United States Department of Labor
Employees' Compensation Appeals Board

J.S., Appellant	)	
and	)	**Docket No. 15-1252**
	)	**Issued: January 19, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Dover, NJ, Employer	)	

Appearances:
James D. Muirhead, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 14, 2015 appellant, through counsel, filed a timely appeal from a March 3, 2015 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 the case.

ISSUE

The issue is whether appellant has more than 54 percent permanent impairment of the right lower extremity for which she received a schedule award.

FACTUAL HISTORY

On January 5, 2002 appellant, then a 47-year-old letter carrier, was injured in a motor vehicle accident while leaving the employing establishment parking lot to deliver mail. OWCP accepted appellant's claim for right shoulder contusion and expanded her claim to include right Achilles tendon strain, plantar fasciitis, and sprain of the right ankle, right shoulder sprain, upper

[1] 5 U.S.C. § 8101 *et seq.*

arm, and rotator cuff.[2] It authorized several surgeries including those noted below. Appellant subsequently returned to work full-time limited duty.

A magnetic resonance imaging (MRI) scan of the right ankle dated February 6, 2003 revealed a nondisplaced intra-articular fracture, extending from the posterolateral tibial metadiaphysis to the joint surface, osteochondral injury with joint space narrowing, T2 weighted hyperintensity of the articulating surface of the tibia and anterior talar dome, and mild-to-moderate osteoarthritis of the tarsal bones. On June 17, 2003 Dr. Steven Stecker, a Board-certified orthopedist, performed a left knee arthroscopy, partial medial meniscectomy, medial femoral condyle chondroplasty, and patellofemoral chondroplasty and diagnosed left knee degenerative joint disease. On March 13, 2006 Dr. Stecker performed a left total knee replacement and diagnosed left knee osteoarthritis. On June 26, 2006 he performed a total right knee replacement and diagnosed right knee osteoarthritis.

On July 23, 2007 appellant requested a schedule award. She submitted a report from Dr. David Weiss, an osteopath, dated July 23, 2007. Dr. Weiss noted maximum medical improvement occurred on July 23, 2007. He diagnosed status post fracture to the right ankle joint by history, chronic post-traumatic right ankle strain and sprain with involvement of the anterior talofibular ligament, cumulative and repetitive trauma disorder to the right knee superimposed upon preexisting right knee pathology (status post sports-related injury 1973 with a tear of the medial meniscus and quadriceps tendon necessitating a 1973 open arthrotomy), aggravation and acceleration of underlying degenerative joint disease to the right knee, and status post right total knee replacement.[3] Dr. Weiss noted that, based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,*[4] (A.M.A., *Guides*) appellant had 50 percent impairment for status post right knee total arthroplasty with fair results;[5] and 7 percent impairment for loss of dorsiflexion in the right ankle range.[6] Using the Combined Values Chart, appellant had 54 percent impairment of the right lower extremity.

On January 23, 2008 an OWCP medical adviser concurred with Dr. Weiss' impairment rating.

[2] Appellant filed a claim on April 1, 2004 for osteoarthritis of her lower right leg caused by her employment duties, file number xxxxxx513. OWCP accepted appellant's claim for aggravation of osteoarthritis of the right knee and left chondromalacia patellae. This claim was consolidated with the current claim before the Board.

[3] Dr. Weiss also addressed conditions affecting other parts of the body. Appellant has only appealed from the schedule award decision for the right leg.

[4] A.M.A., *Guides* (5th ed. 2001).

[5] *Id*. at 547, 549, Table 17-35, Table 17-33.

[6] *Id*. at 537, Table 17-11.

In a decision dated March 31, 2008, OWCP granted appellant a schedule award for 54 percent permanent impairment of the right leg.[7]

Appellant came under the treatment of Dr. Wayne S. Berberian, a Board-certified orthopedist, from October 26, 2011 to February 7, 2012, for right foot pain and cavus foot deformity. Dr. Berberian noted examination findings of a tender cavus foot deformity, a calcaneocuboid joint almost parallel to the posterior cortex of the calcaneus, long extension of the anterior process of the calcaneus which came very close to the navicular, tibiotalar arthritis and subchondral cyst, and osteochondral defect. He recommended an insole to increase the surface area contacting the ground when she walks.

On January 9, 2013 appellant filed a claim for an increased schedule award. She submitted a December 1, 2012 report from Dr. Weiss who noted that she had reached maximum medical improvement on December 1, 2012. Dr. Weiss noted that the lower extremity activity scale (LEAS) revealed an impairment level of 6/18 which equated to a disability of 67 percent involving the right leg. He noted examination of the right foot and ankle revealed diffuse tenderness over the anterior medial and posterior plantar aspects, retrocalcaneal tenderness, tenderness over the anterior talofibular ligament, and tibiotalar joint, tenderness over the medial malleolus and over the deltoid ligament. Range of motion (performed three times) revealed dorsiflexion of 10/15 degrees, plantar flexion of 55/55 degrees, inversion of 30/30 degrees, and eversion of 40/40 degrees. The anterior drawers' sign continued to produce laxity and the talar tilt remained positive. Dr. Weiss diagnosed status post fracture to the right ankle joint by history, chronic post-traumatic right ankle strain and sprain with involvement of the anterior talofibular ligament and the deltoid ligament, chronic plantar fasciitis to the right foot, and calcaneal bursitis to the right foot. He noted that pursuant to Table 16-2, page 503, of the sixth edition of the A.M.A., *Guides*[8] that appellant had a right tibial plafond fracture with mild motion deficit resulting in 10 percent permanent impairment. Dr. Weiss noted that appellant was class 1 with a default value of 10, the grade modifier for functional history was not applicable, the grade modifier for physical examination was 2, and the grade modifier for clinical studies was not applicable for a net adjustment of +1. He noted the default value would shift to class D for 12 percent impairment of the right lower extremity for the right tibial plafond fracture.

In a May 2, 2014 report, an OWCP medical adviser reviewed Dr. Weiss' December 1, 2012 report and concurred in his findings.

In a June 3, 2014 decision, OWCP denied appellant's claim for an increased schedule award. It noted that Dr. Weiss determined that appellant had 12 percent permanent impairment for a right tibial plafond fracture with mild motion deficit and the medical adviser concurred in these findings. However, OWCP found that appellant was previously awarded 54 percent for the

[7] This decision also granted appellant a schedule award for 37 percent impairment of the left leg. OWCP further noted that appellant had 17 percent impairment of the right arm but that, pursuant to OWCP procedures, appellant could not concurrently receive two schedule awards for different body parts. It noted that the award for the right arm would commence after the expiration of the leg awards on July 30, 2012. As noted above, this decision of the Board pertains only to permanent impairment of the right leg.

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

right lower extremity on May 31, 2008 and thus he was not entitled to an increased schedule award as this would be duplicative.

On June 10, 2014 appellant, through counsel, requested a telephonic hearing which was held before an OWCP hearing representative on January 14, 2015. Counsel asserted that the current impairment rating of 12 percent was related to the right foot and ankle not the right knee which was considered a different part of the extremity. Appellant asserted that she was entitled to a separate impairment rating for the ankle/foot impairment.

In a decision dated March 3, 2015, an OWCP hearing representative affirmed the decision dated June 3, 2014. He noted that the rating provided by Dr. Weiss and confirmed by the medical adviser was for the leg even though it was evaluated as a tibial plafond fracture or impairment of the ankle or foot. The hearing representative noted that ankle impairments were those of the lower extremity and were included in the March 31, 2008 decision.

LEGAL PRECEDENT

The schedule award provision of FECA[9] and its implementing federal regulations[10] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members, functions, and organs of the body. FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[11] The A.M.A., *Guides*, has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses. For decisions issued after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[12] For decisions issued after May 1, 2009, the sixth edition will be used.[13]

The sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[14] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

[11] *Ausbon N. Johnson*, 50 ECAB 304 (1999).

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

[13] *Id.* at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *see also id.* at Chapter 3.700, Exhibit 1 (January 2010).

[14] A.M.A., *Guides* 494-531.

ANALYSIS

Appellant's claim was accepted by OWCP for conditions that included right Achilles tendon strain, right plantar fasciitis, sprain of the right ankle, sprain of the right shoulder, upper arm and rotator cuff, aggravation of osteoarthritis of the right knee, and left chondromalacia patellae. OWCP authorized surgery and appellant underwent a left knee arthroscopy on June 17, 2003, a left total knee replacement on March 13, 2006, and a total right knee replacement on June 26, 2006. In its March 3, 2015 decision, it found that appellant had not established an increased permanent impairment to her right lower extremity beyond the 54 percent permanent impairment previously granted.

Regarding appellant's right leg impairment, the Board noted that in 2007 appellant requested a schedule award based on her accepted aggravation of osteoarthritis of the right knee and Achilles tendon strain. On January 23, 2008 an OWCP medical adviser concurred with Dr. Weiss' determination that appellant had 54 percent permanent impairment of the right lower extremity. The medical adviser agreed that the impairment rating was comprised of 50 percent impairment for the right knee and 7 percent impairment for the right ankle. Applying the Combined Values Chart, appellant had 54 percent permanent impairment of the right leg under the A.M.A., *Guides*. However, in its March 3, 2015 decision, OWCP denied appellant's claim for an increased schedule award for the right lower extremity because Dr. Weiss' December 1, 2012 impairment rating for the right lower extremity was duplicative of the schedule award previously granted. Dr. Weiss' December 1, 2012 impairment rating, with whom an OWCP medical adviser concurred, found appellant sustained 12 percent lower extremity impairment for a right tibial plafond fracture with mild motion deficits. This was an increase of five percent impairment in the ankle region since the 2008 award. FECA provides that the period of compensation payable under the schedule award provision of FECA is reduced by the period of compensation paid under the schedule for an earlier injury if compensation in both cases is for disability for the same member or function and OWCP finds that compensation payable for the later disability would in whole or in part duplicate the compensation payable for the preexisting disability.[15] Here, OWCP has not sufficiently explained why the 12 percent permanent impairment attributable to the ankle region by Dr. Weiss would wholly duplicate the compensation previously paid.[16] The A.M.A., *Guides*, Chapter 16, The Lower Extremities, Figure 16-1, page 493-495, provides that the lower extremity is divided into 3 regions (distal to proximal): Foot and ankle, knee and hip. Section 16.3f Combining and Converting Impairments, page 529, provides that if there are multiple diagnoses at maximum medical impairment, the examiner should determine if each should be considered or the impairments are

[15] 5 U.S.C. § 8108.

[16] *T.S.*, Docket No. 09-1308 (issued December 22, 2009) (case remanded where OWCP did not sufficiently explain why appellant's impairment due to a meniscectomy duplicated his previous compensation award paid for the same schedule member).

duplicative. If there are multiple lower extremity impairments in separate regions they are calculated and combined at the lower extremity level.[17]

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, it shares responsibility in the development of the evidence. Accordingly, once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[18]

The Board will remand the case to OWCP for further medical development with regard to whether Dr. Weiss' December 1, 2012 impairment rating for the ankle region, concurred with by an OWCP medical adviser, would wholly duplicate the award previously made. Following this and any other further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds this case not in posture for decision regarding appellant's entitlement to a schedule award.

[17] *See W.H.*, Docket No. 13-146 (issued April 12, 2013) (where the Board noted that it was proper for an OWCP medical adviser to combine ratings from different regions of the extremity and, where this yielded greater impairment than that which was previously granted, an additional award was proper). *See also Erma L. Moore*, Docket No. 99-1554 (issued September 25, 2000) (the fact that appellant established that she had 10 percent impairment of the left arm in 1996 and was evaluated as having two percent impairment of that arm in 1998 did not mean that OWCP could deny her claim for a permanent impairment of the right arm on the grounds that she received a greater total award than she would be entitled to for both arms).

[18] *John W. Butler*, 39 ECAB 852 (1988).

ORDER

IT IS HEREBY ORDERED THAT the March 3, 2015 decision of the Office of Workers' Compensation Programs be set aside and the case remanded for further development in accordance with this decision of the Board.

Issued: January 19, 2016
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board