United States Department of Labor
Employees' Compensation Appeals Board

R.E., Appellant	)	
and	)	**Docket No. 18-1661**
	)	**Issued: May 28, 2019**
DEPARTMENT OF THE INTERIOR, BUREAU OF INDIAN AFFAIRS, Neopit, WI, Employer	)	

Appearances:
Stephanie N. Leet, 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 September 4, 2018 appellant, through counsel, filed a timely appeal from an August 13, 2018 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 his burden of proof to establish more than 12 percent permanent impairment of the right lower extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

On January 20, 2014 appellant, then a 26-year-old logger-sawyer, filed a traumatic injury claim (Form CA-1) alleging that: on January 9, 2014 he was struck by a falling tree limb and sustained multiple fractures of his right leg, ankle, and foot; broken teeth; a right elbow laceration; and a traumatic brain injury while in the performance of duty. He stopped work on the date of injury. By decision dated February 7, 2014, OWCP accepted that appellant sustained a concussion without loss of consciousness and a closed fracture of the right tibia.

Appellant underwent provisional external fixation of the right ankle fractures on an emergent basis soon after the injury. On January 30, 2014 Dr. Brian R. Sears, an attending Board-certified orthopedic surgeon, performed an open reduction and internal fixation (ORIF) of right tibial plafond and lateral malleolus fractures. The fixation was located directly under an intramedullary nail placed after a 2005 motor vehicle accident.[3] OWCP paid appellant compensation for total disability commencing February 25, 2014.[4] Appellant did not return to work.

On November 6, 2014 OWCP expanded its acceptance of the claim to include a closed fracture of the right lateral malleolus and two broken teeth.

On January 12, 2017 appellant filed a claim for a schedule award (Form CA-7).

In support of his claim, appellant submitted an August 4, 2016 report by Dr. Neil Allen, a Board-certified internist and neurologist, who found 22 percent permanent impairment of the right lower extremity due to a moderate inversion deficit of the right ankle caused by the accepted fractures. Dr. Allen noted appellant's history of injury and treatment. His findings on examination included a stiff gait pattern, tenderness to palpation of the right ankle mortise joint, and mild-to-moderate crepitus of the right ankle. Dr. Allen found restricted range of motion of the right ankle, including inversion limited to 10 degrees. He referred to Table 16-2 (ankle grid) on page 503 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) under ankle fracture/dislocation.[5] Dr. Allen determined that appellant fell into a class of diagnosis of 2 for a moderate inversion deficit, grade C impairment with a grade modifier of one for functional history (GMFH) (altered gait, American Academy of

[3] In reports dated January 9 and June 2, 2014, Dr. Sears noted that appellant had sustained right lower extremity injuries in a severe motor vehicle accident in 2005, including a right tibial fracture with intramedullary nail fixation and a right foot fracture. He further noted that, prior to the January 30, 2014 employment injury, he had recovered well and functioned normally from an orthopedic standpoint.

[4] Appellant participated in physical therapy treatments commencing in June 2014.

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

Orthopedic Surgeons (AAOS) lower limb questionnaire score of 66), a grade modifier of 2 for physical examination (GMPE) (mild alteration in alignment/deformity compared to unaffected side, mild palpatory findings, mild motion deficit -- eversion, and 2 cm muscle atrophy at right calf), and a grade modifier of 3 for clinical studies (GMCS) (moderate-to-severe right midfoot degenerative joint space narrowing and advanced arthritic changes within the talonavicular joint and midfoot), for a net adjustment of zero. He opined that appellant had 22 percent right lower extremity permanent impairment. Dr. Allen noted that appellant had reached maximum medical improvement (MMI).

OWCP referred Dr. Allen's report, the medical record, and a statement of accepted facts (SOAF) to Dr. Morley Slutsky, a Board-certified occupational medicine specialist and an OWCP district medical adviser (DMA), to obtain an impairment rating. In a report dated February 23, 2017, the DMA opined that appellant's most impairing diagnosis was a tibial plafond fracture with mild motion loss, rated at class 1, row 2 of Table 16-2 on page 503. He found a GMFH of 1 (AAOS questionnaire, no gait aid or external orthotic device), a GMPE of 2 (tenderness and crepitation), and no GMCS as the studies had been used to place appellant into the correct diagnostic class and could not be used again to assign a grade modifier. Dr. Slutsky calculated a net adjustment of 1, for a final grade of D, equaling 12 percent permanent impairment of the right lower extremity. He noted that appellant had reached MMI as of the date of Dr. Allen's examination.

By decision dated March 23, 2017, OWCP granted appellant a schedule award for 12 percent permanent impairment of the right lower extremity. The award covered a period of 34.56 weeks for the period August 4, 2016 to April 2, 2017.

On July 31, 2017 appellant, through counsel, requested reconsideration, contending that the DMA had misapplied the A.M.A., *Guides* and had failed to consider all relevant medical evidence. She submitted a July 13, 2017 addendum report by Dr. Allen, in which he clarified that appellant's right ankle inversion was limited to five degrees. Dr. Allen also contended that the GMCS of 3 should be allowed. He reiterated his prior assessment of 22 percent permanent impairment of the right lower extremity.

On August 25, 2017 OWCP requested that the DMA review Dr. Allen's addendum report and indicate whether it had established an increased percentage of permanent impairment. In a report dated September 6, 2017, the DMA characterized Dr. Allen's report as confusing, as he provided sets of range of motion measurements in and out of brackets. He noted that he could not perform "final calculations" until OWCP ascertained if Dr. Allen had performed three sets of range of motion measurements as required by the A.M.A., *Guides*.

By decision dated September 13, 2017, OWCP denied modification of its prior decision, finding that the additional medical evidence submitted had not demonstrated a greater percentage of permanent impairment than that which was previously awarded. It noted that, if appellant wished to claim an increased schedule award, he should request that Dr. Allen submit additional information regarding right ankle motion as described by the DMA.

On May 1, 2018 appellant, through counsel, requested reconsideration, contending that the DMA had misapplied the A.M.A., *Guides*, that OWCP should have accorded Dr. Allen's opinion

the weight of the medical evidence, and that referral to a DMA was unnecessary as Dr. Allen's reports were clear and correct. She submitted an October 11, 2017 addendum report by Dr. Allen, in which he clarified that he obtained three trials of all range of motion measurements. Dr. Allen contended that the DMA had misread his measurement of 5 degrees inversion, a moderate deficit, as 10 degrees, a mild deficit. He explained that during the August 4, 2016 examination of appellant's right ankle, he had observed -10 degrees dorsiflexion, 45 degrees plantar flexion, 5 degrees inversion, and 10 degrees eversion. Dr. Allen noted that he had based his impairment rating on a diagnosis-based impairment (DBI) of tibial plafond fracture with moderate motion deficits, based on imaging studies from the date of injury, and a moderate motion deficit of 5 degrees inversion. He concluded that appellant had 22 percent permanent impairment of the right lower extremity.

On July 30, 2018 OWCP requested that the DMA review Dr. Allen's October 11, 2017 addendum report and indicate whether it had established an increased percentage of permanent impairment. In a report dated August 7, 2018, the DMA explained that he selected the DBI rating method as it resulted in 12 percent permanent impairment, whereas the ROM method yielded 7 percent permanent impairment. He explained that Dr. Allen had misapplied the A.M.A., *Guides* as he misclassified "mild" motion deficits at class 1, row 2 of Table 16-2 as a "moderate," class 2 impairment. The DMA explained that Dr. Allen's calculation of a grade C impairment required inclusion of a GMCS of 3, although no grade modifier was warranted as clinical studies had been used to determine the correct diagnostic class. He found a grade D impairment based on a GMFH of 1 and GMPE of 2. The DMA confirmed his prior finding of 12 percent permanent impairment of the right lower extremity.

By decision dated August 13, 2018, OWCP denied modification of its prior decision, finding that the additional medical evidence submitted had not demonstrated a greater percentage of permanent impairment than that previously awarded. It found that the opinion of the DMA remained controlling as Dr. Allen had misapplied the A.M.A., *Guides*.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing 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 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. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[10] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment of the class of diagnosis (CDX) condition, which is then adjusted by grade modifiers of GMFH, GMPE, and 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 to an OWCP DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[13]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than 12 percent permanent impairment of the right lower extremity, for which he previously received schedule award compensation.

In support of his claim for a schedule award appellant submitted an August 4, 2016 report from Dr. Allen, who opined that appellant had 22 percent permanent impairment of the right lower extremity due to his right tibial plafond and lateral malleolus fractures. He reviewed medical records and the history of the employment injury. Dr. Allen also provided examination findings and noted that appellant had reached MMI. He referenced Table 16-2 of the A.M.A., *Guides* (ankle grid), under ankle fracture/dislocation.[14] Dr. Allen also provided July 13 and October 11, 2017 addendum reports clarifying his range of motion measurements.

Dr. Slutsky, a DMA, reviewed Dr. Allen's impairment rating and disagreed with his assessment. In his August 7, 2018 report, he explained that Dr. Allen made an error when he rated mild right ankle motion deficits as moderate, which caused his impairment classification of class

[8] *Id.* at § 10.404(a); *see also Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[10] A.M.A., *Guides*, *supra* note 5 at page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[11] *Id.* at 493-556.

[12] *Id*. at 521.

[13] *M.J.*, Docket No. 17-1776 (issued December 19, 2018); *P.R.*, Docket No. 18-0022 (issued April 9, 2018). *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5 (March 2017).

[14] A.M.A., *Guides*, *supra* note 5 at 503.

2 to be in error. The DMA further explained that Dr. Allen should not have included an adjustment for clinical studies as the imaging studies of record had already been used to determine the correct diagnostic class. The grade C impairment classification was thus in error.

The DMA reviewed the case record and determined that appellant had 12 percent impairment of the right lower extremity. He determined that appellant had attained MMI as of August 4, 2016, the date of Dr. Allen's examination. The DMA explained that appellant had a class 1, row 2 DBI impairment for mild right ankle motion deficits, with a grade D impairment based on a functional history adjustment of 1 for an AAOS lower limb questionnaire score of 66, and a physical examination adjustment of 2 for tenderness and crepitation. These deficits equaled 12 percent permanent impairment of the right lower extremity.

The Board finds that the weight of the medical evidence rests with the opinion of the DMA, as he provided the only impairment rating that properly applied the sixth edition of the A.M.A., *Guides*. The DMA appropriately applied the sixth edition of the A.M.A., *Guides* in determining that appellant had 12 percent permanent impairment of the right lower extremity.[15] The record does not contain any other medical evidence in conformance with the sixth edition of the A.M.A., *Guides* establishing greater than the 12 percent permanent impairment of the right lower extremity previously awarded.[16]

On appeal counsel reiterates arguments made in support of the May 1, 2018 request for reconsideration. As explained above, OWCP properly accorded the DMA the weight of the medical evidence as Dr. Allen had misapplied the A.M.A., *Guides.*

Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish more than 12 percent permanent impairment of the right lower extremity, for which he previously received schedule award compensation.

[15] *M.J.*, *supra* note 13; *M.C.*, Docket No. 15-1757 (issued March 17, 2016). In both cases, the only medical evidence that demonstrated a proper application of the A.M.A., *Guides* was the report of the medical adviser).

[16] A.M.A., *Guides* 516.

ORDER

IT IS HEREBY ORDERED THAT the August 13, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 28, 2019
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