United States Department of Labor
Employees' Compensation Appeals Board

P.E., Appellant	)	
and	)	**Docket No. 17-0961**
	)	**Issued: March 14, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Saint Louis, MO, 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 March 31, 2017 appellant filed a timely appeal from a March 1, 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 has more than six percent permanent impairment of his right lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On February 14, 2012 appellant, then a 56-year-old city carrier, filed a traumatic injury claim (Form CA-1) alleging that on February 13, 2012 he sustained a right foot/ankle injury while he was walking his mail route and started to feel pain in his right foot. He stopped work

[1] 5 U.S.C. § 8101 *et seq.*

on February 14, 2012 and sought medical treatment on that day. OWCP accepted the claim for enthesopathy of the right ankle/tarsus, right Achilles tendinitis, rupture of other tendon right foot/ankle, right ankle sprain/strain, and right contracture of tendon sheath.[2]

Appellant sought treatment with Dr. Ryan Pitts, a Board-certified orthopedic surgeon. On July 11, 2012 Dr. Pitts performed a right ankle arthroscopy, limited arthroscopic debridement, open right ankle peroneal brevis tenodesis, and peroneal longus and brevis tenolysis.

In a May 20, 2013 clinical note, Dr. Pitts provided physical examination findings of right ankle swelling. He diagnosed right ankle peroneal tear -- high grade partial debridement and tenodesis from a February 13, 2012 work-related injury.

On August 8, 2013 appellant filed a claim for a schedule award (Form CA-7).

OWCP routed a statement of accepted facts and the case file to Dr. Daniel Zimmerman, Board-certified in internal medicine serving as an OWCP district medical adviser (DMA), for review and a determination on whether appellant sustained permanent impairment of the right lower extremity and date of maximum medical improvement (MMI).

In an August 27, 2013 report, Dr. Zimmerman reported that per appellant's May 20, 2013 report from Dr. Pitts, he had not yet reached MMI.

By letter dated September 16, 2013, OWCP requested appellant submit an impairment evaluation from his attending physician in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] It afforded him 30 days to submit the requested impairment evaluation.

In a September 27, 2013 medical report, Dr. Pitts reported that appellant's right ankle revealed good strength and mild loss of motion when compared to the left side. He opined that appellant had reached MMI.

In support of his schedule award claim, appellant submitted an August 13, 2014 report pertaining to the right lower extremity from Dr. John W. Ellis, Board-certified in family

[2] The Board notes that appellant has another traumatic injury claim under OWCP subsidiary File No. xxxxxx246, which was combined with this claim, OWCP File No. xxxxxx728. Appellant has another claim, OWCP File No. xxxxxx359 which has also been combined and serves as the master file. On January 28, 2010 he sustained a traumatic injury under OWCP File No. xxxxxx359. On March 22, 2010 OWCP accepted the claim for rotator cuff strain of right shoulder, right shoulder bursitis, and right shoulder tendinitis. Appellant returned to full-duty work on June 17, 2010. By decision dated March 24, 2011, he received a schedule award for six percent permanent impairment of the right upper extremity. On December 14, 2011 appellant sustained a traumatic injury under OWCP File No. xxxxxx246. On January 31, 2012 OWCP accepted the claim for right rotator cuff sprain, right superior glenoid labrum lesion, lateral tear of the right shoulder, and a partial right rotator cuff tear. By decision dated March 1, 2016, it issued a schedule award for nine percent permanent impairment of the upper right extremity. Appellant was awarded 15 percent less the 6 percent previously paid under OWCP File No. xxxxxx359, resulting in an award for 9 percent permanent impairment of the upper right extremity.

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

medicine.[4] In his report, Dr. Ellis opined that appellant reached MMI on August 13, 2014. He determined that appellant would be entitled to a schedule award for 13 percent permanent impairment of the right lower extremity using the diagnosis-based impairment (DBI) method for a peroneal and other tendon tear, class 1 for a mild problem.[5] Dr. Ellis assigned a grade modifier of 2 for functional history, a grade modifier of 2 for physical examination, and no grade modifier was assigned for clinical studies. However, he determined that the range of motion (ROM) method more accurately reflected appellant's lower extremity impairment. Dr. Ellis noted 2 percent impairment for decreased hind foot ROM,[6] and 15 percent impairment of decreased ankle ROM,[7] resulting in a total 17 percent permanent impairment of the right lower extremity. He explained that the decreased ROM method more accurately reflected appellant's impairment as his injury entailed more than just the peroneal tendon, having impairment of tendons, arthritis, and tendinitis in the right foot and ankle.

By letter dated September 3, 2014, OWCP requested that appellant provide further medical evidence from his treating physician in support of his schedule award claim. It specifically requested that he provide a reasoned medical opinion containing rationale for calculation of permanent impairment with references to the applicable criteria and tables in the sixth edition of the A.M.A., *Guides*.

By letter dated September 22, 2014, Dr. Ellis informed OWCP that his prior August 13, 2014 report established appellant's claim for a schedule award and listed the diagnoses utilized along with the tables within the A.M.A., *Guides*.

OWCP routed the case file and referred appellant to Dr. Richard T. Katz, Board-certified in physical medicine and rehabilitation, for a second opinion examination pertaining to permanent impairment of both the right upper and lower extremities.[8] In his report of November 16, 2015, as it relates to lower extremity permanent impairment, Dr. Katz documented a history of injury, summarized prior medical records, reviewed diagnostic testing, and provided physical examination findings. He explained that peroneal tendinitis was rated at page 501 of the A.M.A., *Guides* ranging from three to seven percent.[9] Dr. Katz determined that based on Table 16-2 (Mild Motion Deficits), this resulted in class 1 placement at a default value of five percent. He assigned a grade modifier of 1 for physical examination and a grade modifier of 2 based on the lower extremity questionnaire. Dr. Katz determined that appellant's final rating resulted in grade D, warranting movement one place to the right of the default value resulting in six percent permanent impairment of the right lower extremity.

[4] The Board notes that appellant also submitted another August 13, 2014 report from Dr. Ellis pertaining to the right upper extremity, but that report is irrelevant to the present claim.

[5] *Supra* note 3 at 501, Table 16-2.

[6] *Id.* at 549, Table 16-20.

[7] *Id.* at Table 16-22.

[8] The Board notes that appellant's claim for right upper extremity impairment is not before the Board on appeal. As such, the Board will not discuss findings made pertaining to the right upper extremity.

[9] *Supra* note 5.

On January 6, 2016 OWCP routed the case file to Dr. David H. Garelick, a Board-certified orthopedic surgeon, serving as OWCP's DMA, for review and a determination on whether appellant sustained permanent impairment of the right upper extremity and permanent impairment of the right lower extremity.[10]

In a January 16, 2016 report, Dr. Garelick agreed with Dr. Katz' findings pertaining to the right foot and opined that appellant sustained six percent permanent impairment of the right lower extremity. He further determined that appellant reached MMI for his lower extremity condition on September 27, 2013.

By decision dated March 1, 2016, OWCP granted appellant a schedule award for six percent permanent impairment of the right lower extremity. It found that the weight of the medical evidence rested with Dr. Katz and Dr. Garelick serving as OWCP's DMA. The date of MMI was noted as September 27, 2013. The award covered a period of 17.28 weeks from September 27, 2013 to January 25, 2014.

On March 15, 2016 appellant requested an oral hearing before an OWCP hearing representative.

By decision dated September 23, 2016, an OWCP hearing representative set aside the March 1, 2016 schedule award decision and remanded the case for further development. The hearing representative explained that OWCP referred appellant to Dr. Katz for a second opinion evaluation and that he had opined that appellant sustained six percent permanent impairment of the right lower extremity, which was confirmed by Dr. Garelick serving as OWCP's DMA. However, neither Dr. Katz nor Dr. Garelick discussed Dr. Ellis' August 13, 2014 impairment rating finding 17 percent right lower extremity permanent impairment based on the ROM method. The hearing representative remanded the case for Dr. Katz to review Dr. Ellis' August 13, 2014 report, identify if there were any points of disagreement, and to provide a rationalized explanation pertaining to appellant's right lower extremity impairment rating. It noted that the sixth edition provided that the DBI was the primary method of evaluation. However, ROM impairments could be used as a stand-alone rating when other grids referred the evaluator to this method or when no other diagnosis-based sections were applicable for impairment rating of a condition.[11] As such, if Dr. Katz determined that the DBI method should be utilized as opposed to the ROM method as indicated by Dr. Ellis, then he should provide a rationalized explanation supporting this contention. Following receipt of his supplemental report, the case file would be forwarded to an OWCP DMA for review. The DMA should also be advised that while the DBI method was preferred to the ROM method, both approaches were permissible under the A.M.A., *Guides.* Following any further development as deemed necessary, OWCP was instructed to issue a *de novo* decision on the claim.

On November 2, 2016 OWCP routed the report of Dr. Ellis to Dr. Katz for review and determination on his right lower extremity impairment rating, whether the ROM or DBI methodology should be used, and the appropriate date of MMI. It instructed Dr. Katz to identify

[10] *See supra* note 9.

[11] *Supra* note 3 at 387 and 461.

any points of disagreement. OWCP further noted that if he chose to utilize the DBI method to calculate the right lower extremity impairment, as opposed to the ROM method, he needed to provide a rationalized explanation to support his rating, specifically addressing why Dr. Ellis' chosen ROM-based impairment method was inappropriate.

In a December 14, 2016 supplemental report, Dr. Katz reported that the rating he provided pertained to tendinitis, which differed from that of Dr. Ellis who rated appellant for a tendon tear. He noted that, while he did not have the original records, he believed that Dr. Ellis misrepresented the word tear. Dr. Katz explained that a sprain represented a microscopic tear of the tendon, but not a gross tear. Dr. Ellis, however, portrayed the ankle problem as a gross tear of a tendon. Dr. Katz did not believe that, such a tear took place and rather, appellant had tendinitis which he had previously correctly rated at six percent permanent impairment of the right lower extremity.

On January 6, 2017 OWCP routed the case file to Dr. Garelick, serving as OWCP's DMA, for review of Dr. Katz' reports and a determination on whether appellant sustained a permanent impairment of the right lower extremity, date of MMI, and whether the DBI or ROM methodology should have been used to rate the right lower extremity impairment. It requested that he provide a clear explanation as to why the method chosen was used in lieu of another allowable method (*e.g.*, DBI vs. ROM).

In a January 10, 2017 report, Dr. Garelick reported that there was no change with respect to the right lower extremity impairment rating. The DMA concurred with Dr. Katz' findings pertaining to the September 27, 2013 date of MMI and six percent permanent impairment of the right lower extremity.

By decision dated March 1, 2017, OWCP found that the medical evidence failed to establish that appellant was entitled to more than six percent permanent impairment of the right lower extremity previously awarded.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations 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.[12] However, it 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[13]

[12] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[13] *K.H.*, Docket No. 09-0341 (issued December 30, 2011). For decisions issued after May 1, 2009, the sixth edition will be applied. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[14] 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.[15]

The A.M.A., *Guides* provide a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF). For lower extremity impairments, the evaluator identifies the impairment class for the diagnosed condition should be Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[16] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[17] Evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[18]

OWCP's 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.[19]

ANALYSIS

OWCP accepted appellant's claim for enthesopathy of the right ankle/tarsus, right Achilles tendinitis, rupture of other tendon right foot/ankle, right ankle sprain/strain, and right contracture of tendon sheath. The issue is whether appellant has more than six percent permanent impairment of the right lower extremity, for which he previously received a schedule award.

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

In support of his schedule award claim, appellant submitted an August 13, 2014 report from Dr. Ellis who calculated 13 percent permanent impairment of the right lower extremity utilizing the DBI method for the diagnosis of peroneal and other tendon tear. However, Dr. Ellis determined that the ROM method more accurately reflected appellant's impairment, finding 17 percent permanent impairment of the right lower extremity (2 percent impairment for decreased hind foot ROM and 15 percent impairment of decreased ankle ROM). He explained that the

[14] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *see also* Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (February 2013).

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

[16] *Supra* note 3 at 493-531.

[17] *Id*. at 521.

[18] *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[19] *See supra* note 14 at Chapter 2.808.6(f) (March 2017).

decreased ROM method more accurately reflected appellant's impairment as he had more than just the peroneal tendon with impairment of a few tendons, arthritis, and tendinitis in the right foot and ankle.

On November 16, 2015 OWCP referred appellant to Dr. Katz for a second opinion evaluation pertaining to the right lower extremity impairment. Dr. Katz utilized the DBI diagnosis of peroneal tendinitis to calculate six percent permanent impairment of the right lower extremity. Dr. Garelick, serving as OWCP's DMA, concurred with Dr. Katz' impairment rating.

On September 23, 2016 an OWCP hearing representative set aside the March 1, 2016 schedule award decision and remanded the case for further development. She ordered that Dr. Katz and the DMA review Dr. Ellis' August 13, 2014 impairment rating and address whether the DBI method should be utilized as opposed to the ROM method as indicated by Dr. Ellis.

However, the Board has previously held that Chapter 16 of the sixth edition of the A.M.A., *Guides*, pertaining to the lower extremities, provides that DBI is the primary method of calculation for the lower limb. Furthermore, most impairments are based on the DBI method where impairment class is determined by the diagnosis and specific criteria as adjusted by the grade modifiers for functional history, physical examination, and clinical studies. It further provides that alternative approaches are also provided for calculating impairment for peripheral nerve deficits, complex regional pain syndrome, amputation, and ROM. ROM is primarily used as a physical examination adjustment factor.[20] The A.M.A., *Guides* also explains that some of the DBI grids refer to the ROM section when that is the most appropriate mechanism for grading the impairment. This section is to be used as a stand-alone rating when other grids refer to this section or no other DBI sections of the chapter are applicable for rating a condition.[21]

Following remand, in his December 14, 2016 addendum, Dr. Katz argued that his right lower extremity rating remained at six percent permanent impairment. The Board finds that his supplemental report is insufficient to form the basis of appellant's schedule award claim.[22] Dr. Katz explained that his impairment rating utilized the DBI of tendinitis which differed with that of Dr. Ellis who rated appellant for tendon tear. The Board finds that the opinion of Dr. Katz is speculative as he noted that he did not have the original records, but "believed" that Dr. Ellis misrepresented the word tear. Dr. Katz argued that the sprain represented a microscopic tear of the tendon and not a gross tear as found by Dr. Ellis. Dr. Garelick, serving as OWCP's DMA, simply reported that there was no change in the right lower extremity impairment rating without further explanation. As such, these reports cannot be afforded the weight of the medical opinion evidence and are insufficient to form the basis for a schedule award.[23]

While the hearing representative ordered the supplemental reports to contain a reasoned opinion as to the use of ROM *vs.* DBI, the citation was made to the upper extremity impairment

[20] *See M.M.*, Docket No. 16-1759 (issued April 24, 2017); A.M.A., *Guides* 494-531.

[21] *Id.*; *see also D.F.*, Docket No. 15-0664 (issued January 8, 2016).

[22] *L.R.*, Docket No. 14-0674 (issued August 13. 2014).

[23] *S.S.*, Docket No. 15-1736 (issued August 4, 2016).

chapter which is, obviously, inapplicable to the present lower extremity impairment rating. The Board therefore finds that this remand issue is not relevant in the present claim.

Once OWCP undertakes development of the record it must procure medical evidence that will resolve the relevant issues in the case.[24] It began to develop the evidence by seeking an opinion from Dr. Katz, serving as the second opinion physician, and Dr. Garelick, serving as OWCP's DMA, yet failed to obtain a fully rationalized report pertaining to appellant's right lower extremity impairment rating.[25] It is unclear if appellant's impairment rating should be calculated utilizing peroneal and other tendon tear as noted by Dr. Ellis, or tendinitis as stipulated by Dr. Katz. As the Board is unable to determine from the current record whether Dr. Ellis or Dr. Katz appropriately applied the A.M.A., *Guides* in determining appellant's permanent impairment for schedule award purposes, this case must be remanded for further development and appropriate impairment rating under the A.M.A., *Guides*.[26]

The Board will remand the case to OWCP for further medical development.[27] OWCP should refer appellant to another second opinion physician in accordance with its procedures to properly determine the impairment to his right lower extremity based on a current examination, the accepted employment injuries, and utilizing the proper tables and figures of the A.M.A., *Guides*. After such further development as deemed necessary, OWCP shall issue a *de novo* decision on the extent of impairment to appellant's right lower extremity.

CONCLUSION

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

[24] *Phillip L. Barnes*, 55 ECAB 426 (2004); *see also Virginia Richard, claiming as executrix of the estate of Lionel F. Richard*, 53 ECAB 430 (2002); *Dorothy L. Sidwell*, 36 ECAB 699 (1985); *William J. Cantrell*, 34 ECAB 1233 (1993).

[25] *C.B.*, Docket No. 11-1937 (issued April 6, 2012).

[26] *See C.S.*, Docket No. 14-1085 (issued August 27, 2014) (finding that when the medical adviser does not provide sufficient explanation for his rating that his report is not entitled to constitute the weight of the medical opinion evidence).

[27] *R.R.*, Docket No. 16-0589 (issued February 3, 2017).

ORDER

IT IS HEREBY ORDERED THAT the March 1, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision.

Issued: March 14, 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