United States Department of Labor
Employees' Compensation Appeals Board

S.C., Appellant	)	
and	)	**Docket No. 17-0019**
	)	**Issued: January 11, 2017**
DEPARTMENT OF HOMELAND SECURITY, CUSTOMS & BORDER PROTECTION, Santee, CA, Employer	)	

Appearances:
Appellant, pro se
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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 6, 2016 appellant filed a timely appeal from a May 24, 2016 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 more than five percent permanent impairment of his right lower extremity, for which he received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.[2] The facts and circumstances of the case as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts follow.

On April 24, 2013 appellant, then a 29-year-old border patrol agent, filed a traumatic injury claim (Form CA-1) alleging that he sustained injury on April 21, 2013 when his right foot was caught in a pile of rocks and his right leg twisted as he fell. OWCP accepted sprain of unspecified sites of his right leg and knee. Appellant stopped work and received disability compensation on the daily rolls from June 10 to 24, 2013.

The findings of May 2, 2013 magnetic resonance imaging (MRI) scan testing of appellant's right ankle showed a low-to-moderate grade partial tear at the level of the fibula tip with immediate reconstitution distally, partial tear of the peroneus brevis tendon, bone bruise of the posterior talus, and a low-grade acute sprain of the calcaneofibular ligament with associated marrow edema involving the posterior talus.

On December 20, 2013 appellant filed a claim for compensation (Form CA-7) claiming a schedule award due to his accepted work injury.

On February 6, 2014 OWCP advised appellant that he needed to submit an impairment rating derived in accordance with 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).

By decision dated February 11, 2015, OWCP denied appellant's schedule award claim because he had not submitted medical evidence of an employment-related impairment.

Appellant submitted an October 29, 2013 report in which Dr. Tal S. David, an attending Board-certified orthopedic surgeon, reported findings of the physical examination he conducted on that date. Dr. David noted that appellant complained of mild right calf weakness and loss of right ankle internal rotation. He advised that, upon testing of various ankle motions, appellant had full right ankle range of motion compared to the opposite side, except that his left ankle inversion was to 30 degrees and his right ankle inversion was only to 20 degrees. Dr. David noted that, based on Table 16-2 (Foot and Ankle Regional Grid) beginning on page 501 of the sixth edition of the A.M.A., *Guides*, appellant's moderate motion deficit on right ankle inversion and "mild weakness of both the inversion and posterior tibial tendon" meant that he had 12 percent permanent impairment of his right lower extremity. He indicated that, at the time of the October 29, 2013 examination, appellant had reached maximum medical improvement.

On April 15, 2015 Dr. Leonard A. Simpson, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, discussed his review of the medical evidence of record, including Dr. David's October 29, 2013 report. He noted that, under Table 16-2 (Foot and Ankle Regional Grid) of the sixth edition of the A.M.A., *Guides*, appellant had a right ankle strain with mild motion deficit, which placed him under class 1 for a diagnosis-based rating (five percent default

[2] Docket No. 15-1630 (issued October 23, 2015).

rating). Dr. Simpson indicated that the records documented some loss of subtalar inversion, which would be considered "mild" under Table 16-20 on page 549. He assigned a grade modifier for Functional History (GMFH) of 1 and a grade modifier for Clinical Studies (GMCS) of 1 (confirmed peroneus brevis partial tear). Dr. Simpson found that the grade modifier for Physical Examination (GMPE) was nonapplicable because the documented loss of motion was utilized for placement of appellant's condition under a class 1 diagnosis-based rating. Application of the net adjustment formula resulted in no adjustment from the default value of five percent and therefore appellant had a total permanent impairment of his right lower extremity of five percent.[3] Dr. Simpson indicated that the date of maximum medical improvement would correspond to Dr. David's October 29, 2013 examination and noted, "This reviewer would recommend 5 percent right lower extremity impairment and challenge the higher rating calculated at 12 percent, which is not supported by the data documented."

In a May 4, 2015 decision, OWCP vacated its February 11, 2015 decision, noting that appellant's submission of the October 29, 2013 report of Dr. David was sufficient to require this action. It indicated that a schedule award decision was attached. In another decision also dated May 4, 2015, OWCP granted appellant a schedule award for five percent permanent impairment of his right leg. The award ran for 14.4 weeks from October 29, 2013 to February 6, 2014 and was based on Dr. Simpson's impairment rating derived from the examination findings of Dr. David. Appellant appealed to the Board.

By decision dated October 23, 2015, the Board set aside OWCP's May 4, 2015 decision due to its finding that there was a conflict in the medical opinion evidence regarding the permanent impairment of appellant's right lower extremity between Dr. David, the attending physician, and Dr. Simpson, OWCP's medical adviser. In order to resolve the conflict in the medical opinion evidence, the Board remanded the case to OWCP for referral of appellant to an impartial medical specialist for an examination and evaluation of the permanent impairment of his right lower extremity. The Board directed OWCP to issue a *de novo* decision regarding his entitlement to schedule award compensation after carrying out this development.

On remand OWCP referred appellant to Dr. Harry R. Boffman, Jr., a Board-certified orthopedic surgeon, for an impartial medical examination and opinion on the extent of the permanent impairment of his right lower extremity under the standards of the sixth edition of the A.M.A., *Guides*.

In a March 4, 2016 report, Dr. Boffman recounted appellant's factual and medical history, including the results of diagnostic testing, and detailed findings of the physical examination he performed on March 3, 2016. He noted that appellant had a chief complaint of mild, intermittent pain, and mild weakness in his right calf. Dr. Boffman indicated that examination of the right calf revealed tenderness to deep palpation at the medial musculotendinous junction of the gastrocsoleus group. The sensory examination of the lower extremities was normal, but appellant exhibited some weakness after repeated heel lift in the right posterior calf. Dr. Boffman provided range of motion findings for the knees and ankles and noted that, with respect to ankle motion, there was mild restriction of subtalar motion on the right

[3] *See infra* note 11.

as compared to the left. He diagnosed intact Achilles tendon with edema in the Kager's fat pad compatible with paratendonitis, low-to-mild grade partial tearing of the peroneus brevis tendon at the level of the fibular tip, low grade acute sprain of the calcaneal fibular ligament with associated marrow edema involving the distal fibular tip, and bone bruise over the posterior talus. Dr. Boffman indicated that, using Table 16-2 (Foot and Ankle Regional Grid) on page 501 of the sixth edition of the A.M.A., *Guides*, appellant's right lower extremity condition should be considered under the diagnosis-based category relating to a strain, tendinitis, or history of a partially ruptured peroneus brevis tendon. He noted that appellant's condition would fall under class 1 on Table 16-2, due to motion deficits, with a default value of five percent permanent impairment of the right lower extremity.[4] With respect to grade modifiers, Dr. Boffman referenced Table 16.6, Table 16.7, and Table 16-8 on pages 516 through 520 and indicated that appellant had a GMFH of 1 due to a moderate problem, a GMPE of 1 due to a mild problem, and a GMCS of 2 due to a moderate problem (partial tear of the peroneus tendon). He advised that application of the net adjustment formula yielded the result of +1 and meant that there was movement one space to the right of the default value of five percent permanent impairment on Table 16-2, *i.e.*, to the value of six percent permanent impairment. Dr. Boffman determined that appellant had total permanent impairment of his right lower extremity of six percent.

In a report dated May 16, 2016, Dr. Jovito Estaris, a Board-certified occupational medicine physician and OWCP medical adviser, reviewed the March 4, 2016 report of Dr. Boffman and summarized some of the findings of the report. He indicated that, using Table 16-2 on page 501 of the sixth edition of the A.M.A., *Guides*, appellant's right lower extremity condition should be considered under the diagnosis-based category relating to a strain, tendinitis, or history of a partially ruptured peroneus brevis tendon. Dr. Estaris found that appellant's condition would fall under class 1, due to motion deficits, with a default value of five percent permanent impairment of the right lower extremity. He indicated that, with respect to grade modifiers, appellant had a GMFH of 1 due to intermittent pain, and a GMPE of 1 due to a mild deficit of range of motion. Dr. Estaris determined that GMCS would not be used in the net adjustment formula because the MRI scan showing a partially ruptured right peroneus brevis tendon was used to determine the diagnosis-based class. He advised that application of the net adjustment formula yielded the result of zero and meant that there was no movement from the default value of five percent permanent impairment on Table 16-2. Dr. Estaris concluded that appellant had five percent permanent impairment of his right lower extremity.

By decision dated May 24, 2016, OWCP determined that appellant had no more than five percent permanent impairment of his right lower extremity, for which he received a schedule award.[5] Its determination was based on the impairment rating calculated by Dr. Estaris, OWCP's medical adviser, after reviewing the examination findings of Dr. Boffman. OWCP

[4] Dr. Boffman noted that "range of motion was used for Class Assignment and cannot be used again for Range of Motion Impairment."

[5] The wording of OWCP's May 24, 2016 decision suggests that it was granting appellant a new schedule award for five percent permanent impairment of his right lower extremity, but appellant has only received schedule award compensation for five percent permanent impairment of his right lower extremity through the May 4, 2015 schedule award decision. Appellant received monies from that schedule award covering the period October 29, 2013 to February 6, 2014.

noted that the weight of the medical evidence regarding appellant's permanent impairment rested with the opinion of Dr. Estaris.

LEGAL PRECEDENT

The schedule award provision of FECA[6] and its implementing regulation[7] 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.[8] The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.[9]

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. For evaluation of the claimed impairment in this case, reference is made to Table 16-2 (Foot and Ankle Regional Grid) beginning on page 501.[10] After the class of diagnosis is determined from the Foot and Ankle Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The Net Adjustment Formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

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."[12] 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.[13] 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

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id*. *See also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (January 2010); *id*. Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (January 2010).

[9] *Id*. at Chapter 2.808.5a (February 2013); *see also id.* at Chapter 3.700, Exhibit 1 (January 2010).

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

[11] *Id.* at 515-21.

[12] 5 U.S.C. § 8123(a).

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

conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[14]

OWCP procedures provide that, if a case has been referred for a referee evaluation to resolve the issue of permanent impairment, it is appropriate for OWCP's medical adviser to review the calculations to ensure the referee physician appropriately used the A.M.A., *Guides*. It procedures further note that the Board has held that, while an OWCP medical adviser may review the opinion of a referee specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility. OWCP's medical adviser cannot resolve a conflict in medical opinion. If necessary, clarification to the referee examiner may be needed.[15]

ANALYSIS

OWCP accepted that on April 21, 2013 appellant sustained a sprain of unspecified sites of his right leg and knee and, on December 20, 2013, he filed a Form CA-7 claiming a schedule award due to his accepted work injury. In a decision dated May 4, 2015, it granted him a schedule award for five percent permanent impairment of his right leg. By decision dated October 23, 2015, the Board found that there was a conflict in the medical opinion evidence regarding the permanent impairment of appellant's right lower extremity between Dr. David, an attending physician, and Dr. Simpson, an OWCP medical adviser. It remanded the case to OWCP for referral of appellant to an impartial medical specialist for an examination and evaluation of the permanent impairment of his right lower extremity. On remand appellant was referred to Dr. Boffman for this purpose. By decision dated May 24, 2016, OWCP found that appellant had no more than five percent permanent impairment of his right lower extremity. The determination was based on the impairment rating calculated by Dr. Estaris, an OWCP medical adviser, after reviewing the examination findings of Dr. Boffman.

The Board finds that the case is not in posture for decision regarding whether appellant has more than five percent permanent impairment of his right lower extremity.

Appellant was properly referred to Dr. Boffman due to a conflict in the medical opinion evidence regarding the permanent impairment of his right lower extremity, as noted by the Board in its October 23, 2015 decision.[16] In a March 4, 2016 report, Dr. Boffman determined that appellant had total permanent impairment of his right lower extremity of six percent. He indicated that, using Table 16-2 (Foot and Ankle Regional Grid) on page 501 of the sixth edition of the A.M.A., *Guides*, appellant's right lower extremity condition should be considered under the diagnosis-based category relating to a strain, tendinitis, or history of a partially ruptured peroneus brevis tendon. Dr. Boffman noted that appellant's condition would fall under class 1 under Table 16-2, due to motion deficits, with a default value of five percent permanent impairment of the right lower extremity. With respect to grade modifiers, he referenced Table 16.6, Table 16.7, and Table 16-8 on pages 516 through 520 and indicated that appellant had a

[14] *R.S.*, Docket No. 08-1158 (issued January 29, 2009).

[15] *Supra* note 2 at Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.8k (September 2010); *Richard R. Lemay*, 56 ECAB 341 (2005).

[16] *See supra* notes 12 and 13.

GMFH of 1 due to a moderate problem, a GMPE of 1 due to a mild problem, and a GMCS of 2 due to a moderate problem (partial tear of the peroneus tendon). Dr. Boffman advised that application of the net adjustment formula yielded the result of +1 and meant that there was movement one space to the right of the default value of five percent permanent impairment on Table 16-2, *i.e.*, to the value of six percent permanent impairment.

Instead of evaluating whether the report of Dr. Boffman, the impartial medical specialist, constituted the special weight of the medical evidence with respect to permanent impairment, OWCP decided that the weight of the medical evidence rested with the May 14, 2016 report of Dr. Estaris, which contained an opinion that appellant had five percent permanent impairment of his right lower extremity. The difference between the impairment rating of Dr. Boffman and the impairment rating of Dr. Estaris was due to differing evaluations of the grade modifiers, particularly with regard to the GMCS. However, OWCP procedures and Board precedent provide that, while an OWCP medical adviser may review the opinion of a referee specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility and OWCP's medical adviser cannot resolve a conflict in medical opinion.[17]

In a situation where OWCP secures an opinion from an impartial medical examiner for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, OWCP has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[18] Therefore, the case shall be remanded to OWCP to provide Dr. Boffman an opportunity to provide clarification of his opinion that appellant has six percent permanent impairment of his right lower extremity under the standards of the sixth edition of the A.M.A., *Guides.* Dr. Boffman should explain each step of the impairment rating process, including providing rationale for his choice of grade modifiers, and application of the net adjustment formula.[19] After carrying out such development, OWCP shall issue a *de novo* decision regarding appellant's entitlement to schedule award compensation.

CONCLUSION

The Board finds that the case is not in posture for decision regarding whether appellant has more than five percent permanent impairment of his right lower extremity, for which he received a schedule award.

[17] *See supra* note 15.

[18] *Nancy Lackner (Jack D. Lackner),* 40 ECAB 238 (1988). *See also id.*

[19] *See supra* note 11.

ORDER

IT IS HEREBY ORDERED THAT the May 24, 2016 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: January 11, 2017
Washington, DC

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

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

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