United States Department of Labor
Employees' Compensation Appeals Board

P.R., Appellant	)	
and	)	**Docket No. 18-0022**
	)	**Issued: April 9, 2018**
DEPARTMENT OF TRANSPORTATION, FEDERAL AVIATION ADMINISTRATION, Oklahoma City, OK, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 2, 2017 appellant filed a timely appeal from a September 12, 2017 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 25 percent permanent impairment of his right lower extremity, for which he previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On November 19, 1998 appellant, then a 49-year-old material handler, filed a traumatic injury claim (Form CA-1) alleging that on November 18, 1998 he sustained a right ankle injury at work. He claimed that he was standing on a "Big Joe" pallet jack that was driven by a coworker. The Big Joe moved forward and appellant fell approximately 10 feet. Appellant stopped work on the date of injury.

OWCP accepted the claim for right ankle fracture and a left calcaneus fracture. It authorized an open reduction and internal fixation of the fractured left calcaneus performed on November 30, 1998. OWCP paid appellant compensation benefits on the supplemental rolls effective January 17, 1999.

On February 1, 1999 appellant returned to limited-duty work. On February 19, 1999 he underwent authorized irrigation and debridement with attempted secondary closure ulceration of the left heel. Appellant returned to full-time, limited-duty work on April 26, 1999. He stopped work again on June 10, 1999 due to a wound infection and received compensation benefits on the daily rolls. On July 19, 1999 appellant returned to full-time, limited-duty work.

By decision dated January 28, 2000, OWCP terminated appellant's wage-loss compensation benefits effective January 4, 2000 as his actual wages as a supply technician fairly and reasonably represented his wage-earning capacity.[2] It explained that these wages either met or exceeded the wages of his date-of-injury position. Medical benefits continued.

By decision dated February 24, 2000, OWCP granted appellant a schedule award for 25 percent permanent impairment of each lower extremity. The schedule award was paid during the period January 21, 2000 to October 25, 2002, for a total of 144 weeks of compensation.

On February 15, 2016 appellant underwent subtalar and talonavicular fusions and arthroscopy of the right ankle performed by Dr. Richard Langerman, Jr., a Board-certified orthopedic surgeon. Dr. Langerman noted preoperative diagnoses of talonavicular and subtalar arthrosis with possible right ankle arthrosis. He noted postoperative diagnoses included moderate right ankle arthrosis with advanced talonavicular and subtalar arthritis.

On February 13, 2017 appellant filed a claim for an additional schedule award (Form CA-7).

By development letter dated February 22, 2017, OWCP requested that appellant submit additional medical evidence in support of his schedule award claim, including an impairment rating, which applied the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] It afforded appellant 30 days to submit the requested information.

[2] Appellant voluntarily retired from the employing establishment effective December 28, 2012.

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

In an April 26, 2017 medical report, Dr. John W. Ellis, a Board-certified family practitioner, related a history of the November 18, 1998 employment injury and appellant's medical background. He reviewed medical records, including diagnostic test results. Dr. Ellis noted appellant's complaints related to his right ankle. A Bragard's sign could not be done because of the fusion of the right ankle. Pressure on the tarsal tunnels did not cause any numbness in the feet. The right ankle had surgical scars and was fused in a position of function. There was hypertrophy of the bones of the medial and lateral malleoli and anteriorly and posteriorly in the ankle. Appellant walked with an antalgic gait due to the fused right ankle. There was no swelling over the ankles. Appellant wore a brace on his right ankle. He reported that above the brace, he sometimes had swelling where the sock ended. Dr. Ellis found no pitting edema in the feet. He diagnosed secondary osteoarthritis of the right ankle and foot, chondromalacia of the right ankle and joints of the right foot, and fracture of the right ankle. Dr. Ellis opined that, based on his examination, review of the medical and other records, appellant's impairment arose out of and in the course of appellant's employment. He determined that appellant had reached maximum medical improvement (MMI) as of April 13, 2017, the date Dr. Langerman referred appellant for an impairment evaluation. Thus, Dr. Ellis advised that appellant could be rated for permanent partial impairment.

Regarding impairment of the right lower extremity, Dr. Ellis utilized Table 16-2 on page 507 of the sixth edition of the A.M.A., *Guides*, and found 50 percent diagnosis-based impairment (DBI) due to subtalar and talonavicular fusions of the ankle. Under Table 16-22 on page 549, he found 37 percent impairment due to decreased range of motion (ROM) of the ankle. Dr. Ellis utilized Table 16-20 on the same page and found 10 percent impairment due to decreased range of motion of the hindfoot. He added the ROM impairment ratings for a total 47 percent impairment. Dr. Ellis used the Combined Values Chart to combine the 37 percent and 10 percent ROM impairment ratings to find 43 percent total combined impairment. He concluded that appellant had 50 percent permanent impairment of the right lower extremity based on the DBI method. Dr. Ellis noted Table 2-1, No. 12 on page 20, which indicated that the method producing the higher rating should be used.

On June 5, 2017 Dr. Arthur S. Harris, an OWCP medical adviser and a Board-certified orthopedic surgeon, reviewed the medical record, and Dr. Ellis' April 26, 2017 findings. He also noted appellant's February 15, 2016 right ankle arthroscopy with subtalar and talonavicular fusion, which documented arthroscopic findings of grade 2 to 3 degenerative changes in the tibiotalar joint. Dr. Harris related that a September 7, 2016 right ankle computerized tomography scan demonstrated degenerative changes in the ankle with postsurgical changes in the subtalar joint. In determining impairment to appellant's right lower extremity, he used Table 16-2 on page 508 of the sixth edition of the A.M.A., *Guides* and found 13 percent impairment due to a satisfactory result following right ankle arthroscopy with subtalar and talonavicular fusion (CDX 1E). Dr. Harris further found, under Table 16-2 on page 506, three percent impairment based on documented degenerative changes of the ankle. He utilized the Combined Values Chart and combined the two impairment ratings to calculate 16 percent right lower extremity permanent impairment. Dr. Harris related that the A.M.A., *Guides* did not allow for impairment ratings to be calculated on the ROM method for the diagnosed condition. He maintained that appellant had 16 percent impairment of the right lower extremity resulting from the accepted November 18, 1998 work injury. Dr. Harris determined that the date of MMI was April 26, 2017, the date of Dr. Ellis' impairment evaluation. He disagreed with Dr. Ellis' impairment rating as it was based on the

ROM method. Dr. Harris related that the A.M.A., *Guides* provides that the DBI method was the preferred rating method. He further related that the A.M.A., *Guides* provides that the ROM method was used primarily as a physical examination adjustment factor and only to determine actual impairment values in the rare case when it was not possible to otherwise define impairment. Dr. Harris indicated that, as discussed in his review, appellant's impairment was easily defined using the DBI method for having undergone talonavicular and subtalar fusions, as well as, documented degenerative joint disease of the ankle.

By decision dated September 12, 2017, OWCP denied appellant's claim for an additional schedule award. It based its determination on Dr. Harris' June 5, 2017 report which evaluated the April 26, 2017 findings of Dr. Ellis relative to appellant's right lower extremity.[4]

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing federal regulations[6] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members, functions, and organs of the body. FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[7] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[8] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[9] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[10] It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments are to be included.[11]

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

[4] OWCP noted that appellant had previously received a schedule award for his right and left lower extremities.

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[8] *Id.*

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

[10] *Isidoro Rivera*, 12 ECAB 348 (1961).

[11] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); *supra* note 7 at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.a.3 (January 2010). This portion of OWCP procedures provides that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

and Health (ICF).[12] Under the sixth edition, the evaluator identifies the impairment class for the Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14]

OWCP 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.[15]

ANALYSIS

The Board finds that this case is not in posture for decision.

OWCP accepted appellant's claim for right ankle fracture and a left calcaneus fracture. It authorized an open reduction and internal fixation of the fractured left calcaneus performed on November 30, 1998. OWCP granted appellant a schedule award for 25 percent permanent impairment of each lower extremity. Appellant underwent an arthroscopy of the right ankle with subtalar and talonavicular fusion on February 15, 2016. On February 13, 2017 he filed a claim for an increased schedule award.

In an April 26, 2017 report, Dr. Ellis, an attending physician, utilized the DBI method for rating appellant's permanent impairment and identified the diagnosis of subtalar and talonavicular ankle fusion on page 507 of the A.M.A., *Guides*. He opined that, under Table 16-2 of the sixth edition of the A.M.A., *Guides*, appellant had 50 percent permanent impairment of the right lower extremity. The Board notes that while Dr. Ellis also rated appellant's right lower extremity impairment using ROM methodology, he ultimately concluded that appellant's impairment should be rated using Table 16-2, page 507, for the diagnosis of joint ankylosis fusion, of the talar-calcaneal, talar-navicular.

In a June 5, 2017 report, Dr. Harris, an OWCP medical adviser, similarly utilized the DBI method, but identified the diagnosis of subtalar and talonavicular ankle fusion on page 508 of the A.M.A., *Guides*. He utilized Table 16-2 of the sixth edition of the A.M.A., *Guides* and found 13 percent impairment due to a satisfactory result following surgery. Dr. Harris further found, under Table 16-2 on page 506, three percent impairment based on documented degenerative changes of the ankle. He utilized the Combined Values Chart and combined the two impairment ratings to find that appellant had 16 percent permanent impairment of the right lower extremity.

[12] A.M.A., *Guides* (6th ed. 2009), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

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

[14] *Id.* at 521.

[15] *See supra* note 7 at Chapter 2.808.6(f) (February 2013).

The Board finds that there is an unresolved conflict as to the impairment related to appellant's right lower extremity between Dr. Ellis and Dr. Harris based upon the proper diagnosis utilized within Table 16-2. The Board notes that both utilized the DBI methodology, but relied upon different diagnoses classifications for appellant's condition. If there is disagreement between OWCP's medical adviser and appellant's physician, OWCP will appoint a third physician who shall make an examination.[16] For a conflict to arise, the opposing physicians' viewpoints must be of virtually equal weight and rationale.[17] The Board finds that the two medical opinions of Dr. Ellis and Dr. Harris are of equal weight. The dispute between these physicians centers on their use of Table 16-2, which ostensibly supported their respective opinions. Accordingly, there was an unresolved conflict in medical opinion regarding the extent of appellant's right lower extremity impairment.

Because there is an unresolved conflict in medical opinion regarding the extent of appellant's right lower extremity impairment, pursuant to 5 U.S.C. § 8123(a), the case will be remanded to OWCP for referral of appellant, together with the medical record and a statement of accepted facts, to an appropriate Board-certified specialist for an impartial medical examination to determine the extent and degree of appellant's right lower extremity permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*. After such further development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision.

[16] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

[17] *Darlene R. Kennedy*, 57 ECAB 414 (2006).

ORDER

IT IS HEREBY ORDERED THAT the September 12, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: April 9, 2018
Washington, DC

Christopher J. Godfrey, 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