

Appellant underwent an authorized right eye cataract extraction by phacoemulsification, with placement of posterior chamber lens on April 25, 2002. He received compensation benefits and returned to regular duty on May 16, 2002.

On January 16, 2003 appellant completed a Form CA-7 for compensation for a schedule award.

In a March 26, 2003 report, Dr. Laurence M. Nelson, a Board-certified ophthalmologist and treating physician, noted appellant's history and treatment. He advised that appellant had significant ecchymosis over the right eye, with a tear of the conjunctival tissue nasally without apparent laceration of the globe itself and some crepitus over the right lower lid, suggesting a blow-out fracture on the right. Dr. Nelson also advised that appellant had secondary iritis and that a dilated examination revealed a healthy posterior pole. He indicated that extraocular movement revealed some restriction with diplopia initially in primary gaze and down, as well as significant double vision with gaze to the right. Appellant subsequently developed a cataract in his right eye secondary to the trauma and an extraction was performed with subsequent capsulotomy. Dr. Nelson noted that his best visual acuity with correction was 20/20 and that both the ecchymosis and the iritis abated with time and treatment. He also advised that the vast majority of appellant's double vision also resolved. Appellant currently had double vision in his extreme right gaze and in his double extreme down gaze, which was bothersome, especially when driving and when attempting to look over his right shoulder and attempting to drive spikes. Dr. Nelson indicated that he had direct responsibility for maintaining the railway and tracks and that, since his injury, appellant had continuous light sensitivity, even with sunglasses and that track inspection was difficult. He explained that according to the A.M.A., *Guides*, Chapter 12, page 297,¹ under individual adjustments, a column discussing diplopia suggested "[t]hese functions vary in their affect on activities of daily living. Their significance often depends on the environment and on vocational demands." He explained that standardized measurement techniques to determine visual loss and functional visual impairment have not been developed for these particular problems and that appellant's complaints of double vision with regard to certain important tasks relating to his daily work must be considered when determining impairment secondary to his injury.

By letter dated April 3, 2003, the Office advised appellant that additional information was needed, including verification from his physician that he had reached maximum medical improvement and had a permanent impairment. The Office further advised him to submit medical evidence in support of his claim, based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.

In an October 31, 2003 memorandum, an Office medical adviser indicated that additional assessment was needed regarding impairment. He indicated that the A.M.A., *Guides* were "not terribly helpful in dealing with the issue of diplopia." The Office medical adviser indicated that, if the diplopia was disturbing and interfered with daily living skills, the functional visual score and visual system impairment ratings might be adjusted as indicated in section 12.4b of the

¹ A.M.A., *Guides* at 297, 12.4b.

A.M.A., *Guides*.² The medical adviser recommended that Dr. Nelson perform another rating with this in mind.

By letter dated October 31, 2003, the Office requested that Dr. Nelson address the issues raised by the Office medical adviser. A copy of the medical adviser's October 31, 2003 memorandum was provided.

In an April 5, 2004 report, Dr. Nelson submitted an estimate of permanent impairment pursuant to the fourth edition of the A.M.A., *Guides*. He conducted an external examination which revealed significant ecchymosis over the right eye with a tear of the conjunctival tissue, nasal, without an apparent laceration of the globe and some crepitus over the right lower lid. Dr. Nelson advised that this was suggestive of a blow out fracture on the right. He also noted that appellant had secondary iritis, but that dilated examination revealed a healthy posterior pole. Dr. Nelson noted that extraocular movement revealed some restriction with diplopia, initially in primary gaze and down, as well as significant double vision in gaze to the right. He also advised that appellant had developed a cataract in the left eye and cataract extraction was performed, with a subsequent capsulotomy on the left eye. Dr. Nelson advised that appellant's best visual acuity with correction was 20/20. He indicated that both the ecchymosis and the iritis abated with time and treatment and that the vast majority of appellant's double vision had resolved. Dr. Nelson advised that appellant currently had double vision in extreme right gaze, which was bothersome especially when driving and attempting to look over his shoulder. He explained that according to Figure 3, page 217³ right gaze diplopia in this field suggested an impairment of approximately 10 percent.

On April 21, 2004 the Office medical adviser indicated that a second opinion was needed as there was insufficient information to provide a rating under the A.M.A., *Guides*. He noted that the fourth and the fifth edition of the A.M.A., *Guides*, dealt with diplopia differently.

By letters dated April 26 and May 21, 2004, the Office referred appellant to Dr. Robert L. Trefth, a Board-certified ophthalmologist, to evaluate the extent of permanent impairment due to the accepted employment injury.

In a June 12, 2004 report, Dr. Trefth noted appellant's history and referenced the fifth edition of the A.M.A., *Guides*. He conducted a physical examination and indicated that visual acuity without correction was 20/40 OD and OS. Dr. Trefth noted that correction was + 0.75 +0.25 x60 OD and plano + 1.00 x 166 OS. He advised that appellant could see 20/20 or J1 at near with +2.50 at near. Dr. Trefth noted that appellant had full visual fields to finger confrontation and full extra-ocular muscle motions objectively, but that he complained of diplopia at extreme right gaze (approximately 50 degrees to the right of straight ahead). He indicated that at distance without correction, two diopters of exophoria were evident, but disappeared with his glasses. Dr. Trefth noted the pupils were equal, round and reactive to light and near accommodation. Regarding applanation intra-ocular pressures, he advised that they

² A.M.A., *Guides* at 297, 12.4b (5th ed. 2001).

³ A.M.A., *Guides* at 217 (4th ed. 1993).

were 10/11 (right and left) and mild conjunctival chemosis was seen with the slit-lamp. Dr. Treft noted a normal anterior segment with the exception of a right well-placed posterior chamber intra-ocular lens and advised that the capsule had been cut centrally allowing a clear view. He advised that the left lens was normal with direct and indirect fundus examination. Dr. Treft also noted that the retina and vitreous were normal except for temporal sclera crescents and 0.5 cupping of each optic nerve. He diagnosed subjective diplopia at far right gaze, right pseudo-phakia, right hyperopia, and left astigmatism. Dr. Treft explained that his objective findings included that appellant was pseudo-phakic after his cataract removal of the right eye and required an eye glass prescription for best vision at distance and near. He advised that appellant would have reached maximum medical improvement one year after his surgery. Regarding an impairment rating, he advised that appellant had a functional acuity score of 100, which warranted an impairment of 0 percent for central vision. Dr. Treft indicated that due to the diplopia at the outer 10 percent of right gaze, appellant had a functional field score of 98 or a field related impairment rating of 2. He advised that using the A.M.A., *Guides*, the functional vision score of 98 was equal to an impairment of 2 percent or a Class 1 impairment.

In an August 18, 2004 report, an Office medical adviser reviewed Dr. Treft's June 12, 2004 report and determined that appellant was entitled to a two percent visual impairment of the right eye and that he had reached maximum medical improvement on March 26, 2003.

By decision dated August 31, 2004, the Office awarded appellant compensation for 3.2 weeks from March 26 to April 17, 2003 based upon a 2 percent impairment of the right eye.

LEGAL PRECEDENT

The schedule award provision of the Act⁴ and its implementing regulation⁵ 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 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 regulation as the appropriate standard for evaluating schedule losses.

Section 8107(c)(19) of the Federal Employees' Compensation Act provides that "[t]he degree of loss of vision or hearing under this schedule is determined without regard to correction."⁶ The A.M.A., *Guides* describe a permanent visual impairment as a permanent loss of vision that remains after maximal medical improvement of the underlying medical condition has been reached.⁷ The A.M.A., *Guides* indicates that the evaluation of visual impairment is

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404 (1999).

⁶ 5 U.S.C. § 8107(c)(19).

⁷ A.M.A., *Guides* 278 (5th ed. 2001). The fifth edition of the A.M.A., *Guides*, applicable in the present case, became effective February 1, 2001. See FECA Bulletin No. 01-05 (issued January 29, 2001).

based on functional visual 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.⁸ The A.M.A., *Guides* 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.⁹

ANALYSIS

Appellant submitted an April 5, 2004 report from Dr. Nelson, a Board-certified ophthalmologist, who advised that he had 10 percent impairment to the right eye due to his right gaze diplopia. However, Dr. Nelson provided analysis under the fourth edition of the A.M.A., *Guides*. Office procedures direct the use of the fifth edition of the A.M.A., *Guides* for schedule awards determined on and after February 1, 2001.¹⁰ In this case, appellant filed his claim for a schedule award on January 16, 2003, after the effective date of the fifth edition. As Dr. Nelson provided analysis under the fourth edition of the A.M.A., *Guides*, medical opinions not based on the appropriate edition of the A.M.A., *Guides* are of diminished probative value, the Office properly afforded the report lesser probative value.¹¹ Furthermore, he offered an opinion based on corrected vision. As noted above, the Act provides that “[t]he degree of loss of vision is determined without regard to correction.”¹²

The Office subsequently referred appellant’s case, to Dr. Treft, the second opinion physician. While he utilized the fifth edition of the A.M.A., *Guides* Dr. Treft provided an opinion that appellant’s visual acuity without correction was equal to 20/40 for the right eye and with correction, appellant could see 20/20. Dr. Treft also noted that he had a functional acuity score of 100, which warranted an impairment of 0 percent for central vision. However, these figures suggest that he utilized the corrected figures as opposed to uncorrected figures. The Act notes that the degree of loss of vision is determined without regard to correction.” Additionally, Dr. Treft indicated that due to the diplopia at the outer 10 percent of right gaze, appellant had a functional field score of 98 or a field-related impairment rating of 2. However, he did not explain how this figure was derived. The Board notes that Table 12-2 for impairment of visual acuity suggests that near normal vision of 20/40 would warrant a visual acuity score of 85 and a

⁸ *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 aphasia 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.

⁹ A.M.A., *Guides* at 297.

¹⁰ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6 (August 2002); see *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

¹¹ See *Carolyn E. Sellers*, 50 ECAB 393, 394 (1999) (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).

¹² See *supra* note 6.

visual acuity impairment rating of 15 percent.¹³ In addition, Table 12-5, at page 289 and the text found in section 12.3c at page 290, specify how to determine a single functional field score.¹⁴ Dr. Treft did not provide any explanation as to how these figures were derived. It is unclear how he determined 98 for the functional field score. As the Office medical adviser subsequently concurred with Dr. Treft without providing further explanation addressing the A.M.A., *Guides*, his report is also deficient.

In view of the failure of the second opinion physician and the Office medical adviser to adequately explain how their determinations were reached in accordance with the relevant standards of the A.M.A., *Guides*, the claim requires further development to determine the extent of impairment of appellant's right eye.¹⁵

On remand the Office should further develop the medical evidence of record and obtain an opinion as to whether appellant has any impairment of the right eye causally related to his January 30, 2002 employment injury. Following this and any other further development as deemed necessary, the Office shall issue an appropriate merit decision.

CONCLUSION

The Board finds that this case is not in posture for decision regarding the impairment to appellant's right eye.

¹³ A.M.A., *Guides* at 284, Table 12-2.

¹⁴ A.M.A., *Guides* at 288, Table 12-5 and 289.

¹⁵ While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence to see that justice is done. *Anthony P. Silva*, 55 ECAB ____ (Docket No. 03-2055, issued December 16, 2003).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 31, 2004 is set aside and the case remanded for further development in accordance with this decision of the Board.

Issued: June 3, 2005
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member