United States Department of Labor
Employees' Compensation Appeals Board

H.W., Appellant	)	
and	)	**Docket No. 14-948**
	)	**Issued: September 4, 2014**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE NATIONAL OFFICE, Richmond, VA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 17, 2014 appellant, through counsel, filed a timely appeal from a February 6, 2014 schedule award 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.

ISSUE

The issue is whether appellant sustained more than a 10 percent permanent impairment of the left eye for which she received a schedule award.

FACTUAL HISTORY

On September 17, 1999 appellant, then a 26-year-old criminal investigator, sustained an injury to her left eye when she was hit with a rubber bullet. OWCP accepted the claim for left

[1] 5 U.S.C. § 8101 *et seq.*

superficial injury to cornea, unspecified wound of left eyeball, left hemophtalmos and left posterior subcapsular polar nonsenile cataract. On June 15, 2011 appellant underwent cataract surgery which was approved by OWCP. Following her surgery, appellant continued working without restrictions.

On April 2, 2012 appellant filed a claim for a schedule award.

In an April 3, 2012 report, Dr. Bonnie J. Brooks, a Board-certified ophthalmologist, reported uncorrected visual acuity of the right eye at 20/400 and 20/200 for the left eye. Uncorrected visual acuity for near was noted as Jaeger 3 for the right eye and Jaeger 1 for the left eye. Visual acuity for corrected near vision with contact lenses was documented as 20/20.

In an April 9, 2012 medical report, Dr. Brooks noted that appellant had full accommodation for near vision in her unaffected right eye because of her young age. Historically, appellant was myopic and would wear contact lenses to see clearly at a distance. Since her injury, appellant was provided with an artificial lens implant for the left eye to keep her myopic in an effort to avoid an uncomfortable imbalance between the two eyes; however, when wearing this contact lens for distance in the left eye, appellant could no longer see clearly at near. Therefore, she adapted to wearing her distance correction lens in the right eye and leaving her left eye uncorrected so that she could read. Appellant also attempted to wear a bifocal contact lens in her left eye but did not adjust to it. Although appellant's corrected visual acuity and field vision were technically 100 percent, she sustained some degree of impairment as a result of her injury due to adapting to the limited range of vision supplied by an artificial lens. Appellant diligently tried to find an adequate refractive solution with glasses and contact lenses with modest success. Dr. Brooks determined that appellant had a 25 percent permanent impairment of the left eye as she was relegated to functioning as a monovision patient, thereby using one eye for near vision only while the fellow eye functioned at distance and near adequately.

OWCP routed Dr. Brooks' report, a statement of accepted facts (SOAF) and the case file to Dr. Eric Puestow, a district medical adviser Board-certified in internal medicine. In an April 27, 2012 report, Dr. Puestow disagreed with Dr. Brooks' impairment rating and found that appellant had zero percent (no) impairment of the left eye. He also found that she had reached maximum medical improvement (MMI). Dr. Puestow stated that appellant could wear contact lenses for distance correction in both eyes and for reading, could wear glasses with correction in the left eye that would allow clear close vision.

By decision dated May 18, 2012, OWCP denied appellant's claim for a schedule award.

On May 29, 2012 appellant, through counsel, requested a hearing before the Branch of Hearings and Review.

By decision dated August 31, 2012, a hearing representative vacated the May 18, 2012 schedule award denial. He instructed OWCP to remand the case for a second opinion on permanent impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2]

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

By letter dated September 12, 2012, counsel for appellant noted that appellant had cataract surgery on her left eye. He argued that when she removed her left contact lens, she became blind and had total loss of vision. Counsel submitted an August 2012 visual acuity, visual depth perception and visual field examination by Dr. J. Chris Huffman, Board-certified in internal medicine. Dr. Huffman noted uncorrected visual acuity of the right eye (OD) at 20/600 and 20/400 for the left eye (OS). Visual acuity for both eyes (OU) was not legible as a xerox stripe was blocking the figures.

On November 5, 2012 OWCP referred appellant to Dr. Gene Johnson, a Board-certified ophthalmologist, for a second opinion examination.

In a November 18, 2012 report, Dr. Johnson reported that appellant's corrected vision for both eyes was 20/20. Visual fields were full, the cornea was normal and the anterior chamber of the eye was within normal limits except for the old iris root tear and changes of the angular structures of the eye in the 2 to 3 o'clock area. Dr. Johnson noted that appellant had been functioning at monovision due to failure of bifocal contact lenses and glasses. Appellant used her left eye for near because of her failure to tolerate contact lens correction on that side. Dr. Johnson noted that appellant's visual discomfort from the monovision, as well as the need for consistent monitoring due to the iris root tear, would increase the chance for unilateral glaucoma in the left eye due to disruption of the angular structures. He opined that appellant had 25 percent impairment of the left eye.

In a December 18, 2012 addendum report, Dr. Johnson reported that the date of MMI was August 12, 2011, two months postcataract surgery when appellant's eye had stabilized. He further stated that appellant's uncorrected visual acuity of the left eye was poor at 20/400. Dr. Johnson noted that, from a refractive standpoint, appellant's left eye was the same as her right eye because she was nearsighted in both eyes. Regarding the visual impairment rating, he opined that appellant had 15 percent permanent impairment based on Table 12-3 of the A.M.A., *Guides*.[3]

In a January 4, 2013 report, Dr. James G. Ravin, a medical consultant Board-certified in ophthalmology, reviewed a history of injury and the medical reports. He stated that appellant's conditions had been accepted for left eye corneal abrasion, left eye iris tear and left eye hemorrhage but that the cataract, which was the major issue, was not an accepted condition. Dr. Ravin noted that uncorrected visual acuity was 20/600 right eye, 20/400 left eye and 20/3 with the stripe obscuring the remainder of the number for both eyes. He utilized the visual acuity data from Dr. Brooks' April 3, 2012 examination as the basis for his impairment rating. Dr. Ravin noted that the uncorrected visual acuity of the right eye was 20/400 and the left eye was 20/200. He noted that, at near, appellant's vision was excelled at Jaeger 3 right eye and Jaeger 1 left eye. Dr. Ravin stated that, in calculating appellant's impairment rating, he was using data for uncorrected vision in one eye and corrected vision in the other eye, which was inconsistent with the standards of the A.M.A., *Guides* which instructed use of the best corrected visual acuity for each eye. Using Table 12-2, Impairment of Visual Acuity, Dr. Ravin noted that the unimpaired eye with 20/20 vision had no impairment and a visual acuity score of 100. The injured eye with visual acuity of 20/200 had a visual acuity score of 50 and an impairment rating

[3] *Id.* at 288-89.

of 50.[4] Using Table 12-3 for calculation of the acuity-related impairment rating, Dr. Ravin calculated that appellant's OU rating was 100, representing the excellent vision of the uninjured eye, so that 3 x 100 equaled 300. He then added the uninjured eye of 100 and the injured eye of 50 for a total of 450. This amount was divided by 5 which totaled 90 for appellant's functional acuity score (FAS). Subtracting the acuity impairment rating of 100 from appellant's FAS of 90 resulted in a 10 percent permanent impairment of the left eye.[5] Dr. Ravin concluded that he agreed with Dr. Johnson regarding the August 11, 2011 date of MMI, two months postcataract surgery.

By decision dated January 28, 2013, OWCP granted appellant a schedule award claim for 10 percent permanent impairment of the left eye. The award covered a period of 112 days from November 6, 2012 to February 25, 2013. The date of maximum medical improvement was noted as August 12, 2011. OWCP found that the weight of the medical evidence regarding the percentage of impairment rested with Dr. Ravin.

By letter dated January 31, 2013, appellant, through counsel, requested a hearing before the Branch of Hearings and Review. In a January 31, 2013 report, Dr. William C. Christie, a Board-certified ophthalmologist, reported that he examined appellant on January 16, 2013 and reviewed prior medical records. He provided a history of injury and noted a June 15, 2011 cataract surgery. On examination, Dr. Christie noted uncorrected vision of 20/400 in the right eye and 20/400 in the left eye, with corrected vision of 20/20 in both eyes. He stated that appellant had no accommodation in the left eye due to having a pseudophakic or false lens which was only seeing for distance with glasses and the current bifocal kept her right and left eye from being able to work in tandem. Dr. Christie opined that this was because her right lens did not have an implant and had the more typical 1.25 add for the bifocal power while the left eye having the pseudophakic lens would require a 2.75 add if she were to have optimal reading. He advised that appellant would never regain the ability to accommodate with the two eyes together. Dr. Christie noted that the iris dehiscence made appellant more sensitive to bright lights due to the fact that the iris was not touching the chamber angle. Appellant also remained at high risk for glaucoma in the left eye, risk of her bridging blood vessels breaking with even a tiny amount of trauma causing a hyphema or bleeding into the left eye, risk for retinal detachment and risk of sunset syndrome. Dr. Christie concluded that appellant's impairment of the left eye ranged from 25 to 35 percent.

By decision dated April 9, 2013, a hearing representative vacated the January 28, 2013 schedule award determination. OWCP was directed to remand the case for further development. The hearing representative noted that appellant's June 15, 2011 cataract surgery was approved by OWCP which was not listed as an accepted condition in the SOAF.[6]

[4] *Id.* at 288.

[5] *Id.* at 289.

[6] The hearing representative noted that Dr. Ravin, serving as the district medical adviser, made mention that the diagnosis of cataract was not listed as an accepted condition in his January 4, 2013 report.

On remand, OWCP advised Dr. Ravin that appellant's cataract surgery was approved as an accepted condition. It provided him with a copy of Dr. Christie's report for review and comment on the extent of appellant's left eye impairment.

In a June 4, 2013 supplemental report, Dr. Ravin reported that he reviewed Dr. Christie's report and disagreed with her hypothetical present and future impairment rating of 25 to 35 percent. Although there was a risk of glaucoma with appellant's angle recession, the longer she continued without evidence of this, the less likely that this form of glaucoma would arise in the future. Dr. Ravin stated that the risk of bleeding from fragile blood vessels had not proven to be an event that had taken place, nor had there been any difficulty as of the date of his letter regarding the health of the optic nerve or retina. He opined that appellant's risk of present and future impairment was far lower than the 25 to 35 percent range. Dr. Ravin noted that he was instructed to use the sixth edition of the A.M.A., *Guides* and stated, "You have asked that corrected visual acuity be used." He noted that Table 12-2 indicated that appellant's 20/20 vision indicated zero percent loss.[7] Dr. Ravin concluded that appellant had achieved 20/20 vision and though both eyes had different refractions, this could be treated with glasses or contact lenses.

By decision dated June 28, 2013, OWCP denied appellant's claim for an increased schedule award of the left eye. It found that the medical evidence of record failed to establish that she had more than 10 percent impairment to the left eye.

By letter dated July 2, 2013, appellant, through counsel, requested a telephone hearing before the Branch of Hearings and Review.

At the November 20, 2013 hearing, counsel for appellant argued that she was entitled to a schedule award for 100 percent impairment of the left eye. He argued that appellant's corrected vision was improperly used to determine her impairment rating when her uncorrected vision should have been used, citing *A.G.*, Docket No. 11-1512 (issued April 9, 2011). Counsel contended that appellant's replacement lens was analogous to a prosthetic device.

By decision dated February 6, 2014, the hearing representative affirmed the June 28, 2013 OWCP decision. She found that appellant was not entitled to an increased schedule award.

LEGAL PRECEDENT

Section 8107 of FECA authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. For 100 percent loss of an eye, as with blindness, FECA provides a maximum 160 weeks of compensation.[8] Compensation for

[7] *Supra* note 4.

[8] 5 U.S.C. § 8107(c)(5).

loss of binocular vision is the same as for loss of the eye.[9] Partial losses are compensated proportionately.[10]

Such loss or loss of use is known as permanent impairment. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[11] For impairment ratings calculated on and after May 1, 2009, it should advise any physician evaluating permanent impairment to use the sixth edition and to report findings in accordance with those guidelines.[12]

Although the A.M.A., *Guides* provides that impairment ratings should be based on the best-corrected visual acuity,[13] FECA mandates that the degree of loss of vision must be determined without regard to correction.[14]

ANALYSIS

OWCP accepted appellant's claim for left superficial injury to cornea, unspecified wound of left eyeball, left hemophtalmos and left posterior subcapsular polar nonsenile cataract. It approved left eye cataract surgery on June 15, 2011. The issue is whether appellant has more than a 10 percent permanent impairment of the left eye, for which she received a schedule award. The Board finds that this case is not in posture for decision.

OWCP referred appellant for a second opinion examination with Dr. Johnson, a Board-certified ophthalmologist, for an opinion on permanent impairment of the left eye. The only visual acuity rating provided by Dr. Johnson was corrected 20/20 OU vision. He opined that appellant had 25 percent impairment of the left eye. The Board finds that Dr. Johnson did not make his impairment rating with reference to the applicable sections of the A.M.A., *Guides*. In a December 18, 2012 supplemental report, Dr. Johnson reported that appellant's uncorrected left eye visual acuity was poor at 20/400. He opined that appellant had a 15 percent impairment based on Table 12-3 of the A.M.A., *Guides*.[15] Dr. Johnson failed to explain how he calculated this impairment rating.

In a January 4, 2013 report, Dr. Ravin made reference to Dr. Huffman's August 2012 examination which documented uncorrected visual acuity of 20/600 right eye and 20/400 left

[9] *Id*. at § 8107(c)(14). *See Russell E. Wageneck*, 46 ECAB 653 (1995) (holding there is no provision under section 8107 of OWCP for the combination of each eye into a schedule award for both eyes together, as there is for loss of hearing in both ears; therefore, schedule awards are issued for each eye individually).

[10] *Id*. at § 8107(c)(19).

[11] 20 C.F.R. § 10.404.

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6(a) (January 2010).

[13] A.M.A., *Guides* 283, 284, Chapter 12.2b.

[14] *Supra* note 10.

[15] *Supra* note 3.

eye. He utilized the visual acuity data from Dr. Brooks' April 3, 2012 report which found uncorrected visual acuity of 20/400 right eye and 20/200 left eye, with corrected binocular visual acuity of 20/20. Using 20/400 uncorrected left eye visual acuity, 20/20 corrected right eye visual acuity and 20/20 corrected binocular visual acuity, he rated 10 percent left eye impairment. OWCP granted appellant's schedule award for 10 percent permanent impairment of the left eye based upon Dr. Ravin's January 4, 2013 report.

Subsequent to Dr. Ravin's report, appellant submitted a January 31, 2013 report from Dr. Christie who examined her on January 16, 2013. He documented uncorrected visual acuity of 20/400 left eye and 20/400 right eye and corrected visual acuity of 20/20 in each eye.

Dr. Christie's report was forwarded to Dr. Ravin for review, together with an amended SOAF which noted that appellant's left eye cataract surgery was approved by OWCP. In a June 4, 2013 supplemental report, Dr. Ravin stated, "You have asked that corrected visual acuity be used." Using appellant's corrected visual acuity of 20/20 in accordance with Table 12-2 of the A.M.A., *Guides*, Dr. Ravin opined that appellant had zero percent (no) impairment of the left eye.

OWCP denied appellant's claim for an increased schedule award based on Dr. Ravin's conclusion that she had a zero percent visual system impairment rating. The Board finds that Dr. Ravin's report is insufficient to determine the extent of permanent impairment. The February 6, 2014 decision will be set aside and the case remanded for further development.

The Board notes that Dr. Ravin failed to properly calculate appellant's impairment rating. Dr. Ravin's January 4, 2013 report utilized uncorrected left eye visual acuity of 20/200, corrected 20/20 right eye visual acuity and corrected 20/20 binocular visual acuity to rate 10 percent impairment. His June 4, 2013 report utilized corrected visual acuity scores of 20/20 to determine that appellant had no impairment of the left eye. Although the A.M.A., *Guides* provide that impairment ratings should be based on the best-corrected visual acuity,[16] the Board notes that FECA provides at section 8107(c)(19) that the degree of loss of vision is to be determined without regard to correction.[17] Dr. Ravin incorrectly utilized appellant's corrected visual acuity to rate her left eye impairment and failed to use the uncorrected vision measurements in assessing the degree of vision loss.[18]

[16] *Id.* at Section 12.2c, 287.

[17] For a total loss of use of an eye, an employee shall receive 160 weeks' compensation. 5 U.S.C. § 8107(c)(5). Compensation for loss of 80 percent or more of the vision of an eye is the same as for loss of the eye. 5 U.S.C. § 8107(c)(14). The degree of loss of vision under this schedule is determined without regard to correction. 5 U.S.C. § 8107(c)(19).

[18] *D.F.*, Docket No. 09-1104 (issued November 24, 2009) (the Board affirmed the district medical adviser's calculations establishing 35 percent impairment of the left eye which used uncorrected visual acuity results for both eyes). *See also D.F.*, Docket No. 07-1607 (issued December 21, 2007) (the Board remanded appellant's claim finding that the medical reports failed to provide an impairment rating for the left eye based on measurements of appellant's uncorrected vision, rather than corrected vision).

The Board further notes that visual acuity loss may not account for all of appellant's left eye impairment.[19] Dr. Brooks' report noted that appellant was relegated to functioning as a monovision patient, thereby using one eye for near vision only while the fellow eye functioned at distance and near adequately. Dr. Johnson noted that appellant had been using her left eye for near and functioning at monovision due to failure of bifocal contact lenses and glasses. Dr. Christie noted that appellant had no accommodation in the left eye due to having a pseudophakic or false lens which was only seeing for distance with glasses and even the current bifocal kept her right and left eye from being able to work in tandem. He opined that appellant would never regain the ability to accommodate the two eyes together. Dr. Christie also stated that the iris dehiscence would make appellant more sensitive to bright lights due to the fact that the iris was not touching the chamber angle. The Board notes that it appears that significant factors remain that affect appellant's functional vision which were not accounted for through visual acuity loss.[20] Dr. Ravin's reports failed to discuss whether there was evidence of visual field impairment or whether individual adjustments for functional vision were appropriate pursuant to page 305 of the A.M.A., *Guides*.[21] Therefore, his opinion is of diminished probative value.

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.[22] Once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[23]

On remand, OWCP should further develop the medical evidence of record by referring appellant to an appropriate Board-certified ophthalmologist for a second opinion examination regarding the extent of her left eye impairment. Following this and any other further development as deemed necessary, OWCP shall issue an appropriate merit decision on appellant's schedule award claim.

CONCLUSION

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

[19] *Michele Tousley*, Docket No. 05-1156 (issued October 12, 2005) (the Board held that appellant was entitled to an increase of 15 percent impairment for individual adjustments because of her monocular pseudophakia, glare disability and decreased contrast sensitivity which were not accounted through visual acuity or visual field loss).

[20] *Gary A. Guillory*, Docket No. 03-1872 (issued November 21, 2003).

[21] Adjustments for such functions as contrast sensitivity, glare sensitivity, color vision defects and binocularity, stereopsis, suppression and diplopia are permitted, although they must be well documented and should be limited to an increase in impairment by, at most, 15 points. A.M.A., *Guides* 305. *See also C.B.*, Docket No. 11-1937 (issued April 6, 2012); *S.G.*, Docket No. 10-1405 (issued February 17, 2011).

[22] *See LL*, Docket No. 10-16 (issued October 1, 2010); *Phillip L. Barnes*, 55 ECAB 426 (2004); *Horace L. Fuller*, 53 ECAB 775, 777 (2002); *James P. Bailey*, 53 ECAB 484, 496 (2002); *William J. Cantrell*, 34 ECAB 1223 (1983).

[23] *Richard F. Williams*, 55 ECAB 343, 346 (2004).

ORDER

IT IS HEREBY ORDERED THAT the February 6, 2014 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision.

Issued: September 4, 2014
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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