United States Department of Labor
Employees' Compensation Appeals Board

R.W., Appellant	)	
and	)	**Docket No. 11-104**
	)	**Issued: September 6, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Cleveland, OH, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 19, 2010 appellant filed a timely appeal from a September 24, 2010 decision of the Office of Workers' Compensation Programs (OWCP) regarding a schedule award. Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant sustained a ratable impairment of the lower extremities.

On appeal, counsel contends that OWCP's September 24, 2010 decision was contrary to fact and law.

FACTUAL HISTORY

OWCP accepted that on October 18, 2007 appellant, then a 52-year-old letter carrier, sustained a right gastrocnemius muscle tear/leg sprain while descending steps on his delivery route. Appellant did not stop work or claim wage-loss compensation. OWCP previously

[1] 5 U.S.C. § 8101 *et seq.*

accepted that on July 20, 2002 appellant sustained a lumbar strain, lumbar radiculopathy and aggravation of preexisting degenerative disc disease when he tripped and fell while delivering mail.

Dr. Frank G. Farone, an attending osteopathic physician, released appellant to limited duty as of October 19, 2007 and to full duty effective December 3, 2007. His reports through December 3, 2007 note a resolving right gastrocnemius tear.[2]

On April 8, 2009 appellant claimed a schedule award.

In an April 16, 2009 letter, OWCP requested that Dr. Farone submit an impairment rating according to the grading criteria of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, "A.M.A., *Guides*"). On April 23, 2009 the medical office where Dr. Farone worked in late 2007 noted that he was no longer associated with the practice.

On June 16, 2009 OWCP referred appellant, the medical record and an updated statement of accepted facts to Dr. Manhal Ghanma, a Board-certified orthopedic surgeon, for a second opinion evaluation. In an August 20, 2009 report, Dr. Ghanma reviewed a history of injury and treatment, with left leg fractures in 1975 and left-sided L4-5 surgeries in 1996 and 2004. Appellant's responses to the pain questionnaire at Figure 17-A, page 600[3] of the A.M.A., *Guides*, indicated a minimal pain level not affecting functioning. On examination, Dr. Ghanma noted full right knee range of motion from 0 to 140 degrees, no sensory or motor deficits in either lower extremity, and calf circumference at 48 centimeters in both legs. He opined that appellant reached maximum medical improvement by December 18, 2007. Dr. Ghanma found that the accepted right gastrocnemius tear and sprain and prior aggravation of lumbar degenerative disc disease had resolved without disabling residuals. He stated that any lumbar radiculopathy was likely preexisting and not due to or aggravated by the October 18, 2007 injury. Referring generally to the A.M.A., *Guides*, Dr. Ghanma opined that appellant had no lower extremity impairment. He found appellant able to perform full duty with no restrictions.

On October 16, 2009 OWCP requested that OWCP's medical adviser review Dr. Ghanma's report and provide the appropriate percentage of lower extremity impairment.

In a December 6, 2009 report, Dr. William N. Grant, III, an attending Board-certified internist, provided a history of injury and treatment and noted that appellant had reached maximum medical improvement. He related appellant's symptoms of 3/10 level pain in the right gastrocnemius, increased with right knee flexion or walking on sloped surfaces. Dr. Grant observed that appellant walked "with a limp, favoring his right lower extremity." On examination, he found atrophy of the right posterior calf, a 10 degree flexion contracture and right knee flexion to 70 degrees. Dr. Grant diagnosed a right gastrocnemius muscle tear/leg strain. Referring to Table 16-23, page 549[4] of the A.M.A., *Guides*, he found a 20 percent

[2] An October 24, 2007 magnetic resonance imaging (MRI) scan showed a resolving hematoma of the posterior medial gastrocnemius muscle with compression and mild myositis changes.

[3] Figure 17-A, page 600 of the sixth edition of the A.M.A., *Guides* is entitled "Pain Disability Questionnaire (PDQ)."

[4] Table 16-23, page 549 of the sixth edition of the A.M.A., *Guides* is entitled "Knee Motion Impairments."

impairment of right lower extremity due to knee flexion limited to 70 degrees and an additional 20 percent impairment due to a flexion contracture of 10 degrees. Using the Combined Values Chart on page 604, Dr. Grant found a 36 percent impairment of the right lower extremity.

In a March 9, 2010 report, OWCP's medical adviser reviewed Dr. Ghanma's August 20, 2009 report and concurred that appellant's lumbar radiculopathy was likely to be preexisting in nature. The medical adviser found that appellant had a zero percent impairment of the right lower extremity.

By decision dated March 26, 2010, OWCP denied appellant's schedule award claim on the grounds that the medical evidence did not establish a ratable impairment of the lower extremities. It accorded the weight of the medical evidence to Dr. Ghanma's report as reviewed by OWCP's medical adviser. OWCP did not mention Dr. Grant's report in its decision.

On March 30, 2010 appellant, through counsel, requested a telephonic hearing, held on July 7, 2010. At the hearing, appellant testified that he had not fully recovered from the accepted right gastrocnemius injury but was no longer receiving treatment. He noted frequent spasms of the right calf. Counsel contended that Dr. Ghanma did not perform a thorough examination. Alternatively, he asserted that there was a conflict of medical opinion between Dr. Ghanma and Dr. Grant regarding the appropriate percentage of permanent impairment.

By decision dated and finalized September 24, 2010, OWCP's hearing representative affirmed OWCP's March 26, 2010 decision, finding that appellant did not establish a ratable impairment of either lower extremity, based on Dr. Ghanma's report. The hearing representative mentioned Dr. Grant's report but did not identify any deficiencies in his opinion.

LEGAL PRECEDENT

The schedule award provisions of FECA provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a mater which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized 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 OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[5] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[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

[5] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

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

and Health (ICF).[7] Under the sixth edition, the evaluator identifies 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).[8] The net adjustment formula is (GMFH-CDX) + (GMPE-DCX) + (GMCS-CDX).

Section 8123 of FECA provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician, who shall make an examination.[9] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[10]

ANALYSIS

OWCP accepted that appellant sustained a right gastrocnemius muscle tear/leg sprain. Appellant claimed a schedule award on April 8, 2009. OWCP referred him to Dr. Ghanma, a Board-certified orthopedic surgeon, for an impairment rating. Dr. Ghanma submitted a June 16, 2009 report finding no permanent impairment of the lower extremities. Appellant submitted a December 6, 2009 report from Dr. Grant, an attending Board-certified internist, finding a 36 percent impairment of the right lower extremity. OWCP denied appellant's schedule award claim by March 26 and September 24, 2010 decisions, based on Dr. Ghanma's opinion. The Board finds that there is a conflict of medical opinion between Dr. Ghanma, for the government, and Dr. Grant, for appellant.

Dr. Grant and Dr. Ghanma noted widely divergent clinical findings. On examination, Dr. Ghanma found right knee motion from 0 to 140 degrees, no atrophy of the right calf and did not mention any gait abnormalities. He noted lumbar radiculopathy but did not explain why he did not include it in his impairment rating.[11] In contrast, Dr. Grant found right knee flexion limited to 70 degrees with a 10-degree flexion contracture. He also noted atrophy of the right posterior calf and that appellant walked with a limp, favoring his right leg. Considering the significant differences between the two physicians' observations, the Board finds that the case requires the appointment of an impartial medical examiner.

As stated, 5 U.S.C. § 8123 provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination. Therefore, the case will be

[7] A.M.A., *Guides* (6th ed. 2008), page 3, Section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[8] A.M.A., *Guides* (6th ed. 2008), pp. 494-531.

[9] 5 U.S.C. § 8123; *see Charles S. Hamilton*, 52 ECAB 110 (2000).

[10] *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

[11] The Board notes that it is well established that all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment. *Robert V. Disalvatore*, 54 ECAB 351 (2003).

remanded to OWCP for selection of an impartial medical examiner to determine the appropriate percentage of permanent impairment. Following this and any other development deemed necessary, OWCP will issue an appropriate decision in the case.

On appeal, appellant contends that OWCP's September 24, 2010 decision was "contrary to fact and law." As stated, the case will be remanded to OWCP for appointment of an impartial medical examiner and issuance of an appropriate decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 24, 2010 is set aside and the case remanded to OWCP for further development consistent with this decision.

Issued: September 6, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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

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