United States Department of Labor
Employees' Compensation Appeals Board

A.C., Appellant	)	
and	)	**Docket No. 19-1333**
	)	**Issued: January 8, 2020**
U.S. POSTAL SERVICE, POST OFFICE, Great Bend, KS, 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
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 31, 2019 appellant filed a timely appeal from a May 15, 2019 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.[2]

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than 10 percent permanent impairment of the right lower extremity, for which she previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that appellant submitted additional evidence on appeal. However, the Board's *Rules of Procedure* provides: The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal. 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

FACTUAL HISTORY

On December 16, 2016 appellant, then a 61-year-old city carrier, filed a traumatic injury claim (Form CA-1) alleging that on that date she fractured her right ankle while in the performance of duty. She stopped work on December 16, 2016. On January 18, 2017 OWCP accepted that appellant sustained a displaced trimalleolar fracture of the right lower leg, closed fracture.

On December 17, 2016 appellant underwent an open reduction and internal fixation of the right ankle trimalleolar fracture. On April 19, 2017 she underwent right ankle arthroscopy with extensive debridement, hardware removal right distal fibula, and hardware removal right distal tibia. Appellant was released to regular work on August 14, 2017.[3]

In a February 2, 2018 report, Dr. Joshua J. Boone, a podiatrist, noted appellant's history of injury and treatment, and that she was released to work without restrictions. He indicated that she reached maximum medical improvement (MMI) on August 14, 2017. Dr. Boone referred to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] He opined that appellant had 10 percent permanent impairment of the right lower extremity for the displaced trimalleolar fracture and 5 percent permanent impairment for the distal ankle sydesmosis rupture. Dr. Boone referred to Table 16-2 of A.M.A., *Guides*, pages 502-03 and the Combined Values Chart at page 604 and opined that appellant had 15 percent right lower extremity permanent impairment.

On January 12 and August 9, 2018 appellant filed a claim for a schedule award (Form CA-7).

In a report dated January 25, 2019, Dr. Michael Katz, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), applied the A.M.A., *Guides* to the medical findings provided by Dr. Boone and determined that appellant had 10 percent permanent impairment of the right lower extremity. He referred to the Foot/Ankle Regional Grid, Table 16-2, at page 503, and explained that the ankle fracture, trimalleolar, mild malalignment (syndemosis rupture), fell into class of diagnosis (CDX) of 1 with a default value of 10 percent, and that the treating physician incorrectly calculated an impairment rating for two overlapping conditions within the same regional grid (Table 16-2). The DMA noted that the A.M.A., *Guides* at page 497 related that "If a patient has two significant diagnoses, for instance ankle instability and posterior tibial tendinitis, the examiner should use the diagnosis with the highest causally-related impairment rating for the impairment calculation." He explained that in this case, only the fracture was rated, with the key factor of "malalignment" to include any residual syndesmosis abnormality.

In a February 25, 2019 report, the DMA indicated that further clarification was warranted with regard to Dr. Boone's findings. He noted that Dr. Boone had not provided range of motion measurements for the ankle, however, in finding 10 percent impairment on the basis of the fracture,

[3] The record reflects that appellant had a prior claim for a right knee injury on January 1, 2006. OWCP accepted this claim for a right knee tear of the posterior horn of the medial meniscus under OWCP File No. xxxxxx948. OWCP File No. xxxxxx250 has been administratively combined with prior File No. xxxxxx948 serving as the master file.

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

the key factor under Table 16-2 was mild loss of motion as defined by Table 16-22. The DMA recommended that Dr. Boone be contacted and offered the opportunity to submit a supplemental report to include range of motion measurement of the right ankle, to document his mild loss of range of motion. If Dr. Boone was unable to comply, the DMA recommended that a second opinion evaluation be scheduled.

On March 12, 2019 OWCP referred appellant to Dr. Michael J. Johnson, a Board-certified orthopedic surgeon, for a second opinion evaluation for examination consistent with the provisions of the A.M.A., *Guides.*

In a report dated April 11, 2019, Dr. Johnson conducted a physical examination and made findings based on appellant's right ankle range of motion, sensation, strength, weakness, ambulation, and tenderness. He diagnosed right ankle trimalleolar displaced fracture/dislocation, status post right ankle open reduction and internal fixation, post right ankle arthroscopy debridement, and post hardware removal distal fibula/tibia. Dr. Johnson explained that if more than one diagnosis was involved, the examiner should use the diagnosis with the highest impairment rating. He indicated that he would utilize the displaced trimalleolar fracture and referred to Table 16-2, Foot and Ankle Regional Grid at page 503 of the A.M.A., *Guides*. Dr. Johnson opined that appellant had a CDX of 1 for a diagnosis for the ankle (trimalleolar), with mild motion deficit, a default value of C under the net adjustment formula, and 10 percent permanent impairment of the right lower extremity. He also opined that appellant had reached MMI.

In a May 2, 2019 report, the DMA reviewed the second opinion report from Dr. Johnson and concurred with the assessment and rating provided for the right ankle and the date of MMI. He referred to the A.M.A., *Guides*, Foot/Ankle Regional Grid, Table 16-3, at page 501 and used the diagnostic key factor of trimalleolar fracture, mild motion deficit, to conclude that appellant had a CDX of 1, default value of 10 percent permanent impairment of the right lower extremity. The DMA assigned a grade modifier of 0 for functional history (GMFH), a grade modifier of 1 for physical examination (GMPE), and a grade modifier of 2 for clinical studies (GMCS), applied the net adjustment formula (GMFH-CDX)(0-1= -1) + (GMPE-CDX)(1-1= 0) + (GMCS-CDX)(2-1= +1), and calculated a net adjustment of 0.[5] He also explained that use of ROM methodology as a stand-alone rating of appellant's permanent impairment of the right ankle was not permissible given the accepted diagnosis.

On May 15, 2019 OWCP granted appellant a schedule award for 10 percent permanent impairment of the right lower extremity. The award covered a period of 28.8 weeks from April 11 to October 29, 2019.[6]

[5] The DMA also provided an impairment rating of two percent for the knee. OWCP advised appellant that she would receive a separate decision regarding the impairment to the right knee under OWCP File No. xxxxxx948).

[6] While the schedule award noted that appellant had 10 percent permanent impairment of the right ankle, the award for 28.8 weeks of compensation corresponded to 10 percent permanent impairment of the right lower extremity pursuant to 5 U.S.C. § 8107(c)(2).

LEGAL PRECEDENT

The schedule award provisions of FECA,[7] and its implementing federal regulations,[8] 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. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such a determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 2009.[9] 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.[10]

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).[11] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by GMFH, GMPE, and GMCS.[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[14]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the percentage of permanent impairment using the A.M.A., *Guides*.[15]

[7] *Supra* note 1.

[8] 20 C.F.R. § 10.404.

[9] For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides*, (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[10] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[11] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3, International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[12] *Id.* at 494-531.

[13] *Id.* at 521.

[14] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[15] *Supra* note 9 at Chapter 2.808.6(f) (March 2017); *B.B.*, Docket No. 18-0782 (issued January 11, 2019).

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish greater than 10 percent permanent impairment of the right lower extremity, for which she previously received a schedule award.

OWCP accepted that appellant sustained a displaced trimalleolar fracture of the right lower ankle, closed fracture. On December 17, 2016 appellant underwent an open reduction and internal fixation of the right ankle trimalleolar fracture. On April 19, 2017 she underwent right ankle arthroscopy with extensive debridement and hardware removal right distal fibula and right distal tibia.

Appellant provided a February 2, 2018 report from her treating physician, Dr. Boone, who utilized the A.M.A., *Guides.* However, Dr. Boone incorrectly calculated an impairment rating by adding together the ratings for two diagnoses, instead of selecting the diagnosis with the highest causally-related impairment rating and using only that rating. The A.M.A., *Guides* caution that, if a claimant has two significant diagnoses, the examiner should use the diagnosis with the highest impairment rating in that region that is causally related for the impairment calculation.[16] Dr. Boone also failed to provide documentation for his range of motion examination.

In light of the deficiencies in Dr. Boone's report, OWCP on March 12, 2019, referred appellant to Dr. Johnson for a second opinion evaluation pursuant to the A.M.A., *Guides.* In a report dated April 11, 2019, Dr. Johnson made findings to include range of motion, applied Table 16-2, Foot and Ankle Regional Grid at page 503 of the A.M.A., *Guides*, to the diagnosed condition of displaced trimalloloar fracture, with mild motion deficit, and opined that appellant had a CDX of 1 with a default value of C under the net adjustment formula, and 10 percent permanent impairment of the right lower extremity. He also opined that appellant had reached MMI.

OWCP properly routed the medical evidence to the DMA, Dr. Katz.[17] The DMA, utilized the examination findings from Dr. Johnson's report, applied Table 16-2 on page 501 of the A.M.A., *Guides*, identified the diagnosis as trimalleolar fracture with mild motion deficit, found the appropriate grade modifiers, and utilized the net adjustment formula to calculate that appellant had 10 percent impairment of the right lower extremity. The DMA also properly explained that the ROM methodology for rating appellant's permanent impairment of the right ankle was not available, given the accepted diagnosis.[18]

[16] *Supra* note 4 at page 497.

[17] *See supra* note 16.

[18] *See supra* note 4 at page 543. This section of the A.M.A., *Guides* relates that the Range of Motion Impairment section is to be used as a stand-alone rating when other grids refer to this section or no other diagnosis-based sections of this chapter are applicable for impairment rating of a condition.

As the DMA's report is detailed, well rationalized, and based on a proper factual background, his opinion represents the weight of the medical evidence.[19]

As the record contains no other probative, rationalized medical opinion which indicates that appellant has a greater than 10 percent permanent impairment of the right lower extremity based upon the A.M.A., *Guide*s, she has not met her burden of proof to establish a greater permanent impairment.[20]

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 her burden of proof to establish greater than 10 percent permanent impairment of the right lower extremity, for which she previously received a schedule award.

[19] *See D.S.*, Docket No. 18-1816 (issued June 20, 2019).

[20] *See J.H.*, Docket No. 18-1207 (issued June 20, 2019).

ORDER

IT IS HEREBY ORDERED THAT the May 15, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 8, 2020
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board