United States Department of Labor
Employees' Compensation Appeals Board

C.H., Appellant	)	
and	)	**Docket No. 16-1806**
	)	**Issued: March 9, 2017**
DEPARTMENT OF LABOR, EMPLOYMENT & TRAINING ADMINISTRATION, Washington, DC, Employer	)	

Appearances:
Thomas Van Tiem, 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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On September 12, 2016 appellant filed a timely appeal from a March 22, 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.

[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.*

ISSUE

The issue is whether appellant has established that she has more than 10 percent right leg permanent impairment, for which she received a schedule award on December 16, 2014.

FACTUAL HISTORY

On July 12, 2005 appellant, then a 43-year-old office automation clerk, filed a traumatic injury claim (Form CA-1) alleging that she sustained injuries in the performance of duty on June 29, 2005. She reported that the heel of her right foot caught in a pavement crack, tearing ligaments in the right ankle. The case was accepted for the following conditions: right ankle sprain; right ankle and foot tenosynovitis; congenital planus, right foot; rupture of right Achilles tendon; other postoperative infection, right foot; open wound with complications, right foot; right sciatic nerve lesion; right tarsal tunnel syndrome; right lateral popliteal nerve lesions; and right plantar nerve lesion.

OWCP paid appellant wage-loss compensation commencing August 14, 2005. On January 24, 2007 appellant underwent triple arthrodesis fusion surgery on the right foot, performed by Dr. Paul Cooper, a Board-certified orthopedic surgeon. She returned to work at four hours per day in a light-duty position on October 3, 2011, and began full-time work as of July 1, 2013. By decision dated September 13, 2013, OWCP found appellant's actual wages fairly and reasonably represented her wage-earning capacity, and that appellant had no loss of wage-earning capacity.

With respect to permanent impairment, appellant submitted a June 15, 2014 report from Dr. Edward Magur, a Board-certified orthopedic surgeon. Dr. Magur provided a history and results on examination. He reported appellant "has a valgus position to her triple arthrodesis." Dr. Magur found that x-rays of the right foot and ankle demonstrate a completely healed triple arthrodesis, early degenerative change of multiple tarsometatarsal, and intertarsal joints, as well as grade 1 osteoarthritis of the right ankle with anterior osteophyte formation and joint space narrowing. The diagnoses were: continued lower extremity pain and dysfunction status post posterior tibial tendon rupture with multiple subsequent surgeries; osteoarthritis right ankle and right midfoot; and moderate grade hallux rigidus right great toe. Dr. Magur opined that appellant had 17 percent right foot permanent impairment under the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009) (hereinafter A.M.A., *Guides*). He identified Table 16-2, with a diagnosis of triple arthrodesis, and Class 2 (moderate problem) for "moderate valgus malalignment." Dr. Magur found the net adjustment was plus 1, for physical examination showing severe findings with significant calf atrophy, weakness, restricted motion, causalgia-type discomfort along the swat nerve distribution, numbness and burning pain along the tibial nerve distribution, and global weakness. He then noted, "It is customary in the District of Columbia and the State of Maryland to include the so-called Five Modifying Factors of pain, weakness, atrophy, loss of endurance, and loss of function. I would apportion the patient an additional 2 [percent] functional impairment for atrophy, 3 [percent] for loss of function, 2 [percent] for loss of endurance, and 2 [percent] for pain resulting in overall 26 [percent] lower extremity permanent partial disability rating."

OWCP requested that an OWCP medical adviser, Dr. Daniel Zimmerman, review the medical evidence. In a report dated July 8, 2015, Dr. Zimmerman wrote that the rating from Dr. Magur could not be accepted as there were no x-ray findings of a mild malalignment, as required by the A.M.A. *Guides* for a Class 2 impairment.[3]

Appellant was referred for a second opinion examination by Dr. Stuart Gordon, a Board-certified orthopedic surgeon. In a report dated September 18, 2014, Dr. Gordon provided a history and results on examination. He reported a neutral position of the hind foot with multiple scars. Dr. Gordon indicated that appellant's tendon appeared to be intact, the tibiotalar joint had full range of motion, with no motion in the subtalar region. He reported motor and sensory were intact, with no pain in the plantar fascial insertional area. Dr. Gordon noted that the fusion appeared to be solid at the triple arthrodesis site. He identified Table 16-2 and opined that appellant had 16 percent right leg impairment, for Class 2 triple arthrodesis. In addition, Dr. Gordon referred to Table 16-12, peripheral nerve impairments, and found one percent for sensory impairment and one percent for motor impairment.

In a report dated October 8, 2014, Dr. Zimmerman again found that Class 2 was not appropriate for the diagnosis of triple arthrodesis. He noted that for a neutral position Class 1 was proper, with a default impairment of 10 percent. Dr. Zimmerman opined the grade modifier for functional history was two, and for physical examination zero, resulting in no adjustment. With respect to peripheral nerve impairments, the medical adviser found this was inapplicable. He indicated that Dr. Gordon did not describe any weakness, sensory changes, or peripheral nerve-related pain complaints.

By decision dated December 16, 2014, OWCP issued a schedule award for 10 percent permanent impairment to the right leg. The period of the award was 28.80 weeks from September 18, 2014.

On January 13, 2015 appellant requested a hearing before an OWCP hearing representative. A hearing was held on April 21, 2015. Appellant's representative argued that OWCP should not have referred the case for a second opinion, but should have requested a clarifying report from Dr. Magur. He argued that x-rays were not required to show malalignment.

By decision dated July 28, 2015, the hearing representative vacated the December 16, 2014 decision and remanded the case for further development. She indicated that Dr. Gordon should provide clarification as to why he chose a class 2 impairment, and whether he agreed with the medical adviser that class 1 was proper under the A.M.A., *Guides*.

In a report dated August 8, 2015, Dr. Gordon wrote that "whi1e the claimant categorizes to class 1 due to the lack of malalignment, her case is much more complicated and, in my opinion, warrants elevation to class 2. In my opinion, class 1 would be reserved for a straightforward case with surgical intervention and routine follow up." Dr. Gordon noted

[3] Dr. Zimmerman referred to a report dated May 3, 2012 from Dr. Patrick Noel, a Board-certified orthopedic surgeon who was selected as a referee physician on the issue of continuing employment-related disability. Dr. Noel reported that x-rays showed the subtalar fusion was solid, with severe arthritis of the talonavicular joint.

appellant had soft tissue problems requiring multiple surgical debridements, concerns for infection, and multiple surgeries. He opined that, while appellant's case "does not fit the exact classification, with respect to alignment" it was a complex case and therefore class 2 was appropriate in his opinion.

Dr. Zimmerman provided a report dated August 31, 2015. He opined there was no basis for "bumping up" the severity of the class for a diagnosed condition because the case was complex. Dr. Zimmerman reiterated his opinion that the examination findings from Dr. Gordon established only a class 1 impairment for 10 percent, which was the right leg permanent impairment.

By decision dated October 1, 2015, OWCP found that appellant was not entitled to an increased schedule award. It found that the weight of the evidence was represented by OWCP's medical adviser.

On October 19, 2015 appellant requested a review of the written record. By decision dated March 22, 2016, the hearing representative affirmed the October 1, 2015 decision. He found that the weight of the medical evidence was represented by the rationalized opinion from OWCP's medical adviser.

LEGAL PRECEDENT

5 U.S.C. § 8107 provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[4] Neither FECA nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[5] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition.[6]

With respect to an ankle impairment, the A.M.A., *Guides* provides a regional grid at Table 16-2.[7] The class of impairment (CDX) is determined based on specific diagnosis, and then the default value for the identified CDX is determined. The default value (Grade C) may be adjusted by using grade modifiers for functional history (GMFH, Table 16-6), physical

[4] 5 U.S.C. § 8107. This section enumerates specific members or functions of the body for which a schedule award is payable and the maximum number of weeks of compensation to be paid. Additional members of the body are found at 20 C.F.R. § 10.404(a).

[5] *A. George Lampo*, 45 ECAB 441 (1994).

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

[7] A.M.A., *Guides*, 501-08, Table 16-2.

examination (GMPE, Table 16-7) and clinical studies (GMCS, Table 16-8). The adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[8]

ANALYSIS

OWCP issued a schedule award for 10 percent permanent impairment of the right leg on December 16, 2014. The Board finds that appellant has not established that she has more than the 10 percent permanent impairment of the right leg previously awarded.

The attending physician, Dr. Magur, identified Table 16-2 and the diagnosis of triple arthrodesis. Under this diagnosis, a class 2 impairment is described as follows: "mild malalignment (varus position, 1 degree to 3 degrees greater than opposite normal), or valgus five to nine inches of normal."[9] No other description is provided. Appellant's representative argues that Dr. Magur did describe in his findings a class 2 malalignment. While the Board has held that x-rays may not be the only basis for malalignment, there must be a clear description of the malalignment.[10] Dr. Magur reports only a "valgus position" with no other detail or explanation. The A.M.A., *Guides*, as noted, are quite specific in requiring five to nine inches from normal to assign class 2. It is unclear what specific valgus position Dr. Magur found, or other description of any malalignment. This is particularly important in view of the apparent lack of x-rays, and the findings of Dr. Gordon regarding a neutral position.

The Board accordingly finds that Dr. Magur's report was of diminished probative value with respect to Table 16-2. The additional impairments briefly mentioned with respect to the "five modifying factors" do not evaluate appellant's impairment from the A.M.A., *Guides* and do not establish an additional impairment.

Dr. Gordon's reports applied the diagnosis of triple arthrodesis and a class 2 impairment, however, in his August 14, 2015 report, Dr. Gordon clearly indicated that there was no evidence of malalignment. He was basing his classification on his opinion that the A.M.A., *Guides* would require such a classification for a "complex" case. There is no basis under Table 16-2, or anywhere in the A.M.A., *Guides*, for basing the diagnostic criteria on a general finding of the complexity of a case. Table 16-2 is quite specific: neutral position is a class 1 impairment.[11]

Dr. Gordon provided a brief reference to an additional one percent for sensory impairment and one percent for motor impairment under Table 16-12.[12] Without additional explanation, this opinion is of diminished probative value. The actual nerve affected is not identified by Dr. Gordon, and it is unclear how Table 16-12 was applied. Moreover, Dr. Gordon

[8] The net adjustment is up to +2 (Grade E) or -2 (Grade A).

[9] A.M.A., *Guides* 508.

[10] *S.B.*, Docket No. 13-0214 (issued August 15, 2013).

[11] A.M.A., *Guides* 508, Table 16-2.

[12] *Id.* at 534-36, Table 16-12.

provided no description in his report of a sensory or motor peripheral nerve impairment. His findings failed to describe weakness or sensory changes.

It is OWCP's medical adviser, Dr. Zimmerman, who provided the only medical opinion under the A.M.A., *Guides* supported by sound medical rationale.[13] He correctly indicates there was no probative evidence of a specific malalignment that would make the diagnostic criteria of class 2 an appropriate classification in the case. Dr. Gordon had reported neutral position, and Dr. Magur failed to explain his reference to "valgus position." A neutral position is a class 1 impairment, with a default (Grade C) impairment of 10 percent. OWCP's medical adviser found that there was no adjustment from the default value after applying the net adjustment formula noted above. He found that appellant had a grade modifier two for functional history under Table 16-6, and grade modifier zero for physical examination under Table 16-7.[14]

On appeal appellant's representative argues that OWCP should not have referred the case to a second opinion physician, without first seeking clarification from the attending physician. There is no evidence that OWCP violated its procedures in developing the evidence in this case. Appellant provided a report from Dr. Magur, and the case was referred to an OWCP medical adviser for review, in accord with OWCP procedures.[15] When the medical adviser properly indicated that the report was of diminished probative value, OWCP then referred the case for a second opinion examination. At any time appellant could have submitted an additional report from Dr. Magur.

Appellant's representative also argues there was a conflict in the medical evidence, but for the reasons discussed above, the medical reports from Dr. Magur and Dr. Gordon were of diminished probative value on the issue. When medical reports are of diminished probative value, there is no conflict in the medical evidence warranting referral to a referee physician.[16] The medical evidence was insufficient to create a conflict. The Board also notes that when an OWCP medical adviser provides a rationalized medical opinion, it can represent the weight of the medical evidence even if it is different from a second opinion or attending physician.[17]

Finally, appellant's representative argues that OWCP had improperly found that malalignment could only be established by x-rays, but, as the Board has discussed above, the deficiency in Dr. Magur's report was not simply that he did not refer to x-rays. If he was not relying on x-rays, there must be some explanation as to how the valgus malalignment was

[13] Medical rationale is a medically sound explanation for the opinion offered. *See Ronald D. James, Sr.*, Docket No. 03-1700 (issued August 27, 2003); *Kenneth J. Deerman*, 34 ECAB 641 (1983) (the evidence must convince the adjudicator that the conclusion drawn is rational, sound, and logical).

[14] The medical adviser did not use a clinical studies adjustment. A.M.A., *Guides* 518.

[15] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(e) (February 2013).

[16] *See Mary L. Henninger*, 52 ECAB 408 (2001).

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

determined, and specifically how it fell within the five to nine inches for class 2 under Table 16-2.[18]

For the reasons discussed, the Board finds that the weight of the medical evidence does not establish more than 10 percent right leg permanent impairment. OWCP properly determined that appellant was not entitled to an additional schedule award.

Appellant may request a schedule award or increase 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 established that she has more than 10 percent right leg permanent impairment for which she previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 22, 2016 is affirmed.

Issued: March 9, 2017
Washington, DC

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

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

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

[18] *Supra* note 10.