United States Department of Labor
Employees' Compensation Appeals Board

S.B., Appellant	)	
and	)	**Docket No. 17-1665**
	)	**Issued: January 28, 2019**
DEPARTMENT OF HOMELAND SECURITY, IMMIGRATION & CUSTOMS ENFORCEMENT, Bloomington, MN, Employer	)	

Appearances:
Stephen V. Barszcz, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 28, 2017 appellant, through counsel, filed a timely appeal from a July 7, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP).[2] Pursuant to the Federal

[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] The Board notes that during the pendency of this appeal, OWCP issued an August 15, 2017 decision denying appellant's claim to move the date of maximum medical improvement (MMI). This decision, however, is null and void as the Board and OWCP may not simultaneously have jurisdiction over the same issue. *See Terry L. Smith*, 51 ECAB 182 (1999); *Arlonia B. Taylor*, 44 ECAB 591 (1993); *Russell E. Lerman*, 43 ECAB 770 (1992); *Douglas E. Billings*, 41 ECAB 880 (1990).

Employees' Compensation Act[3] (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 OWCP properly determined MMI for appellant's schedule award.

FACTUAL HISTORY

On July 15, 2009 appellant, then a 35-year-old special agent, filed a traumatic injury claim (Form CA-1) alleging that, during a practice exercise, she was pulled forward by another agent and lost her grip, landing on both knees while in the performance of duty.

On December 2, 2009 OWCP accepted appellant's claim for bilateral knee medial collateral ligament sprain. On January 8, 2010 it expanded acceptance of the claim to include right ankle sprain, left hip strain/sprain, and left hip trochanteric bursitis. On June 28, 2011 OWCP expanded acceptance of the claim to include: unspecified bone and cartilage disorder; right lower limb anomaly; joint derangement, ankle and foot, right; articular cartilage disorder, pelvis and thigh, right; and bulging disc at L4-5. It again expanded the acceptance of the claim on December 4, 2013, to include hemarthrosis, ankle and foot, right; nonunion of fracture, right; sprain of shoulder and upper arm left; and adhesive capsulitis of the shoulder on the left. OWCP continued to develop appellant's claim and paid her appropriate compensation benefits. Appellant stopped work on January 14, 2014. She elected to receive benefits from the Office of Personnel Management (OPM), effective November 6, 2015.

On January 12, 2016 appellant submitted a claim for a schedule award (Form CA-7). In support of her claim for a schedule award, she submitted an October 19, 2015 report from Dr. John W. Ellis, a Board-certified family practitioner. Dr. Ellis noted appellant's history of injury and treatment and utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (6th ed. 2009) (A.M.A., *Guides*). He determined that appellant had 13 percent permanent impairment of the left upper extremity based upon the range of motion (ROM) method. Regarding the lower extremities, Dr. Ellis utilized the diagnosis-based impairment (DBI) method and determined that appellant had 63 percent permanent impairment of the right lower extremity and 24 percent permanent impairment of the left lower extremity.

On January 19, 2016 OWCP forwarded the report of Dr. Ellis to Dr. Taisha S. Williams, a physiatrist and district medical adviser (DMA) for review.

In a February 9, 2016 report, the DMA noted the history and Dr. Ellis' report, determined that regarding the left upper extremity, she was in agreement that the left arm should be rated using the range of motion method, but did not agree on the impairment ratings applied to flexion and abduction of the shoulder. Regarding the right lower extremity, she noted that Dr. Ellis used the DBI methods for all of the parts of the lower extremity and combined them with the neurologic impairment. The DMA opined that the ankle and hip were best rated using the range of motion impairment method because limitations in range are affecting her function. She explained that the

[3] 5 U.S.C. § 8101 *et seq.*

foot and knee were best rated using the DBI rating. The DMA also noted that they arrived at different numbers for the nerve impairment. She also added that Dr. Ellis rated for ankle fusion; however, appellant did not have an ankle fusion, but a subtalar fusion in the foot.

The DMA explained that regarding the left lower extremity, they were in agreement regarding the rating for the knee. She noted that for the hip, Dr. Ellis had a higher figure for range of motion. The DMA indicated that she was unsure why, as the worksheet showed the same number of 15. She also noted that they arrived at different numbers for nerve impairment. The DMA opined that the date of MMI was October 19, 2015, the date of the impairment rating by Dr. Ellis as no further significant intervention was done after this date.

OWCP referred appellant along with a statement of accepted facts (SOAF), and the medical record to Dr. Paul T. Wicklund, a Board-certified orthopedic surgeon for an impartial medical evaluation to resolve the conflict in opinion between Drs. Ellis and the DMA regarding the extent and degree of impairment.

In an October 17, 2016 report, Dr. Wicklund noted appellant's history of injury and treatment, examined appellant and provided findings. He determined that appellant had 21 percent left upper extremity permanent impairment due to degenerative joint disease, using ROM in Table 15-34.[4] For the right lower extremity, Dr. Wicklund advised that appellant was post hip arthroscopy and labral debridement with correction on the right as well as status post subtalar arthrodesis of the right ankle and exploration of the anterior talofibular ligament. He also explained that appellant had medial collateral ligament laxity and L5 and S1 radiculopathies. Dr. Wicklund indicated that for the hip and ankle, the range of motion method was higher. He referred to Table 16-24[5] for the right hip range of motion and found 20 percent permanent impairment of the right lower extremity. Regarding the knee, Dr. Wicklund applied Table 16-3[6] and found 10 percent permanent impairment of the right lower extremity. He referred to Table 16-22[7] for the right ankle and found seven percent permanent impairment. Additionally, regarding the right foot, Dr. Wicklund referred to Table 16-2,[8] Table 16-6,[9] and Table 16-7,[10] and determined that appellant had 10 percent impairment. He also found four percent impairment for L5 radiculopathy and one percent impairment for S1 radiculopathy. Dr. Wicklund referred to Table 16-12, Table 16-6, and Table 16-7.[11] He determined that appellant had a combined total of 43 percent permanent impairment of the right lower extremity.

[4] A.M.A., *Guides* 475.

[5] *Id.* at 549.

[6] *Id.* at 510.

[7] *Id.* at 549.

[8] *Id.* at 508.

[9] *Id.* at 516.

[10] *Id.* at 517.

[11] *Id.* at 535, 216, 517.

Dr. Wicklund applied the above-noted tables for the left lower extremity and found 15 percent impairment for the left hip, 10 percent for the left knee, 4 percent for L5 radiculopathy, and 1 percent for S1 radiculopathy. Using the Combined Values Chart,[12] he found 28 percent permanent impairment of the left lower extremity. Dr. Wicklund opined that October 19, 2015 would be considered the date of MMI as she was evaluated for permanent impairment on that date by Dr. Ellis. He explained that it did not appear that any further treatment was pursued since then and he opined that further treatment would not be helpful.

On November 9, 2016 the DMA noted that clarification was required from Dr. Wicklund regarding his spinal nerve impairment calculation.

By letter dated November 16, 2016, OWCP requested that Dr. Wicklund provide clarification regarding the impairment rating.

In a December 5, 2016 report, Dr. Wicklund responded to OWCP's request for clarification on the spinal nerve impairment. He explained that, with regard to his determination of impairment pertaining to the right and left lower extremities, on the basis of spinal nerve impairment, there was an error in his original report. Dr. Wicklund explained that he referenced Table 16-12 as opposed to proposed Table 2, *Spinal Nerve Impairment: Lower Extremity Impairment*, as published in "*The Guides Newsletter*" of July/August 2009 and as requested by OWCP. He advised that all references to Table 16-12 should be replaced with proposed Table 2, noting that his calculations otherwise remained unchanged.

OWCP subsequently forwarded Dr. Wicklund's supplemental report to a DMA, Dr. Michael M. Katz, a Board-certified orthopedic surgeon, for review. In a December 9, 2016 report, the DMA found that appellant had 21 percent left upper extremity permanent impairment. Using the Combined Values Chart, she opined that the total impairment for the right lower extremity was 43 percent.[13] Dr. Katz also determined that appellant had 28 percent permanent impairment of the left lower extremity. The DMA opined that the date of MMI was September 6, 2016, the date of Dr. Wicklund's examination upon which impairment was based.

By decision dated February 27, 2017, OWCP issued appellant a schedule award for 21 percent permanent impairment of the left upper extremity and 71 percent permanent impairment of the bilateral lower extremity. The award was scheduled to run for 270 weeks from September 6, 2016 to November 8, 2021. The date of MMI was listed as September 6, 2016.

On April 12, 2017 appellant, through counsel, requested reconsideration. Counsel argued that the schedule award decision should be modified to reflect the bilateral lower extremity impairments as separate impairments and that the date of MMI should be changed to October 19, 2015. He contended that there was no conflict as to the date and all three physicians agreed that the date of MMI was October 19, 2015. Counsel further argued that the DMA could not resolve a conflict or clarify the date of MMI. He referred to the FECA Procedure Manual

[12] *Id.* at 604.

[13] *Id.*

Chapter 2.808.6(g) (1).[14] Counsel also included case law in support of his arguments. He explained that appellant should receive a lump-sum payment for 270 weeks of compensation beginning November 15, 2015, as the payment should commence from the last date she received wage-loss compensation benefits, which was November 14, 2015.

By decision dated July 7, 2017, OWCP granted appellant a revised award of compensation to reflect separate impairment ratings for the left and right lower extremities. It awarded appellant 21 percent permanent impairment of the left upper extremity, 28 percent permanent impairment of the left lower extremity, and 43 percent permanent impairment of the right lower extremity. The award was to run for 270 weeks for the period September 6, 2016 to November 8, 2021. The date of MMI was listed as September 6, 2016. OWCP explained that the weight of the medical evidence regarding the percentage of impairment was given to the DMA because he correctly applied the A.M.A., *Guides* to the examination findings.

LEGAL PRECEDENT

Section 8149 of FECA delegates to the Secretary of Labor the authority to prescribe rules and regulations for the administration and enforcement of FECA. The Secretary of Labor has vested the authority to implement FECA program with the Director of OWCP.[15] Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.[16] 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 under the law, good administrative practice requires the use of uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[17]

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A. issued a 52-page document entitled "Clarifications and Corrections, Sixth Edition, *Guides to the Evaluation of Permanent Impairment*." The document included various changes to the original text, intended to serve as an *erratum*/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[18] The Board has approved the use by OWCP of the A.M.A., *Guides*

[14] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(g) (March 2017).

[15] *See* 20 C.F.R. §§ 1.1-1.4.

[16] For a complete loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

[17] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[18] *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).

for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[19]

The period covered by a schedule award commences on the date that the employee reaches MMI from the residuals of the employment injury. MMI means that the physical condition of the injured member of the body has stabilized and will not improve further.[20] The determination of the date of MMI is factual in nature and depends primarily on the medical evidence.[21] The date of MMI is usually considered to be the date of the evaluation accepted as definitive by OWCP.[22]

ANALYSIS

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

The Board notes that appellant has not contested the amount of the schedule award. With appellant's April 12, 2017 request for reconsideration, counsel argued that the schedule award decision should be modified to reflect the bilateral lower extremity impairments as separate impairments and that the date of MMI should be changed to October 19, 2015. He further argued that Dr. Ellis, Dr. Williams, and Dr. Wicklund, were all in agreement that the date of MMI was October 19, 2015.

The Board notes that in the last report, the DMA opined that MMI was reached on September 6, 2016, the date of Dr. Wicklunds's independent medical examination. However, Dr. Wicklund opined that October 19, 2015 was the date of MMI as appellant was evaluated for a permanent impairment on that date by Dr. Ellis. He further explained that it did not appear that any further treatment was pursued since then and he opined that further treatment would not be helpful. The Board finds, however, that the DMA failed to provide a reasoned medical opinion to explain how the physical condition of the injured member of the body had stabilized as of September 6, 2016, rather than October 19, 2015 as agreed by the treating physicians, the prior DMA, and the IME physician. The determination of the date of MMI is factual in nature and depends primarily on the medical evidence, which the Board finds insufficient to establish MMI as of September 6, 2016.

The case will be remanded to OWCP to obtain a supplemental report from the DMA, clarifying his opinion as to the date of MMI. Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision.

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

[20] *Adela Hernandez-Piris*, 35 ECAB 839 (1984).

[21] *J.B.*, Docket No. 11-1469 (issued February 14, 2012); *Franklin L. Armfield*, 28 ECAB 445 (1977).

[22] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5 (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the July 7, 2017 decision of the Office of Workers' Compensation Programs is set aside and remanded for additional development consistent with this decision.

Issued: January 28, 2019
Washington, DC

Patricia H. Fitzgerald, Deputy 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