United States Department of Labor
Employees' Compensation Appeals Board

D.O., Appellant	)	
and	)	**Docket No. 14-1528**
	)	**Issued: December 11, 2014**
U.S. POSTAL SERVICE, MAPLE VALLEY POST OFFICE, Akron, 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:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On June 25, 2014 appellant, through counsel, filed a timely appeal of a May 28, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP) concerning a schedule award. 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 this case.

ISSUE

The issue is whether appellant has established that she is entitled to a greater than four percent impairment of the left lower extremity, for which she received a schedule award.

On appeal, counsel contends that the opinion of the Dr. Morley Slutsky, an OWCP medical adviser Board-certified in occupational medicine, is biased and unfair.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On January 10, 2009 appellant, then a 38-year-old letter carrier, filed an occupational disease claim alleging that on April 24, 2008 she first became aware of left foot condition, but did not realize it was employment related until October 16, 2008. OWCP accepted her claim for subacute traumatic capsulitis left foot second metatarsophalangeal (MP) joint, which was expanded to include left gastrocnemius equinus, left tarsus and ankle enthesopathy, left tendon sheath contracture, benign neoplasm of connective tissue of left lower limb and hip, and left hammer toe. It authorized left foot contracture surgery, which was performed on January 14, 2010.

On February 8, 2011 appellant filed a claim for a schedule award.

In a March 23, 2011 report, Dr. William N. Grant, an examining Board-certified internist, opined that appellant had a 25 percent left lower extremity impairment using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). A physical examination of the left ankle revealed tenderness on palpation and limited range of motion. Dr. Grant found a seven percent left lower extremity impairment based on plantar flexion and a seven percent left lower extremity for five degrees of dorsiflexion. Next, he provided physical findings and an impairment rating for appellant's left toes. Dr. Grant reported limited range of motion, hyperpigmentation of the left foot dorsal surface, tenderness on palpation, and multiple toe impaired movements. Using Tables 16-18 page 549, he determined that appellant had a five percent left lower extremity impairment for the great toe. Next, Dr. Grant found a two percent left lower extermity impairment using Table 16-19, page 549 for the remaining four left foot toes. He then combined the impairments to find a total 25 percent left lower extremity impairment.

In a March 7, 2013 report, the medical adviser reviewed Dr. Grant's March 23, 2011 report and found that he could not provide an impairment rating due to the exaggerated findings. The medical adviser recommended referral to a second opinion examiner.

On April 11, 2013 OWCP referred appellant to Dr. Manhal Ghanma, a Board-certified orthopedic surgeon, for a second opinion evaluation to deterime appellant's left lower extremity permanent impairment. In a May 3, 2013 report, Dr. Ghanma determined there was a nine percent left lower extremity impairment using the sixth edition of the A.M.A., *Guides*. A physical examination of the left ankle revealed 45 degrees plantar flexion, 5 degrees dorsiflesion, 32 degrees inversion, and 10 degrees eversion. Range of motion for her left second toe was 35 degrees distal interphalangeal flexion with ankyosed proximal interphalangeal (PIP), 10 degrees MP flexion, and 40 degrees MP extension. Using Table 16-2, page 508 he found a class 1 with a default grade C for PIP arthrodesis, which was a one percent lower extremity impairment. Next, applied the grade modifier which included grade modifier 2 for functional history using Table 16-6, page 516, a grade modifier 1 for physical examination using Table 16-7, page 517, no modifiers were applied for clinical studies. Dr. Ghanma applied the net adjustment formula which resulting class D or an adjustment of one, which resulted in a two percent impairment using Table 16-8, page 517. Using Table 16-2, page 508, he assigned a grade D or two percent lower extremity impairment for PIP total fusion. Dr. Ghanma found that appellant was entitled to an additional five percent impairment using Table 16-2, page 501 for

decreased left ankle dorsiflexion and mild motion deficit. He then found a grade modifier 2 for functional history, which resulted in a grade D or six percent lower extremity impairment. Using Table 16-22, page 549, Dr. Ghanma determined that appellant had a seven percent lower extremity impairment for mild dorsiflexion abnormality. As this was a higher number, he chose to use this method of calculation for left ankle impairment. Using Table 16-17, page 545, he determined that her functional history adjutment was one higher, resulting in an increase of five percent for her total range of motion impairment. Multiplying 7 percent by 5 percent equalied .35 percent, which rounded up to 0.40 percent and no increase to her seven percent left lower extremity impairment. Lastly, Dr. Ghanma combined the impairments for her left lower extremity to find a total nine percent left lower extremity impairment.

In a May 23, 2013 report, Dr. Martin Fritzhand, a Board-certified urologist, concluded that appellant had a 16 percent left lower extremity impairment. A physical examination showed that appellant had difficulty walking on toes, heels and heel to toe; that she ambulated with a limping gait, a five centimeter longitudinal surgical scar over the medial left calf; left medial malleolus was tender on palpation; no movement of the left second toe interphalangeal or MP joints, mild left *pes* planovalgus deformity and 5 centimeter longitudinal scar over the left second toe dorsum into the metattarsal. Range of motion revealed 10 degrees left ankle dorsiflexion, which was diminished to 20 degrees with plantar flexion; 20 degrees left foot inversion; 0 degrees left foot eversion. Dr. Fritzhand also conducted a neurological examination which revealed intact modalities, an absent left Achilles tendon reflex, well-preserved left lower extremity muscle strength and no evidence of atrophy. He stated that appellant's subjective symptoms were supported by the objective findings he found on physical examination. Dr. Fritzhand stated that he used Table 16-2, page 501[2] for posterior tibial strain, tendinitis or ruptured tendon in evaluating her impairment. He found that appellant was a class 2 based on loss of specific tendon function and flexible deformity. Next, using Table 16-6, page 516 Dr. Fritzhand assigned a modifier 1 to functional capacity and using Table 16-7, page 517, he assigned a modifier of a two for physical examination findings. Using Table 16-8, page 519 he found a grade modifier of two for clinical studies, which resulted in the assigned grade C being moved to B or a 15 percent lower extremity impairment. Dr. Fritzhand next evaluated appellant's minor toe impairment using Table 16-2 and found a class 1 impairment. Using Tables 16-6, 16-7, and 16-8 at pages 516, 517 and 519, he assigned modifiers 1 for functional history, and physical examination findings and one for clinicial studies. Dr. Fritzhand found the grade C was unchanged which resulted in a one percent impairment for the left toe. Lastly, he used the Combined Values Chart to find a total 16 percent left lower extremity impairment.

In a July 1, 2013 report, Dr. Slutsky, an OWCP medical adviser, reviewed the medical evidence and concluded that appellant had a four percent left lower extremity impairment. He reviewed reports from Drs. Ghanma and Fritzhand. Dr. Slutsky noted that Dr. Ghanma used the less preferred range of motion in determining impairment rating while Dr. Fritzhand used the preferred diagnosis based impairment rating method. He agreed with Dr. Fritzhand's method of impairment rating, but disagreed with his impairment determination.[3] Dr. Slutsky noted that,

[2] There appears to be a typographical error as Dr. Fritzhand noted Table 16-3, but the reference to strain, tendinitis; or H/O ruptured tendon involving the posterior or anterior tibia is contained in Table 16-2, page 501.

[3] Dr. Slutsky notes a final left lower extremity impairment of five percent for left gastrocnemius recession, but later finds the impairment rating to be two percent.

under Table 16-2, Foot and Ankle Regional Grid, appellant was a class 1 and grade C for left gastrocnemius recession, instead of a grade 2 as found by Dr. Fritzhand. He agreed with Dr. Fritzhand regarding the grade modifiers for functional history and physical examination, but disagreed with the grade modifier for clinical studies. Dr. Slutsky indicated that the final net adjustment was one with a final grade D or two percent left lower extremity impairment. Next, he determined that appellant had two percent left lower extremity impairment for her left toe impairment. Dr. Slutsky found that appellant was a class 1 for her left toe arthrodesis. He disagreed with the grade modifiers assigned by Dr. Fritzhand and concluded the final net adjust is two with a final grade E, resulting in a two percent impairment for the left lower extremity.

By decision dated September 19, 2013, OWCP granted appellant a schedule award for a four percent left lower extremity permanent impairment. The period of the award was from May 23 to August 11, 2013.

On September 24, 2013 appellant's counsel requested a telephonic hearing before an OWCP hearing representative, which was held on March 15, 2014. At the hearing counsel alleged, amongst other assertions, that Dr. Slutsky was biased as the physician always gave lower impairment ratings than initial rating assignment.

By decision dated May 28, 2014, the hearing representative affirmed the September 19, 2013 schedule award determination.

LEGAL PRECEDENT

The schedule award provision of FECA[4] and its implementing regulation[5] 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. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[6] Effective May 1, 2009, OWCP adopted the sixth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[7] 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 and Health (ICF).[8]

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id. See C.M.*, Docket No. 09-1268 (issued January 22, 2010); *Billy B. Scoles*, 57 ECAB 258 (2005).

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

[8] A.M.A., *Guides* (6th ed. 2009), page 3, section 1.3, The Disability and Health ICF: A Contemporary Model of Disablement.

In addressing lower extremity impairments, the sixth edition requires identifying 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).[9]

The schedule award provision of FECA[10] and its implementing regulation[11] 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. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[12] Effective May 1, 2009, OWCP adopted the sixth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[13] 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 and Health (ICF).[14]

In addressing lower extremity impairments, the sixth edition requires identifying the impairment class for the diagnosed condition Class of Diagnosed (CDX), which is then adjusted by grade modifiers based on (GMFH), (GMPE), and (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[15]

Section 8123(a) 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.[16] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.[17]

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[9] A.M.A., *Guides* 521. *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

[12] *Id. See C.M.*, Docket No. 09-1268 (issued January 22, 2010); *Billy B. Scoles*, 57 ECAB 258 (2005).

[13] *See supra* note 7.

[14] A.M.A., *Guides* (6th ed. 2009), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[15] *See supra* note 9.

[16] 5 U.S.C. § 8123(a). *See S.R.*, Docket No. 09-2332 (issued August 16, 2010); *Y.A.*, 59 ECAB 701 (2008); *Darlene R. Kennedy*, 57 ECAB 414 (2006).

[17] *A.R.*, Docket No. 09-1566 (issued June 2, 2010); *M.S.*, 58 ECAB 328 (2007); *Bryan O. Crane*, 56 ECAB 713 (2005).

ANALYSIS

OWCP accepted the claim for subacute traumatic capsulitis left foot second MP joint, which was expanded to include left gastrocnemius equinus, left tarsus and ankle enthesopathy, left tendon sheath contracture, benign neoplasm of connective tissue of left lower limb and hip, and left hammer toe. By decision dated September 19, 2013, it granted appellant a schedule award for a four percent left lower extremity impairment based upon the report by Dr. Slutsky, an OWCP medical adviser.

In a June 27, 2013 report, Dr. Slutsky, an OWCP medical adviser, advised that based on the A.M.A., *Guides* appellant had four percent impairment of the left lower extremity. He reviewed reports from Drs. Ghanma and Fritzhand. He noted that Dr. Ghanma used the less preferred range of motion in determining impairment rating while Dr. Fritzhand used the preferred diagnosis based impairment rating method. Dr. Slutsky agreed with Dr. Fritzhand's method of impairment rating, but disagreed with his impairment determination. Using Table 16-2, Foot and Ankle Regional Grid, Dr. Slutsky determined that appellant was a class 1, with a default grade C. He agreed with Dr. Fritzhand regarding the grade modifiers for functional history and physical examination, but disagreed with the grade modifier for clinical studies. Using the net adjustment formula resulted in a final grade of D or two percent left lower extremity impairment for her ankle impairment. Next, Dr. Slutsky found that appellant was a class 1 for her left toe arthrodesis. He disagreed with the grade modifiers assigned by Dr. Fritzhand and concluded the final net adjust to be 2 with a final grade E, resulting in a two percent impairment.

By contrast, in a May 18, 2013 report, Dr. Fritzhand opined that appellant had a total 16 percent impairment of the left lower extremity. Using Table 16-2, page 501, he concluded that appellant was a class 2 impairment with a default value of 16 for flexible deformity and loss of specific tendon function. Dr. Fritzhand noted that the net adjustment formula resulted in a change to B or 15 percent impairment. Next, he utilized Table 16-2, page 508 for minor toes was a class 1 or one percent impairment. Using the net adjustment formula, Dr. Fritzhand found no change. He then determined that appellant had a 16 percent left lower extremity impairment by combining the impairment ratings for the ankle and toe.

The Board finds that there is an unresolved conflict in the medical opinion evidence concerning the extent of permanent impairment arising from appellant's accepted employment injury. Both Dr. Slutsky, an OWCP medical adviser, and Dr. Fritzhand used Table 16-2 of A.M.A., *Guides* to come to differing calculations as to appellant's permanent impairment of the left lower extremity. Therefore, in order to resolve the conflict in the medical opinions, the case will be remanded to OWCP for referral of the case record, including a statement of accepted facts and appellant, to an impartial medical specialist, pursuant to 5 U.S.C. § 8123(a), for a determination regarding the extent of her left lower extremity impairment as determined in accordance with the relevant protocols of the A.M.A., *Guides.* After such further development as OWCP deems necessary, a *de novo* decision should be issued regarding the extent of appellant's left lower extremity impairment.

CONCLUSION

The Board finds that this case is not in posture for a decision due to an unresolved conflict in the medical opinion evidence regarding the percentage of impairment of the left lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 28, 2014 is set aside and the case remanded for further proceedings consistent with the above opinion.

Issued: December 11, 2014
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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