United States Department of Labor
Employees' Compensation Appeals Board

C.K., Appellant	)	
and	)	**Docket No. 16-1294**
	)	**Issued: January 13, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Painesville, 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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 3, 2016 appellant, through counsel, filed a timely appeal from a March 31, 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 met her burden of proof to establish that she has permanent left lower extremity impairment due to the accepted conditions.

[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

This case has previously been before the Board.[3] In an October 24, 2008 order, the Board remanded File No. xxxxxx099 to OWCP because, in a March 27, 2008 decision, an OWCP hearing representative referenced an additional claim, adjudicated by OWCP under File No. xxxxxx604. The Board remanded the case to OWCP to obtain File No. xxxxxx604 and for further reconstruction and assemblage deemed necessary, to be followed by a *de novo* decision on the merits of appellant's claim.[4]

On remand, OWCP combined File Nos. xxxxxx099 and xxxxxx604, with the latter becoming the master file.[5] In a February 10, 2009 decision, OWCP denied appellant's July 2007 claim because the record did not contain a detailed and definitive medical opinion explaining how her diagnosed degenerative disc disease and disc bulges of the lumbar spine were causally related to her employment duties. Appellant, through counsel, timely requested a hearing, that was held on August 19, 2009. In an October 23, 2009 decision, an OWCP hearing representative affirmed the February 10, 2009 decision. Following an appeal, the Board, in an October 18, 2010 decision, found that appellant had not established that the diagnosed lumbar spine conditions were caused or aggravated by employment factors.[6] In 2010, appellant relocated from Ohio to Florida.

Under File No. xxxxxx604, on February 18, 2011 appellant filed a schedule award claim. She submitted a July 8, 2011 report in which Dr. William N. Grant, Board-certified in internal medicine, described her medical and surgical history and her complaint of constant painful discomfort in the left ankle. Left ankle examination demonstrated synovial change and a fallen arch with thickening of the plantar aspect of the left foot and marked tenderness to palpation of the plantar aspect of the left foot. Dr. Grant advised that, under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[7] under Table 16-22, Ankle Motion Impairments, left ankle flexion to 15 degrees yielded seven percent impairment, and extension to 50 degrees yielded seven percent impairment. He added that, under Table 16-20, Hindfoot Motion Impairments, inversion to 10 degrees yielded two percent impairment, and eversion to 8 degrees yielded two percent impairment. Dr. Grant added the range of motion impairments, finding a total of 18 percent left leg permanent impairment. He then advised that under Table 16-2, Foot and Ankle Regional Grid, appellant

[3] Docket No. 08-1396 (issued October 24, 2008) and Docket No. 10-0369 (issued October 18, 2010).

[4] Docket No. 08-1396 (issued October 24, 2008). Under File No. xxxxxx099, on July 12, 2007 appellant, then a 54-year-old city letter carrier who had retired in February 2007, filed an occupational disease claim (Form CA-2a) alleging that the constant walking and weight-bearing of her mail route caused back problems including bulging discs and degenerative disc disease.

[5] File No. xxxxxx604 had previously been combined with File No. xxxxxx979, a closed file accepted for bilateral calcaneal spurs, and File No. xxxxxx264, an open file accepted for left ankle sprain. Under File No. xxxxxx604, OWCP accepted appellant's traumatic injury claim for left ankle sprain and right foot plantar fasciitis. On November 4, 2005 OWCP expanded File No. xxxxxx604 to include lumbar radiculopathy.

[6] Docket No. 10-369 (issued October 18, 2010).

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

had a class 1 impairment with grade modifiers of 2 each for functional history and physical examination, which yielded 13 percent diagnosis-based impairment (DBI). Dr. Grant utilized the Combined Values Chart and concluded that she had a total of 29 percent permanent impairment of the left lower extremity.

An OWCP medical adviser reviewed Dr. Grant's report. He noted that DBI could not be combined with range of motion, which was a stand-alone impairment and, furthermore, that Dr. Grant did not explain his DBI findings. The medical adviser further explained that Dr. Grant's findings were not consistent with the findings by other physicians who noted a normal gait, normal strength, etc. He recommended a second opinion.

In July 2014 OWCP referred appellant to Dr. William Dinenberg, a Board-certified orthopedic surgeon, for an evaluation and impairment rating. The statement of accepted facts listed accepted conditions as left ankle sprain, right plantar fasciitis, chronic left ankle instability, bilateral heel spurs, and lumbar radiculopathy.

In an August 11, 2014 report, Dr. Dinenberg noted the history of injury for the combined case files, appellant's medical and surgical history, his review of the record including Dr. Grant's report, and those of her current physician, Dr. Michael D. Solomon, Board-certified in anesthesiology and pain medicine.[8] He indicated that appellant's only complaint was back pain. Dr. Dinenberg noted that she walked with a nonantalgic gait and climbed on the examination table independently. Lumbosacral spine was diffusely tender to light touch in the paraspinous region. Straight leg tests were negative bilaterally, and strength 5/5 in quadriceps, hamstrings, gastrocsoleus, tibialis anterior, and extensor hallucis longus bilaterally. Examination of the left ankle revealed a well-healed surgical scar laterally. Appellant was nontender to palpation over the medial and lateral malleolus and had no varus or valgus laxity of the left ankle. No anterior drawer or posterior drawer was noted, and the plantar fascia on the left was nontender to palpation. Ankle range of motion was equal bilaterally. A well-healed surgical scar on the medial hindfoot consistent with prior endoscopic plantar fascial release was noted on the right. Dr. Dinenberg diagnosed chronic low back pain without radiculopathy; "right" ankle sprain with history of chronic instability, now status post stabilization procedure with resolution of instability; and right ankle plantar fasciitis, now status post endoscopic plantar fascial release with resolution of symptomatology. He advised that appellant was at maximum medical improvement (MMI) on the date of his examination, August 8, 2014, and that she had no objective evidence of left ankle instability, having successfully undergone a stabilization procedure.

Dr. Dinenberg further opined that as appellant's left ankle range of motion was equal to that on the right, she had no range of motion impairment, and with no radiculopathy present in regard to her lower back, she had no ratable permanent impairment of the lumbosacral spine. He

[8] Dr. Dinenberg reviewed an April 17, 2014 treatment note in which Dr. Solomon noted appellant's complaint of back heaviness. He described her pain management. Dr. Solomon first saw appellant on November 19, 2010 and submitted pain management notes on a regular basis. He did not evaluate impairment. In December 2014, appellant began treatment with Dr. Miguel D. Attias, an anesthesiologist, for pain management. Dr. Attias noted her complaint of severe low back pain and described her pain management. He did not provide an impairment evaluation.

reported that she had no ratable permanent impairment due to right ankle plantar fasciitis, based on a successful plantar fascial release.

On August 21, 2014 Dr. James W. Dyer, an OWCP medical adviser and a Board-certified orthopedic surgeon, indicated that MMI was reached on August 8, 2014. He agreed with Dr. Dinenberg's assessment that appellant had no ratable permanent impairment of either leg due to the accepted diagnoses of left ankle sprain, right plantar fasciitis with release, or lumbar radiculopathy. Dr. Dyer noted that she had good results from a left ankle stabilization procedure and right plantar fascial release, and no radicular pain or sensory deficit of either leg. He concluded that appellant had zero impairment of each lower extremity.

By decision dated August 25, 2014, issued under File No. xxxxxx604, OWCP found that appellant was not entitled to a schedule award for either lower extremity due to the accepted conditions of left ankle sprain and other joint derangement, right plantar fibromatosis, and thoracic or lumbosacral neuritis or radiculitis. It found that the weight of the medical evidence rested with the opinion of Dr. Dinenberg, as reviewed by OWCP's medical adviser.

Appellant, through counsel, timely requested a hearing before an OWCP hearing representative and submitted a December 9, 2014 impairment evaluation from Dr. Robert R. Reppy, an osteopath. He advised that she was wearing orthopedic shoes with arch supports. Calf circumference was 34.5 centimeter (cm) on the right and 36.5 on the left; thigh circumference 50 cm on the right and 45 cm on the left. Plantar flexion was 40 degrees on the right and 45 degrees on the left, with extension 30 degrees on the right and 25 degrees on the left. Right ankle inversion was 51 degrees, eversion 50 degrees; left ankle inversion was 39 degrees and eversion 35 degrees. Straight leg raising was positive bilaterally, and deep tendon reflexes were diminished bilaterally. Moderate spasticity was present in the para-lumbar muscles, with diminished sensation to monofilament testing distal to the ankles bilaterally along the distribution of the L4-5 and L5-S1 nerve roots. Dr. Reppy diagnosed status post reconstruction of the left ankle, plantar fasciitis, and lumbar radiculopathy/neuritis, grade 2 left ankle sprain, calcaneal spurs, and talar dome defect. He advised that appellant was at MMI, and rated impairment under the A.M.A., *Guides*.

Dr. Reppy indicated that under Table 16-20, left ankle inversion of 10 degrees and eversion of 8 degrees yielded two percent impairment, and that under Table 16-22, plantar flexion of 15 degrees and dorsiflexion of 5 degrees yielded seven percent impairment. He further found that, under Table 16-2, appellant had a class 1 impairment for a diagnosis of moderate ligamentous laxity of 10 to 15 degrees. Dr. Reppy found grade modifiers of 2 for functional history and 4 for physical examination. After applying the net adjustment formula, he concluded that appellant had a grade E, class 1 left lower extremity DBI of 13 percent.

Dr. Reppy further rated appellant's legs under Table 15-14, Sensory and Motor Severity of the upper extremity, finding a class 1 (mild) impairment based on abnormal monofilament testing. Under Table 16-12, Peripheral Nerve Impairment-Lower Extremity Impairments, Dr. Reppy advised that, for tibial nerve impairment, appellant had a class 1, mild motor deficit. He found grade modifiers of 2 for functional history, 4 for physical examination, and 1 for clinical studies. After applying the net adjustment formula, Dr. Reppy found nine percent left lower extremity peripheral nerve impairment. He then utilized the Combined Values Chart and,

by combining appellant's DBI of 13 percent for ligamentous laxity with 9 percent peripheral nerve impairment, he concluded that appellant had 16 percent lower extremity permanent impairment.

At the hearing, held on March 17, 2015, appellant testified that her left ankle continued to ache. Counsel maintained that Dr. Reppy's report should be considered.

In a June 3, 2015 decision, an OWCP hearing representative remanded the case to OWCP for review of Dr. Reppy's report by OWCP's medical adviser, to be followed by a *de novo* decision.

On June 8, 2015 Dr. Dyer, OWCP's medical adviser, reviewed the record, including Dr. Reppy's report. He indicated that Dr. Reppy incorrectly used the A.M.A., *Guides*, noting that he improperly combined range of motion with a DBI impairment, and that he did not apply the A.M.A., *Guides* newsletter for appellant's spinal nerve root impairments. Dr. Dyer concluded that her leg impairments remained at zero percent.

By decision dated June 16, 2015, issued under File No. xxxxxx604, OWCP found that appellant was not entitled to a schedule award for either lower extremity due to the accepted conditions.

Appellant, through counsel, timely requested a hearing, that was held on February 8, 2016. She testified that her right foot hurt occasionally, and that her left ankle hurt more. Appellant stated that she was on medication and had steroid injections for back pain. Counsel argued that Dr. Dyer improperly analyzed Dr. Reppy's report and maintained that, at the least, a conflict in medical evidence had been created.

In a March 31, 2016 decision, an OWCP hearing representative found that the weight of the medical evidence rested with the opinion of Dr. Dyer and affirmed the June 16, 2015 decision.

LEGAL PRECEDENT

It is the claimant's burden of proof to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of any employment injury.[9]

The schedule award provision of FECA[10] and its implementing federal regulations,[11] 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

[9] *See Tammy L. Meehan*, 53 ECAB 229 (2001).

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants.[12] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[13]

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).[14] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[15] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[16] 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.[17] Section 16.2a of the A.M.A., *Guides*, provides that if the class selected is defined by physical examination findings or clinical studies results, these same findings may not be used as grade modifiers to adjust the rating.[18]

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, under FECA a schedule award is not payable for injury to the spine.[19] In 1960, amendments to FECA modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Therefore, as the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[20]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. The A.M.A., *Guides* for decades has offered an alternative approach to rating spinal nerve impairments.[21] OWCP has adopted this approach for rating impairment of the upper or lower extremities caused by a spinal injury, as provided in

[12] *Id*. at § 10.404(a).

[13] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *see also* Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

[14] *Supra* note 7 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

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

[16] *Id*. at 521.

[17] *Id*. at 23-28.

[18] *Id*. at 500.

[19] *Pamela J. Darling*, 49 ECAB 286 (1998).

[20] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[21] *Rozella L. Skinner*, 37 ECAB 398 (1986).

section 3.700 of its procedures, which memorializes proposed tables outlined in the July to August 2009, *The Guides Newsletter*.[22] Specifically, OWCP will address lower extremity impairments originating in the spine through Table 16-11[23] and upper extremity impairment originating in the spine through Table 15-14.[24]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's 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.[25] In determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[26]

ANALYSIS

Under appellant's combined files, OWCP accepted left ankle sprain, right plantar fasciitis, chronic left ankle instability, bilateral heel spurs, and lumbar radiculopathy. The Board has evaluated the evidence of record and finds that she has not met her burden of proof to establish permanent impairment of the left leg due to the accepted conditions.

The July 8, 2011 report submitted by Dr. Grant, who opined that appellant had 29 percent left lower extremity impairment, was not in accordance with the A.M.A., *Guides*. He rated her left ankle under both the range of motion and DBI methods. Section 16.2 of the A.M.A., *Guides* provides that a rating based on range of motion cannot be combined with other approaches and is primarily used as a physical examination adjustment factor.[27] The Board has long held that an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's impairment.[28] Dr. Grant's opinion is therefore of limited probative value regarding her left lower extremity impairment.

Likewise, Dr. Reppy's report is insufficient to establish permanent impairment of the left leg. He rated appellant both using range of motion measurements and under the DBI method. In finalizing his impairment rating, he only used the DBI method, finding 13 percent impairment for moderate ligamentous laxity, and combined this with a peripheral nerve impairment of 9 percent, finding a total left lower extremity impairment of 16 percent. Regarding his DBI impairment, Dr. Reppy indicated that a stress fluoroscopy, done in February 2007, showed a 15

[22] FECA Transmittal No. 10-04 (issued January 9, 2010); *supra* note 13 at Chapter 3.700, Exhibit 1, note 5 (January 2010); *The Guides Newsletter* is included as Exhibit 4.

[23] *Supra* note 7 at 533.

[24] *Id*. at 425.

[25] *See supra* note 13 at Chapter 2.808.6(f) (February 2013).

[26] *Peter C. Belkind*, 56 ECAB 580 (2005).

[27] *Supra* note 7 at 497; *see B.W.*, Docket No. 14-1834 (issued September 18, 2015).

[28] *Carl J. Cleary*, 57 ECAB 563 (2006).

degree talar tilt which, under Table 16-2, yielded a class 1 impairment for moderate ligamentous laxity. The record, however, indicates that the stress fluoroscopy was done by Dr. Tozzi in June 2002, not in February 2007, and this was prior to the stabilization procedure done by Dr. Tozzi in October 2002.[29] Following the surgery, Dr. Tozzi reported that appellant's left ankle was very stable and that the surgery rehabilitated her ankle.[30] Thus, Dr. Reppy's basis for finding a DBI due to moderate ligamentous laxity is based on an inaccurate history. Moreover, he indicated that he based appellant's physical examination grade modifier of 4 on atrophy of 4.0 cm or more. This again raises questions because, while he found the left thigh smaller than the right, measuring 45 cm and 50 cm respectively, he found the left calf larger than the right, measuring 36.5 cm and 34.5 cm respectively. Lastly, Dr. Reppy's impairment rating for peripheral nerve impairment was not done properly. As noted above, the proper mechanism for rating impairment of the upper or lower extremities caused by a spinal injury is provided in section 3.700 of OWCP procedures, which memorializes proposed tables outlined in the July to August 2009 *The Guides Newsletter*.[31] In finding a peripheral nerve impairment of nine percent, Dr. Reppy referenced Table 15-14, which is to be used for upper extremity impairments, and Table 16-12. Specifically, OWCP will address lower extremity impairments originating in the spine through Table 16-11[32] and upper extremity impairment originating in the spine through Table 15-14.[33] For these reasons, Dr. Reppy's opinion is of diminished probative value and insufficient to meet appellant's burden of proof to establish impairment of the left lower extremity.[34]

The Board finds that Dr. Dinenberg's opinion represents the weight of the medical evidence. In his comprehensive August 11, 2014 report, Dr. Dinenberg described extensive physical examination findings properly applied the A.M.A., *Guides*, and advised that appellant had no objective evidence of instability of the left ankle, having successfully undergone a stabilization procedure. He further opined that she had no range of motion impairment, and no ratable impairment of the lumbosacral spine. There are no additional impairment ratings in the combined case record.

It is appellant's burden of proof to establish permanent impairment.[35] The Board has carefully reviewed Dr. Dinenberg's report and finds that his opinion has reliability, probative value, and convincing quality with respect to its conclusions regarding the relevant issue in the present case. Dr. Dinenberg's opinion was based on a proper factual and medical history, and he thoroughly reviewed the factual and medical history and accurately summarized the relevant

[29] *Supra* note 5.

[30] *Id*.

[31] *Supra* note 22.

[32] *Supra* note 7 at 533.

[33] *Id*. at 425.

[34] *Supra* note 28.

[35] *See supra* note 9.

medical evidence.[36] He provided medical rationale for his opinion by explaining that, after careful review of all medical documentation and his clinical examination of appellant, appellant had no ratable impairment due to the accepted conditions. Appellant, therefore, has not established permanent impairment of the left leg.

Appellant may request a schedule award or increased schedule award at any time 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 not met her burden of proof to establish permanent left lower extremity impairment due to the accepted conditions.

ORDER

IT IS HEREBY ORDERED THAT the March 31, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 13, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[36] *See D.K.*, Docket No. 15-1312 (issued October 6, 2015).