extent of the permanent impairment and he failed to provide an explanation of how his assessment was derived in accordance with the standards adopted by the Office and approved by the Board as appropriate for evaluating

¹⁵ *Id.* at 284, Table 12-2.

¹⁶ *Id.*

¹⁷ *Id.* at 289, Table 12-5.

¹⁸ *Id.* at 289, Table 12-6.

¹⁹ *Id.* at 296.

²⁰ Dr. Spiegel specifically indicated it was not necessary to make individual adjustments for other functional deficits not reflected in the visual acuity loss or visual field loss. *See supra* notes 5 and 6 accompanying text.

²¹ *See Gordon G. McNeill*, 42 ECAB 140, 145 (1990).

schedule losses.²² As Dr. Siegel's report is the only medical evidence in the record that conforms with the A.M.A., *Guides*, his report is the weight of the medical evidence.²³

CONCLUSION

The Board finds that appellant did not meet her burden of proof to establish that she has more than a 60 percent permanent impairment of her left eye, for which she received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated January 8, 2003 and March 29, 2002 are affirmed.

Issued: June 21, 2004
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

²² See *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989).

²³ See *Bobby L. Jackson*, 40 ECAB 593, 601 (1989).