United States Department of Labor
Employees' Compensation Appeals Board

A.M., Appellant	)	
and	)	**Docket No. 16-0816**
	)	**Issued: November 2, 2016**
U.S. POSTAL SERVICE, CINCINNATI BULK MAIL CENTER, Cincinnati, OH, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On March 15, 2016 appellant, through counsel, filed a timely appeal from a February 12, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (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 has established that he has more than four percent permanent impairment of his right lower extremity, for which he received a schedule award.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On February 8, 2006 appellant, then a 46-year-old mail clerk, filed a traumatic injury claim (Form CA-1) alleging that on February 7, 2006 he injured his right ankle when he slipped and fell from a platform at work. OWCP accepted the claim for right ankle distal fibula fracture with deltoid ligament rupture and paid benefits. Appellant stopped work on the date of injury and underwent surgery on February 10, 2006. He resumed limited-duty work on May 6, 2006 and returned to his regular duties on July 3, 2007.

A progress note from Dr. Lisa L. Vickers, Board-certified in orthopedic surgery, dated December 7, 2007, related that appellant was working full-time, full duty, but he had been with pain in his ankle for which he was on prescription medication. Physical examination revealed no swelling in the ankle, no restriction in range of motion, no significant tenderness. Appellant was neurovascularly intact. Previous x-rays revealed well-fixed and well-healed distal fibular fracture. A magnetic resonance imaging (MRI) scan showed an OCD lesion of the medial talus, but appellant never followed through on the suggested ankle arthroscopy. Dr. Vickers recommended that appellant work sedentary duty and return on an as needed basis.

On September 13, 2010 OWCP received appellant's request for a schedule award (Form CA-7).

In an August 26, 2010 report, Dr. Martin Fritzhand, a specialist in occupational medicine, noted appellant's history of injury. He found that maximum medical improvement (MMI) had been achieved in February 2007. Dr. Fritzhand related that appellant's examination revealed a mildly antalgic gait, with squatting to 80 percent of normal. Forward bending was accomplished to 90 degrees. Appellant's entire right ankle was tender to palpation. Plantar flexion was limited to 20 degrees, inversion to 0 degrees, and dorsiflexion to 10 degrees. Strength was normal and no atrophy was found. Sensation was intact, but the right Achilles tendon reflex was absent.

Utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[3] (hereinafter A.M.A., *Guides)*, and citing to tables and figures, Dr. Fritzhand opined that appellant had 12 percent permanent impairment of the right lower extremity. Using Table 16-2, he found the default value for malleolar ankle fracture with mild motion deficit was 10. Dr. Fritzhand found that appellant had grade modifier 2 for functional history under Table 16-6, a grade modifier 1 for physical examination under Table 16-7, and a grade modifier of 1 for clinical studies under Table 16-8. The grade modifiers therefore moved the default value from C to D, which resulted in a finding of 12 percent permanent impairment of the right lower extremity.

By letters dated September 16, 2013 and February 11, 2014, counsel asked OWCP the status of the schedule award claim.

On February 24, 2014 OWCP advised appellant of the evidence needed to support a schedule award claim, noting that there was no narrative report outlining his current condition. Appellant was afforded 30 days for submission of the additional evidence.

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

On March 18, 2014 appellant submitted a claim for compensation (Form CA-7), requesting schedule award compensation benefits. No additional medical evidence was submitted.

By decision dated April 1, 2014, OWCP denied the claim for a schedule award, noting the lack of current medical evidence of file to support impairment. It found that Dr. Fritzhand's August 26, 2010 report was too stale to consider.

On April 8, 2014 OWCP received counsel's request for a telephonic hearing before an OWCP hearing representative. By decision dated September 10, 2014, the Branch of Hearings and Review remanded the case to OWCP, finding it not in posture for a hearing as Dr. Fritzhand's report constituted *prima facie* evidence of impairment and instructed OWCP to forward the evidence to its medical adviser for consideration of a schedule award.

In a September 12, 2014 report, an OWCP medical adviser, Dr. Morley Slutsky, a Board-certified occupational medicine specialist, reviewed the statement of accepted facts (SOAF) and the medical record. He found the date of MMI was December 7, 2007. Dr. Slutsky indicated that on December 7, 2007 appellant had mild discomfort related to the ankle and had a normal examination with full ankle range of motion and no tenderness, crepitation, or swelling.

Using the diagnosis of right ankle malleolus fracture, Dr. Slutsky noted imaging studies which documented the injury and recovery. Multiple examinations had found a healed fracture, with normal examination of the ankle. Dr. Slutsky found Dr. Fritzhand's findings inconsistent with appellant's best efforts at MMI. Therefore, he used the findings from the December 7, 2007 report of Dr. Vickers in the determination of impairment. Citing normal motion of the right ankle, Dr. Slutsky found no ratable impairment of the preexisting ankle conditions and found class 0 under Table 16-2 of A.M.A., *Guides*. He found that Dr. Fritzhand's use of the default value for the fracture was incorrect, as no motion loss was documented. Using the diagnosis of fracture with no loss of motion or malalignment, Dr. Slutsky assigned class 1 default value or five percent. He disagreed with Dr. Fritzhand's functional history grade modifier as there was no consistent evidence of altered gait or positive Trendelenburg test. Dr. Slutsky assigned a grade modifier of 1, whereas Dr. Fritzhand had assigned modifier of 2. For physical examination modifier, he found a value of 0, as there was no crepitus, tenderness or swelling at MMI. After application of grade modifiers, a final impairment rating of three percent permanent impairment of the right lower extremity was calculated.

On November 14, 2014 OWCP declared a conflict in medical opinion evidence between Dr. Fritzhand and Dr. Slutsky, the medical adviser, and arranged for an impartial medical examination with Dr. Thomas Bender, a Board-certified orthopedic surgeon, to provide an impartial medical opinion.

In a February 2, 2015 report, Dr. Bender noted the history of injury, reviewed the SOAFs and medical record, and noted examination findings. He noted that, while appellant was being followed by a podiatrist, no treatment for the ankle injury had occurred since 2009, when implanted hardware was removed. Since then, appellant continued to work in a full-duty capacity. The date of MMI was noted as January 31, 2015. Dr. Bender noted that appellant could briskly walk, without aid. Examination findings revealed no external rotation of the ankle

or weakness and intact posterior tibial tendon. Bilaterally, the third metatarsal was prominent with reactive calluses bilaterally. Ankle motion was symmetrical bilaterally and some numbness noted over the surgical scar. No asymmetry with the contralateral ankle was found relative to shoe wear, atrophy, edema, motion, or skin integrity. Under Table 16-2, of the A.M.A., *Guides*, Dr. Bender used the diagnosis of ankle fracture with no loss of motion or malalignment to establish class 1. He indicated that the final permanent impairment rating of appellant's right lower extremity was four percent.

In a March 20, 2015 report, an OWCP medical adviser, Dr. Daniel Zimmerman, a Board-certified internist, reviewed the SOAF and the medical record, including Dr. Bender's report. He noted that Dr. Bender failed to apply the grade modifiers found in Table 16-6 through Table 16-8. Dr. Zimmerman noted that class 1 for the diagnosis of fracture, nondisplaced with minimal findings, had a default value of C or five percent impairment. As appellant's gait was reported as normal with no specialized footwear, he assigned a Functional History (GMFH) modifier of 0. As Dr. Bender had found surgical scar numbness, he assigned a Physical Examination (GMPE) modifier of 1. He indicated that the Clinical Studies (GMCS) modifier was not used as the studies were used to establish the diagnosis. A net adjustment of -1 was found under the net adjustment formula, (GMFH - CDX)(0-1) + (GMPE - CDX)(1-1) + (GMCS - CDX) (N/A), which resulted in four percent permanent impairment of the right lower extremity.

By decision dated April 22, 2015, OWCP granted appellant a schedule award for four percent permanent impairment of the right lower extremity. The award ran for 11.52 weeks of compensation for the period January 31 to April 21, 2015.

On May 4, 2015 OWCP received counsel's April 29, 2015 request for a telephonic hearing before an OWCP hearing representative. The hearing was held on December 16, 2015. Appellant testified that he was working full duty as a mail handler and not receiving any treatment for his ankle. Counsel argued that Dr. Bender was not selected by an outside vendor or in accordance with the referee selection protocols. He asked that OWCP declare a conflict and arrange an impartial examination to resolve the conflict between Drs. Bender and Fritzhand.

By decision dated February 12, 2016, an OWCP hearing representative affirmed the prior decision.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations 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.[4] 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

[4] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[5]

The A.M.A., *Guides* provide a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[6] 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 upper extremity to be rated. After the Class of Diagnosis (CDX) is determined for the diagnosed condition (including identification of a default grade value), the net adjustment formula is applied using the grade modifier for functional history, grade modifier for physical examination, and grade modifier for clinical studies.[7] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[8] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[9]

Section 8123(a) of FECA 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.[10] When 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 on a proper factual background, must be given special weight.[11] OWCP's medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.[12]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP 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]

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[5] *K.H.*, Docket No. 09-341 (issued December 30, 2011). For decisions issued after May 1, 2009, the sixth edition will be applied. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

[6] A.M.A., *Guides*, *supra* note 3, section 1.3, The ICF: A Contemporary Model of Disablement.

[7] *Id*. at 493-531.

[8] *Id*. at 521.

[9] *Id.* at 23-28; *see also R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[10] 5 U.S.C. § 8123(a); *see J.J.*, Docket No. 09-27 (issued February 10, 2009); *Geraldine Foster*, 54 ECAB 435 (2003).

[11] *B.P.*, Docket No. 08-1457 (issued February 2, 2009); *J.M.*, 58 ECAB 478 (2007); *Barry Neutuch*, 54 ECAB 313 (2003); *David W. Pickett*, 54 ECAB 272 (2002).

[12] *V.G.*, 59 ECAB 635 (2008); *Thomas J. Fragale*, 55 ECAB 619 (2004); *see also Richard R. LeMay*, 56 ECAB 341 (2005).

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

ANALYSIS

OWCP accepted appellant's claim for right ankle fracture with deltoid ligament rupture and approved his February 10, 2006 surgery. The issue is whether appellant has more than four percent permanent impairment of the right lower extremity for which he received a schedule award. The Board finds that appellant has not met his burden of proof to establish that he has permanent impairment of the right lower extremity greater than the four percent previously awarded.

In his August 26, 2010 report, Dr. Fritzhand found that MMI had been achieved in 2007 and opined appellant had 12 percent permanent impairment to the right lower extremity. Dr. Slutsky, an OWCP medical adviser, on September 12, 2014 reviewed Dr. Fritzhand's report and found MMI had been reached by December 7, 2007. He found that Dr. Fritzhand's findings were inconsistent with appellant's best efforts at MMI and used the findings from Dr. Vickers' December 7, 2007 report to opine that appellant had three percent permanent impairment to the right lower extremity. OWCP thereafter declared a conflict in the medical opinion evidence.

The Board finds that OWCP improperly found a conflict in medical opinion and referred appellant to Dr. Bender for an impartial medical opinion on the degree of impairment. The Board has held that stale evidence cannot create a conflict of medical opinion or require the selection of a referee physician.[14] Dr. Vickers' report from December 2007 contained stale findings, which were not properly utilized in 2014 to create a conflict in the medical opinion evidence. The Board has held that an impairment rating that is not based on reasonably current examination findings is of little probative value. Thus, the Board previously found that it was inappropriate for an OWCP medical adviser to base his impairment rating on examination findings which were nearly three years old at the time of the medical adviser's impairment calculation.[15] As a proper conflict did not exist in the medical opinion evidence at the time appellant was referred to Dr. Bender, his report is not entitled to the special weight given to an impartial medical specialist. His report however should be considered for its own intrinsic value.[16]

In his February 2, 2015 medical report, Dr. Bender opined that appellant had four percent permanent impairment of his right lower extremity and MMI was noted as January 31, 2015. According to Table 16-2, page 503, he utilized his examination findings and medical records to determine class 1 diagnosed-based impairment for an ankle fracture with no loss of motion or malalignment. Dr. Bender provided no explanation, utilizing grade modifiers, to explain how he arrived at four percent right lower extremity impairment.

Dr. Zimmerman, serving as OWCP's medical adviser, reviewed Dr. Bender's report and agreed with the rating of four percent permanent impairment. He noted that Dr. Bender failed to apply the grade modifiers found in Table 16-6 through Table 16-8 and that the default value for

[14] *See D.B.*, Docket No. 16-0261 (issued June 9, 2016).

[15] *T.M.*, Docket No. 16-0429 (issued August 11, 2016).

[16] *See M.R.*, Docket No. 11-1419 (issued May 21, 2012).

class 1 diagnosed-based impairment for an ankle fracture with no loss of motion or malalignment was five percent. Utilizing the findings in Dr. Bender's report, the medical adviser assigned a functional history grade modifier of 0, a physical examination modifier of 1 and advised the clinical studies modifier was not used as the studies were used to establish the diagnosis. Applying the net adjustment formula, (GMFH - CDX) (0-1) + (GMPE - CDX) (1-1) + (GMCS - CDX) (N/A), the medical adviser found a net adjustment of -1. Application of the net adjustment formula meant that movement was warranted one place to the left of class 1 default value C to grade B for four percent lower right extremity permanent impairment. Dr. Zimmerman confirmed MMI was reached as of January 31, 2015.

The Board finds that the opinion of Dr. Zimmerman is thorough and well rationalized. Dr. Zimmerman utilized the findings from Dr. Bender. Board precedent is well settled that when a physician's report gives an estimate of impairment but does not address how the estimate is based upon the A.M.A., *Guides*, OWCP may follow the advice of its medical adviser where he or she has properly applied the A.M.A., *Guides*.[17] Dr. Zimmerman properly utilized Table 16-2 of the A.M.A., *Guides* finding class 1 grade B ankle fracture, nondisplaced with minimal findings, resulted in a schedule award for four percent permanent impairment of the right lower extremity.

Accordingly, the Board finds Dr. Zimmerman correctly applied the A.M.A., *Guides* to find that appellant had four percent permanent impairment of the right lower extremity, for which he received a schedule award.[18] Appellant has not submitted sufficient evidence to establish that he has more than four percent permanent impairment to the right lower extremity.[19]

On appeal, counsel contends that OWCP's decision is contrary to fact and law. As noted above, Dr. Bender's examination findings were used by the medical adviser, who correctly applied the A.M.A., *Guides* to find that appellant had four percent impairment to the right lower extremity, for which he received a schedule award.

Appellant 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.

CONCLUSION

The Board finds that appellant has failed to establish more than four percent permanent impairment of the right lower extremity.

[17] *See T.R.*, Docket No. 15-1862 (issued March 24, 2016); *Ronald J. Pavlik*, 33 ECAB 1596 (1982); *Robert R. Snow*, 33 ECAB 656 (1982); *Quincy E. Malone*, 31 ECAB 846 (1980).

[18] *Y.K.*, Docket No. 11-1623 (issued June 25, 2012).

[19] *J.S.*, Docket No. 12-1170 (issued November 9, 2012); *J.J.*, Docket No. 10-839 (issued December 23, 2010).

ORDER

IT IS HEREBY ORDERED THAT the February 12, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 2, 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