United States Department of Labor
Employees' Compensation Appeals Board

S.J., Appellant	)	
and	)	**Docket No. 17-0426**
	)	**Issued: July 13, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Canton, OH, 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 December 19, 2016 appellant, through counsel, filed a timely appeal from a November 1, 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 met her burden of proof to establish more than 15 percent permanent impairment of her left lower extremity, for which she previously received schedule awards.

FACTUAL HISTORY

On March 31, 2005 appellant, then a 29-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that she sustained pain in her ankle and tendon due to walking on a daily basis in the performance of her federal employment duties. She noted that she first became aware of her claimed condition on March 15, 2005 and of its relation to her federal employment on March 30, 2005. Appellant did not stop work. However, she was placed on limited duty to include secretarial duties until April 6, 2005.

Following a July 6, 2005 initial denial of the claim, on March 7, 2006, OWCP vacated the July 6, 2005 decision and accepted the claim for left posterior tibial tendinitis. It subsequently expanded the acceptance of the claim to include contracture of tendon sheath on the left, and pain in the joint, ankle, and foot on the left. The record reflects that appellant underwent left foot surgery (gastroc recession, osteotomy, and cuneiform navicular effusion) on April 7, 2006. Appellant wore a cast for approximately six weeks following surgery. She underwent surgical removal of hardware on June 23, 2006. On April 1, 2006 appellant returned to full-time work with restrictions and full-time regular-duty work on August 1, 2006. OWCP paid her wage-loss compensation and medical benefits.

On September 10, 2008 OWCP granted appellant a schedule award for 14 percent permanent impairment of the left foot. The award covered a period of 28.7 weeks from April 23 to November 9, 2008.

On September 13, 2013 Dr. Leslie P Niehaus, a Board-certified podiatrist, performed left foot surgery to include arthrodesis of the first metatarsal cuneiform and second metatarsal cuneiform joints.

On March 21, 2014 appellant filed a claim for an increased schedule award (Form CA-7).

By letter dated March 24, 2014, OWCP advised appellant that it was unable to process her claim for an increased schedule award as additional information was needed, including verification from her physician that she had reached maximum medical improvement. It further advised her to submit medical evidence in support of her claim based on the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] No additional information was received.

By decision dated April 28, 2014, OWCP denied appellant's claim for an increased schedule award.

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

On May 1, 2014 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative.

In a May 29, 2014 report, Dr. Catherine Watkins Campbell, Board-certified in occupational and family medicine, noted appellant's history of injury and treatment. She examined appellant and provided findings which included that appellant's gait was minimally antalgic in shoes, but it became more antalgic when walking in her bare feet as she had some difficulty getting her left heel planted on the floor to fully bear weight. Dr. Watkins Campbell determined that active range of motion of the left foot and ankle measured 30 degrees of plantar flexion, 4 degrees of dorsiflexion (mild impairment), 14 degrees of eversion and 14 degrees of inversion (mild impairment). She found variable left foot and ankle tenderness and no identified laxity in the left foot or ankle. Dr. Watkins Campbell determined that motor strength in the foot was normal. Additionally, there was no gross varus or valgus deformity of the left ankle or mid-foot. Dr. Watkins Campbell also explained that the x-ray of the foot from November 14, 2013 showed that the first metatarsal and big toe were hyper-corrected medially creating a fixed space between the first and second metatarsal that was greater than normal. She advised that the primary originating and primary impairing diagnosis in the claim was contracture of left tendon sheath (Achilles tendon). Dr. Watkins Campbell referred to Table l6-2[4] under the criteria for strain/tendinitis or history of a ruptured tendon specifically involving the Achilles tendon. She explained that the shortening of the Achilles tendon caused the arch of the foot to fall, ultimately resulting in the loss of the posterior tibial tendon function requiring arthrodesis in the mid-foot and a calcaneal osteotomy to correct to a mild fixed over correction of a valgus mid-foot deformity (as evidenced of a widened space between the second toes and metatarsal and an over-corrected medial displaced first metatarsal and big toe) placing the impairment in class 3. Dr. Watkins Campbell explained that a physical examination modifier was not utilized in that physical examination findings were applied to the choice of class in this instance. She noted that a functional modifier of 2 was chosen based on the data presented in the body of the report. Dr. Watkins Campbell advised that the aforenoted x-rays reflected a moderate correction of a mid-foot valgus deformity, a moderate correction of calcaneal valgus deformity and moderate correction of a fallen arch and as a result, a clinical studies modifier of 1 was chosen. She utilized the net adjustment formula and determined that appellant had 28 percent left lower extremity permanent impairment. Dr. Watkins Campbell noted that this was an increase of 14 percent from the previous schedule award of 14 percent. She determined that maximum medical improvement was reached on February 11, 2014 as determined by her treating physician, Dr. Niehaus.

By decision dated September 30, 2014, OWCP's hearing representative set aside the April 28, 2014 decision, finding that the case was not in posture for decision. The hearing representative determined that the report from Dr. Watkins Campbell constituted new medical evidence which should be reviewed by OWCP's medical adviser for an opinion regarding the nature and percentage of impairment.

On October 29, 2014 the case was forwarded to an OWCP medical adviser for an updated calculation of impairment.

[4] *Id.* at 501.

In an October 31, 2014 report, OWCP's medical adviser, Dr. Morley Slutsky, Board-certified in occupational medicine, indicated that he needed all postoperative notes since the surgery performed on September 13, 2013 to determine if there was a fixed deformity and or consistent, significant loss of motion of appellant's ankle related to the Achilles tendon.

In a December 12, 2014 report, Dr. Slutsky noted that appellant underwent x-rays on November 14, 2013 and they were a key factor when rating the double foot arthrodesis. He requested a copy of those x-rays.

In a letter dated January 16, 2015, OWCP requested that appellant provide a copy of the November 14, 2013 left foot x-rays.

On February 3, 2015 OWCP notified OWCP's medical adviser that a copy of the x-ray report was received.

In a February 5, 2015 report, Dr. Slutsky noted the history of injury and treatment. He also noted that on April 7, 2006 appellant had a gastrocnemius recession, a medially displaced calcaneal osteotomy, a medial cuneiform navicular fusion, an intermediate cuneiform fusion, and a medial cuneiform intermediate cuneiform fusion of the left foot. The postoperative diagnoses included posterior tibial tendinitis, gastrocnemius equines, calcaneal valgus, and degenerative changes to the cuneiform navicular joint. Dr. Slutsky indicated that on June 23, 2006 appellant's left foot was diagnosed with painful internal fixation. On January 22, 2009 appellant underwent removal of painful hardware of the heel and removal of painful hardware, dorsum of foot. On September 13, 2013 she had an arthrodesis of the first metatarsal cuneiform and second metatarsal cuneiform joints. Dr. Slutsky explained that x-rays performed on November 14, 2013 demonstrated no significant mal-alignment (varus or valgus). As a result, appellant was placed into class 1. Dr. Slutsky indicated that Dr. Watkins Campbell rated appellant for the initial diagnoses (Achilles tendinitis) which eventually resulted in the fusions mentioned. He explained that the impairment range for double arthrodesis (no mal-alignment) was in the 7 to 13 percent range. Dr. Slutsky explained that the impairment for Achilles tendon repair with flexible deformity and loss of function was in the range of 14 to 18 percent. He indicated that a fixed deformity would lead to ankylosis (complete absence of motion in plantar flexion which the Achilles tendon controls), however, Dr. Slutsky explained that, in this case, there was a loss of motion, but not complete absence of motion. As a result, he rated appellant for flexible deformity in the Achilles tendon and determined that the impairment rating was 15 percent of the left lower extremity. Dr. Slutsky opined that May 29, 2014 was the date of maximum medical improvement. He found that appellant's condition had stabilized and there was no further treatment planned.

The November 14, 2013 x-ray, read by Dr. Niehaus, revealed findings to include hardware placement intact with a tarsal plate and an additional headless screw in the first metatarsal cuneiform joint. He also found good arthrodesis of the multiple joint complex at this time. Dr. Niehaus also determined that appellant had an old correction of the flatfoot deformity on the calcaneus and a small amount of degenerative change of the tarsal talar joint. He also found removal of a previous tibial sesamoid bone on the first metaphalangeal joint and previous fusion of the navicular cuneiform joints.

On July 22, 2015 OWCP requested that Dr. Watkins Campbell review the opinion and calculations provided by Dr. Slutsky, its medical adviser. However, no response was received from Dr. Watkins Campbell. In a letter dated August 11, 2015, counsel indicated that Dr. Watkins Campbell was unable to provide a medical opinion. He requested that OWCP proceed with the schedule award determination.[5]

On January 28, 2016 OWCP requested an updated opinion from an OWCP medical adviser. It noted that it was unclear whether Dr. Slutsky was aware of appellant's prior schedule award.

In a January 28, 2016 report, OWCP's medical adviser, Dr. Michael M. Katz, a Board-certified orthopedic surgeon, noted that Dr. Slutsky's February 5, 2015 report was correct. He explained that Dr. Slutsky believed that fixed deformity did not exist, and instead determined an impairment rating of 15 percent on the basis of Achilles tendon loss of specific tendon function and flexible deformity. Dr. Katz concurred that appellant was entitled to a schedule award in the amount of 15 percent to the left lower extremity. He explained that, in the prior report, Dr. Slutsky was unaware of a prior schedule award under the claim in the amount of 10 percent to the left lower extremity (foot/ankle). Dr. Katz opined that 15 percent subtracted from the prior award, resulted in an additional impairment of 5 percent permanent impairment of the left lower extremity.

By decision dated February 22, 2016, OWCP granted appellant a schedule award for an additional five percent permanent impairment of the left lower extremity. The award covered a period of 14.4 weeks from April 24 to August 2, 2014.

On March 1, 2016 appellant, through counsel, requested a telephonic hearing, which was held before an OWCP hearing representative on September 22, 2016. During the hearing, appellant noted that she was working her full route with restrictions "just for street time." Counsel argued that the impairment ratings differed and were based on a fixed (*vs.* flexible) deformity. Furthermore, he argued that Dr. Watkins Campbell actually examined appellant while OWCP's medical adviser did not examine her. Counsel questioned how loss of tendon function would not result in a deformity that is fixed. Appellant also explained that her arch had collapsed and her heel had been cut off and moved forward to create an arch and her Achilles tendon lengthened. There had been a fusion at the ankle with screws and staples. A subsequent procedure was described as an additional fusion where a plate and four screws were used. Appellant indicated that she had to wear a pad in the tongue of her left shoe to offset the effects of friction from one of the screws.

By decision dated November 1, 2016, OWCP's hearing representative affirmed the February 22, 2016 decision, finding that there was no evidence of greater permanent impairment than that which was previously awarded.

[5] Counsel again requested that OWCP render an opinion on the schedule award in letters dated October 14 and December 2, 2015.

LEGAL PRECEDENT

The schedule award provisions of FECA,[6] and its implementing federal regulations,[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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[8] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used.[9] 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 and Health (ICF).[10]

In addressing lower extremity impairment, the sixth edition requires identifying the impairment Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed through 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.

Section 8123(a) of FECA which 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 and resolve the conflict of medical evidence.[13]

ANALYSIS

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

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[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id*. at § 10.404(a).

[9] *See* 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] A.M.A., *Guides*, page 3, section 1.3, ICF: A Contemporary Model of Disablement.

[11] *Id.* at 494-531; *see J.B.*, Docket No. 09-2191 (issued May 14, 2010).

[12] *Id.* at 521.

[13] 5 U.S.C. § 8123; *M.S.*, 58 ECAB 328 (2007); *B.C.*, 58 ECAB 111 (2006).

OWCP accepted appellant's claim for left posterior tibial tendinitis. It subsequently expanded the acceptance of the claim to include contracture of tendon sheath on the left, and pain in the joint, ankle, and foot on the left. The record reflects that appellant underwent left foot surgery (gastroc recession, osteotomy, and cuneiform navicular effusion) on April 7, 2006. She wore a cast for approximately six weeks following surgery. Appellant underwent surgical removal of hardware on June 23, 2006. On September 10, 2008 OWCP granted her a schedule award for 14 percent permanent impairment of the left lower extremity. Thereafter, appellant filed a claim for an increased schedule award and furnished a May 29, 2014 report from Dr. Watkins Campbell citing various tables in the A.M.A., *Guides* and calculating an impairment rating of 28 percent permanent impairment of the left lower extremity.

Alternatively, the reports from OWCP's medical advisers, including the January 28, 2016 report, conflict with the findings of Dr. Watkins Campbell. Appellant's impairment to the left ankle region, was selected by the treating and OWCP's physicians as the most impairing diagnosis. All physicians selected Achilles tendinitis. However, the crux of disagreement arose with regard to whether appellant had a fixed or flexible deformity. For example, the treating physician, Dr. Watkins Campbell, opined that appellant had a fixed deformity, while Dr. Slutsky opined that it was a flexible deformity. While OWCP asked for an opinion from Dr. Watkins Campbell to review Dr. Slutsky's report, counsel for appellant advised that a new opinion could not be obtained and to proceed with the schedule award. Dr. Slutsky indicated that a fixed deformity would lead to a complete absence of motion in plantar flexion which the Achilles tendon controlled. He explained that there was not a complete absence of motion, and thus, appellant was rated at a flexible deformity in the Achilles tendon. However, the Board notes that Dr. Watkins Campbell explained that a contracture of the left tendon sheath, Achilles tendon, would be rated under Table 16-2,[14] criteria for strain/tendinitis or history of a ruptured tendon specifically involving the Achilles tendon. She explained that the shortening of the Achilles tendon caused the arch of the foot to fall ultimately resulting in the loss of the posterior tibial tendon function requiring arthrodesis in the mid foot and a calcaneal osteotomy to correct to a mild fixed over correction of a valgus mid-foot deformity (as evidenced of a widened space between the second toes and metatarsal and an over corrected medial displaced first metatarsal and big toe) placing the impairment in class 3. Dr. Watkins Campbell also indicated that there was no identified laxity in the left foot or ankle. The Board notes that no laxity suggests no motion or a fixed deformity. It is unclear how OWCP's medical adviser, Dr. Slutsky, as confirmed by Dr. Katz, found this meaning based upon these findings. Furthermore, in Table 16-2, with regard to fixed deformity, it notes fixed deformity and loss of specific tendon function. There is no specification that it must be 100 percent and it is unclear how Dr. Slutsky reached this conclusion.[15] As such, there is a conflict in medical opinion regarding the explanations for loss of specific tendon function and referral to an impartial medical examiner is warranted.

[14] *Supra* note 4.

[15] *Id.*

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."[16]

The Board will thus remand the case for referral to an impartial medical specialist for an opinion regarding the extent of appellant's left lower extremity permanent impairment. After such further development as deemed necessary, OWCP shall issue a *de novo* decision on the extent of appellant's left lower extremity permanent impairment.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the November 1, 2016 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision.

Issued: July 13, 2018
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

[16] *Supra* note 13; *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207, 210 (1993).