

FACTUAL HISTORY

On February 22, 2011 appellant, then a 61-year-old team leader, fell on her left elbow and knee and twisted her right ankle in the performance of duty. She stopped work on February 22, 2011. OWCP accepted the claim for sprain of the right ankle, contusion of the left knee, contusion of the left elbow and right lateral ankle instability. It also authorized a February 7, 2012 right ankle surgery. Appellant received appropriate compensation and benefits.

In a letter dated May 16, 2013, OWCP advised appellant that she may be entitled to a schedule award of compensation. On June 10, 2013 appellant filed a claim for a schedule award.

In a letter dated June 14, 2013, OWCP informed appellant of the type of evidence needed to support her claim for a schedule award and requested that she submit such evidence within 30 days. It advised her that her physician should provide a medical report and opinion on whether her condition had reached maximum medical improvement and a detailed description of any impairment in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (6th ed. 2009) (*hereinafter*, A.M.A., *Guides*).

In a June 19, 2013 report, Dr. Richard B. Helfrey, an orthopedic surgeon and osteopath, noted appellant's history of injury and treatment and indicated that on February 7, 2012 he performed a Brostrom-Gould lateral ankle reconstruction to her right ankle and she was placed in a splint. He advised that she tolerated this procedure well and indicated that she had no immediate postoperative concerns. Dr. Helfrey noted that on appellant's last visit on December 28, 2012, she demonstrated no instability whatsoever to talar or tilt testing. He advised that her ankle was well aligned and the incision was completely healed. Dr. Helfrey noted that she had tenderness over the sinus tarsi fat pad areas, no deltoid ligament laxity and 10 to 12 degrees of dorsiflexion and 35 to 40 degrees of plantar flexion. He explained that he thought appellant's strength was quite good at the time and released her to maximum medical improvement. Dr. Helfrey opined that with her range of motion and persistent symptoms, she had two percent whole person impairment which equated to five percent impairment of the lower extremity or seven percent to the foot and ankle. He did not indicate that he used the A.M.A., *Guides*.

On August 21, 2013 OWCP referred appellant for a second opinion to determine the extent of her work-related residuals and whether she sustained a permanent impairment, along with a statement of accepted facts, a set of questions and the medical record to Dr. Richard T. Katz, Board-certified in physical medicine and rehabilitation.

In an October 3, 2013 report, Dr. Katz noted appellant's history of injury and examined her right ankle. The right ankle showed clear swelling without warmth or redness and pain on the medial and lateral portion of the ankle. Dr. Katz opined that appellant reached maximum medical improvement on October 28, 2012. He explained that the most appropriate way to rate her ankle, was to use range of motion (ROM). Dr. Katz noted that appellant had dorsiflexion of 20 degrees, plantar flexion of 30 degrees, inversion of 10 degrees and eversion of 20 degrees. He advised that her fracture healed without objective findings and referred to page 503 of the A.M.A., *Guides*, which revealed a zero percent rating for the fracture. Dr. Katz noted that appellant's range of motion revealed a slight loss of plantar flexion, which according to page 549 of the A.M.A., *Guides*, was not ratable. He noted that the hindfoot impairment revealed five

degrees of inversion or five percent lower extremity impairment. Dr. Katz referred to Table 16.25 of the A.M.A., *Guides* and noted that this was a class 1 impairment. He found a functional history of grade 2 impairment and found “the PE” was “a grade 2 impairment with significant swelling.” Dr. Katz explained that according to page 548 of the A.M.A., *Guides*, “if functional history modifier exceeds the impairment class and requirements stated above are met, modify the final impairment.” He indicated that no further instructions were given and opined that appellant had a seven percent lower extremity impairment based on the loss of ROM, swelling and functional history.

In an October 16, 2013 report, OWCP’s medical adviser noted that the date of maximum medical improvement was October 3, 2013, the date of Dr. Katz’s report. He utilized Table 16-20, Table 16-22 and Table 16-25 of the A.M.A., *Guides*. The medical adviser explained that Dr. Katz incorrectly reported a finding for ROM for inversion that was not supported by the right ankle examination. He explained that dorsiflexion of 20 degrees corresponded to zero percent impairment, plantar flexion of 30 degrees corresponded to zero percent impairment, inversion of 10 degrees corresponded to two percent impairment and eversion of 20 degrees was zero percent impairment. The medical adviser referred to Table 16-17 and found that the 2 percent rating for ROM multiplied by 5 percent (for a functional history net modifier) yielded 0.1 percent, which, when added to 2 percent impairment, was equal to 2.1 percent, which rounded down to 2 percent. He explained that since the rating was a hindfoot rating, it was rounded off as two percent pursuant to Table 16-25. The medical adviser explained that Dr. Katz incorrectly calculated that the rating had been five degrees of inversion whereas the examination finding was 10 degrees. He determined that appellant had two percent impairment of the right leg.

Accordingly, on November 15, 2013, OWCP granted appellant a schedule award for two percent permanent impairment of the right leg. The award covered a period of 5.76 weeks from October 3 to November 12, 2013.

LEGAL PRECEDENT

The schedule award provision of FECA³ and its implementing federal regulations,⁴ 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.⁵ For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.⁶ For decisions issued after May 1, 2009, the sixth edition will be used.⁷

³ 5 U.S.C. § 8107.

⁴ 20 C.F.R. § 10.404.

⁵ *Id.* at § 10.404(a).

⁶ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

⁷ FECA Bulletin No. 09-03 (issued March 15, 2009).

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 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.⁹

Range of motion should be measured after a warm up, in which the individual moves the joint through its maximum range of motion at least three times. The range of motion examination is then performed by recording the active measurements from three separate range of motion efforts. All measurements should fall within 10 degrees of the mean of these three measurements. The maximum observed measurement is used to determine the range of motion impairment.¹⁰

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*.¹¹

ANALYSIS

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

OWCP accepted appellant's claim for sprain of the right ankle, contusion of the left knee, contusion of the left elbow and right lateral ankle instability. It issued a schedule award for a two percent impairment of the right leg based on the October 16, 2013 opinion of OWCP's medical adviser.

In support of her claim, appellant submitted a June 19, 2013 report from Dr. Helfrey, who noted appellant's February 7, 2012 right ankle surgery and her postoperative course. Dr. Helfrey noted that on her last visit on December 28, 2012, she demonstrated no instability whatsoever to talar or tilt testing and that her ankle was well aligned and the incision was completely healed. He indicated that appellant had 10 to 12 degrees of dorsiflexion and 35 to 40 degrees of plantar flexion. Dr. Helfrey opined that with her range of motion and persistent symptoms, she had two percent whole person impairment, five percent lower extremity impairment or seven percent impairment to the foot and ankle. The Board notes that it is unclear how he arrived at these values as he did not refer to the A.M.A., *Guides*. It is well established that when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his or

⁸ A.M.A., *Guides* 521.

⁹ *L.B.*, Docket No. 12-910 (issued October 5, 2012).

¹⁰ A.M.A., *Guides* 464.

¹¹ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

her opinion is of diminished probative value in establishing the degree of permanent impairment.¹² Thus, OWCP properly referred appellant to Dr. Katz.

In his October 3, 2013 report, Dr. Katz examined appellant and opined that range of motion was the best way to rate her impairment due to her right ankle injury. Although he noted right ankle inversion of 10 degrees in noting examination findings, he reported it as five degrees when conducting his rating which he found equated to five percent lower extremity impairment. Dr. Katz advised that appellant had a class 1 impairment under Table 16-25 of the A.M.A., *Guides* and that she had a functional history grade 2 net modifier. He explained that according to page 548 of the A.M.A., *Guides*, “if functional history modifier exceeds the impairment class and requirements stated above are met, modify the final impairment.” Dr. Katz noted that there were no further instructions in the A.M.A., *Guides* and opined that appellant had a seven percent lower extremity impairment.

In an October 16, 2013 report, OWCP’s medical adviser explained that Dr. Katz incorrectly reported a finding for ROM for inversion that was not supported by his right ankle examination. He advised that inversion of 10 degrees corresponded to two percent leg impairment and that application of the functional history net modifier did not change this percentage.

The Board notes that both Dr. Katz, the second opinion physician and OWCP’s medical adviser provided findings and an opinion utilizing range of motion method for rating appellant’s impairment. While OWCP’s medical adviser correctly noted that Dr. Katz used an incorrect measurement for inversion, neither physician provided a range of motion rating fully in conformance with the procedure outlined in the A.M.A., *Guides*. In particular, the Board notes that there is no indication that Dr. Katz measured range of motion three times after a warm up and then utilized the average of the measurements as required by section 15.7 of the A.M.A., *Guides*.¹³ As Dr. Katz did not follow the appropriate procedures for documenting range of motion, his report and that of the medical adviser, who used Dr. Katz’s measurements, are of limited probative value.¹⁴

It is well established that proceedings under FECA are not adversarial in nature and, while the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.¹⁵ Once OWCP undertakes development of the medical evidence, it has the responsibility to do so in a proper manner.¹⁶ The reports from Dr. Katz and OWCP’s medical adviser are insufficient to resolve the issue of whether appellant was entitled to a greater schedule award. As OWCP did not properly discharge its responsibilities in developing the record, the Board finds that the case must be remanded for

¹² *Linda Beale*, 57 ECAB 429 (2006); *see also E.S.*, Docket No. 11-1162 (issued November 17, 2011).

¹³ *See supra* note 10.

¹⁴ *See D.U.*, Docket No. 13-2086 (issued February 11, 2014) (where there was no indication that a physician obtained three joint measurements, the physician’s report was of diminished probative value).

¹⁵ *Richard E. Simpson*, 55 ECAB 490 (2004).

¹⁶ *Melvin James*, 55 ECAB 406 (2004).

further development of the medical evidence and a reasoned opinion regarding whether appellant has more than a two percent permanent impairment of her right leg, for which she received a schedule award.¹⁷ Following such further development as deemed necessary, OWCP shall issue a *de novo* decision.

On appeal, appellant argued that she believed she was entitled to a greater award as both her physician and the second opinion physician gave her a higher rating. However, as found above, the case is not in posture for decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the November 15, 2013 decision of the Office of Workers' Compensation Programs is set aside and remanded.

Issued: October 15, 2014
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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

¹⁷ *Richard F. Williams*, 55 ECAB 343 (2004).