

that OWCP inappropriately ignored the recommended additional impairment and issued a decision that it knew to be incorrect.

FACTUAL HISTORY

On January 22, 1992 appellant, then a 35-year-old city carrier, filed a traumatic injury claim alleging that on January 15, 1992 she sustained an injury to the bottom of her right foot when both feet were frozen and she put her right foot down a step, causing a sharp pain. On September 2, 1992 OWCP accepted her claim for bilateral frostbite in her foot. It later accepted appellant's claim for bilateral plantar fibromatosis.

Appellant had previously filed a claim for a traumatic injury that occurred on April 12, 1985 when she felt pain while lifting cases onto a table from a pallet on the floor while employed as a commodity grader with the Department of Agriculture. This claim was accepted for lumbosacral strain.² Appellant had a separate claim for a traumatic injury of December 26, 1998 that was accepted by OWCP for right knee contusion, right knee strain, and right knee chondromalacia resulting from falling on a slippery concrete floor when exiting a locker room while employed as a rehabilitation letter carrier.³

OWCP has previously issued multiple schedule awards for impairments to appellant's left and right lower extremities. As of the date of its November 7, 2008 schedule award, it had issued schedule awards totaling 13 percent for appellant's left lower extremity and 20 percent for appellant's right lower extremity.

In an August 27, 2009 report, Dr. Raja K. Khuri, a physician Board-certified in internal medicine and occupational medicine, diagnosed appellant with bilateral plantar fasciitis; Morton's neuroma in left foot; osteoarthritis right knee, status post menisectomy; and chondromalacia patella. In an August 28, 2009 permanent impairment worksheet, he determined that appellant had 12 percent impairment of her right lower extremity pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

In an October 2, 2009 letter to appellant, OWCP noted that although the newly submitted medical evidence indicates that appellant had 12 percent impairment to the right lower extremity, she had already been paid a total of 20 percent permanent impairment of the right lower extremity in this case, and therefore no additional schedule award was due at this time.

On December 8, 2009 appellant filed a claim for an additional schedule award.

In a December 8, 2009 report, Dr. Khuri noted that in the initial diagnosis he only mentioned Morton's neuroma in appellant's left foot, but that she also has strong clinical evidence for Morton's neuroma in the right foot. He noted subjective interdigital pain in third

² OWCP Docket No. xxxxxx224.

³ OWCP Docket No. xxxxxx040. The record reveals that appellant resigned from the employing establishment on February 4, 2002.

and fourth metatarsals and objective findings of point tenderness over interdigital area of the right foot at the third and fourth metatarsals. Dr. Khuri noted pain on squeezing the right foot. He also noted bilateral tibial nerve entrapment neuropathies at the level of the ankle, right greater than left. Dr. Khuri noted that the impairment ratings in the lower extremities that he listed were separate from and in addition to the prior provided 20 percent impairment for the right lower extremity and 13 percent for the left lower extremity.

Dr. Khuri sent an updated permanent impairment worksheet wherein he listed appellant's diagnoses as Morton's neuroma, plantar fasciitis, tibial tunnel syndrome, and chondromalacia patella. He then evaluated appellant's bilateral impairment to her lower extremities. Dr. Khuri noted that, pursuant to Table 16-2 of the A.M.A., *Guides*, appellant had a class 1 impairment due to "soft tissue knee" with grade modifiers of 2 for functional history, 1 for physical examination and 1 for clinical studies. He then found a grade D impairment which equaled a lower extremity impairment of four percent. Dr. Khuri noted that, pursuant to Table 16-3, appellant had a soft tissue injury class 1 with modifiers for functional history of 2, physical examination of 2 and clinical studies of 2, for a grade E impairment, or three percent impairment of the lower extremity. He also used Table 16-3 for another soft tissue with grade modifiers of 2 each for functional history, physical examination, and clinical studies resulting in a grade E impairment of five percent. Adding these figures together, Dr. Khuri determined that appellant had 12 percent bilateral impairment to the lower extremities. With regard to peripheral nerve impairment, he found that, pursuant to Table 16-2 on page 536 of the A.M.A., *Guides*, appellant's sensory impairment of the right and left tibial for a grade 3 class 1 impairment, and that, after grade modifiers of 2 for functional history, and clinical studies, appellant's impairment was a grade C, or six percent impairment. Dr. Khuri then determined that there was a total 12 percent impairment for diagnosis-based impairment and 6 percent impairment for peripheral nerve, for a bilateral lower extremity impairment of 18 percent.

In a February 10, 2010 report, an OWCP medical adviser, Dr. Neil Ghodadra, a Board-certified orthopedic surgeon, noted that Dr. Khuri's additional impairment ratings were given on the basis of the additional diagnoses of tarsal tunnel syndrome and bilateral Morton's neuroma. However, he noted that OWCP was yet to accept these conditions as a work-related injury and thus they should not be used in the additional permanent impairment determination. Dr. Ghodadra concluded that as such, the original permanent impairment ratings of 20 percent of the right lower extremity and 13 percent impairment of the left lower extremity and further permanent partial impairment cannot be awarded until the claims of bilateral Morton's neuroma and tarsal tunnel syndromes are accepted as work related.

By letter dated May 27, 2011, OWCP asked Dr. Ghodadra to determine whether bilateral tarsal tunnel syndrome and Morton's neuroma are consequential to the accepted conditions of bilateral frostbite and plantar fascial fibromatosis. It also asked for an opinion with regard to permanent impairment.

In a June 2, 2011 report, Dr. Ghodadra, noted that appellant had already received schedule awards for 20 percent impairment of the right lower extremity and 13 percent impairment of the left lower extremity. He concluded that bilateral tarsal tunnel syndrome and Morton's neuroma are consequential to the accepted conditions of bilateral frostbite and plantar fascial fibromatosis. Dr. Ghodadra then determined that according to Table 16-12 of the

A.M.A., *Guides*, appellant's history of tarsal tunnel syndrome corresponds to a default grade C rating of three percent due to sensory impairment. According to Table 16-12 of the A.M.A., *Guides*, appellant's history of Morton's neuroma corresponds to a one percent permanent impairment based on a grade A rating due to mild symptoms. Adding 4 percent to each prior rating, he determined that appellant now has 24 percent impairment of the left lower extremity and 17 percent impairment of the right lower extremity.

On July 15, 2011 OWCP expanded appellant's claim to include acceptance for bilateral tarsal tunnel syndrome and bilateral lesion of the plantar nerve.

In a letter to appellant dated October 6, 2011, OWCP noted that appellant's claim was processed initially based upon Dr. Ghodadra's report of June 2, 2011. It noted that, following further review, it determined that Dr. Ghodadra's report was drafted in error. OWCP explained that an OWCP medical adviser was not provided with relevant medical information about appellant's other claim, No. xxxxxx224, and that as a result the schedule award claim was deferred.

On January 30, 2012 OWCP referred appellant's claim to an OWCP medical adviser and asked for a determination on impairment to the bilateral lower extremities pursuant to the sixth edition of the A.M.A., *Guides*. In a response dated February 6, 2012, Dr. David H. Garelick, a physician Board-certified in orthopedic surgery with a Board-certified subspecialty in orthopedic sports medicine, noted that bilateral tarsal tunnel and plantar nerve lesion (Morton's neuroma) have been successfully accepted as work-related conditions. He stated that the June 2, 2011 report by Dr. Ghodadra, caused some confusion, in that he recommended an additional three percent bilateral lower extremity impairment for tarsal tunnel and one percent lower extremity for permanent impairment for Morton neuroma according to Table 16-2, page 501 of the A.M.A., *Guides*. However, Dr. Garelick determined that Dr. Ghodadra mixed up the right/left impairment ratings. Given that appellant had previously been awarded a schedule award for 13 percent left lower extremity impairment, an additional 3 percent plus 1 percent, would allow a total of 16 percent left lower extremity permanent impairment according to the Combined Values Chart on page 604 of the A.M.A., *Guides*. Using the same rationale, Dr. Garelick concluded that 20 percent impairment to the right lower extremity plus 3 percent plus 1 percent equaled a total 23 percent impairment to the right lower extremity when using the Combined Values Chart.

By decision dated May 30, 2013, OWCP issued appellant a schedule award for an additional 3 percent impairment to her right lower extremity and an additional 3 percent impairment to her left lower extremity, for a total schedule award of 23 percent for right lower extremity impairment and 16 percent for her left lower extremity impairment.

On September 15, 2013 appellant requested reconsideration.

In a September 11, 2013 evaluation, Dr. Michael Flood, a podiatrist, determined that pursuant to Table 16-22 and Table 16-25 of the A.M.A., *Guides*, appellant had a class 3 impairment of the bilateral ankle with grade modifiers of 2 for functional history, physical examination and clinical studies, for a final grade rating of A, or an impairment to the lower extremity of 26 percent based on Table 16-22 and Table 16-25 of the A.M.A., *Guides*. With regard to her right foot, he found that, pursuant to Table 16-8 and Table 16-2 of the A.M.A.,

Guides, appellant had a class 3 with grade modifiers of 2, for a grade A final class grade rating of a right extremity impairment of 26 percent or 10 percent whole person impairment. For the left foot, using the same tables, Dr. Flood found class 3 with grade modifiers of 2 for a final class grade rating of A, for a lower left extremity impairment of 26 percent or 10 percent of the whole person. He calculated the total whole person impairment as 36 percent. Dr. Flood noted that previous ratings did not include arthritis as a condition and that it is a consequential condition to postsurgical procedure performed bilaterally on the feet within six months to one year after surgery. He also noted that appellant presented with worsening of the plantar fasciitis condition due to physical stresses on her feet. Dr. Flood concluded with a reasonable degree of medical certainty that the frostbite was causative in the development of the conditions described in the diagnosis along with the Norton's neuroma and tibial nerve entrapment already accepted in this case. He noted that appellant relies on the use of a cane because of stiffness, pain, weakness of the feet and instability of her knee conditions.

By memorandum dated October 23, 2013, OWCP asked an OWCP medical adviser to reconsider appellant's impairment. In an October 27, 2013 report, Dr. Christopher Gross, an OWCP medical adviser Board-certified in psychiatry and neurology, recommended an "independent medical examination." He believed that appellant's impairment was significantly less than what had been awarded.

On December 5, 2013 OWCP referred appellant to Dr. Allan Brecher, a Board-certified orthopedic surgeon, for a second opinion. It sent Dr. Brecher a statement of accepted facts dated November 19, 2013 stating, *inter alia*, that OWCP accepted appellant's claim for bilateral plantar fibromatosis, bilateral tarsal tunnel syndrome, and bilateral lesion of the plantar nerve. In a January 20, 2014 report, Dr. Brecher noted that appellant did not have clear tarsal tunnel syndrome, so he did not give her any impairment rating for that. He did note that appellant still had chondromalacia of the right knee based on imaging and examination. Dr. Brecher noted decreased strength but no atrophy, that he believed is due to fibromyalgia. He noted residual plantar fasciitis on examination and chondromalacia of both knees. Dr. Brecher noted that her knees would be eight percent on both sides, however, only the right side is accepted. He noted that appellant has two percent impairment for her ongoing plantar fasciitis.

In a January 24, 2014 report, Dr. Brecher calculated appellant's impairment. He noted that for the right knee, appellant had impairment based on the knee regional grid, page 511, Table 16-3, class 1. Grade modifiers were listed for functional history as 2, for physical examination was 1, and clinical studies were 2 which equaled grade D giving her eight percent impairment for her chondromalacia of the knee. As for her plantar fibromatosis, Dr. Brecher looked at the foot and ankle regional grid, page 501, Table 16-2. Grade modifiers for functional history was 2, physical examination was 2, and clinical studies were 1 giving her a grade of D and a score of two percent. Dr. Brecher added them together yielding a rating of 10 percent. As for the left leg, the plantar fasciitis was accepted, but the knee was not. Therefore, using the same criteria as the right side, Dr. Brecher determined that appellant would actually have a 10 percent impairment of the leg, but as only the plantar fasciitis is accepted, he found the amount would be 2 percent.

In a February 24, 2014 report, Dr. Gross, an OWCP medical adviser, concluded that based on Table 16-2, appellant has a class 1 diagnosis of bilateral plantar fasciitis, which has a

base impairment of one percent. Based on functional history, he noted that appellant walked with a cane, and therefore had a grade 2 modifier. Dr. Gross noted that, based on her physical examination of moderate palpatory findings and normal range of motion, he has a grade 2 modifier. He stated that clinical studies were not applicable. Dr. Gross concluded that appellant had a net adjustment formula of +2, and adjustment which corresponds to a permanent impairment of two percent bilaterally, which was in agreement with Dr. Brecher. He stated that appellant's right knee osteoarthritis (left knee not accepted) is class 1 diagnosis with a three millimeter cartilage interval, pursuant to Table 16-3. Based on functional history, appellant uses a cane and thus had a grade 2 modifier. On physical examination, she had normal range of motion and minimal tenderness on palpitation and thus a grade 1 modifier. Clinical studies were used in the determination of the diagnosis. Using the net adjustment formula, the net adjustment is +1, which corresponds to a class D adjustment of eight percent right lower extremity.

On March 10, 2014 OWCP noted that the medical adviser, Dr. Gross, did not discuss Dr. Flood's report, and asked that he do so. In a March 17, 2014 report, Dr. Gross did not change his impairment findings. He pointed out that Dr. Flood "makes arbitrary ratings based on range of motion measurements" but that the diagnosis-based impairments are the preferred methods of calculating impairment. Dr. Gross noted that Dr. Flood could not comment on appellant's right knee osteoarthritis as he is a podiatrist.

By decision dated April 7, 2014, OWCP determined that the evidence was not sufficient to modify the prior decision.

LEGAL PRECEDENT

The schedule award provision of FECA⁴ and its implementing regulations⁵ 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. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.⁶ The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.⁷ For impairment ratings calculated on or after May 1, 2009, OWCP should advise any physician evaluating per impairment to use the sixth edition.⁸

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404.

⁶ *Id.* at § 10.404. For impairment ratings calculated on and after May 1, 2009, OWCP should advise any physician evaluating permanent impairment to use the sixth edition. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5.a (February 2013).

⁷ *See id.*; *Jacqueline S. Harris*, 54 ECAB 139 (2002).

⁸ Federal (FECA) Procedure Manual, *supra* note 6 at Chapter 2.808.5.a (February 2013).

The sixth edition requires identifying the impairment Class for Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Evidence (GMPE) and Clinical Studies (GMCS).⁹ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).¹⁰ 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.¹¹ The sixth edition of the A.M.A., *Guides* provides that lower extremity impairments be classified by diagnosis which is then adjusted by using grade modifiers according to the formula noted above.¹²

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the 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.¹³

OWCP's procedures further provide as follows:

“The [claims examiner] is responsible for ensuring that the [statement of accepted facts] is correct, complete, unequivocal, and specific. When the [medical adviser], second opinion specialist or referee physician renders a medical opinion based on an [statement of accepted facts] which is incomplete or inaccurate or does not use the [statement of accepted facts] as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.¹⁴

It is well established that proceedings under FECA are not adversarial in nature, nor is OWPC a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation OWCP shares the responsibility in the development of the evidence to see that justice is done.¹⁵ When OWCP undertakes to develop the medical aspects of a case, it must exercise extreme care in seeing that its administrative processes are impartially and fairly conducted.¹⁶

⁹ A.M.A., *Guides* 494-531.

¹⁰ *Id.* at 521.

¹¹ *L.B.*, Docket No. 12-910 (issued October 5, 2012).

¹² FECA Bulletin No. 09-03 (issued March 15, 2009); *see also M.K.*, Docket No. 10-478 (issued November 17, 2010).

¹³ *See* Federal (FECA) Procedure Manual, *supra* note 6 at Chapter 2.808.6(f) (February 2013).

¹⁴ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990).

¹⁵ *Richard Kendall*, 43 ECAB 790 (1992); *Isidore J. Gennino*, 35 ECAB 442 (1983).

¹⁶ *See J.F.*, Docket No. 13-1814 (issued January 27, 2014); *Peter C. Belkind*, 56 ECAB 580 (2005).

ANALYSIS

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

OWCP initially accepted appellant's claim for frostbite in her foot and bilateral plantar fibromatosis. However, Dr. Khuri made additional diagnoses, including tibial tunnel syndrome. In his June 2, 2011 report, Dr. Ghodadra, an OWCP medical adviser, concluded that appellant's bilateral tarsal tunnel syndrome and Morton's neuroma are consequential to the accepted conditions of bilateral frostbite and plantar fascial fibromatosis. On July 15, 2011 OWCP added to the list of accepted conditions bilateral tarsal tunnel syndrome and bilateral lesion of the plantar nerve. In a February 6, 2012 report, Dr. Garelick, the second OWCP medical adviser, determined that appellant had a 16 percent impairment of her left lower extremity and a 23 percent impairment of her right lower extremity. Based on this opinion, on May 30, 2013 OWCP issued a schedule award for 16 percent of the left lower extremity and 23 percent of the right lower extremity. Subsequently, Dr. Flood, appellant's podiatrist, found that appellant had a 26 percent permanent impairment of her right foot and a 26 percent impairment of her left foot. OWCP referred appellant's case to another OWCP medical adviser, Dr. Gross, who believed that appellant's impairment was significantly less than what she received, and recommended a referral for an "independent medical examination."

On December 5, 2013 OWCP referred appellant to Dr. Allan Brecher for a second opinion examination. In reaching his conclusion with regard to permanent impairment, Dr. Brecher indicated that appellant did not have clear tarsal tunnel syndrome. Based on his application of the A.M.A., *Guides*, he concluded that appellant had 10 percent permanent impairment of the right leg and 2 percent permanent impairment of the left, noting that only plantar fasciitis was accepted. However, the statement of accepted facts sent to Dr. Brecher, dated November 19, 2013, clearly indicated that appellant's claim had been accepted for bilateral tarsal tunnel syndrome.

To assure that the report of a medical specialist is based upon a proper factual background, OWCP provides a statement of accepted facts. When a second opinion physician does not use the statement of accepted facts as the framework in forming his opinion, the probative value of the opinion is diminished or negated altogether.¹⁷

Therefore, the Board finds that as Dr. Brecher's opinion is outside the framework of the statement of accepted facts, it is based on an inaccurate factual history.¹⁸ Since he rendered his opinion based on incomplete factual information, Dr. Brecher's report is of limited value.¹⁹ Proceedings before OWCP are not adversarial in nature and OWCP is not a disinterested arbiter, in a case where OWCP proceeds to develop the evidence and to procure medical evidence, it must do so in a fair and impartial manner.²⁰ As OWCP undertook development of the evidence

¹⁷ *J.F.*, Docket No. 13-1814 (issued January 27, 2014).

¹⁸ *V.A.*, Docket No. 14-722 (issued May 8, 2014).

¹⁹ *T.M.*, Docket No. 12-1654 (issued April 4, 2013).

²⁰ *Walter A. Fundringer, Jr.*, 37 ECAB 200, 204 (1985).

by referring appellant to a second opinion physician, it has the duty to secure an appropriate report.²¹ Because Dr. Brecher did not base his report on an accurate factual history, the case will be remanded to OWCP for further development of the medical evidence, to be followed by a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision regarding the extent and degree of impairment.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 7, 2014 is set aside and the case is remanded for further development consistent with this opinion.

Issued: July 2, 2015
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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

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

²¹ When OWCP refers a claimant for a second opinion evaluation and the report does not adequately address the relevant issues, OWCP should secure an appropriate report on relevant issues. *Ayanle A. Hashi*, 56 ECAB 234 (2004). *See also Mima Cruz*, Docket No. 06-183 (issued April 5, 2006) (where the Board found that the second opinion physician's medical report was of little probative value and could not constitute a basis for denying the claim because it was not based on the statement of accepted facts. The Board remanded the case to OWCP).