

percent impairment of the right lower extremity or 7 percent impairment of the left lower extremity.² The Board accorded special weight to the medical opinion of Dr. James H. Rutherford, an impartial specialist selected to resolve the conflict in medical evidence between Dr. Brian F. Griffin, appellant's treating physician and Dr. Manhal Ghanma, the second opinion examiner, regarding permanent impairment. The facts of this case as set forth in the prior decision are incorporated by reference. The facts relevant to this appeal are set forth.

Appellant requested reconsideration on July 26, 2009. In a July 24, 2008 report, Dr. Nancy Renneker, a Board-certified physiatrist, reviewed the medical records and presented her examination findings. She found that appellant reached maximum medical improvement with respect to the November 1, 1998 work injury. Based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), Dr. Renneker opined that appellant had 31 percent left leg impairment and 41 percent right leg impairment. She noted the various tables in the fifth edition of the A.M.A., *Guides* along with her impairment calculations and provided an impairment worksheet. Physical therapy reports beginning August 13, 2009 were also provided.

On October 9, 2009 OWCP reviewed appellant's file and noted that Dr. Rutherford, who served as the impartial medical examiner with respect to her schedule award determination, had previously examined her on July 2, 2002 at OWCP's direction to assess the nature and extent of her injury-related condition. It noted that the Board precedent did not allow a physician previously connected with the claim to serve as an impartial medical examiner. Therefore, referral to a new impartial examiner was necessary as the conflict between Drs. Griffin and Ghanma remained unresolved.

OWCP initially referred appellant to Dr. Charles Lowrey, a Board-certified orthopedic surgeon, to resolve the medical conflict as to whether appellant reached maximum medical improvement and, if so, the extent of permanent impairment. He provided a November 17, 2009 report that required clarification as he provided an impairment rating of seven percent whole person, which was comprised of four percent impairment due to injury to the right knee and lateral plantar nerve secondary to tarsal tunnel syndrome and three percent impairment due to plantar fasciitis. Dr. Lowrey also advised the impairment was confined to the foot and did not involve the lower extremity.

On December 15, 2009 OWCP requested that Dr. Lowrey clarify his opinion; but it received no response from him other than a copy of his November 17, 2009 report with February 26, 2010 annotations. Dr. Lowrey indicated that appellant had 14 percent lower extremity impairment. The worksheet noted the tables used, which appeared to be from the fifth edition of the A.M.A., *Guides* and showed how the 14 percent lower extremity impairment was calculated for the right leg only.

On April 6, 2010 OWCP determined Dr. Lowrey's response was insufficient to resolve the conflict. It referred appellant for an impartial examination by Dr. Kenneth Doolittle, a Board-certified orthopedic surgeon.

² Docket No. 08-2380 (issued July 7, 2009).

In a May 26, 2010 report, Dr. Doolittle noted the history of injury, reviewed the medical records and presented his examination findings. Bilateral foot and lower extremity examination showed well-healed incisions at the medial feet bilaterally without erythema, edema, ecchymosis or infection. Vascular and skin examination were essentially normal, with a mild positive plantar fascia sign bilaterally. Neurological examination was also essentially normal with dysesthesia complaint with light touch or palpation. There were no focal motor or sensory deficits. Based on prior medical documentation, Dr. Doolittle opined that appellant reached maximum medical improvement since November 29, 2005. He further opined that she had no active residuals from her work-related bilateral foot conditions. Dr. Doolittle stated that the medical documentation and objective medical evidence showed appellant reached maximum medical improvement. He further found no permanent impairment secondary to active residuals from the surgeries performed on October 31, 2000 or June 15, 2001. Utilizing the sixth edition of the A.M.A., *Guides*, Dr. Doolittle opined that there was zero percent impairment of the whole body.

On June 28, 2010 OWCP's medical adviser reviewed the medical record and opined that he was unable to provide an opinion regarding permanent impairment of the legs or the date of maximum improvement. He indicated that the medical record included treatment as recent as April 2, 2010 for the reflex sympathetic dystrophy condition and, thus, it was unclear whether appellant had truly reached maximum medical improvement. The medical adviser recommended appellant's file be reviewed by someone with more experience in the treatment of chronic pain syndromes for clarification.

Physical therapy reports and a May 20, 2009 report, from Dr. Nikesh Batra, a Board-certified pain specialist, were provided. Dr. Batra provided a diagnostic code number and noted appellant's treatment options.

On August 11, 2010 OWCP requested a medical adviser to note the impairment to appellant's left and right foot and/or lower extremity based solely on the findings of Dr. Doolittle, the impartial medical examiner, who opined that appellant no longer suffered from any of the accepted conditions, including reflex sympathetic dystrophy.

In an August 25, 2010 report, the medical adviser rereviewed the medical record and statement of accepted facts. Based on Dr. Doolittle's findings, he opined that the date of maximum medical improvement was November 29, 2005. He concurred with Dr. Doolittle that there was no permanent impairment due to the accepted conditions of aggravation of bilateral plantar fasciitis and tarsal tunnel syndrome due to her negative objective findings and a mildly tender plantar fascia. The medical adviser noted that Dr. Doolittle's examination was essentially negative for objective findings. He deferred to Dr. Doolittle's opinion that appellant had no residuals due to reflex sympathetic dystrophy due to a normal objective physical examination. Under Table 16-2, page 501 of the A.M.A., *Guides* the medical adviser opined that appellant had no impairment to her legs.

By decision dated September 9, 2010, OWCP denied modification of the July 7, 2009 OWCP decision on the grounds that the evidence was insufficient to support an impairment greater than 10 percent for the right lower extremity and 7 percent for the left foot.

LEGAL PRECEDENT

The schedule award provision of FECA³ and its implementing regulations⁴ 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. 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.⁵ 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.⁶ As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.⁷

The sixth edition requires identifying 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).⁸ The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).⁹

It is well established that preexisting impairments to the scheduled member are to be included when determining entitlement to a schedule award.¹⁰ OWCP's procedures state that any previous impairment to the member under consideration is included in calculating the percentage of loss except when the prior impairment is due to a previous work-related injury, in which case the percentage already paid is subtracted from the total percentage of impairment.¹¹

If there is disagreement between the physician making the examination for the United States and the physician of the employee, OWCP shall appoint a third physician who shall make an examination.¹² When 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 rationalized and based upon a

³ 5 U.S.C. §§ 8101-8193.

⁴ 20 C.F.R. § 10.404.

⁵ *Linda R. Sherman*, 56 ECAB 127 (2004); *Daniel C. Goings*, 37 ECAB 781 (1986).

⁶ *Ronald R. Kraynak*, 53 ECAB 130 (2001).

⁷ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

⁸ A.M.A., *Guides* 494-531.

⁹ *Id.* at 521.

¹⁰ *Michael C. Milner*, 53 ECAB 446, 450 (2002); *Raymond E. Gwynn*, 35 ECAB 247 (1983).

¹¹ Federal (FECA) Procedure Manual, *supra* note 7, Chapter 2.808.7.a(2) (November 1998).

¹² 5 U.S.C. § 8123(a).

proper factual background, must be given special weight.¹³ Physicians who may not be used as referees include those previously connected with the claim or the claimant or physicians in partnership with those already so connected.¹⁴

When OWCP obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to correct the defect in the original report.¹⁵ However, when the impartial specialist is unable to clarify or elaborate on the original report or if a supplemental report is also vague, speculative or lacking in rationale, OWCP must submit the case record and a detailed statement of accepted facts to another impartial specialist for the purpose of obtaining a rationalized medical opinion on the issue.¹⁶

ANALYSIS

Appellant received a schedule award for 10 percent impairment of the right lower extremity and 7 percent impairment of the left lower extremity, which the Board previously found was proper. She submitted additional medical evidence in an attempt to show increased impairment. While reviewing appellant's file, OWCP noted that Dr. Rutherford, who served as the impartial medical specialist with respect to the schedule award determination, had previously examined appellant on July 2, 2002. It properly disqualified him as the impartial medical specialist as he was previously connected with the claim.¹⁷

Thereafter, OWCP referred appellant to Dr. Lowrey, who found that appellant had not reached maximum medical improvement but assigned an impairment rating. It properly requested clarification from Dr. Lowrey; but his February 26, 2010 response was inadequate to resolve the conflict. OWCP properly referred appellant to Dr. Doolittle to resolve the conflict in medical opinion.

In a May 26, 2010 report, Dr. Doolittle reviewed the medical record, the statement of accepted facts and presented his examination findings. Examination was essentially normal with no motor or sensory deficits. Dr. Doolittle stated that the medical documentation and objective medical record supported that appellant had reached maximum medical improvement. Based on his examination findings, he further found no active residuals of the accepted conditions. Dr. Doolittle found no basis on which to attribute permanent impairment and opined that appellant had no permanent impairment.

¹³ *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

¹⁴ Federal (FECA) Procedure Manual, *supra* note 7, *Medical Examinations*, Chapter 3.500.4.b(3)(b) (March 1994, October 1995, May 2003), citing *Raymond E. Heathcock*, 32 ECAB 2004 (1981).

¹⁵ *Raymond A. Fondots*, 53 ECAB 637, 641 (2002); *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232 (1988); *Ramon K. Ferrin, Jr.*, 39 ECAB 736 (1988).

¹⁶ *Nancy Keenan*, 56 ECAB 687 (2005); *Roger W. Griffith*, 51 ECAB 491 (2000); *Talmadge Miller*, 47 ECAB 673 (1996).

¹⁷ *See supra* note 14.

On June 28, 2010 OWCP's medical adviser reviewed Dr. Doolittle's report and the medical record and opined that it was unclear whether appellant reached maximum medical improvement as she was recently treated for reflex sympathetic dystrophy. The medical adviser substituted his judgment for Dr. Doolittle, the impartial medical specialist. He may review a report to verify the correct application of the A.M.A., *Guides* and confirm the percentage of permanent impairment,¹⁸ but it is the impartial medical specialist who must resolve a conflict in medical opinion.¹⁹ It is well established that, when a referee examination is arranged to resolve a conflict in medical opinion, the medical adviser is not to attempt clarification or expansion of the impartial medical specialist's opinion.²⁰ Thus, OWCP properly requested its medical adviser to calculate appellant's impairment solely on the findings of Dr. Doolittle, the impartial medical examiner.

In an August 25, 2010 report, OWCP's medical adviser concurred with Dr. Doolittle's findings that there was no permanent partial impairment as there were no objective findings and only a mildly tender plantar fascia. The medical adviser applied Dr. Doolittle's findings to Table 16-2, page 501 of the A.M.A., *Guides* and opined that appellant had zero percent impairment to her bilateral lower extremities.

Dr. Doolittle reported essentially normal examination findings and provided a well-rationalized opinion that there were no continuing symptoms of appellant's accepted conditions on which permanent impairment could be based. The Board finds that Dr. Doolittle's opinion is sufficiently well rationalized and based upon a proper factual and medical background such that it is entitled to special weight. Dr. Doolittle found that there was no basis for permanent impairment of either lower extremity.

The Board finds that there is no medical evidence of record to establish more than 10 percent impairment of the right lower extremity and more than 7 percent impairment of the left lower extremity. In her July 24, 2008 report, Dr. Renneker opined that appellant had 31 percent left lower extremity impairment and 41 percent right lower extremity impairment under the fifth edition of the A.M.A., *Guides*. A medical opinion not based on the appropriate edition of the A.M.A., *Guides* has diminished probative value in determining the extent of a claimant's permanent impairment.²¹ Appellant's impairment was appropriately evaluated under the standards of the sixth edition of the A.M.A., *Guides* as the September 9, 2010 OWCP decision denying additional schedule award compensation was issued after May 1, 2009, the effective date of the sixth edition.²² The other medical evidence, including Dr. Batra's May 20, 2009

¹⁸ See also Federal (FECA) Procedure Manual, *supra* note 7, *Developing and Evaluating Medical Evidence*, Chapter 2.810.7(c) (April 1993); see *I.H.*, Docket No. 08-1352 (issued December 24, 2008).

¹⁹ *Richard R. LeMay*, 56 ECAB 341, 348 (2005).

²⁰ Federal (FECA) Procedural Manual, *supra* note 7, *Medical Examinations*, Chapter 3.500.5(c) (October 1995).

²¹ *Fritz A. Klein*, 53 ECAB 642 (2002).

²² FECA Bulletin No. 09-03 (issued March 15, 2009).

report, does not contain impairment ratings and, thus, does not provide a basis for a schedule award under FECA.²³

On appeal, appellant argues OWCP's decision is contrary to fact and law. As noted, the medical evidence of record does not establish greater impairment than 10 percent of the right lower extremity and 7 percent of the left lower extremity. Appellant may request an increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has no more than 10 percent permanent impairment of the right lower extremity and 7 percent permanent impairment of the left lower extremity, previously awarded.

ORDER

IT IS HEREBY ORDERED THAT the September 9, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 9, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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

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

²³ The Board notes that a description of appellant's impairment must be obtained from appellant's physician, which must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations. *See Peter C. Belkind*, 56 ECAB 580, 585 (2005).