

**United States Department of Labor
Employees' Compensation Appeals Board**

F.B., Appellant

and

**U.S. POSTAL SERVICE, WEST WABASH
STATION, Evansville, IN, Employer**

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**Docket No. 13-1755
Issued: January 9, 2014**

Appearances:

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

Case Submitted on the Record

DECISION AND ORDER

Before:

RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On July 18, 2013 appellant, through counsel, filed a timely appeal of a June 20, 2013 decision of the Office of Workers' Compensation Programs (OWCP) concerning a schedule award. Pursuant to the Federal Employees' Compensation Act¹ (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 an 11 percent impairment of the right leg, for which he received schedule awards.

FACTUAL HISTORY

On March 25, 2004 appellant, then a 51-year-old city letter carrier, developed a blood clot behind his right knee due to prolonged sitting in his vehicle. OWCP accepted the claim for right leg thrombophlebitis of the lower extremities; right venous embolism and thrombosis of the

¹ 5 U.S.C. § 8101 *et seq.*

deep vessels distal lower extremity. Appellant sustained recurrences of disability on April 6, 2005 and August 13, 2006.²

By decision dated March 22, 2006, OWCP granted appellant a schedule award for a nine percent permanent impairment of the right leg.

On May 24, 2012 appellant filed a claim for an additional schedule award.

In a June 4, 2012 report, Dr. Martin Fritzhand, a Board-certified urologist, noted the injury date of March 25, 2004 and listed appellant's continued knee pain and deep vein thrombosis (DVT) involving the right lower extremity. He stated that appellant had been on Coumadin for the past 12 years. Dr. Fritzhand evaluated appellant under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). He utilized Table 9-12, p. 208, to assess appellant's history of DVT. Dr. Fritzhand determined that appellant had a "Class D" impairment based on the two thrombotic events, which classification was moved left as there were no hypocoagulable states. Using the Combined Values Chart, he added five percent based on appellant's use of Coumadin. Dr. Fritzhand found that appellant had 19 percent whole person impairment or 47.5 percent right lower extremity impairment.

On October 9, 2012 Dr. Eric Preston, an OWCP medical adviser, reviewed Dr. Fritzhand's report and concluded that the impairment rating was not appropriate. He noted that the accepted condition was deep vein thrombophlebitis of the right lower extremity; that there was no history of a pulmonary emboli or pulmonary hypertension or any record of employment-related peripheral arterial occlusive disease. Dr. Preston stated that Table 4-12 was not appropriate to rate peripheral vascular disease and Table 4-14 was similarly inapplicable.

By letter dated October 18, 2012, OWCP informed appellant that Dr. Fritzhand incorrectly used Table 9-12 to rate impairment. There was no medical evidence to establish an employment-related impairment for purposes of a schedule award. OWCP requested a rating in conformance with the sixth edition of the A.M.A., *Guides*.

In a November 10, 2012 report, Dr. Fritzhand reiterated that Table 9-12 was appropriate to rate appellant's impairment. He noted Table 9-12 was applicable for thrombotic events and that he had previously described the level of impairment. Dr. Fritzhand reiterated that maximum medical improvement was met by March 2005.

On February 1, 2013 Dr. James W. Dyer, an OWCP medical adviser, reviewed the medical evidence. He found that the 48 percent right leg impairment by Dr. Fritzhand was incorrect. Dr. Dyer explained that the impairment rating was based on Table 9-12, page 208, which rated a whole person impairment. Table 4-12 of the sixth edition of the A.M.A., *Guides*, page 69, rated impairment to lower extremities based on peripheral vascular disease. Dr. Dyer determined that appellant had a class 2 impairment with a default rating of 17 percent. He assessed a functional history modifier as minus one, the clinical studies modifier as minus one, and the physical examination modifier as zero. This resulted in a minus two net modifier which moved the rating to the left resulting in a grade A or 11 percent impairment to the right leg.

² Appellant retired effective October 1, 2007 and elected to receive retirement benefits from the Office of Personnel Management effective September 30, 2007.

Dr. Dyer subtracted the nine percent impairment previously awarded, resulting in an additional two percent impairment.

By decision dated February 5, 2013, OWCP granted appellant a schedule award for an additional 2 percent permanent impairment of the right leg, or a total of 11 percent.

In a letter dated February 14, 2013, appellant's counsel requested a hearing before an OWCP hearing representative, which was held on May 13, 2013.

By decision dated June 20, 2013, OWCP's hearing representative affirmed the May 5, 2013 schedule award decision.

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. 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.⁵ Effective May 1, 2009, OWCP adopted the sixth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.⁶ The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).⁷

In addressing lower extremity impairments, 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). The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).⁸

The lower extremity chapter of the A.M.A., *Guides* states that vascular conditions are rated in accordance with section 4.8 of the A.M.A., *Guides Vascular Diseases Affecting the*

³ 5 U.S.C. § 8107.

⁴ 20 C.F.R. § 10.404.

⁵ *Id.* See *C.M.*, Docket No. 09-1268 (issued January 22, 2010); *Billy B. Scoles*, 57 ECAB 258 (2005).

⁶ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claim*, Chapter 2.808.6.6a (January 2010); see also Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

⁷ A.M.A., *Guides* (6th ed. 2009), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

⁸ *Id.* at 521. *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

Extremities, and may be combined with diagnosis-based impairments using the Combined Values Chart.⁹

Section 9.6 Thrombotic Disorders states that impairment is based on both the thrombotic disorder itself and the impact of the thrombosis that have occurred on a particular affected body system. This includes the degree of injury to the end-organ, such as the lungs, heart, brain, kidney and extremities from thrombosis and on how the disorder affects the individual's capacity to perform the activities of daily living.¹⁰ The A.M.A., *Guides* state, "Regardless of the system involved, the rating that results due to the sequelae of thrombotic disease should be combined with the impairment from the thrombotic disease itself (to which is added five percent for the use of anticoagulants, if appropriate, before combining) using the Combined Values Chart in the Appendix."¹¹

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the percentage of impairment using the A.M.A., *Guides*.¹²

ANALYSIS

OWCP accepted appellant's claim for right leg thrombophlebitis, deep vessels, lower extremities, right venous embolism and thrombosis of deep vessels distal lower extremity. By decision dated March 22, 2006, it granted him a schedule award for a nine percent permanent impairment of the right leg. Appellant filed a claim for an additional schedule award. By decision dated February 5, 2013, OWCP granted him an additional two percent permanent impairment.

In reports dated June 4 and November 10, 2012, Dr. Fritzhand described appellant's knee pain and DVT involving the right leg. He stated that appellant had been on Coumadin for the past 12 years. Dr. Fritzhand utilized Table 9-12 of the A.M.A., *Guides* to rate appellant's permanent impairment.¹³ The table provides whole person impairment ratings for thrombotic disorders. Dr. Fritzhand found that appellant had 19 percent whole person impairment which was added to 5 percent impairment due to the use of Coumadin under section 9.c.¹⁴ He stated that 40 percent impairment of the whole person correlated to 47.5 percent impairment of the right leg. In a November 10, 2012 report, Dr. Fritzhand reiterated that Table 9-12 was the proper table to use to assess appellant's impairment.

⁹ *Id.* at 497.

¹⁰ *Id.* at 206-8, section 9.6 *Thrombotic Disorders*.

¹¹ *Id.* at 207, section 9.6c.

¹² *Tommy R. Martin*, 56 ECAB 273 (2005).

¹³ A.M.A., *Guides* 208, Table 9-12.

¹⁴ *Id.* at 207. If the individual is receiving long-term anticoagulant therapy for the thrombotic disorder with Warfarin, low-molecular-weight heparin or heparin, five percent is added to the impairment rating.

On February 1, 2013 Dr. Dyer noted that Dr. Fritzhand incorrectly utilized Table 9-12, page 208, which is based on a whole person impairment, to determine appellant's impairment. Under the sixth edition of the A.M.A., *Guides*, he used Table 4-12, page 69, to determine that appellant, had a class 2 impairment with a default rating of 17 percent. Dr. Dyer assessed the functional history modifier as minus one, the clinical studies modifier as minus one, and the physical examination modifier as zero resulting. This resulted in a minus two net modifier which required movement to the left column resulting in a grade A and 11 percent impairment to the right leg. After subtracting the nine percent previously awarded, Dr. Dyer concluded that appellant was entitled to a schedule award for an additional two percent right lower extremity impairment.

The Board finds that Dr. Dyer properly applied the sixth edition of the A.M.A., *Guides* to rate impairment to appellant's right lower extremity. He reviewed the medical evidence and determined that appellant had no more than 11 percent impairment for the right lower extremity under the sixth edition of the A.M.A., *Guides*. Dr. Dyer noted that as appellant was entitled to an additional two percent right lower extremity impairment as he had previously been issued a schedule award for a nine percent right lower extremity impairment. His rating is the only report in accordance with the protocols pertaining to lower extremity impairment determinations for thrombotic disease and represents the weight of medical opinion. Appellant did not submit any other medical evidence, which conformed to the A.M.A., *Guides*, to establish that he sustained greater impairment.

CONCLUSION

The Board finds that appellant has not established entitlement to more than 11 percent permanent impairment of the right leg, for which he received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 20, 2013 is affirmed.

Issued: January 9, 2014
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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