United States Department of Labor
Employees' Compensation Appeals Board

F.F., Appellant	)	
and	)	**Docket No. 17-1122**
	)	**Issued: November 2, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Schaumberg, IL, 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 May 1, 2017 appellant, through counsel, filed a timely appeal from a February 27, 2017 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 more than six percent permanent impairment of the right lower extremity, for which he previously received schedule awards.

[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 March 28, 2011 appellant, then a 57-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that he sustained a right ankle condition causally related to factors of his federal employment. He indicated on the claim form that he had rolled his right ankle on November 12, 2009, and he continued to work in pain as his condition worsened. Appellant reported that a February 8, 2011 magnetic resonance imaging (MRI) scan showed a tear in the right ankle tendon. He stopped work on February 15, 2011.

OWCP accepted the claim for right ankle sprain and chronic right peroneal tendinitis. Appellant began receiving wage-loss compensation on the supplemental rolls as of February 28, 2011. He received wage-loss compensation and medical benefits on the periodic rolls as of June 13, 2012.

Appellant underwent right ankle surgery on May 20, 2011. In a report of that date, Dr. Mary Morrell, a Board-certified orthopedic surgeon, indicated that the surgery included right peroneal tendon debridement and repair.

As part of the medical development of the case, OWCP referred appellant to Dr. Allan Brecher, a Board-certified orthopedic surgeon for a second opinion evaluation. In a report dated July 10, 2012, Dr. Brecher opined that it appeared that appellant's peroneal tendinitis had resolved, but he continued to have foot pain which appeared to be plantar fasciitis and fifth metatarsal inflammation.

In a report dated January 3, 2013, Dr. Morrell diagnosed status post right peroneal tendon repair, right foot pain, and possible diabetic neuropathy versus stress fracture. She opined that appellant remained disabled from work.

OWCP determined that there was a conflict in the medical evidence between Drs. Morrell and Brecher, and referred appellant to Dr. Michael Pinzur, a Board-certified orthopedic surgeon, to resolve the conflict. In an April 23, 2013 report, Dr. Pinzur opined that appellant likely had a preexisting cavus deformity that made him prone to developing peroneal tendon disease. He wrote that it was reasonable to assume appellant rolled his ankle as described. Dr. Pinzur indicated some of the right foot pain was related to the peroneal tendon injury and repair, and some was due to mechanical overloading from the preexisting cavus deformity. He opined that it was unlikely appellant could perform his date-of-injury job, and he suspected this disability was permanent.

The record indicates that on April 16, 2014 appellant accepted an offer for a full-time modified job at the employing establishment.

In a report dated July 3, 2014, Dr. Neil Allen, a Board-certified internist, provided a history and results on examination. He reported a stiff gait, limitations on right ankle range of motion (ROM), and tenderness along the lateral aspect of the right foot. Dr. Allen indicated that there was no instability or weakness. As to permanent impairment, he opined that appellant had seven percent right lower extremity permanent impairment. Dr. Allen indicated that he applied Table 16-2 of the American Medical Association, *Guides to the Evaluation of Permanent*

Impairment (A.M.A. *Guides*),[3] which provides a default lower extremity permanent impairment rating of five percent. He then adjusted the default permanent impairment rating to seven percent, based on grade modifiers for physical examination, functional history, and clinical studies.

OWCP referred the case to Dr. Michael Hellman, a Board-certified orthopedic surgeon and OWCP medical adviser, for review. In a report dated August 19, 2014, Dr. Hellman opined that appellant's right lower extremity permanent impairment was one percent under Table 16-2. He noted that as appellant had peroneal tendon tear, which required repair on May 20, 2011, "his diagnosis is best described as having some mild palpatory findings." Dr. Hellman opined that the default lower extremity permanent impairment rating for the diagnosed condition was one percent, because mild motion deficits had not been established, As to grade modifiers, he found that clinical studies was not applicable, as this was used to establish the diagnosis. Dr. Hellman found a grade modifier of one was proper for functional history as appellant had no motion deficit, and a grade modifier of one for physical examination due to mild pain over the peroneal tendons, resulting in no adjustment from the default one percent.

By decision dated October 6, 2014, OWCP issued a schedule award for one percent right lower extremity permanent impairment. The period of the award was 2.88 weeks from May 13, 2014.

Appellant, through counsel, requested a hearing before an OWCP hearing representative on October 10, 2014. A hearing was held on May 6, 2015. On July 6, 2015 appellant submitted an undated addendum report from Dr. Allen, who again opined that appellant had seven percent right lower extremity permanent impairment. He found that appellant did have mild motion deficits based on his physical examination.

In a decision dated July 6, 2015, the hearing representative set aside the October 6, 2014 OWCP decision. He directed OWCP to refer appellant for a second opinion examination with respect to a right lower extremity permanent impairment.

OWCP referred appellant to Dr. James Elmes, a Board-certified orthopedic surgeon. In a report dated October 22, 2015, Dr. Elmes provided a history, results on examination, and review of medical records. He indicated that appellant had medial anterolateral tenderness about the right ankle, and he provided ROM testing results. Dr. Elmes diagnosed torn peroneal tendon, chronic right peroneal tendinitis, right ankle sprain, and depressive disorder. As to permanent impairment, he opined that appellant had six percent right lower extremity permanent impairment under Table 16-2. Dr. Elmes diagnosed peroneal tendinitis with mild motion deficits, with a default permanent impairment rating of five percent. He used grade modifier two for functional history, and one for physical examination. The clinical studies were found to be not applicable, as they were used in making the diagnosis. The default permanent impairment rating of five percent was adjusted to six percent based on the grade modifiers.

The case was referred to another OWCP medical adviser, Dr. Morley Slutsky, Board-certified in occupational medicine. In a report dated March 15, 2016, Dr. Slutsky opined that

[3] 6th ed. 2009.

appellant's right lower extremity permanent impairment was five percent under Table 16-2. He found there would be no adjustment from the default of five percent, as he found a functional history grade modifier of one, rather than two as provided by Dr. Elmes. Dr. Slutsky also noted that under a ROM approach appellant would have 11 percent right lower extremity permanent impairment. He indicated that ROM was primarily used as a physical examination adjustment factor, and the diagnosis-based impairment (DBI) method was preferred under the A.M.A., *Guides*.

By decision dated May 24, 2016, OWCP issued an additional schedule award for five percent right lower extremity permanent impairment. The period of the award was 14.40 weeks from October 22, 2015.

On June 3, 2016 appellant, through counsel, requested a hearing before an OWCP hearing representative. During the hearing, held on January 23, 2017, counsel argued that Dr. Slutsky had referred to a rating of 11 percent permanent impairment, and case should therefore be further developed.

By decision dated February 27, 2017, the hearing representative affirmed the May 24, 2016 decision. She found the medical evidence of record did not establish greater than five percent permanent impairment of appellant's right lower extremity.

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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* 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 a foot or ankle impairment, the A.M.A., *Guides* provides a regional grid at Table 16-2.[7] The Class of Diagnosis (CDX) impairment is determined based on specific diagnosis, and then the default value for the identified CDX is determined.[8] The default value (grade C) may be adjusted by using grade modifiers for Functional History (GMFH, Table 16-6),

[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] FECA Bulletin No. 09-03 (March 15, 2009).

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

[8] The CDX ranges from 0 (n problem) to 4 (very severe problem).

Physical Examination (GMPE, Table 16-7), and Clinical Studies (GMCS, Table 16-8). The adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[9]

ANALYSIS

OWCP has accepted appellant's conditions of right ankle sprain and chronic right peroneal tendinitis as employment related. With respect to right lower extremity permanent impairment, appellant submitted a report dated July 3, 2014 from Dr. Allen, and an undated supplemental report from Dr. Allen. According to Dr. Allen appellant had seven percent right lower extremity permanent impairment under Table 16-2 of the A.M.A., *Guides*.

The Board notes that all of the physicians in this case have applied Table 16-2, the DBI regional grid for the foot and ankle. Counsel argued during the January 23, 2017 hearing that Dr. Slutsky, an OWCP medical adviser, had found 11 percent permanent impairment based on loss of ankle ROM. However, Dr. Slutsky did not opine that appellant had 11 percent right lower extremity permanent impairment under the A.M.A., *Guides* using the ROM method. Rather he actually applied Table 16-2 and found five percent permanent impairment using the DBI method. The A.M.A., *Guides* clearly provide that the DBI method is the primary method of evaluation for the lower extremities.[10] ROM is used to determine impairment values only when it is not possible to otherwise define impairment.[11] The physicians in this case properly used the DBI method to evaluate appellant's right lower extremity permanent impairment.

Drs. Allen, Elmes, and Slutsky agreed that for peroneal tendinitis, with mild motion deficits, the default (class 1, grade C) lower extremity permanent impairment is five percent under Table 16-2. The grade C impairment may then be adjusted according to the net adjustment formula. Dr. Allen adjusted the permanent impairment to a grade E impairment of seven percent. He did not provide a reasoned opinion with respect to the grade modifiers applied. For example, for clinical studies adjustment, Dr. Allen referred to Table 17-9, which is for the spine, not the lower extremities.[12] FECA does not provide for a schedule award for impairment to the back or to the body as a whole.[13]

The proper table for the lower extremities clinical studies adjustment is Table 16-8.[14] Moreover, Dr. Elmes and Dr. Slutsky found that a clinical studies adjustment was not applicable, as clinical studies were used to determine the diagnosis. If a grade modifier is used for the primary placement in the regional grid, it is not used again in the impairment calculation.[15]

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

[10] A.M.A., *Guides* 497.

[11] *Id.*

[12] *Id*. at 581, Table 17-9.

[13] *See James E. Jenkins*, 39 ECAB 860 (1988); 5 U.S.C. § 8101(20).

[14] A.M.A., *Guides* 519, Table 16-8.

[15] *Id.* 515-16.

Dr. Allen does not address the issue. Moreover, he found a grade modifier two for physical examination based on moderate palpatory findings. Dr. Allen also noted stability, and lack of atrophy, which under Table 16-7 is a grade modifier zero.[16] He did not clearly explain why a grade modifier two was appropriate.

The Board finds that Dr. Elmes provided a rationalized medical opinion with respect to the net adjustment. Dr. Elmes explained that clinical studies were not applicable, as noted above. He found that grade modifier 1 (mild problem) was established under Table 16-7 based on the physical examination. As to functional history, Dr. Elmes found a grade modifier 2 under Table 16-6. While Dr. Slutsky felt it was a grade modifier one, Dr. Elmes explained that he was applying the AAOS (American Academy of Orthopedic Surgery) Lower Limb Instrument results. Under Table 16-6, Dr. Elmes may use the AAOS Lower Limb Instrument in establishing the GMFH.[17]

Based on the evidence of record, the Board finds that the weight of the evidence is represented by Dr. Elmes, who found six percent right lower extremity permanent impairment. The Board notes that appellant has previously received schedule awards totaling six percent permanent impairment. OWCP issued a schedule award for one percent (2.88 weeks) on October 6, 2014, and an additional five percent (14.40 weeks) on May 24, 2016. Appellant has received 17.28 weeks of compensation, or six percent of the maximum of 288 weeks for the lower extremity under 5 U.S.C. § 8107. Since the weight of the medical evidence established six percent right lower extremity permanent impairment, the Board finds appellant has not established entitlement to an increased schedule award.

On appeal counsel argues that the case should be remanded under *T.H.*[18] However, *T.H.* was a case involving the upper extremities and the methods of evaluating upper extremity permanent impairment. This case involves the lower extremities, and as noted, all of the physicians properly followed the provisions of the A.M.A., *Guides* and used the DBI method in evaluating the permanent impairment.

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.[19]

CONCLUSION

The Board finds appellant has not established more than six percent permanent impairment of the right lower extremity permanent for which he previously received schedule awards.

[16] *Id*. at 517, Table 16-7.

[17] *Id*. at 516, Table 16-6.

[18] Docket No. 14-0943 (issued November 25, 2016).

[19] *See Linda T. Brown*, 51 ECAB 115 (1999).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 27, 2017 is affirmed.

Issued: November 2, 2017
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