United States Department of Labor
Employees' Compensation Appeals Board

J.H., Appellant	)	
and	)	**Docket No. 15-0899**
	)	**Issued: August 7, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Bellmawr, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 18, 2015 appellant, through counsel, filed a timely appeal from a December 5, 2014 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.

ISSUE

The issue is whether appellant met his burden of proof to establish that he has more than seven percent permanent impairment of his right leg, for which he received a schedule award.

FACTUAL HISTORY

OWCP accepted that on April 20, 2010 appellant, then a 44-year-old letter carrier, sustained partial rupture of his right Achilles tendon, right tarsal tunnel syndrome, and temporary contraction of his right tendon sheath due to stepping down from a truck at work.

[1] 5 U.S.C. §§ 8101-8193.

In a May 10, 2010 report by Dr. Richard Chesnick, his interpretation of the magnetic resonance imaging (MRI) scan of appellant's right ankle showed small interstitial partial thickness tear of the distal Achilles tendon, and retrocalcaneal bursitis with a Haglund's deformity of the calcaneus. MRI scan testing of his right ankle on September 29, 2010 demonstrated focal tenosynovitis of the flexor halluces longus tendon just below the level of the subtalar joint, and focal collection contiguous with the flexor halluces longus tendon sheaths extending to the adjacent soft tissues close to the tibial neurovascular bundle (possibly associated with tarsal tunnel syndrome). The findings also showed distal Achilles tendinopathy, mild partial intrasubstance tear at the Achilles insertion, and partial tearing of the deep fibers of the deltoid ligament with remote appearing evulsion fragment in the region.

On November 2, 2010 Dr. William Newcomb, an attending Board-certified orthopedic surgeon, performed a right foot tenolysis of the flexor halluces longus tendon and right ankle release of the tarsal tunnel. The procedure was authorized by OWCP.

In a January 13, 2012 report, Dr. Arthur F. Becan, an attending Board-certified orthopedic surgeon, determined that appellant sustained 15 percent permanent impairment of his right leg under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (6th ed. 2009). He indicated that physical examination of appellant's right foot and ankle revealed tenderness of the medial malleolus, subtalar joint, posterior tibial tendon, distal Achilles tendon, and retrocalcaneal bursae right tarsal tunnel. Dr. Becan explained how he calculated appellant's right leg impairment under the A.M.A., *Guides*. He stated that, using Table 16-2 (Foot and Ankle Regional Grid) on page 501, the diagnosed-based impairment of partial Achilles tendon rupture fell under class 1 with a default value (mild motion deficit) of five percent impairment. Dr. Becan determined that, per Table 16-6 on page 516, the functional history modifier fell under grade modifier 1 (mild problem); per Table 16-7 on page 517, the physical examination modifier was grade modifier 2 (moderate problem); per Table 16-8 on page 519, the clinical studies modifier fell under grade modifier 1 (mild problem). Applying the net adjustment formula to the grade modifiers, he adjusted the default five percent impairment to six percent impairment. Dr. Becan noted that appellant had severe sensory deficits of the right tibial nerve and therefore his condition, under Table 16-12 (Peripheral Nerve Impairment -- Lower Extremity Impairments) on page 536, fell under class 1 with a default value of 10 percent. He indicated that appellant's functional history modifier, physical examination modifier, and clinical studies modifiers all fell under grade modifier 1 and, therefore, after application of the net adjustment formula, there was no adjustment from the default value of 10 percent. Thus, appellant had 10 percent impairment due to his tibial nerve condition. Using the Combined Values Chart on page 604, the six percent impairment combined with the 10 percent impairment equaled a total right leg impairment of 15 percent.

On April 13, 2012 appellant claimed a schedule award.

In a July 10, 2012 report, Dr. Arnold T. Berman, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, found that appellant sustained a seven percent permanent impairment of his right leg under the standards of the sixth edition of the A.M.A., *Guides.* He stated that, using Table 16-2 (Foot and Ankle Regional Grid) on page 501, the diagnosed-based impairment of partial Achilles rupture fell under class 1 with a default value (mild motion

deficit) of five percent impairment. Dr. Berman determined that, per Table 16-6 on page 516, the functional history modifier fell under grade modifier 1 (mild problem); per Table 16-7 on page 517, the physical examination modifier was grade modifier 1 (mild problem); and per Table 16-8 on page 519, the clinical studies modifier fell under grade modifier 1 (mild problem). He applied the net adjustment formula on page 521 to find that there was zero net adjustment from the default rating of five percent. Dr. Berman stated that Dr. Becan improperly found that appellant's tibial nerve condition was "severe" with a class 1 default value of 10 percent under Table 16-12 on page 536.[2] He felt that the findings of Dr. Becan's January 13, 2012 examination fell under the category of mild motor and moderate sensory tarsal deficits per Table 16-12 and therefore appellant's tarsal condition fell under the class 1 default value of two percent. Dr. Berman noted that the grade modifiers did not warrant an adjustment modification and concluded that appellant's tarsal condition equaled two percent impairment of his right leg. He indicated that, using the Combined Values Chart on page 604, the five percent impairment due to the Achilles tear combined with the two percent impairment due to the tibial nerve condition equaled a total right leg impairment of seven percent.

In a July 19, 2012 decision, OWCP granted appellant a schedule award for a seven percent permanent impairment of his right leg. The award ran for 20.16 weeks from January 13 to June 2, 2012. The award was based on the July 10, 2012 report of Dr. Berman, the medical adviser.

Appellant requested a hearing. During a November 29, 2012 hearing with an OWCP hearing representative, counsel argued that there was a conflict in the medical opinion evidence regarding the extent of appellant's right leg impairment between Dr. Becan and Dr. Berman.

In a February 19, 2013 decision, the hearing representative affirmed OWCP's July 19, 2012 schedule award decision. She found that the weight of the medical evidence regarding appellant's right leg impairment rested with the opinion of Dr. Berman.

By decision dated December 18, 2013, the Board set aside OWCP's February 19, 2013 decision and remanded the case to OWCP for further development.[3] The Board determined that there was a conflict in the medical opinion evidence regarding the extent of appellant's right leg impairment between Dr. Becan and Dr. Berman. The Board remanded the case to OWCP for referral of appellant to an impartial medical specialist for examination and an opinion on his right leg impairment. OWCP was instructed to issue an appropriate decision after carrying out such development.

On remand OWCP referred appellant and the case record to Dr. Andrew Gelman, a Board-certified orthopedic surgeon, for an impartial medical examination and evaluation of his right leg impairment. In his March 6, 2014 report, Dr. Gelman discussed appellant's factual and medical history, including the course of treatment for his work injuries -- partial rupture of his right Achilles tendon, right tarsal tunnel syndrome, and temporary contraction of his right tendon sheath. He reported findings of his March 6, 2014 physical examination, including the findings

[2] Dr. Berman indicated that appellant's tarsal tunnel syndrome involved a branch of the tibial nerve.

[3] Docket No. 13-1475.

for range of motion and sensory loss testing. Regarding the partial Achilles tendon tear, Dr. Gelman noted that reference should be made to Table 16-2 on page 501 of the sixth edition of the A.M.A., *Guides*. He stated that, recognizing symmetric range of motion relative to the right lower extremity versus the left lower extremity, appellant fell under class 1 which resulted in a one percent default value. Referencing Tables 16-6 through 16-8, Dr. Gelman indicated that appellant had a grade modifier 0 for functional history, a grade modifier 1 for physical examination, and a grade modifier 1 for clinical studies. Application of the Net Adjustment Formula yielded a value of -1 and the resultant movement one place to the left on Table 16-2 still yielded a one percent impairment value. Dr. Gelman concluded that the contribution of the Achilles tendon tear provided an impairment rating of one percent.

In his March 6, 2014 report, Dr. Gelman further advised that the tarsal tunnel component of appellant's right leg impairment would be addressed under Table 16-12 beginning on page 534 of the sixth edition of the A.M.A., *Guides*. Recognizing the data regarding peripheral nerve impairment of the right lower extremity, appellant fell between mild and severe sensory residual deficit. The mild sensory deficit default was two percent with the severe sensory deficit being 10 percent. Dr. Gelman indicated that appellant's situation fell within that range and that his right leg impairment due to the tarsal tunnel residuals was six percent. There was no change to this value after applying calculations for grade modifiers for functional history, physical examination, and clinical studies. Therefore, after combining the one percent and six percent impairment values, appellant had total right leg impairment of seven percent. Dr. Gelman found that appellant reached maximum medical improvement by January 13, 2012.

In a March 27, 2014 report, Dr. Morley Slutsky, a Board-certified occupational medicine physician serving as an OWCP medical adviser, stated that he had reviewed the medical evidence of record, including the March 6, 2014 report of Dr. Gelman. Dr. Slutsky recommended that a supplemental report be obtained from Dr. Gelman to answer the question of whether he used a goniometer to evaluate range of motion and to obtain additional information about the method he used to evaluate sensory loss.

In a supplemental report dated April 21, 2014, Dr. Gelman stated that his March 6, 2014 examination included motor testing, sensory testing via light touch and pin prick, and goniometer measurement with regard to ankle range of motion. He provided further details of his calculation of appellant's right leg impairment as initially described in his March 6, 2014 report. With respect to Dr. Gelman's finding that appellant had one percent impairment due to his right Achilles tendon tear, Dr. Gelman noted that he had utilized an inclinometer (an angled goniometer) for range of motion testing and made measurements under the standards of Figures 16-6 and 16-7 on page 546 of the sixth edition of the A.M.A., *Guides*. He also further discussed his prior finding that appellant had a six percent impairment of his right leg due to peripheral nerve impairment associated with the tarsal tunnel (specifically in the saphenous and medial plantar nerve distributions). Dr. Gelman stated that he carried out light touch and pin prick under

the standards of section 16.4 on pages 532 and 533 of the sixth edition of the A.M.A., *Guides* and that his impairment values were derived from Table 16-12 beginning on page 534.[4]

In a June 4, 2014 decision, OWCP found that appellant did not meet his burden of proof to establish that he has more than seven percent permanent impairment of his right leg, for which he received a schedule award. It noted that the impartial medical specialist, Dr. Gelman, found that appellant had seven percent permanent impairment of his right leg. Therefore, there was no evidence that appellant had a greater right leg impairment.

Appellant requested a video hearing with an OWCP hearing representative. During the October 20, 2014 hearing, counsel argued that Dr. Gelman did not conduct a thorough examination, particularly with regard to range of motion and sensory loss testing.

In a December 5, 2014 decision, the hearing representative affirmed OWCP's June 4, 2014 decision finding that appellant did not establish that he has more than seven percent permanent impairment of his right leg. He found that Dr. Gelman, the impartial medical specialist, properly evaluated appellant's right leg impairment and that his impairment rating had special weight.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing 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 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 regulations as the appropriate standard for evaluating schedule losses.[7] For OWCP decisions issued on or after May 1, 2009, the sixth edition of the A.M.A., *Guides* (6th ed. 2009) is used for evaluating permanent impairment.[8]

In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the ankle, the relevant portion of the leg for the present case,

[4] On May 17, 2014 Dr. Slutsky discussed Dr. Gelman's impairment rating reports. He noted that he believed that appellant actually had a lesser impairment associated with the right saphenous and medial plantar nerve distributions and concluded that appellant had a total right leg impairment of three percent.

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404 (1999).

[7] *Id*.

[8] *See* FECA Bulletin No. 9-03 (issued March 15, 2009). For OWCP decisions issued before May 1, 2009, the fifth edition of the A.M.A., *Guides* (5th ed. 2001) is used.

reference is made to Table 16-2 (Foot and Ankle Regional Grid) beginning on page 501.[9] After the Class of Diagnosis (CDX) is determined from the Foot and Ankle Regional Grid (including identification of a default grade value), the Net Adjustment Formula is applied using the Grade Modifier for Functional History (GMFH), Grade Modifier for Physical Examination (GMPE) and Grade Modifier for Clinical Studies (GMCS). The Net Adjustment Formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10]

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."[11] 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.[12] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[13]

ANALYSIS

OWCP accepted that on April 20, 2010 appellant sustained partial rupture of his right Achilles tendon, right tarsal tunnel syndrome, and temporary contraction of his right tendon sheath due to stepping down from a truck at work. In a July 19, 2012 decision, it granted him a schedule award for a seven percent permanent impairment of his right leg.

In a December 18, 2013 decision, the Board set aside OWCP's prior schedule award determination and remanded the case to OWCP for further development. The Board determined that there was a conflict in the medical opinion evidence regarding the extent of appellant's right leg impairment between Dr. Becan, an attending Board-certified orthopedic surgeon, and Dr. Berman, a Board-certified orthopedic surgeon serving as an OWCP medical adviser.[14]

On remand, OWCP referred appellant and the case record to Dr. Gelman, a Board-certified orthopedic surgeon, for an impartial medical examination and evaluation of his right leg impairment. In his March 6 and April 21, 2014 reports, Dr. Gelman found that appellant had a seven percent permanent impairment of his right leg under the standards of the sixth edition of

[9] *See* A.M.A., *Guides* (6th ed. 2009) 501-08.

[10] *Id.* at 515-22.

[11] 5 U.S.C. § 8123(a).

[12] *William C. Bush*, 40 ECAB 1064, 1975 (1989).

[13] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

[14] In a January 13, 2012 report, Dr. Becan determined that appellant had 15 percent permanent impairment of his right leg under the standards of the sixth edition of the A.M.A., *Guides.* In contrast, Dr. Berman determined on July 10, 2012 that appellant had seven percent permanent impairment of his right leg under the standards of the sixth edition of the A.M.A., *Guides.*

the A.M.A., *Guides.* The Board notes that the weight of the medical evidence with regard to appellant's right leg impairment is represented by the well-rationalized reports of Dr. Gelman.[15]

Dr. Gelman noted that, regarding appellant's partial Achilles tendon tear, reference should be made to Table 16-2 on page 501 of the sixth edition of the A.M.A., *Guides*. He indicated that appellant fell under class 1 which resulted in a one percent default value. Referencing Tables 16-6 through 16-8, Dr. Gelman stated that appellant had a grade modifier 0 for functional history, a grade modifier 1 for physical examination, and a grade modifier 1 for clinical studies. Application of the Net Adjustment Formula yielded a value of -1 and the resultant movement one place to the left on Table 16-2 still yielded a one percent impairment value. Dr. Gelman concluded that the contribution of the Achilles tendon tear provided an impairment rating of one percent. He considered the tarsal tunnel component of appellant's right leg impairment under Table 16-12 beginning on page 534 of the sixth edition of the A.M.A., *Guides*. Appellant fell between a mild and severe sensory residual deficit related to his saphenous and medial plantar nerve distributions. His right lower extremity impairment attributable to the tarsal tunnel residuals was six percent.[16] Therefore, after combining the one percent and six percent impairment values, appellant had a total right leg impairment of seven percent.

On appeal, counsel argued that Dr. Gelman did not conduct adequate range of motion testing for appellant's right leg. However, in his April 21, 2014 supplemental report, Dr. Gelman explained that he had utilized an inclinometer (an angled goniometer) for range of motion testing and made measurements under the standards of Figures 16-6 and 16-7 on page 546 of the sixth edition of the A.M.A., *Guides*. Counsel also argued that Dr. Gelman did not conduct adequate sensory loss testing. However, Dr. Gelman noted that that he carried out light touch and pin prick under the standards of section 16.4 on pages 532 and 533 of the sixth edition of the A.M.A., *Guides* and that his peripheral nerve impairment values were derived from Table 16-12 beginning on page 534. The Board notes that his range of motion and sensory loss testing was carried out in accordance with the standards of the sixth edition of the A.M.A., *Guides.*

Appellant has not submitted probative medical evidence showing that he has more than seven percent permanent impairment of his right leg, for which he received a schedule award.[17] He may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

[15] *See supra* notes 11 through 13.

[16] *See supra* notes 8 and 9.

[17] On May 17, 2014 Dr. Slutsky, a Board-certified occupational physician serving as an OWCP medical adviser, found that appellant had a total right leg impairment of three percent. There is no evidence or record showing that appellant has more than seven percent right leg impairment.

CONCLUSION

The Board finds that appellant did not met his burden of proof to establish that he has more than a seven percent permanent impairment of his right leg, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the December 5, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 7, 2015
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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

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