United States Department of Labor
Employees' Compensation Appeals Board

M.O., Appellant	)	
and	)	**Docket No. 14-928**
	)	**Issued: November 21, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Troy, 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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 11, 2014 appellant, through her attorney, filed a timely appeal from a February 12, 2014 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 OWCP properly denied appellant's claim for a schedule award.

FACTUAL HISTORY

On September 4, 2010 appellant, then a 42-year-old distribution clerk, was moving an all-purpose container and tripped over a net injuring her right leg and foot. OWCP accepted her claim for right foot strain, right lower leg strain, right ankle sprain and expanded her claim to include right foot plantar fasciitis and rupture of other tendons of the right foot and ankle.

[1] 5 U.S.C. §§ 8101-8193.

Appellant returned to limited-duty work. She received appropriate wage-loss compensation for intermittent time missed from work.

Appellant submitted a September 4, 2010 x-ray of the right foot which revealed a calcaneal spur. She was treated by Dr. Laurie A. Nielsen-Haak, a podiatrist, from September 28, 2010 to May 15, 2012 for a work-related right foot injury that occurred on September 4, 2010. Appellant diagnosed muscle tear of the right foot, plantar fascia rupture of the foot with nerve damage. A magnetic resonance imaging (MRI) scan of the right foot dated December 8, 2010 revealed severe right plantar fasciitis involving medial fibers, a partial tear of the muscular fibers of the abductor digiti minimi and adjacent subcutaneous edema of the right heel, tiny foci of subchondral bone marrow edema involving the medial and lateral talar dome consistent with osteochondral lesion. A March 15, 2011 electromyogram (EMG) revealed no clear evidence of tarsal tunnel syndrome, lumbar radiculopathy or peripheral neuropathy. A December 29, 2011 MRI scan of the right foot revealed active plantar fasciitis pattern including plantar fascial thickening and low grade interstitial and deep fiber attachment tearing in the medial and lateral cord, mild Achilles tendinosis and peritendinitis, chronic osteochondral injuries of the medial and lateral talar dome, chronic collateral ligament sprain pattern at the tibiotalar joint and atrophy of the abductor digiti minimi muscle.

On January 24, 2013 appellant filed a claim for a schedule award. She submitted a December 6, 2012 report from Dr. Nielsen-Haak, who noted that appellant reached maximum medical improvement and released appellant from her care.

On January 31, 2013 OWCP requested that appellant submit a rating of permanent impairment pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2]

In a February 26, 2013 report, Dr. Nielsen-Haak indicated that she was unable to provide an impairment rating. On April 11, 2013 OWCP referred appellant for a second opinion to Dr. E. Gregory Fisher, a Board-certified orthopedic surgeon, for a determination of permanent impairment attributable to her accepted conditions.

On April 22, 2013 OWCP received an April 10, 2013 report from Dr. Martin Fritzhand, a Board-certified physiatrist, who noted a history of injury and subsequent treatment. Dr. Fritzhand noted findings on examination of the right ankle for dorsiflexion of 20 degrees, plantar flexion of 40 degrees, inversion of 10 degrees and eversion of 20 degrees. He noted that the plantar surface of the mid-foot was tender to palpation, muscle strength was intact, the right calf measured 15½ inches and the left calf was 16 inches, pinprick and light touch were diminished over the medial aspect of the right lower leg and right foot and the right Achilles tendon reflex was absent. Dr. Fritzhand noted that range of motion of the right foot was 10 degrees on inversion for mild motion impairment,[3] there was significant atrophy of the right leg associated with sensory loss, appellant found it difficult to stand and weight bear for more than short periods of time, participate in household chores and recreational activities. He noted

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

[3] *See id*. at Table 16-20.

appellant's subjective symptoms were corroborated by objective findings. Dr. Fritzhand opined that pursuant to Chapter 16 of the sixth edition of the A.M.A., *Guides* appellant had one percent right lower extremity impairment. In a permanent impairment worksheet, he diagnosed chronic ankle pain and ankle instability. Dr. Fritzhand noted under Table 16-2, Foot and Ankle Regional Grid, ruptured tendons of the ankle, she was a class 1 with mild motion deficits.[4] The American Association of Orthopedic Surgeons inventory score of 13. Applying Table 16-6 for Functional History (GMFH) grade modifier of 0, Table 16-7 for Physical Examination (GMPE) grade modifier of 1 and Table 16-8 for Clinical Studies (GMCS) grade modifier of 0, to the net adjustment formula moved the default grade of C to grade A. Dr. Fritzhand found that this yielded one percent impairment to the right lower extremity.

In a May 15, 2013 report, Dr. Fisher noted reviewing the statement of accepted facts, history of injury and subsequent treatment. He noted that appellant was not wearing splints, braces or orthotics and did not walk with external support. Dr. Fisher noted normal alignment of the foot and ankle, normal gait, normal dorsalis pedal pulse and posterior tibia pulse, no swelling, thickness or redness over the right foot, range of motion for the right ankle was 10 degrees for dorsiflexion, 40 degrees for plantar flexion, normal subtalar and mid tibial motion and negative Tinel's sign over tarsal tunnel and peroneal nerve. He noted that palpation over the right heel plantar surface and plantar fascia was nontender, there was no pain over the medial or lateral side of the heel, no sensory loss to light touch over the right ankle, mid tarsal, forefoot or toes of the right foot, intact Achilles tendon, intact strength of the right foot and ankle and intact range of motion of the foot and ankle. Dr. Fisher noted no objective findings of right ankle sprain, right foot sprain, right lower leg strain, muscle tear over the right foot or right foot plantar fasciitis. He noted that appellant's symptom of numbness over the right heel did not correlate with an EMG performed in March 2011 which was normal. Dr. Fisher noted that she reached maximum medical improvement on June 21, 2012. He diagnosed resolved right foot sprain, right lower leg strain, right ankle sprain, right foot plantar fasciitis and right foot muscle tear. Dr. Fisher opined that pursuant to Chapter 16 of the sixth edition of the A.M.A., *Guides* appellant had zero percent right lower extremity impairment. In a permanent impairment worksheet, he diagnosed plantar fasciitis, foot sprain, lower leg sprain, ankle sprain and muscle tear. Dr. Fisher noted under Table 16-2, Foot and Ankle Regional Grid, sprains/strains and plantar fasciitis, appellant was a class 0 for zero percent impairment. He noted no significant abnormalities over the right foot or ankle, no pain on palpation over the plantar surface of the right heel or other finding denoting residuals of plantar fasciitis. With regards to the sprains/strains involving the right foot/ankle and lower leg and muscle tear of the right foot, there was no positive residuals on examination or objective findings of the right foot, ankle and heel, no swelling or pain over the medial or lateral side of the right ankle and foot, no evidence of muscle tear of the right foot with intact motor strength of the right ankle on the dorsal and plantar surface. Pursuant to Table 16-2, page 501, sprains/strains and muscle tears of the right foot, ankle and lower leg, appellant was a class 0 for zero percent leg impairment.

In a May 30, 2013 report, the medical adviser reviewed Dr. Fisher's report and concurred in his determination that appellant sustained zero percent impairment of the right lower extremity

[4] This rating has a grade C default impairment of two percent of the leg. *See* A.M.A., *Guides*, Table 16-2, 501.

in accordance with the A.M.A., *Guides*. He noted that Dr. Fisher found no objective evidence of right foot plantar fasciitis and right ankle strain.

On June 26, 2013 OWCP requested that the medical adviser review Dr. Fritzhand's April 10, 2013 report. In a report dated June 27, 2013, the medical adviser noted that Dr. Fritzhand did not document performing valid range of motion measurements for rating purposes. He noted Dr. Fritzhand's findings of diminished sensation over the medial aspect of the right lower leg and right foot and tenderness to palpation over the mid foot were inconsistent with Dr. Fisher's May 15, 2013 findings of good range of motion, no muscle loss, no atrophy and no objective sensory deficits. The medical adviser opined that Dr. Fritzhand's evaluation represented a temporary aggravation of appellant's symptoms as her condition had significantly improved and stabilized by the May 15, 2013 examination. He disagreed with the one percent impairment of the right leg by Dr. Fritzhand as this was during a temporary exacerbation of symptoms which resolved by May 15, 2013. The medical adviser opined that appellant had no impairment of the right lower extremity.

In a decision dated July 3, 2013, OWCP denied appellant's claim for a schedule award. On July 8, 2013 appellant requested an oral hearing which was held on November 25, 2013.

In a decision dated February 12, 2014, an OWCP hearing representative affirmed the decision dated July 3, 2013.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing federal regulations[6] 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.[7] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides*, will be used.[8]

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).[9] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment class for the Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History, Physical Examination and Clinical Studies.[10] The

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.* at § 10.404(a).

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

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

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

net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11] 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.[12]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with the medical adviser providing rationale for the percentage of impairment specified.[13]

ANALYSIS

On appeal, appellant contends that she is entitled to a schedule award for permanent impairment of the right lower extremity. OWCP accepted her claim for right foot strain, right lower leg strain, right ankle sprain, right foot plantar fasciitis and rupture of other tendons of the right foot and ankle. The Board finds that there is a conflict in medical opinion between Dr. Fisher, the second opinion physician, and the medical adviser, for OWCP and Dr. Fritzhand, appellant's treating physician.

The medical adviser, in a June 27, 2013 report, disagreed with Dr. Fritzhand's rating, opining that, based on the A.M.A., *Guides,* appellant had no impairment of the right leg. He based his conclusions on the May 15, 2013 report of Dr. Fisher, the second opinion physician, who opined that pursuant to the A.M.A., *Guides* appellant had zero percent right leg impairment. In a permanent impairment worksheet, Dr. Fisher noted no significant abnormalities over the right foot or ankle, no pain on palpation over the plantar surface of the right heel or other finding denoting residuals of plantar fasciitis. He noted that, under Table 16-2, Foot and Ankle Regional Grid, sprains/strains and plantar fasciitis, appellant was a class 0 for zero percent impairment. With regards to the sprains/strains involving the right foot/ankle and lower leg and muscle tear of the right foot, there were no positive residuals on examination or objective findings. Pursuant to Table 16-2, page 501, sprains/strains and muscle tears of the right foot, ankle and lower leg, appellant was a class 0 for zero percent lower extremity impairment.

By contrast, in an April 10, 2013 report, Dr. Fritzhand advised that based on the A.M.A., *Guides* appellant had one percent impairment of the right lower extremity. He noted range of motion of the right foot was diminished to 10 degrees on inversion for mild motion impairment, there was significant atrophy of the right leg associated with sensory loss. Dr. Fritzhand noted that, under Table 16-2, Foot and Ankle Regional Grid, ruptured tendons of the ankle, appellant was a class 1 with mild motion deficits and applying the grade modifier and net adjustment formula yielded an impairment of one percent impairment to the right lower extremity. He supported an impairment rating of the right lower extremity, noting the basis of his rating under

[11] *Id.* at 521.

[12] *Id.* at 497.

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

the A.M.A., *Guides*, while the medical adviser and second opinion physician opined that appellant sustained no ratable 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."[14] 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.[15] 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 appellant's accepted employment injury.

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, if necessary, appellant, to an impartial medical specialist for a determination regarding the extent of her right lower extremity impairment as determined in accordance with the relevant standards of the A.M.A., *Guides*.[16] After such further development as OWCP deems necessary, an appropriate decision should be issued regarding the extent of appellant's right lower extremity impairment.

[14] 5 U.S.C. § 8123(a).

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

[16] *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 February 12, 2014 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: November 21, 2014
Washington, DC

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

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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