United States Department of Labor
Employees' Compensation Appeals Board

D.P., Appellant	)	
and	)	**Docket No. 12-1521**
	)	**Issued: February 7, 2013**
U.S. POSTAL SERVICE, CARRIER ANNEX, Albany, NY, Employer	)	

Appearances:
Brett E. Blumstein, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On July 9, 2012 appellant, through his counsel, filed a timely appeal of a January 13, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant sustained a ratable impairment entitling him to a schedule award.

FACTUAL HISTORY

On January 14, 2000 appellant, then a 33-year-old letter carrier, injured his right foot while delivering mail. On October 25, 2000 OWCP accepted his traumatic injury claim for right

[1] 5 U.S.C. § 8101 *et seq.*

ankle sprain/strain and right tibia/fibula fracture.[2] On August 5, 2003 it accepted right foot drop and indicated that right tibia/fibula fracture was no longer accepted.[3]

A January 15, 2001 electromyogram (EMG) and nerve conduction study (NCS) performed by Dr. James P. Wymer, a Board-certified neurologist, noted diminished right ankle muscle recruitment, but did not present clear evidence of an ongoing neuropathic cause. Stimulation of the right posterior tibial nerve on January 23, 2001 was unremarkable. A February 1, 2001 duplex ultrasound of the right leg obtained by Dr. Mitchell E. Tublin, a Board-certified diagnostic radiologist, did not exhibit signs of deep venous thrombosis. A second EMG and NCS performed by Dr. Wymer on October 16, 2001 was normal while a December 4, 2001 magnetic resonance imaging (MRI) scan obtained by Dr. Frederick J. Fletcher, a Board-certified orthopedic surgeon, showed right intraosseous calcaneal lipoma and otherwise intact osseous tissue, muscles and tendons.

Appellant filed a claim for a schedule award on November 26, 2007 and submitted medical evidence.[4] In a November 15, 2006 report, Dr. Daniel J. Arenos, a Board-certified family practitioner, examined appellant and observed lack of ankle, hind foot and toe range of motion (ROM) and mild varus deformity. He determined that appellant had impairment ratings of 74 percent for the right foot, 52 percent for the right lower extremity and 21 percent for the whole body as a result of the January 14, 2000 employment injury.[5]

OWCP's December 10, 2007 statement of accepted facts detailed that appellant sprained his right ankle and fractured his right tibia/fibula while in the performance of duty on January 14, 2000. On December 10, 2007 Dr. Henry J. Magliato, an OWCP medical adviser and Board-certified orthopedic surgeon, disagreed with Dr. Arenos' impairment ratings. He calculated that appellant had a 47 percent permanent impairment of the right leg.[6]

OWCP found that a conflict in medical opinion arose between Dr. Arenos and Dr. Magliato regarding the extent of appellant's permanent impairment due to his accepted employment injury. It referred appellant to Dr. John V. Ioia, a Board-certified orthopedic surgeon, for a referee examination. In an August 22, 2008 report, Dr. Ioia reviewed the medical file and noted that appellant was treated for deep venous thrombosis of the right lower extremity sometime after the January 14, 2000 work injury. On examination, he found lack of right ankle

[2] OWCP subsequently authorized ankle-foot orthosis.

[3] OWCP specified that the medical evidence did not sufficiently establish that the January 14, 2000 employment injury resulted in a fractured tibia and/or fibula.

[4] Appellant filed a prior claim for a schedule award on November 29, 2006, which OWCP denied by decision dated August 24, 2007.

[5] Dr. Arenos based his calculations on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). In addition, his November 20, 2007 report essentially restated his earlier findings.

[6] Dr. Magliato based his calculations on the fifth edition of the A.M.A., *Guides*.

reflexes, dorsiflexion and plantar flexion, calf and pretibial atrophy and weakened active knee extension.[7]

On September 8, 2008 Dr. Andrew A. Merola, an OWCP medical adviser and Board-certified orthopedic surgeon, pointed out that Dr. Ioia failed to address appellant's impairment. On October 6, 2008 OWCP requested a supplemental opinion from Dr. Ioia, who did not respond.

OWCP referred appellant to Dr. Robert S. Block, a Board-certified orthopedic surgeon, for a second referee examination. In a July 1, 2009 letter, it instructed Dr. Block to base his impairment rating on the sixth edition of the A.M.A., *Guides*.[8]

In a September 11, 2009 report, Dr. Block reviewed the medical file and performed a physical examination of the right leg.[9] He noted localized superior fibula tenderness, diminished medial calf, anterior ankle and lateral foot sensation to pinprick, decreased hip, knee and ankle strength and lack of active ankle and toe ROM to voluntary contraction. Dr. Block commented:

> "[Appellant] is observed to extend the right knee actively when moving onto and off the exam[ination] table. When asked to voluntarily contract the quadriceps he provides a minimal force. With [appellant] seated he fails to provide a right hamstring contraction but when actively lifting the left leg the right hamstring is palpated to contract at near normal force. In moving onto and off the exam[ination] table [he] is observed to have a weak but present anterior tibialis contraction at the ankle but will not provide any voluntary anterior tibialis contraction [or] any extensor hallucis longus contraction.... As noted above, active contraction of anterior tibialis only identified when [appellant] is asked to move spontaneously but not when he is asked to actively contract the anterior tibialis or extensor hallucis. When [appellant] is observed ambulating [using a cane in the right hand] ... he is supporting himself without sign of giving way or weakness in the right knee.... There is no sign of gluteal or hamstring weakness in the gait phase."

Applying Tables 16-18 (Lesser Toe Impairments), 16-19 (Greater Toe Impairments), 16-20 (Hindfoot Motion Impairments) and 16-22 (Ankle Motion Impairments) of the sixth edition of the A.M.A., *Guides*, Dr. Block assigned ratings of 6 percent for the lesser toes, 5 percent for the greater toes, 5 percent for the hindfoot and 30 percent for the ankle, respectively, for a combined 46 percent leg impairment.[10] He listed November 20, 2007 as the date of maximum medical improvement.

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[7] Although Dr. Ioia remarked that he would utilize the fifth edition of the A.M.A., *Guides*, in conjunction with New York's workers' compensation guidelines, he did not discuss the extent of appellant's impairment.

[8] A.M.A., *Guides* (6th ed. 2008).

[9] The case record indicates that Dr. Block received the December 10, 2007 statement of accepted facts.

[10] Dr. Block also included an impairment rating based on the fifth edition of the A.M.A., *Guides*.

On January 20, 2010 Dr. Morley Slutsky, an OWCP medical adviser and Board-certified physiatrist, pointed out that the December 10, 2007 statement of accepted facts mistakenly identified the right tibia/fibula fracture as an accepted injury.[11] He added that a proper diagnosis was required to account for appellant's ankle symptoms in view of Dr. Block's remarks and recommended a neurological evaluation.[12]

OWCP found that a conflict in medical opinion existed between Dr. Block and Dr. Slutsky regarding the extent of appellant's permanent impairment due to his accepted work injury and referred him to Dr. Shashi D. Patel, a Board-certified orthopedic surgeon, for a third referee examination. In a May 26, 2010 report, Dr. Patel reviewed the December 10, 2007 statement of accepted facts and medical file. On examination, he found right thigh and calf muscle atrophy, quadriceps weakness, "floppy" ankle with limited ROM and lack of deep tendon ankle reflexes. Dr. Patel diagnosed right flail ankle and weakness of the quadriceps and hamstring muscles. Applying Table 16-2 (Foot and Ankle Regional Grid) and Table 16-3 (Knee Regional Grid) of the sixth edition of the A.M.A., *Guides*, he assigned ratings of 50 percent for the ankle and 40 percent for the knee for a combined total of 70 percent.

On July 27, 2010 Dr. Magliato disagreed with Dr. Patel's impairment rating. He asserted that Dr. Patel did not adequately explain how he used the sixth edition of the A.M.A., *Guides* to reach his conclusion. Dr. Magliato also articulated the need to properly diagnose appellant ankle, in view of previous normal EMG and NCS and to determine whether the condition was attributable to the January 14, 2000 employment injury.

OWCP referred appellant to Dr. Frank L. Genovese, a Board-certified neurological surgeon. In a December 1, 2010 report, Dr. Genovese examined appellant's right leg extremity and observed minimal hip flexor weakness, lack of ankle dorsiflexion, limited plantar flexion and diminished ankle reflexes. He noted during gait analysis without orthosis that appellant's right foot would "glide over the floor in an almost L-shaped manner, making me think that there was some dorsiflexion of the right foot which was unable to be revealed with direct testing...." Following a review of the medical file, Dr. Genovese diagnosed right foot drop, but pointed out that appellant spontaneously demonstrated dorsiflexion and the radiological records did not support a specific neuropathy or deep venous thrombosis. He concluded:

> "My working diagnosis with the information that has been given to me at this point is right ankle sprain with severe weakness of unknown etiology. I certainly am in agreement with the degrees of disabilities as per the disability ratings by the other physicians, but again, not having a clear definitive diagnosis is of concern."[13]

[11] The case record contains an October 14, 2010 statement of accepted facts addendum that did not correct this error.

[12] Dr. Slutsky offered the same opinion in a March 25, 2010 report.

[13] In an April 6, 2011 supplemental report, Dr. Genovese reviewed the December 10, 2007 statement of accepted facts, the October 14, 2010 statement of accepted facts addendum and a February 8, 2011 lumbar MRI scan obtained by Dr. Salvatore Richard Cavoli, a Board-certified diagnostic radiologist, exhibiting multilevel intervertebral disc bulges. He did not revise his opinion.

In an April 7, 2011 report, Dr. Ish R. Kumar, a Board-certified neurosurgeon and OWCP medical consultant, reviewed the medical file, the December 10, 2007 statement of accepted facts and the October 14, 2010 statement of accepted facts addendum. He did not conduct a physical examination. Dr. Kumar concluded that the objective findings, namely the absence of posterior tibial, deep peroneal and superficial peroneal nerve damage, lack of atrophy and negative diagnostic testing, were incompatible with appellant's subjective complaints and, in turn, did not support disability due to foot drop, deep venous thrombosis or any neuropathic condition. Dr. Kumar recommended a psychiatric evaluation, suggesting functional overlay or symptom magnification.

On April 14, 2011 Dr. Magliato remarked that an objective schedule award calculation could not be ascertained in light of Dr. Genovese's findings.

By decision dated January 13, 2012, OWCP denied appellant's schedule award claim, finding the medical evidence insufficient to establish that he sustained a permanent impairment to a scheduled member due to accepted employment injury.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss of or loss of use of scheduled members or functions of the body.[14] 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. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[15]

The A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF). For lower extremity impairments, 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). The net adjustment formula is (GMFH -- CDX) + (GMPE -- CDX) + (GMCS -- CDX). Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[16]

If there is a conflict in medical opinion between the employee's physician and the physician making the examination for the United States, OWCP shall appoint a third physician, known as a referee physician or impartial medical specialist, to make what is called a referee

[14] 5 U.S.C. § 8107; 20 C.F.R. § 10.404. No schedule award is payable for a member, function or organ of the body not specified under FECA or the implementing regulations. *J.Q.*, 59 ECAB 366 (2008).

[15] *K.H.*, Docket No. 09-341 (issued December 30, 2011).

[16] *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

examination.[17] Where OWCP has referred appellant to a referee physician to resolve a conflict, the referee's opinion, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[18]

ANALYSIS

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

OWCP initially accepted that appellant sustained right ankle sprain/strain and right tibia/fibula fracture while in the performance of duty on January 14, 2000. Following further radiological and neurological testing, OWCP amended the list of accepted conditions to replace right tibia/fibula fracture with right foot drop. Appellant claimed a schedule award and provided November 15, 2006 and November 20, 2007 reports from Dr. Arenos, who calculated impairment ratings of 74 percent for the right foot, 52 percent for the right leg and 21 percent for the whole body. On the other hand, Dr. Magliato, an OWCP medical adviser, determined that appellant sustained a 47 percent permanent impairment of the right leg. After finding that a conflict in medical opinion existed between Dr. Arenos and Dr. Magliato concerning the extent of appellant's impairment,[19] OWCP referred the case to Dr. Ioia for a referee examination.

Dr. Ioia's August 22, 2008 report presented physical examination findings, but otherwise neglected to address the degree of appellant's impairment based on the A.M.A., *Guides*. In order to resolve a medical conflict arising in a schedule award case, the impartial medical specialist should provide a reasoned opinion as to a permanent impairment to a scheduled member of the body in accordance with the A.M.A., *Guides*.[20] In an October 6, 2008 letter, OWCP asked Dr. Ioia to clarify his August 22, 2008 report to correct this deficiency, but did not receive a response. Consequently, Dr. Ioia's August 22, 2008 report cannot be accorded special weight or be used to resolve the outstanding medical conflict.[21] Thereafter, OWCP properly appointed Dr. Block, a Board-certified orthopedic surgeon, as the new referee physician.[22]

In a September 11, 2009 report, Dr. Block reviewed the medical file, performed a physical examination and concluded that appellant had 46 percent permanent impairment of the right leg based on Table 16-18, Table 16-19, Table 16-20 and Table 16-22 of the sixth edition of the A.M.A., *Guides*. As noted, the report of an impartial medical specialist will be accorded special weight so long as the report is sufficiently rationalized and based upon a proper factual

[17] *See* 5 U.S.C. § 8123(a); 20 C.F.R. § 10.321.

[18] *L.W.*, 59 ECAB 471 (2007); *James P. Roberts*, 31 ECAB 1010 (1980).

[19] *See Harold Travis*, 30 ECAB 1071 (1979) (OWCP medical adviser may create a conflict in medical opinion necessitating a referee examination under 5 U.S.C. § 8123(a)).

[20] *Thomas J. Fragale*, 55 ECAB 619 (2004).

[21] *See also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.11(d)(2) (September 2010) (the referee specialist's report must actually fulfill the purpose for which it was intended; it must resolve the conflict in medical opinion).

[22] *See L.R. (E.R.)*, 58 ECAB 369, 375 (2007); FECA Procedure Manual, *id.*, Chapter 2.810.11(e).

background.[23] Dr. Block's report, however, contained extensive remarks indicating that appellant did not exert full effort during the assessment. In particular, when he carried out unprompted activities, such as walking or climbing on and off the examination table, he demonstrated anterior tibialis and extensor hallucis longus contractions that were otherwise absent when he was being evaluated. Dr. Block did not explain how or if he accounted for these inconsistent findings when he calculated appellant's impairment rating.[24] Thus, his September 11, 2009 report is insufficient to resolve the outstanding medical conflict.

OWCP referred appellant to Dr. Patel, another Board-certified orthopedic surgeon, for a third referee examination after OWCP obtained Dr. Block's September 11, 2009 report. At the time of this referral, it erroneously attributed the medical conflict to Dr. Block, a referee physician and Dr. Slutsky, an OWCP medical adviser. Under 5 U.S.C. § 8123(a), a conflict cannot exist between two physicians making the examination for the United States.[25] However, the case record does not indicate that OWCP requested a supplemental report from Dr. Block correcting the inadequacies of his original report before it proceeded with this referral. When OWCP obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to cure the defect in his original report. Only if the referee physician does not respond or does not provide a sufficient response after being asked, should OWCP request a new referee examination.[26] In this case, because OWCP did not give Dr. Block the opportunity to clarify his opinion before it referred appellant for a new referee examination, Dr. Patel's May 26, 2010 report must be excluded from consideration.[27]

On the basis of January 20 and March 25, 2010 reports from Dr. Slutsky, an OWCP medical adviser who reviewed Dr. Block's September 11, 2009 report and recommended a neurological consultation, OWCP referred appellant to Dr. Genovese, a Board-certified neurological surgeon. Although Dr. Patel's appointment as a referee examiner was improper, OWCP's procedures allow for a separate examination by a physician who specializes in a different field "to fully address work-related injuries and any complications that may be

[23] *See also James T. Johnson*, 39 ECAB 1252, 1256 (1988) (the Board reviews the medical evidence to determine whether the medical report was based on incomplete information and looks at such factors as the opportunity for and thoroughness of examination performed by the physician; the accuracy and completeness of the physician's knowledge of the facts and medical history; the care of analysis manifested; and the medical rationale expressed by the physician on the medical issues addressed to him by OWCP).

[24] *See K.S.*, Docket No. 11-2071 (issued April 17, 2012); *Cleona M. Simmons*, 38 ECAB 814 (1987). *See also Robert P. Bourgeois*, 45 ECAB 745 (1994); *Kenneth J. Deerman*, 34 ECAB 641 (1983) (medical evidence must convince the adjudicator that the conclusion drawn is rational, sound and logical).

[25] *See Albert J. Scione*, 36 ECAB 717 (1985).

[26] *See supra* note 22.

[27] *Jeannine E. Swanson*, 45 ECAB 325 (1994); *Joseph R. Alsing*, 39 ECAB 1012 (1988). When an improperly-obtained medical report requires exclusion from the case record, it is annotated so that it is not retained and considered in subsequent reviews of the file. *Swanson, id. See also* FECA Procedure Manual, *supra* note 21, Chapter 2.810.11(d)(12); *Terrance R. Stath* , 45 ECAB 412, 420-21 (1994).

associated with the injuries."[28] In a December 1, 2010 report, Dr. Genovese diagnosed right foot drop and simply agreed "with the degrees of disabilities as per the disability ratings by the other physicians" without providing any reasoned opinion regarding impairment. His opinion cannot represent the weight of the evidence as there is an outstanding conflict that remains unresolved. The case record also contains an April 7, 2011 report from Dr. Kumar, an OWCP consultant, who reviewed the record, generally addressed appellant's disability status but did not address permanent impairment.

Because the conflict in medical opinion between Dr. Arenos and Dr. Magliato concerning the extent of appellant's impairment remains unresolved, the case must be remanded. OWCP shall request a supplemental opinion from Dr. Block. If he is unavailable or submits a report that is not responsive to OWCP's request, OWCP shall refer appellant to a new appropriate Board-certified specialist for another referee examination,[29] provide an updated statement of accepted facts and annotated medical file[30] and obtain a rationalized medical opinion, based upon a complete and accurate factual background and in accordance with the sixth edition of the A.M.A., *Guides*, resolving the outstanding conflict. After conducting such further development as deemed necessary, OWCP shall issue an appropriate merit decision.

CONCLUSION

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

[28] FECA Procedure Manual, *supra* note 21, Part 3 -- Medical, *OWCP Directed Medical Examinations*, Chapter 3.500.4(b)(7) (July 2011).

[29] *See supra* note 22.

[30] The Board notes that the December 10, 2007 statement of accepted facts mistakenly identified right tibia/fibula fracture as an accepted condition. The October 14, 2010 addendum did not correct this error. In addition, neither listed right foot drop as an accepted condition. The statement of accepted facts must include all accepted conditions. *See* FECA Procedure Manual, *supra* note 21, Chapter 3.600.3(a)(4) (October 1990).

ORDER

IT IS HEREBY ORDERED THAT the January 13, 2012 decision of the Office of Workers' Compensation Programs be set aside and the case remanded for further action consistent with this decision of the Board.

Issued: February 7, 2013
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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