United States Department of Labor
Employees' Compensation Appeals Board

W.W., Appellant	)	
and	)	**Docket No. 13-1801**
	)	**Issued: March 18, 2014**
DEPARTMENT OF THE INTERIOR, BUREAU OF LAND RECLAMATION, Riverside, CA, Employer	)	

Appearances:
Martin Kaplan, Esq. for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 29, 2013 appellant, through his attorney, filed a timely appeal from a June 3, 2013 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 this case.[2]

ISSUE

The issue is whether appellant sustained more than a 10 percent permanent impairment of the right lower extremity, for which he received a schedule award.

On appeal, counsel asserts that OWCP failed to include impairment to appellant's right ankle in calculating the June 3, 2013 schedule award.

[1] 5 U.S.C. § 8101 *et seq*.

[2] Counsel did not appeal a May 29, 2013 loss of wage-earning capacity determination. Therefore, the Board will address only the evidence relevant to the schedule award issue.

FACTUAL HISTORY

OWCP accepted that on April 17, 2007 appellant, then a 46-year-old hydrologic technician, sustained right leg, knee and ankle sprains and a torn right medial meniscus when he slipped and fell on rocks while disembarking from a boat.[3] He remained off work until September 24, 2007, when he returned to light duty and sustained a second right knee injury when he tripped and fell while walking with crutches. OWCP accepted cervical and lumbar sprains related to the September 24, 2007 incident. Appellant stopped work on September 24, 2007 and did not return. He separated from the employing establishment in May 2008. Appellant received wage-loss compensation benefits on the periodic rolls.

Dr. Douglas J. Roger, an attending Board-certified orthopedic surgeon, followed appellant beginning in October 2007. On November 13, 2007 he performed partial right lateral and medial meniscectomies, abrasion chondroplasty, debridement of a medial synovial plica and removal of small loose bodies. OWCP authorized the procedures.

In a September 2, 2008 report, Dr. David A. Friscia, an attending Board-certified orthopedic surgeon, diagnosed a deltoid ligament injury of the right ankle with chronic instability.[4]

Dr. Roger opined on November 26, 2008 that appellant needed a Brostrom lateral ankle repair with synovectomy to address possible tears of the subtalar and calcaneal ligaments demonstrated by January 30 and October 2, 2008 MRI scans and an October 9, 2008 CT scan.

On February 20, 2009 OWCP obtained a second opinion regarding appellant's work limitations from Dr. Jon T. Abbott, a Board-certified orthopedic surgeon, who recommended right ankle arthroscopy to address sequeale of the accepted right ankle sprain.

In a June 19, 2009 report, Dr. Roger diagnosed right medial and lateral meniscus tears, a right talus contusion and a talofibular ligament injury. He opined that appellant had reached maximum medical improvement.

On March 15, 2010 appellant claimed a schedule award. He submitted a February 9, 2010 right lower extremity impairment rating from Dr. Roger utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). Dr. Roger found a class 1, grade C diagnosis-based impairment for status post partial

[3] By decision dated August 8, 2007, OWCP initially denied compensation for the period June 4, 2007 and continuing. Following additional development on December 7, 2007 it reversed that decision.

[4] A July 19, 2007 magnetic resonance imaging (MRI) scan of the right ankle showed a lateral talar dome contusion and an anterior talofibular ligament sprain with synovitis. A January 30, 2008 MRI scan of the right ankle showed an ossicular structure in the deltoid ligament due to injury, bone marrow edema indicative of reinjury or avascular necrosis and sinus tarsi edema suggestive of a partial tear of the subtalar and calcaneal ligaments or chronic ligament degeneration. An October 2, 2008 MRI scan of the right ankle showed increased ossification of the deltoid ligament and resolved sinus tarsi edema. An October 9, 2008 computerized tomography (CT) scan of the right ankle showed a prominent fragment subjacent to the medial malleolus, most likely due to remote avulsion residua.

medial and lateral meniscectomies, equaling a 10 percent impairment of the right lower extremity according to Table 16-3.[5] Regarding the right ankle, Dr. Roger noted gait disturbance, instability and limited motion. Referring to Table 16-2,[6] Dr. Roger assessed a class for the diagnosed condition (CDX) of class 2, grade C, with a default value of 22 percent, converted to a 16 percent lower extremity impairment using Table 16-10.[7]

On May 1, 2010 an OWCP medical adviser opined that Dr. Roger misapplied the A.M.A., *Guides* and that additional information was needed to assess the right ankle impairment.[8]

On August 1, 2012 OWCP obtained a second opinion from Dr. Ronald M. Lampert, a Board-certified orthopedic surgeon, who reviewed the medical record and a statement of accepted facts. On examination, Dr. Lampert noted a stable right knee with anterior and posterior joint line tenderness, right ankle plantar flexion at 10 degrees and dorsiflexion at 25 degrees. He diagnosed postoperative status of the right knee and subjective right ankle pain without instability. Dr. Lampert opined that appellant had attained maximum medical improvement as of March 16, 2010. He concurred with Dr. Roger's determination of a 10 percent impairment of the right lower extremity due to status post partial medial and lateral meniscectomies according to Table 16-2. Dr. Lampert found no permanent impairment of the right ankle as appellant had no objective residuals consistent with the accepted right ankle sprain.

In an October 16, 2012 report, Dr. Roger noted that, as of February 27, 2012, appellant had significant lateral instability of the right ankle with varus stressing of the hind foot, with flexion limited to 23 degrees, extension at 4 degrees, inversion to 11 degrees and eversion to 6 degrees. Appellant's right knee was stable, with slightly restricted motion.

In a February 13, 2013 report, Dr. Eduardo E. Anguizola, an attending physician Board-certified in pain management, diagnosed right ankle instability.

On April 14, 2013 an OWCP medical adviser reviewed Dr. Lampert's report and the medical record. He concurred with Dr. Lampert's determination of a 10 percent impairment of the right lower extremity due to status post partial medical and lateral meniscectomies. The

[5] Table 16-3, pages 509-11 of the sixth edition of the A.M.A., *Guides* is entitled "Knee Regional Grid -- Lower Extremity Impairments."

[6] Table 16-2, pages 501-08 of the sixth edition of the A.M.A., *Guides* is entitled "Foot and Ankle Regional Grid -- Lower Extremity Impairments."

[7] Table 16-10, pages 530-31 of the sixth edition of the A.M.A., *Guides* is entitled "Impairment Values Calculated From Lower Extremity Impairment."

[8] On March 23, 2010 OWCP obtained a second opinion regarding appellant's work capacity from Dr. Aubrey A. Swartz, a Board-certified orthopedic surgeon, who opined that he continued to have active residuals of the right knee and ankle injuries. On July 12, 2011 it obtained a second opinion regarding appellant's work capacity from Dr. Sohail Ahmad, a Board-certified orthopedic surgeon. Although he was not requested to do so, Dr. Ahmad offered an impairment rating for the right lower extremity according to the fifth edition of the A.M.A., *Guides*. OWCP did not rely on Dr. Ahmad's opinion on the schedule award issue.

medical adviser opined that the medical record did not "indicate any additional impairment for residua of [a] right ankle 'sprain.'"

By decision dated June 3, 2013, OWCP granted appellant a schedule award for 10 percent impairment of the right lower extremity. The period of the award ran from June 2 to December 20, 2013.

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.[9] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[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 and Health (ICF).[11] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX). It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[13]

ANALYSIS

OWCP accepted that appellant sustained right leg, knee and ankle sprains in an April 17, 2007 slip and fall incident and cervical and lumbar sprains in a September 24, 2007 fall. Appellant underwent partial right medial and lateral meniscectomies on November 13, 2007,

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

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, 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).

[11] 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."

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

[13] *M.R.*, Docket No. 13-1292 (issued January 10, 2014); *see supra* note 10 Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3(a)(3) (January 2010); *see Dale B. Larson*, 41 ECAB 481, 490 (1990). This portion of OWCP's procedures provides that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

authorized by OWCP. He claimed a schedule award on March 15, 2010. OWCP issued a schedule award on June 3, 2013 for a 10 percent impairment of the right lower extremity due to sequelae of the accepted right knee sprain, but found no ratable impairment of the right ankle. On appeal, counsel contends that OWCP wrongly failed to include ankle impairment in calculating the June 3, 2013 schedule award for the right lower extremity.

Several physicians of record diagnosed objective right ankle conditions. On September 2, 2008 Dr. Friscia, an attending Board-certified orthopedic surgeon, diagnosed a deltoid ligament injury and chronic instability. Dr. Abbott, a Board-certified orthopedic surgeon and second opinion physician, recommended right ankle arthroscopy on February 20, 2009 to address sequelae of the accepted right ankle sprain. Dr. Anguizola, an attending physician Board-certified in pain management, diagnosed right ankle instability on February 13, 2013. Dr. Roger, an attending Board-certified orthopedic surgeon, diagnosed subtalar, talofibular and calcaneal ligament tears, chronic instability and a right talus contusion. On February 9, 2010 he found 10 percent impairment of the right lower extremity due to postsurgical status of the knee according to Table 16-3 and 16 percent impairment of the right leg due to instability and limited motion of the right ankle.

Dr. Lampert, a Board-certified orthopedic surgeon and second opinion physician, opined that on August 1, 2012 appellant had a 10 percent impairment of the right lower extremity due to postsurgical status of the knee. However, he stated that there were no objective findings of right ankle impairment that could be caused by the accepted right ankle sprain. An OWCP medical adviser concurred with Dr. Lampert's opinion.

Dr. Roger, as well as attending physicians Drs. Friscia and Anguizola and second opinion physician Dr. Abbott, all diagnosed objective abnormalities of the right ankle, which they attributed to the accepted right ankle sprain. Dr. Lampert opined that any objective findings were not attributable to the accepted sprain.[14] The Board therefore finds that there is a conflict of medical opinion between Dr. Roger, for appellant, and Dr. Lampert, for the government, regarding the appropriate percentage of permanent impairment for the right lower extremity. 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.[15] Accordingly, the Board will set aside the June 3, 2013 OWCP decision and remand the case to OWCP to refer appellant, the case record and a statement of accepted facts to an appropriate independent medical specialist to determine the nature and the degree of his permanent impairment due to the accepted right knee, right ankle and right lower extremity sprains.[16] After such further development of the record as it deems necessary, OWCP shall issue a *de novo* decision in the case.

[14] Furthermore, to the extent that appellant had any preexisting impairment, it is well established that, in determining the amount of a schedule award for a given member of the body that sustained an employment-related permanent impairment, preexisting impairments of that scheduled member of the body are to be included. *K.H.*, Docket No. 09-341 (issued December 30, 2009).

[15] 5 U.S.C. § 8123(a).

[16] *M.R.*; Federal (FECA) Procedure Manual, Chapter 3.700.3(a)(3) (January 2010), *supra* note 13.

On appeal, counsel asserts that OWCP failed to include impairment to appellant's right ankle in calculating the June 3, 2013 schedule award. As stated above, the case is not in posture for a decision as there is a conflict of medical opinion regarding the appropriate percentage of permanent impairment of the right lower extremity.

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 June 3, 2013 is set aside and the case remanded for additional development consistent with this decision.

Issued: March 18, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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