

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of GARY A. GUILLORY and DEPARTMENT OF THE ARMY,
CORP OF ENGINEERS, New Orleans, LA

*Docket No. 03-1872; Submitted on the Record;
Issued November 21, 2003*

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether the Office of Workers' Compensation Programs properly rescinded its acceptance of appellant's claim for a schedule award.

Appellant, a 47-year-old lock and dam equipment worker, filed a notice of traumatic injury on December 10, 1997 alleging that, on December 9, 1997, he was struck in the face by a spacer block. The Office accepted appellant's claim for facial fracture, broken teeth and right eye orbital tissue contusion on January 16, 1998. He stopped work on December 9, 1997 and returned to his regular duties on January 26, 1998. Appellant filed a notice of recurrence of disability on March 3, 2000 alleging difficulty seeing at night, with bright lights and pain from the cold. The Office accepted this recurrence of disability on May 12, 2000.

In a report dated September 14, 2000, Dr. John S. McCabe, a Board-certified plastic surgeon, opined that appellant had ten percent permanent impairment of his right eye due to his orbital scar and deformity. On January 2, 2001 Dr. James G. Ralston, a Board-certified ophthalmologist, found that appellant had 42 percent impairment of his right eye due to loss of monocular vision field, glare disability and orbital scar and deformity. Appellant requested a schedule award for the loss of use of his right eye on January 11, 2001.

The Office referred appellant for a second opinion evaluation with Dr. Russell J. Saloom, a Board-certified ophthalmologist, on February 13, 2001. In a report dated March 26, 2001, Dr. Saloom concluded that appellant had a ten percent impairment of his right eye due to loss of vision field. On April 16, 2001 a district medical adviser reviewed the medical evidence and requested that the Office obtain appellant's actual visual acuity and visual field scores. The Office requested this information from Dr. Saloom on April 19, 2001. There is no response in the record. On August 13, 2001 a second district medical adviser reviewed the medical evidence and concluded that appellant had ten percent permanent impairment of his right eye due to loss of visual field.

By decision dated August 29, 2001, the Office granted appellant a schedule award for ten percent loss of use of his right eye. He requested an oral hearing on September 26, 2001. By decision dated January 11, 2002, the hearing representative found that the case was not in posture for a hearing and remanded the case for additional medical evidence including appellant's visual acuity and visual field scores.

The Office further developed the medical evidence with additional referrals to Dr. Saloom. The district medical adviser reviewed these reports on March 5, 2003 and concluded that appellant had no visual impairment of his right eye. By decision dated March 14, 2003, the Office denied appellant's claim for a schedule award.

The Board finds that the Office failed to properly rescind its acceptance of appellant's schedule award.

The Board has upheld the Office's authority to reopen a claim at any time on its own motion under section 8128(a) of the Federal Employees' Compensation Act¹ and, where supported by the evidence, set aside or modify a prior decision and issue a new decision.² The Board has noted, however, that the power to annul an award is not an arbitrary one and that an award for compensation can only be set aside in the manner provided by the compensation statute.³ It is well established that once the Office accepts a claim, it has the burden of justifying termination or modification of compensation.⁴ In the present case, on August 29, 2001, the Office granted appellant a schedule award for ten percent impairment of loss of use of his right eye. This award was premised on the March 26, 2001 report from Dr. Saloom, a Board-certified ophthalmologist, that appellant had ten percent impairment of his right eye due to loss of vision field. On March 14, 2003, however, the Office disallowed appellant's schedule award claim. In other schedule award cases, the Board has reiterated that the Office bears the burden of proof to modify an award of compensation benefits.⁵ The Office, therefore, bears the burden of proof to modify appellant's schedule award benefits in this case.

The schedule award provisions of the Act⁶ and its implementing regulation⁷ 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, the Act 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

¹ 20 C.F.R. §§ 8101-8193, 8128(a).

² *Eli Jacobs*, 32 ECAB 1147, 1151 (1981).

³ *Shelby J. Rycroft*, 44 ECAB 795, 802-03 (1993).

⁴ *Mike E. Reid*, 51 ECAB 543, 546 (2000).

⁵ See *Loretta P. Myers*, Docket No. 00-1326 (issued June 21, 2002); *Sharyn D. Bannick*, 54 ECAB ____ (Docket No. 03-567, issued April 18, 2003); *Leonard J. Khajet*, 41 ECAB 283, 292 (1989).

⁶ 5 U.S.C. §§ 8101-8193; 8107.

⁷ 20 C.F.R. § 10.404 (1999).

necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The American Medical Association, *Guides to the Evaluation of Permanent Impairment* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.⁸

Section 8107(c)(19) of the Act provides that “[t]he degree of loss of vision or hearing under this schedule is determined without regard to correction.”⁹ The A.M.A., *Guides* define a permanent visual impairment as a permanent loss of vision that remains after maximal medical improvement of the underlying medical condition has been reached.¹⁰ The A.M.A., *Guides* indicate that the evaluation of visual impairment is based on the functional vision score, 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.¹¹ The A.M.A., *Guides* also allow for 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.¹² However, the A.M.A., *Guides* specifically limit adjustment of the impairment rating for these deficits to cases which are well documented and state, “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.”¹³

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.¹⁴ 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 20/100.¹⁵ The formula for functional visual acuity is $(3 \times \text{OU} + \text{OD} + \text{OS}) / 5$ where OU is binocular vision, OD is vision in the right eye and OS is vision in the left eye.¹⁶ The acuity-related impairment rating is calculated by subtracting the functional

⁸ A.M.A., *Guides*, 5th ed. (2000).

⁹ 5 U.S.C. § 8107(c)(19).

¹⁰ A.M.A., *Guides*, 278.

¹¹ *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 aphakia 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.

¹² A.M.A., *Guides*, 297.

¹³ *Id.*

¹⁴ *Id.* at 281.

¹⁵ *Id.*

¹⁶ *Id.* at 284, Table 12-3, 283.

acuity score from 100. Table 12-4, *Classification of Visual Acuity Impairment*, correlates the numerical value of the functional acuity score to a class of impairment for visual acuity.¹⁷

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.¹⁸ When using automated perimetry, for functional assessment of visual field loss testing to 60 degrees or beyond is mandatory, rather than the standard of 30 degrees in clinical testing. In order to determine the visual field score, the number of points seen on a standardized visual field grid is counted. The average normal field is 100 points. Procedure under the A.M.A., *Guides* is to apply the same formula to calculated visual field scores,¹⁹ subtract the visual field score from 100 and then to utilize Table 12-5, *Impairment of the Visual Field*, to convert the visual field score to visual field impairment rating.²⁰ The functional vision score is reached by multiplying the visual field score by the functional acuity score and dividing that by 100.²¹

In a report dated January 25, 2000, Dr. Ralston, a Board-certified ophthalmologist, diagnosed light sensitivity and stated that appellant had marked difficulty with his vision at night or in the vicinity of bright lights.²² On January 2, 2001 Dr. Ralston again noted appellant's light sensitivity and found that, based on the fourth edition of the A.M.A., *Guides*, appellant had a 12 percent loss of monocular visual field in the right eye and an additional 20 percent impairment of visual function for glare and 10 percent for orbital scar and deformity for a total eye impairment of 42 percent. Before the A.M.A., *Guides* can be utilized, a description of appellant's impairment must be obtained from appellant's physician. In obtaining the medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment 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.²³

Dr. Ralston did not provide the result of visual acuity testing, did not provide any test results explaining how he reached his visual field impairment rating and did not correlate his findings with the appropriate edition of the A.M.A., *Guides*. As the Office could not determine appellant's permanent impairment based on this report, the Office properly referred appellant for

¹⁷ *Id.* at 285, Table 12-4.

¹⁸ *Id.* at 287. 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.

¹⁹ *Id.* at 289, Table 12-6.

²⁰ *Id.* at 290, Table 12-7.

²¹ *Id.* at 296. The A.M.A., *Guides*, specifically provided that ability scores not impairment ratings should be multiplied to reach the total impairment.

²² Appellant's attending physician, Dr. McCabe, a Board-certified plastic surgeon, opined that appellant had ten percent impairment due to orbital scar and deformity. The Office did not address appellant's claim for facial disfigurement and the Board may not consider this issue on appeal. 20 C.F.R. § 501.2(c).

²³ *Robert B. Rozelle*, 44 ECAB 616, 618 (1993).

a second opinion evaluation with Dr. Saloom, a Board-certified ophthalmologist, to determine appellant's physical findings in accordance with the A.M.A., *Guides*.

In his March 26, 2001 report, Dr. Saloom noted appellant's history of injury and his complaints of glare and limited night vision. He stated that appellant's visual acuity was 20/20 in both eyes, that intraocular pressures were 13 on both sides and that extraocular motility was normal without diplopia. Dr. Saloom found a small scar in the area of the right brow and a right superior sulcus deformity which denoted right globe ptosis, that the right eye was slightly lowered within the orbit. He found a slight depressed fracture of the right inferior orbital rim and paresthesia of the fifth cranial nerve on the right side. Dr. Saloom utilized Hertel exophthalmometry with a base of 90 mm which showed 4 mm of right enophthalmos. He stated that appellant's visual field test indicated a ten percent impairment of the right eye in accordance with the A.M.A., *Guides*. Dr. Saloom concluded, "The A.M.A., *Guides*, fifth edition does not provide for the calculation of possible impairment due to such subjective complaints as glare, cold and sensitivity or chemical irritation."

The district medical adviser reviewed this report on April 16, 2001 and stated that Dr. Saloom did not provide the actual figures for the visual acuity or the visual fields. He requested that the Office obtain this information from Dr. Saloom. A second district medical adviser reviewed Dr. Saloom's report on August 13, 2001 and found that, based on this report, appellant had ten percent loss of use of his right eye due to loss of visual field. The Office granted appellant a schedule award for ten percent loss of use of his right eye on August 29, 2001.

The hearing representative remanded appellant's claim for further development of the medical evidence on January 11, 2002, specifically requesting that the Office obtain visual acuity and visual field scores. The Office requested a supplemental report from Dr. Saloom on March 27, 2002.

In a report dated April 9, 2002, Dr. Saloom stated that appellant's visual acuity was 20/20 in both eyes, that extraocular motility was normal without restriction or diplopia, but that "refraction for glasses prescription showed a minimal prescription in the right and no prescription in the left eye allowing vision of 20/20 in each eye." He stated that appellant's right eye was slightly lower in its orbit than the left eye or a right superior sulcus deformity which denotes right globe ptosis. Appellant also demonstrated a backward displacement of the eyeball into the orbit or enophthalmos of three mm. Dr. Saloom stated, "A visual field test performed today using a central 24-2 threshold test on a Humphrey automated perimetry instrument showed normal visual field findings for the right eye measurable to 30 degrees from central fixation." He also noted that confrontational visual fields were full on both sides showing no evidence of compromise. Dr. Saloom concluded:

"With regard to the A.M.A., *Guides* edition Table 12-2, [appellant] has no impairment involving functional visual acuity with the right eye. A visual field test performed today for the right eye also appears completely normal, therefore, a visual field impairment rating of zero percent. His functional visual score using the method outlined in Section 12.4a.1 is 100. However, adjustments to this score as outlined in Section 12.4b need to be made because of the presence of glare,

photophobia and discomfort affecting his vocational demands. This subjective measurement, on my part, would be worth at best ten points at current status but possible less should his dry eyes be addressed and treated....”

This report is not sufficient to establish the extent of appellant’s permanent impairment as Dr. Saloom indicated that appellant had not reached maximum medical improvement, requiring further treatment for his dry-eye condition which could improve the presence of glare and photophobia. Maximum improvement means that the physical condition of the injured member of the body has stabilized and will not improve further.²⁴ The determination of maximum medical improvement is not to be based on surmise or prediction of what may happen in the future. A schedule award is appropriate only where the physical condition of an injured member has stabilized, despite the possibility of an eventual change in the degree of functional impairment in the member.²⁵

Furthermore, Dr. Saloom’s report indicated that he based his visual acuity scores on corrected vision, noting that appellant had a slight prescription for glasses in his right eye, but not providing appellant’s uncorrected visual acuity. The Act specifically provides that an impairment of vision will be calculated without regard to correction.²⁶ In addition, Dr. Saloom’s reporting of the visual field based on confrontation is not appropriate under the A.M.A., *Guides* and he indicated testing only to 30 degrees by perimetry rather than the greater than 60 degrees for functional impairment mandated by the A.M.A., *Guides*. Finally, Dr. Saloom failed to provide the actual findings on visual field examination to allow the claims examiner or medical adviser to calculate appellant’s visual field impairment.

The Office referred appellant for an additional evaluation with Dr. Saloom on January 27, 2003. In a report dated February 5, 2003, Dr. Saloom stated that appellant’s visual acuity without need for correction is 20/20 in both eyes for distance, but that appellant did require reading glasses. He stated that confrontational visual fields were full and that automated visual field testing was normal using a 24-2 program on a Humphrey field analyzer. Dr. Saloom concluded that appellant had reached maximum medical improvement sometime prior to his first examination in March 26, 2001 and applied the A.M.A., *Guides* to his findings. He stated that appellant had no impairment rating for visual acuity, no loss or impairment of the visual field for his right eye and, therefore, zero percent impairment. Dr. Saloom concluded that the A.M.A., *Guides* did not provide for impairment due to appellant’s assertion that cold, wind and bright light bother him.

This report shares many of the defects of the April 9, 2002 report. Although Dr. Saloom stated that, appellant’s visual acuity was 20/20 in both eyes, he did not explain his earlier report that appellant required a corrective prescription in his right eye and further noted that appellant required correction for reading. In regard to the visual field test, Dr. Saloom again mentioned confrontation testing, did not indicate the extent of his testing on perimetry and did not provide

²⁴ *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989).

²⁵ *Id.*

²⁶ *Supra* note 8.

his actual findings on visual field testing. Finally, Dr. Saloom incorrectly stated that the A.M.A., *Guides* did not provide an impairment rating for glare or bright lights. The A.M.A., *Guides* allow for individual adjustments for functional deficits, such as contrast and glare sensitivity if these deficits are not reflected in a visual acuity or visual field loss.²⁷ Therefore, Dr. Saloom did not provide the findings necessary for the Office to calculate appellant's permanent impairment and did not appropriately correlate his findings in accordance with the A.M.A., *Guides*.

The Board finds that the medical evidence in the record is not sufficient to establish appellant's permanent impairment of the right eye and that, due to the defects in Dr. Saloom's reports, this evidence is not sufficient to justify the Office's March 13, 2003 rescission of appellant's schedule award. The Office has not resolved the issue of appellant's uncorrected visual acuity, his vision field score and any permanent impairment allowable under the A.M.A., *Guides* due to contrast and glare sensitivity.²⁸ Therefore, the Office did not properly rescind the schedule award.

The decision of the Office of Workers' Compensation Programs dated March 13, 2003 is hereby reversed.

Dated, Washington, DC
November 21, 2003

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member

²⁷ A.M.A., *Guides*, 297.

²⁸ *Ezell Wills*, 49 ECAB 375, 378 (1998).