



## ISSUE

The issue is whether appellant has greater than 20 percent permanent impairment of the right lower extremity for which he previously received schedule award compensation.<sup>3</sup>

## FACTUAL HISTORY

This case has previously been before the Board.<sup>4</sup> The facts and circumstances as set forth in the prior Board decisions are incorporated herein by reference. The relevant facts are as follows.

On March 12, 2007 appellant, then a 55-year-old supervisor of customer service, filed an occupational disease claim (Form CA-2) alleging that he sustained exacerbation of a foot deformity and torn right knee meniscus due to factors of his federal employment. He noted that he first became aware of his claimed condition on May 18, 2000 and that it was related to his federal employment on December 14, 2006. OWCP assigned the present claim File No. xxxxxx373 and accepted it for right lower extremity conditions of aggravation of preexisting diabetic neuropathy, right flatfoot, arthropathies associated with neurological disorders, and tear of the medial meniscus of the knee.

Appellant also has a prior relevant OWCP claim under File No. xxxxxx316. On October 4, 2004 appellant, then a 52-year-old distribution window clerk, filed a traumatic injury claim (Form CA-1). OWCP accepted the claim for lumbar sprain and thoracic or lumbosacral neuritis or radiculitis. Its File Nos. xxxxxx373 and xxxxxx316 have been administratively combined, with File No. xxxxxx373 serving as the master file.<sup>5</sup>

Appellant filed a claim for a schedule award (Form CA-7) on December 15, 2006 under OWCP File No. xxxxxx316. OWCP granted him a schedule award on January 16, 2007 for four percent permanent impairment of each lower extremity. It denied modification of this schedule award by decision dated July 26, 2007. Appellant subsequently requested reconsideration. On March 7, 2008 OWCP denied modification of its July 26, 2007 decision.

Appellant appealed to the Board. By decision dated January 14, 2009, the Board found that he had not established more than four percent permanent impairment of each lower extremity due to spinal nerve impairment.<sup>6</sup>

On October 19, 2009 appellant filed a claim for an increased schedule award.

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<sup>3</sup> Appellant's left lower extremity permanent impairment rating is not the subject of this appeal.

<sup>4</sup> Docket No. 08-1744 (issued January 14, 2009); Docket No. 13-2072 (issued September 19, 2014).

<sup>5</sup> The record also reflects that appellant also has a third claim, adjudicated by OWCP under File No. xxxxxx902, and accepted for bilateral carpal tunnel syndrome. File No. xxxxxx902 has not been administratively combined with appellant's other two claims and is not a part of this appeal.

<sup>6</sup> Docket No. 08-1744 (issued January 14, 2009).

By decision dated February 19, 2010, OWCP granted appellant a schedule award for an additional 9 percent permanent impairment, for a total of 13 percent permanent impairment of the right lower extremity.

After further development of the medical evidence, OWCP expanded acceptance of the claim to include aggravation of Charcot's arthropathy and tear of medial meniscus of the right knee. On November 10, 2010 it granted appellant a schedule award for an additional 7 percent permanent impairment, for a total of 20 percent permanent impairment of the right lower extremity.

On September 12, 2013 appellant appealed to the Board. By decision dated September 19, 2014, the Board concluded that a conflict in the medical evidence remained regarding appellant's lower extremity impairment. The Board remanded the case to OWCP to prepare a new statement of accepted facts and forward the case record to a new impartial medical specialist.<sup>7</sup>

On March 12, 2015 OWCP referred appellant to Dr. Donald F. Leatherwood, II, a Board-certified orthopedic surgeon, for an impartial evaluation.<sup>8</sup>

In an April 21, 2015 report, Dr. Leatherwood noted his review of the medical record and appellant's report of the employment-related conditions and complaints of stabbing low back pain that radiated down both legs, a throbbing right knee and foot, with difficulty walking and standing. He described examination findings of the lumbar spine and both lower extremities. Dr. Leatherwood performed an impairment evaluation using the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter the A.M.A., *Guides*),<sup>9</sup> and advised that he found no employment-related neurologic deficit in appellant's lower extremities and no ongoing radicular issues of an objective nature. He noted electromyography (EMG) findings claiming to show radicular issues and opined that EMGs were notoriously subjective on the part of the practitioner and were historical in nature whereby a person could be fully recovered from a neurologic issue yet the EMG could remain positive for several years or even forever. Dr. Leatherwood indicated that he found no left lower extremity impairment of any kind. With regard to appellant's right knee, he noted that, under Table 16-3, Knee Regional Grid, a maximum partial meniscal injury yielded three percent impairment. Dr. Leatherwood noted that appellant's right knee magnetic resonance imaging (MRI) scan demonstrated no cartilage deficit, but, since the condition had been accepted, he found an additional five percent impairment. He noted that, under Table 16-23, Knee Motion Impairments, appellant's loss of knee range of motion yielded 10 percent impairment. Dr. Leatherwood concluded that, as range of motion yielded the higher rating, appellant had 10 percent right lower extremity impairment of the knee. As to the right ankle and foot, for loss of range of motion under Table 16-20 and Table 16-22, appellant had 12 percent impairment and that under Table 16-2, Foot and Ankle Regional Grid, for metatarsal fracture-dislocation, he had a class 2, 16 percent impairment, which was greater than 12 percent based on range of motion. Dr. Leatherwood then combined the 10 percent knee impairment with

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<sup>7</sup> *Supra* note 5.

<sup>8</sup> The record includes an OWCP ME023 appointment schedule notification form and a bypass log.

<sup>9</sup> A.M.A., *Guides* (6<sup>th</sup> ed. 2009).

the 16 percent foot impairment, and concluded that appellant had 24 percent right lower extremity impairment.

In a July 15, 2015 report, Dr. Arnold Berman, a Board-certified orthopedic surgeon serving as OWCP's medical adviser, noted that he had previously reviewed this case. He reviewed Dr. Leatherwood's report and agreed that appellant was not entitled to an additional schedule award for left lower extremity. Dr. Berman also agreed with Dr. Leatherwood that appellant had a total 24 percent right lower extremity impairment.

By decision dated September 8, 2015, OWCP granted appellant a schedule award for an additional 4 percent permanent impairment of the right lower extremity, for a total of 24 percent permanent impairment of the right lower extremity.

On September 16, 2015 appellant requested a hearing before an OWCP hearing representative. By decision dated March 30, 2016, an OWCP hearing representative remanded the case to OWCP. She found that OWCP did not direct Dr. Leatherwood to obtain x-rays of appellant's right foot, ankle, and knee. The hearing representative further found that Dr. Leatherwood did not sufficiently document his range of motion measurements or his assignment of class or grade modifiers to support his impairment ratings. She noted that OWCP did not advise Dr. Leatherwood to use *The Guides Newsletter* to assess appellant's lower extremity impairment caused by spinal injury, and that he failed to provide sufficient rationale to support his opinion that the EMG and nerve conduction velocity (NCV) findings were not reliable in this case. The hearing representative remanded the case to OWCP to refer appellant for reexamination by Dr. Leatherwood, to obtain the foot, ankle, and knee x-rays, and to provide an impairment analysis in accordance with the A.M.A., *Guides*, including the July/August 2009 *The Guides Newsletter*. Following this, OWCP was to refer the referee's report to an OWCP medical adviser other than Dr. Berman for review, to be followed by a *de novo* decision as to the degree of appellant's lower extremity permanent impairment.

Appellant submitted standing anteroposterior, oblique, and lateral view x-rays of the right foot and ankle dated April 6, 2016. The right foot demonstrated progression of neuropathic joint disease in the mid-foot with sclerosis, osteophytosis, and deformity which had progressed from a December 12, 2006 study. *Pes planus* was again seen. The right ankle showed only minimal degenerative disease. Anteroposterior, lateral, anteroposterior tunnel, and patellar sunrise views of the right knee on April 6, 2016 demonstrated chondrocalcinosis, as seen on May 8, 2013 films, and mild degenerative change. An EMG/NCV study of the lumbar paraspinals and both lower extremities on April 14, 2016 demonstrated many denervation potentials compatible with severe bilateral L4-5 lumbar radiculopathy. Prolonged peroneal, tibial, and sural nerve conduction velocities in both lower extremities suggested superimposed polyneuropathy.

OWCP again referred appellant to Dr. Leatherwood for examination and an impairment evaluation in accordance with the A.M.A., *Guides*, including its July/August 2009 *The Guides Newsletter*. In a July 19, 2016 report, Dr. Leatherwood noted his review of actual x-rays, and appellant's report of sciatic pain down both legs, and right knee, foot, and ankle pain. Physical examination demonstrated chronic changes to suggest vascular insufficiency of a mild-to-moderate nature. Light touch sensation was intact throughout, and motor strength was 5/5 for all major motor groups of both lower extremities. Straight leg raise testing was negative bilaterally.

Examination of appellant's right ankle and foot revealed obvious chronic valgus deformity. The ankle was stable to varus and valgus stress with tenderness in the area of the lateral joint line. The foot and medial aspect were nontender. The right knee demonstrated no synovitis, effusion, or instability with tenderness in the lateral joint line greater than the medial joint line. The patella was nontender and tracking appropriately, and the knee had normal stability to varus and valgus stress, negative Lachman testing.

Dr. Leatherwood noted his review of the actual April 6, 2016 x-ray films of appellant's right foot, ankle, and knee. He indicated that right foot x-rays demonstrated sclerotic changes and bone atrophy primarily at the area of the midfoot with *pes planus* and spurring. Right ankle x-ray showed minimal degenerative disease, and right knee x-ray demonstrated general degenerative changes throughout. Dr. Leatherwood also reviewed the March 18, 2010 lumbosacral MRI scan. He indicated that it revealed degenerative disc disease throughout with degenerative disc protrusion at L2-3, L3-4, and L4-5. Dr. Leatherwood also noted the findings of the April 14, 2016 EMG/NCV. He advised that, in accordance with Proposed Table 2 of the July/August 2009 *The Guides Newsletter*, appellant had mild sensory deficits at L3, L4, L5, and S1 based on subjective complaints and EMG/NCV findings. Dr. Leatherwood concluded that appellant had one percent permanent impairment for each nerve root, for a total four percent lower extremity impairment, which correlated with the previously awarded schedule award for appellant's lower extremity impairment due to his lumbar spine injury. He also found an additional one percent impairment utilizing Table 17-4, Lumber Spine Regional Grid. Regarding appellant's right knee, Dr. Leatherwood indicated that appellant had full right knee motion, but that in his previous examination appellant had decreased motion. He noted that the right knee x-ray demonstrated no loss of cartilage, and found that, under Table 16-3, appellant had 3 percent impairment for the meniscus and 5 percent impairment for the patella, for 8 percent total but, based of appellant's previous loss of knee motion, he would give appellant the benefit of the doubt and found 10 percent right lower extremity permanent impairment due to loss of right knee motion. For the right foot and ankle, Dr. Leatherwood indicated that, under Table 16-2, for a diagnosis of metatarsal fracture dislocation, appellant had 16 percent right foot and ankle impairment. By using the Combined Values Chart, he concluded that appellant's 10 percent knee impairment combined with 16 percent foot and ankle impairment, yielded 24 percent impairment, combined with 4 percent neurological impairment for a total 27 percent permanent impairment of the right lower extremity.

OWCP referred the record to Dr. Michael M. Katz, a Board-certified orthopedic surgeon and OWCP medical adviser, for review. In an August 22, 2016 report, Dr. Katz noted his review of Dr. Leatherwood's April 21, 2015 and July 19, 2016 reports. He advised that, while Dr. Leatherwood reviewed and documented pertinent history and diagnostic reports and performed a focused physical examination addressing the accepted conditions, he did not properly apply the methodology set forth in the A.M.A., *Guides*. Dr. Katz explained that Dr. Leatherwood did not describe the methodology of determining his net adjustment in assessing spinal nerve and right ankle impairment.

On August 25, 2016 OWCP forwarded a copy of Dr. Katz's report to Dr. Leatherwood for review and comment. It asked that he provide further explanation of his impairment assessment, in accordance with the procedures found in the A.M.A., *Guides*.

In a September 8, 2016 report, Dr. Leatherwood advised that for the right foot and ankle, the process seen in the metatarsal joint (fracture dislocation) was the single diagnostic key factor. He utilized this diagnosis under Table 16-2 and reiterated that appellant had a class 2, 16 percent impairment of the right foot and ankle. With regard to lower extremity impairments due to the lumbar spine injury, Dr. Leatherwood indicated that, when he performed his second examination, it was his impression that EMG/NCV study date was to be taken into consideration and used for the evaluation. He advised that, upon further review, it appeared that EMG data did not need to be used in calculating impairment if it was at odds with clinical examination as in appellant's case. Dr. Leatherwood found that, based on the fact that appellant had clinically intact neurological examination on both of his evaluations, he had no impairment due to the lumbar spine injury.

OWCP referred Dr. Leatherwood's September 8, 2016 report to Dr. Katz for review. In a September 21, 2016 report, Dr. Katz noted the accepted conditions and analyzed Dr. Leatherwood's April 21, 2015, July 19, and September 18, 2016 reports. OWCP's medical adviser opined that Dr. Leatherwood properly reviewed and documented the pertinent history and diagnostic reports and performed a focused physical examination in which he addressed the accepted conditions and correctly applied the procedures set forth by FECA and OWCP and the methodology set forth in the A.M.A., *Guides* in rendering his medical opinion regarding a compensable impairment. Dr. Katz opined that Dr. Leatherwood correctly referenced Table 16-23 for a stand-alone range of motion rating for the right knee as it most accurately assesses the degree of knee impairment. He agreed with Dr. Leatherwood's conclusion that appellant had 24 percent right lower extremity impairment with maximum medical improvement reached on July 19, 2016, the date of Dr. Leatherwood's most recent referee examination.

By decision dated September 27, 2016, OWCP found that the weight of the medical evidence rested with the opinion of Dr. Leatherwood and denied appellant's claim for an additional right lower extremity schedule award.

Appellant, through counsel, timely requested a hearing before an OWCP hearing representative on October 4, 2016. By decision dated December 2, 2016, the hearing representative noted that the case must be remanded to OWCP. She found that further medical development was required in order to address the deficiencies outlined in the March 30, 2016 decision of an OWCP hearing representative. The hearing representative reviewed Dr. Leatherwood's reports and found that he failed to address exactly how he arrived at his calculation under Table 16-2 of the A.M.A., *Guides*, noting that he made no reference to applicable grade modifiers. She further found that, regarding right knee impairment, Dr. Leatherwood also did not explain how he arrived at the figures provided for meniscus tear and patellar chondromalacia, again not addressing the class of impairment or applicable grade modifiers. With regard to the lumbar spine, the hearing representative found that Dr. Leatherwood had failed to provide a rationalized medical explanation to support that the findings on EMG/NCV studies were invalid and unreliable. She remanded the case to OWCP to obtain clarification from Dr. Leatherwood regarding these deficiencies in his reports. Dr. Leatherwood was also to address findings from Semmes-Weinstein monofilament testing which documented sensory deficits, the motor deficits documented in the record, and provide an impairment rating in which he referenced the A.M.A., *Guides* and July/August 2009 *The Guides Newsletter* for rating extremity impairment due to spinal nerve root deficits.

In a January 3, 2017 letter, OWCP asked that Dr. Leatherwood address the issues enumerated in the December 2, 2016 hearing representative decision.

By report dated January 26, 2017, Dr. Leatherwood reiterated that the diagnosis of metatarsal fracture-dislocation was the best method to address appellant's foot and ankle issues which, he opined yielded a severity grade of C for 16 percent right lower extremity impairment under Table 16-2. Regarding the right knee, he explained that he followed instructions in the A.M.A., *Guides* indicating that the preferred method of determining impairment was diagnosis-based, and that only the most severe diagnosis is to be used. Dr. Leatherwood concluded that for a diagnosis of patellofemoral arthritis, under Table 16-3, Knee Regional Grid, appellant had a class 1 grade E impairment which yielded five percent right knee impairment. With regard to appellant's nerve root deficits, he summarized his reports and maintained that EMG studies were not object in the same sense as an MRI scan or x-ray. Dr. Leatherwood noted that the NCV portion should be objective in nature, but that the EMG was subject to interpretation by the examiner, and that a patient could be well recovered from a given condition and the EMG would continue to show the condition. He reiterated his opinion that clinical examination should take precedence over EMG findings. Dr. Leatherwood, however, indicated that, if he was required to use the EMG evidence, he would again find four percent deficits as he had previously reported. He also maintained that Semmes-Weinstein testing was also subjective. Dr. Leatherwood utilized the Combined Values Chart, and combined the 16 percent foot/ankle impairment with 5 percent knee impairment for a total 20 percent right lower extremity impairment, noting that, if radiculopathy was required, combining 4 percent impairment with 20 percent, yielded a total of 23 percent permanent impairment. He concluded that he had tried his best to be both fair and impartial in his evaluation. Dr. Leatherwood indicated that, if his explanations were insufficient, he advised choosing another referee physician.

On March 28, 2017 Dr. Katz, OWCP's medical adviser, reviewed Dr. Leatherwood's January 26, 2017 report. He indicated that this report amended, restated, and superseded his September 21, 2016 report. Dr. Katz noted his review of Dr. Leatherwood's and his prior reports, and that he had not been asked to review Dr. Leatherwood's January 26, 2017 report. He noted that Dr. Leatherwood explained that electrodiagnostic tests should not take precedence over objective clinical examination, and that he did not find objective evidence on spinal nerve physical examination of the lower extremities to qualify for an impairment. Dr. Katz further expressed the opinion that electrodiagnostic interpretation could be subjective. He further noted Dr. Leatherwood's opinion that regarding appellant's right knee diagnosis-based impairment of 5 percent. Dr. Katz found a total 20 right lower extremity impairment for which appellant had received a schedule award.

By decision dated April 4, 2017, OWCP found the weight of the medical evidence rested with the opinion of Dr. Leatherwood and denied appellant's claim for an additional right lower extremity schedule award.

On April 11, 2017 appellant, through counsel, timely requested a hearing before an OWCP hearing representative. During the hearing, counsel maintained that Dr. Leatherwood did not address the deficiencies outlined in the December 2, 2016 hearing representative's decision. He noted that OWCP had made three attempts to have Dr. Leatherwood clarify his opinion, and he

had not done so. Counsel asserted that the case should be remanded for OWCP to refer appellant to a different referee physician.

By decision dated August 23, 2017, an OWCP hearing representative affirmed the April 4, 2017 decision, finding that the weight of the medical evidence rested with the referee opinion of Dr. Leatherwood who explained his impairment rating and provided proper rationale. He noted that OWCP's medical adviser concurred with Dr. Leatherwood's opinion. The hearing representative therefore found that appellant had not established greater permanent impairment of his right lower extremity than that previously awarded.

### **LEGAL PRECEDENT**

It is the claimant's burden of proof to establish that he or she sustained permanent impairment of a scheduled member or function of the body as a result of an employment injury.<sup>10</sup>

The schedule award provisions of FECA<sup>11</sup> and its implementing federal regulations,<sup>12</sup> 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 the A.M.A., *Guides* as the uniform standard applicable to all claimants.<sup>13</sup> For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.<sup>14</sup>

The sixth edition of the A.M.A., *Guides*<sup>15</sup> provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).<sup>16</sup> Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical

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<sup>10</sup> See *Tammy L. Meehan*, 53 ECAB 229 (2001).

<sup>11</sup> 5 U.S.C. § 8107.

<sup>12</sup> 20 C.F.R. § 10.404.

<sup>13</sup> *Id.* at § 10.404(a).

<sup>14</sup> Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id.* at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

<sup>15</sup> *Supra* note 9.

<sup>16</sup> *Supra* note 9, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

Studies (GMCS).<sup>17</sup> The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).<sup>18</sup>

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.<sup>19</sup> 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.<sup>20</sup>

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.<sup>21</sup> OWCP has adopted this approach for rating impairment of the upper or lower extremities caused by a spinal injury, as provided in section 3.700 of its procedures, which memorializes proposed tables outlined in a July/August 2009 *The Guides Newsletter*.<sup>22</sup> Specifically, OWCP will address lower extremity impairments originating in the spine through Table 16-11<sup>23</sup> and upper extremity impairment originating in the spine through Table 15-14.<sup>24</sup>

Section 8123(a) of FECA provides that, 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.<sup>25</sup> The implementing regulation states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination, and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.<sup>26</sup>

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<sup>17</sup> A.M.A., *Guides* 494-531.

<sup>18</sup> *Id.* at 521.

<sup>19</sup> *Pamela J. Darling*, 49 ECAB 286 (1998).

<sup>20</sup> *Thomas J. Engelhart*, 50 ECAB 319 (1999).

<sup>21</sup> *Rozella L. Skinner*, 37 ECAB 398 (1986).

<sup>22</sup> Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1, (January 2010); *The Guides Newsletter* is included as Exhibit 4.

<sup>23</sup> A.M.A., *Guides* 533.

<sup>24</sup> *Id.* at 425.

<sup>25</sup> 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

<sup>26</sup> 20 C.F.R. § 10.321.

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.<sup>27</sup> If a case has been referred for a referee evaluation to resolve the issue of permanent impairment, it is necessary to route the file to a new OWCP medical adviser to review the calculations to ensure that the referee physician appropriately used the A.M.A., *Guides*. Where a referee examination is arranged to resolve a conflict created between a claimant's physician and the medical adviser with respect to a schedule award issue, the same OWCP medical adviser should not review the referee's report for proper application of the A.M.A., *Guides*.<sup>28</sup>

### ANALYSIS

The Board finds that this case is not in posture for decision as a conflict in medical opinion evidence remains regarding the degree of appellant's right lower extremity impairment.

Under the master file, OWCP File No. xxxxxx373, the accepted conditions are right lower extremity polyneuropathy in diabetes, flatfoot, arthropathies associated with neurological disorders, tear of medial meniscus of knee, current, and chondromalacia patellae. OWCP accepted lumbar sprain and lumbar radiculopathy. On January 16, 2007 it granted appellant a schedule award for four percent permanent impairment of the right lower extremity. On February 19, 2010 OWCP granted appellant a schedule award for an additional nine percent permanent impairment of the right lower extremity. On November 10, 2010 it granted appellant an additional 7 percent impairment of the right lower extremity, and on September 8, 2015 he was awarded an additional 4 percent right lower extremity impairment, for a total 24 percent permanent impairment of the right lower extremity.

OWCP referred appellant to Dr. Leatherwood for an impartial evaluation. Dr. Leatherwood examined appellant on two occasions, April 21, 2015 and July 19, 2016. He also furnished supplementary reports on September 8, 2016 and January 26, 2017. In each of these reports, Dr. Leatherwood discussed his findings and conclusions regarding appellant's right lower extremity impairment and indicated that he had rated appellant in accordance with the sixth edition of the A.M.A., *Guides*.

Section 16.2 of the A.M.A., *Guides* instructs the examiner to perform history and examination and determine if the individual is at maximum medical improvement, establish the appropriate diagnosis for each part of the lower limb to be rated, use the regional grid in the corresponding region to determine the associated class, and use the adjustment grid and the grade modifiers to determine what grade of associated impairment should be chosen within the class defined by the regional grid, use the regional grid to identify the appropriate impairment rating

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<sup>27</sup> See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (March 2017).

<sup>28</sup> A.M.A., *Guides* 449.

value for the impairment class, modified by the adjustments as calculated (Net Adjustment Formula), and combine lower extremity percentages using the Combined Values Chart.<sup>29</sup>

Dr. Leatherwood, however, did not address application of the grade modifiers or the net adjustment formula in his analysis under Chapter 16 of the A.M.A., *Guides*. Moreover, in his application of the rating process for spinal nerve impairment, found in Proposed Table 2, Dr. Leatherwood did not address grade modifiers, as explained on page 3 of the July/August 2009 *The Guides Newsletter*.

As Dr. Leatherwood's opinion regarding appellant's right lower extremity permanent impairment remains insufficient, a conflict remains. The case must, therefore, be remanded to OWCP for selection of a new impartial medical specialist for resolution of the outstanding conflict in medical evidence.<sup>30</sup> After such further development deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's right lower extremity impairment.

### **CONCLUSION**

The Board finds this case not in posture for decision.

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<sup>29</sup> *Id.* at 499.

<sup>30</sup> *See G.W.*, Docket No. 17-0957 (issued June 19, 2017).

**ORDER**

**IT IS HEREBY ORDERED THAT** the April 4 and August 23, 2017 decisions of the Office of Workers' Compensation Programs are set aside, and the case is remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: August 13, 2018  
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