United States Department of Labor
Employees' Compensation Appeals Board

T.L., Appellant	)	
and	)	**Docket No. 13-1435**
	)	**Issued: March 13, 2014**
DEPARTMENT OF VETERANS AFFAIRS, TOMAH VETERANS ADMINISTRATION MEDICAL CENTER, Tomah, WI, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 4, 2013 appellant filed a timely appeal from a May 17, 2013 decision of the Office of Workers' Compensation Programs (OWCP) regarding 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 the case.

ISSUE

The issue is whether appellant has more than two percent permanent impairment of the right lower extremity for which she received a schedule award.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On September 25, 2009 appellant, then a 41-year-old psychiatric nursing assistant, injured her right ankle while transferring a patient to the bathroom. OWCP accepted the claim for right ankle sprain. It authorized a November 5, 2009 and March 17, 2010 right ankle surgery. Appellant worked intermittently thereafter.[2]

Appellant was treated by Dr. Kevin J. Weber, a Board-certified orthopedist, from November 5 to December 15, 2009, for a right ankle injury that occurred at work three years prior which she reinjured on September 25, 2009. Dr. Weber performed an arthroscopy of the right ankle with chondroplasty of the medial talus and partial synovectomy and diagnosed chronic right ankle pain. A magnetic resonance imaging (MRI) scan of the right ankle revealed a small tibiotalar and subtalar joint effusion with multiple ganglion cysts, mild synovitis of the joints of the ankle and mid foot and scarring of the anterior syundesmotic ligament. Appellant was also treated by Dr. Richard G. Rilling, a Board-certified orthopedist, who performed a March 17, 2010 right ankle arthroscopy and debridement of scar tissue and right ankle superficial and deep peroneal nerve decompression. Dr. Rilling diagnosed right ankle medial tara dome osteochondritis dissecans (OCD) and right ankle superficial deep peroneal neuropathy.

On May 19, 2010 appellant filed a claim for a schedule award.[3] She subsequently submitted a December 15, 2010 report from Dr. Steven R. Kirkhorn, a Board-certified physiatrist, who noted a history of injury and diagnosed chronic ankle pain and possible instability of the right ankle. Appellant reported numbness up to her knees and ankles, periodic falls, difficulty going up stairs and squatting and uses a cane for longer distances. Dr. Kirkhorn noted findings of antalgic gait, pain on squatting, discoloration around the ankle with erythema, no edema or effusion, and tenderness in the dorsum of the ankle. Reflexes were symmetrical and strength and sensation were intact. Calf measures were 36 centimeters on the right and 38.5 centimeters on the right. Dorsiflexion was 15 degrees on the right and 20 degrees on the left, plantar flexion was 25 degrees on the right and 40 degrees on the left, inversion was 25 degrees on the right 25 degrees on the left, and eversion was 20 degrees on the right and 38 degrees on the left. Dr. Kirkhorn noted that he could not provide an impairment rating until he reviewed her x-rays and operative reports.

In a January 25, 2011 report, an OWCP medical adviser reviewed Dr. Kirkhorn's reports as well as the second opinion physician, Dr. Barron, and opined that appellant had subjective complaints without examination findings. In accordance with the sixth edition of the American

[2] On March 10, 2007 appellant tripped and bumped her right ankle on an intervaneous pole and OWCP accepted right ankle sprain, claim number xxxxxx678. This claim is consolidated with the current claim before the Board.

[3] OWCP subsequently referred appellant to Dr. Stephen Barron, a Board-certified orthopedist, for a second opinion regarding the extent of her condition. In an August 3, 2010 report, Dr. Barron opined that appellant's subjective complaints were not consistent with any objective medical finding. He advised that appellant did not have work restrictions from her 2007 to 2009 injuries. OWCP referred her to Dr. Gordon L. Clark, a Board-certified orthopedic surgeon, to resolve the medical conflict regarding the extent of any residuals and work restrictions from the accepted injuries. In a November 22, 2003 report, Dr. Clark opined that appellant's objective findings supported chronic pain secondary to her work injures. He opined that her 2007 and 2009 work injuries caused her ankle pathology and she was permanently restricted from using stairs or squatting.

Medical Association, *Guides to the Evaluation of Permanent Impairment*[4] (A.M.A., *Guides*), the medical adviser opined that appellant had no impairment of the right leg.

Appellant submitted a March 3, 2011 report from Dr. Kirkhorn, who opined that pursuant to Chapter 16 of the sixth edition of the A.M.A., *Guides* appellant had seven percent right lower extremity impairment. In a permanent impairment worksheet, he diagnosed chronic ankle pain and ankle instability. He noted under Table 16-2, Foot and Ankle Regional Grid, arthritis of the ankle, appellant was a class 1. Applying grade modifiers, Dr. Kirkhorn found a Functional History (GMFH) grade modifier of 2, a Physical Examination (GMPE) grade modifier of 2, Clinical Studies (GMCS) grade modifier of 0 and an American Association of Orthopedic Surgeons (AAOS) inventory score of two. He used the net adjustment formula to find a net adjustment of two, which yielded a grade E impairment of seven percent leg impairment.

In an April 2, 2011 report, an OWCP medical adviser noted that Dr. Kirkhorn rated appellant based on ankle osteoarthritis which was not an accepted condition. The medical adviser opined that appellant had no impairment of the right leg under the A.M.A., *Guides*.

Appellant submitted an August 16, 2011 report from Dr. Kirkhorn, who opined that appellant had post-traumatic arthrosis from her work injury. Dr. Kirkhorn diagnosed chronic ankle pain, post-traumatic arthrosis, complex regional pain syndrome symptoms, gait disorder and weakness of the right ankle. He opined that appellant had work-related synovitis. Dr. Kirkhorn calculated a score of -10 in the lower limb questionnaire, for a grade 3 modifier. Pursuant to Table 16-20, page 549 of the A.M.A., *Guides*, appellant had two percent leg impairment for inversion and two percent impairment for eversion. Under Table 16-22, he had seven percent leg impairment for plantar flexion and for extension for a total of 18 percent impairment for active range of motion. Dr. Kirkhorn then noted appellant's rating under Table 16-2, page 501 for a strain with motion deficits. He advised that the adjustment formula yielded a -1 or grade B impairment consistent with four percent leg impairment. Dr. Kirkhorn noted that appellant had four percent impairment of the lower extremity or two percent whole person impairment using the diagnosis-based estimate. Using the range of motion figures appellant had 18 percent leg impairment which correlated to seven percent whole person impairment. In a September 22, 2011 report, Dr. Kirkhorn noted that appellant had some, but not all, elements of complex regional pain syndrome. He stated that he rated appellant based on range of motion and the grid method.

In an October 23, 2011 report, an OWCP medical adviser reviewed Dr. Kirkhorn's reports. He noted that Dr. Kirkhorn did not report on x-ray findings that would support post-traumatic degenerative changes. The medical adviser further advised that, although Dr. Kirkhorn reported decrease range of motion of the right ankle, the second opinion physician found full range of motion of the right ankle. He determined that without x-ray evidence of arthrosis and with full range of motion of the ankle, he could not support the diagnoses of post-traumatic arthrosis. The medical adviser opined that appellant had no permanent impairment of the lower extremity.

[4] A.M.A., *Guides* (6th ed. 2009).

A December 9, 2011 x-ray of the right ankle revealed spurring of the inferior calcaneal tuberosity with no evidence of acute or chronic bone, joint or soft tissue pathology.

OWCP referred appellant's case record to an OWCP medical adviser. In a January 15, 2012 report, the medical adviser noted that Dr. Kirkhorn reported right ankle arthrosis despite a second opinion physician showing excellent range of motion. He reviewed the December 9, 2011 x-ray report which was essentially normal and opined that there was no evidence to support ankle arthrosis. The medical adviser opined that appellant sustained a zero percent impairment of the right lower extremity.

In a decision dated April 20, 2012, OWCP denied appellant's claim for a schedule award.

On April 25, 2012 appellant requested a review of the written record. She submitted a May 4, 2012 report from Dr. Kirkhorn who noted that appellant presented limping with, pain in the dorsum of the foot, swelling, coolness of the right foot with paresthesias into the toes. Dr. Kirkhorn diagnosed persistent ankle pain and right calf atrophy secondary to ankle pain. He noted findings of moderate antalgic gait, moderately tender over the dorsum of the ankle and incisions, no edema of the ankle, normal color and temperature, no instability, intact sensation with some atrophy on the right calf as compared to the left calf. Dorsiflexion of the right ankle was 10 degrees and on the left 20 degrees, plantar flexion was 10 degrees on the right and 40 degrees on the left, inversion was 15 degrees on the right and 40 degrees on the left and eversion was 10 degrees on the left and 30 degrees on the right. Dr. Kirkhorn noted that appellant's AAOS questionnaire score was -13.25 which indicates moderate disability. He noted that, pursuant to Table 16-2, page 501 of the A.M.A., *Guides*, under strain, chronic tendinitis, appellant was Class 1, mild motion deficit, for a default impairment of five percent. Dr. Kirkhorn noted a grade 2 modifier for functional history, a grade 2 modifier for observed and palpatory findings under Table 16-7, page 517 and a grade zero for clinical studies. He opined that using the net adjustment formula appellant was a grade E for strain, tendinitis under mild motion deficits for seven percent impairment of the lower extremity.

In a decision dated August 6, 2012, an OWCP hearing representative affirmed the decision dated April 20, 2012.

Appellant appealed his case to the Board. In an April 12, 2013 order, the Board remanded the case to OWCP. The Board found that OWCP, in its August 6, 2012 decision, failed to consider the May 4, 2012 report from Dr. Kirkhorn that was received by OWCP on May 14, 2012. The Board instructed OWCP to consider all the evidence submitted at the time of the August 6, 2012 decision and issue an appropriate decision.[5]

Appellant submitted a December 31, 2012 CT of the right ankle which revealed no significant osteoarthritis involving the ankle joint or subtalar joint, an age commensurate degeneration of the first metatarsophalangeal joint. A February 5, 2013 electromyogram (EMG) revealed right superficial peroneal sensory neuropathy and no evidence of right lumbosacral radiculopathy.

[5] Docket No. 13-134 (issued April 12, 2013).

OWCP referred appellant's case record to a medical adviser. In an April 28, 2013 report, an OWCP medical adviser reviewed Dr. Kirkhorn's reports as well as reports from OWCP referral physicians. He noted that based on Dr. Barron's August 3, 2010 report appellant had full range of motion of the right ankle without sensory deficits. Maximum medical improvement occurred on August 3, 2010. The medical adviser noted that in accordance with Chapter 16 of the sixth edition of the A.M.A., *Guides* appellant had two percent impairment of the right lower extremity. He noted that, under Table 16-2, Foot and Ankle Regional Grid, appellant had a class 1, full thickness articular cartilage defect of the ankle joint, which yielded a default grade C impairment of two percent pursuant to Table 16-2, page 506 of the A.M.A., *Guides*. The medical adviser applied grade modifiers, finding that the grade for functional history, pursuant to Table 16-6, was one (for antalgic gait) for a mild problem; the grade for physical examination at Table 16-7 was one, for a mild problem (normal range of motion with minimal palpatory findings) and the grade for clinical studies pursuant to Table 16-8 was one (for an osteochondral lesion debridement on MRI scan, mild pathology). The medical adviser utilized the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) or (1-1) + (1-1) + (1-1) to find a net adjustment of zero which yielded a grade C modifier or two percent impairment of the right lower extremity. The medical adviser noted that Dr. Kirkhorn incorrectly rated appellant for tendinitis and not objective finding of the OCD lesion which was treated surgically.

On May 17, 2013 appellant was granted a schedule award for two percent impairment of the right lower extremity. The period of the award was May 5 to June 14, 2013.

LEGAL PRECEDENT

The schedule award provision of FECA[6] and its implementing federal regulations,[7] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[8] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[10]

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

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id.* at § 10.404(a).

[9] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[10] FECA Bulletin No. 09-03 (issued March 15, 2009).

and Health (ICF).[11] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13] The grade modifiers are used on the net adjustment formula described above to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down the default value C, by the calculated net adjustment.[14]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical consultant for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with OWCP's medical consultant providing rationale for the percentage of impairment specified.[15]

ANALYSIS

On appeal, appellant contends that he is entitled to a schedule award greater than two percent permanent impairment of the right lower extremity. OWCP accepted appellant's claim for right ankle sprain. The Board finds that there is a conflict in medical opinion between OWCP's medical adviser and Dr. Kirkhorn, appellant's treating physician, regarding the impairment of the right lower extremity.

OWCP's medical adviser who, in a report dated April 28, 2013, advised that based on the A.M.A. *Guides* appellant had two percent impairment of the right lower extremity. He based his report on the findings of Dr. Barron, the second opinion physician, who issued a report on August 3, 2010. The medical adviser rated appellant pursuant to Table 16-2, Foot and Ankle Regional Grid, noting that appellant had a class 1, full thickness articular cartilage defect of the ankle joint, which yielded a default grade C impairment of two percent pursuant to Table 16-2, page 506 of the A.M.A., *Guides*. He applied grade modifiers, finding that the grade for functional history, was one for a mild problem; the grade for physical examination was one, for a mild problem (relying on Dr. Barron's findings of normal range of motion with minimal palpatory findings) and the grade for clinical studies pursuant to Table 16-8 was one (for an osteochondral lesion debridement on MRI scan, mild pathology). The medical adviser utilized the net adjustment formula to find a net adjustment of zero which yielded a grade C modifier or two percent impairment of the right lower extremity. He noted that Dr. Kirkhorn incorrectly rated appellant for tendinitis and not objective finding of the OCD lesion which was treated surgically.

[11] A.M.A., *Guides* 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[12] *Id.* at 494-531.

[13] *Id.* at 521.

[14] A.M.A., *Guides* 497.

[15] *See Federal* (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

By contrast, in a May 4, 2012 report, Dr. Kirkhorn advised that based on the A.M.A., *Guides* appellant had seven percent impairment of the right lower extremity. He rated appellant pursuant to Table 16-2, page 501 of the A.M.A., *Guides*, under ankle strain, chronic tendinitis. Dr. Kirkhorn noted mild range of motion deficits in his physical examination on May 4, 2012 contrary to Dr. Barron's report of August 3, 2010 which found normal range of motion of the right ankle. He noted range of motion for dorsiflexion of the right ankle was 10 degrees and on the left 20 degrees, plantar flexion was 10 degrees on the right and 40 degrees on the left, inversion was 15 degrees on the right and 40 degrees on the left and eversion was 10 degrees on the left and 30 degrees on the right. Dr. Kirkhorn noted appellant's AAOS questionnaire score was -13.25 which indicates moderate disability. He noted that, pursuant to Table 16-2, page 501 of the A.M.A., *Guides*, under strain, chronic tendinitis, appellant was class 1, mild motion deficit, for a default impairment of five percent. Dr. Kirkhorn noted a grade 2 modifier for functional history, a grade 2 modifier for physical examination with observed and palpatory findings under Table 16-7, page 517 and a grade zero for clinical studies. He opined that using the net adjustment formula appellant was a grade E for strain, tendinitis under mild motion deficits for seven percent impairment of the lower extremity. Dr. Kirkhorn supported an increased impairment rating of the right lower extremity, noting the basis of his rating under the A.M.A., *Guides*, while OWCP's medical adviser opined that appellant sustained no more than two percent permanent impairment of the right lower extremity pursuant to the A.M.A., *Guides*. Each physician used the A.M.A., *Guides* to come to differing calculations regarding appellant's permanent impairment of the right lower extremity.

Section 8123(a) of FECA provides in pertinent part: "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] The Board finds that OWCP should have referred appellant to an impartial medical specialist to resolve the medical conflict regarding the extent of permanent impairment arising from appellants accepted employment injury.

Therefore, in order to resolve the conflict in the medical opinions as to permanent impairment, the case will be remanded to OWCP for referral of the case record, including a statement of accepted facts, and, if necessary, appellant, to an impartial medical specialist for a determination regarding the extent of appellant's right lower extremity impairment as determined in accordance with the relevant standards of the A.M.A., *Guides*.[18] After such further development as OWCP deems necessary, an appropriate decision should be issued regarding the extent of appellant's right lower extremity impairment.

[16] 5 U.S.C. § 8123(a).

[17] *William C. Bush*, 40 ECAB 1064 (1989).

[18] *See Harold Travis*, 30 ECAB 1071, 1078-79 (1979).

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the May 17, 2013 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for further development in accordance with this decision.

Issued: March 13, 2014
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

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

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