United States Department of Labor
Employees' Compensation Appeals Board

P.S., Appellant	)	
and	)	**Docket No. 21-0758**
	)	**Issued: June 10, 2022**
U.S. POSTAL SERVICE, POST OFFICE, Providence, RI, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 7, 2021 appellant filed a timely appeal from October 27, 2020 and March 11, 2021 merit decisions 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 greater than one percent permanent impairment of the left lower extremity, for which she previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq*.

FACTUAL HISTORY

This case has previously been before the Board on a different issue.[2] The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On October 6, 2003 appellant, then a 39-year-old mail processing clerk, filed a traumatic injury claim (Form CA-1) alleging that on October 2, 2003 she twisted her left ankle when she tripped on a rubber mat while in the performance of duty. OWCP accepted the claim for a closed fracture of the tarsal and metatarsal. It paid appellant wage-loss compensation on the periodic rolls from March 10, 2013 until January 10, 2015.

A November 2, 2006 magnetic resonance imaging (MRI) scan of the left foot and ankle revealed hypertrophied lateral tubercle of the calcaneus with severe peroneus brevis tendinitis and a peroneus brevis spit tear, peroneus longus tendinitis, mild tenosynovitis, mild sinus tarsi strain, a lateral spur of the fifth metatarsal articulation, mild Achilles tendinitis, and a mild anterior talofibular ligament sprain.

On May 21, 2010 appellant underwent a peroneal tendon repair of the left foot.

By decision dated December 11, 2014, OWCP terminated appellant's wage-loss compensation and entitlement to a schedule award effective January 11, 2015 as she had refused an offer of suitable work under 5 U.S.C. § 8106(c)(2). By decision dated January 20, 2016, it denied modification of the December 11, 2014 decision.

On March 28, 2017 OWCP expanded the acceptance of appellant's claim to include left ankle tendinitis.

On May 16, 2017 appellant filed a claim for compensation (Form CA-7) for a schedule award. In support of her claim, she submitted a March 2, 2016 report from Dr. Frank Graf, a Board-certified orthopedic surgeon. Dr. Graf discussed appellant's complaints of numbness in the lateral ankle and low back pain. Referencing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] he found 13 percent permanent impairment of the left lower extremity due to L5 radiculopathy with motor and sensory deficits, 5 percent impairment due to lateral cutaneous nerve deficits, 5 percent impairment due to the talus fracture, and 5 percent impairment due to chronic peroneal tendinitis after surgery. Dr. Graf combined these impairments to reach 25 percent permanent impairment of the left lower extremity.

By decision dated May 30, 2017, OWCP determined that appellant's schedule award claim was not payable based on its January 11, 2015 termination of her wage-loss compensation and entitlement to a schedule award for refusing suitable work under 5 U.S.C. § 8106(c)(2).

[2] Docket No. 18-0396 (issued August 17, 2018).

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

On August 11, 2017 appellant requested reconsideration. By decision dated November 15, 2017, OWCP denied modification of its December 11, 2014 termination decision.

Appellant appealed the November 15, 2017 OWCP decision to the Board.

An electromyogram (EMG) and nerve conduction velocity (NCV) study dated August 1, 2018 showed no response at the left peroneal motor nerve at the ankle. The study indicated that the remaining nerves were within normal limits and that muscles showed no electrical instability.

By decision dated August 17, 2018, the Board reversed the November 15, 2017 decision.[4] The Board found that OWCP had failed to establish that appellant was capable of performing the position offered by the employing establishment and thus had failed to meet its burden of proof to terminate her wage-loss compensation and entitlement to a schedule award effective January 11, 2015 based on her refusal of suitable work under 5 U.S.C. § 8106(c)(2).

On December 18, 2018 Dr. Ari Kaz, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), advised that he was unable to calculate any impairment due to loss of range of motion (ROM) of the foot and ankle as Dr. Graf had provided incomplete documentation. He further noted that there was no objective evidence showing L5 radiculopathy, motor or sensory weakness in the left foot and ankle, or residual findings from the healed talus, navicular, and cuboid fractures. Dr. Kaz related, "The lateral cutaneous nerve deficit as noted by Dr. Graf is actually a sural nerve problem, which is a well-known complication of the sinus tarsi approach to debride the sinus tarsi and to repair the peroneal tendons. This is part and parcel of the peroneal tendon pathology, and as such should be included in the rating for the peroneal tendon repair."

OWCP referred appellant to Dr. Jerald W. Katz, a Board-certified orthopedic surgeon, for a second opinion examination regarding the extent of any employment-related permanent impairment.

In a report dated March 5, 2019, Dr. Kaz found normal ROM of the ankle and hind foot and tenderness over the sural nerve with "light touch sensation where [appellant] is hypalgesic." He further found a negative straight leg raise and no back spasm. Dr. Kaz asserted that there were no objective findings on examination. He identified the class of diagnosis (CDX) as class 1 sural nerve neuropraxia, which yielded a default impairment value of three percent according to Table 16-12 on page 534 of the A.MA. *Guides.* Dr. Kaz applied a grade modifier for functional history (GMFH) of two, a grade modifier for physical examination (GMPE) of two, and found no grade modifier for clinical studies (GMCS). Utilizing the net adjustment formula, he found five percent permanent impairment of the left lower extremity due to sural nerve neuropraxia. Dr. Kaz further found three percent permanent impairment of the lumbar spine, for a total left lower extremity impairment of eight percent. He opined that appellant had reached maximum medical improvement (MMI) in 2011.

On April 28, 2019 Dr. Kaz concurred with Dr. Katz' finding that the applicable CDX for rating appellant's impairment was a sural nerve injury using the peripheral nerve impairment

[4] *Supra* note 2.

section of the A.M.A., *Guides*. He asserted that Dr. Katz had not supported his grade modifier determination with objective evidence. Dr. Kaz applied a GMFH of zero as appellant had no limp. He further determined that a GMPE was not applicable as there were no "objective abnormal findings documented other than pain over the sural nerve and altered sensation, which was used to place [appellant] in class and cannot be used again." Utilizing the net adjustment formula, Dr. Kaz moved the rating two places to the left, to find a left lower extremity impairment of one percent according to Table 16-12 on page 534. He indicated that using the diagnosis-based impairment (DBI) method was preferred over the ROM method. Dr. Kaz noted that there was no evidence that appellant's low back pain was related to her foot injury.

By decision dated July 23, 2019, OWCP granted appellant a schedule award for one percent permanent impairment of the left lower extremity. The period of the award ran for 2.88 weeks from March 5 to 25, 2019.

On August 12, 2019 appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review.

Following a preliminary review, by decision dated October 1, 2019, OWCP's hearing representative vacated the July 23, 2019 decision. The hearing representative found that FECA Bulletin No. 17-06 applied when the A.M.A., *Guides* offered alternative rating methods for lower extremity impairments, and thus determined that a supplemental report should be obtained including sufficient ROM measurements to meet the validity criteria of the A.M.A., *Guides*.

In a progress report dated November 26, 2019, Dr. Anthony P. Mechrefe, a Board-certified orthopedic surgeon, found that appellant had an antalgic gait with a positive Tinel's sign on the superficial peroneal nerve and sural nerve of the left foot. He diagnosed ongoing chronic left neuropathic foot pain and advised that he was awaiting surgical authorization to release the nerves.

On November 7, 2019 Dr. Kaz opined that appellant had a definite diagnosis of a sural nerve injury and thus the impairment should be rated using the DBI impairment method.[5]

In a report dated January 15, 2020, Dr. Todd Fellars, a Board-certified orthopedic surgeon serving as a DMA, advised that the proposed release of the sural nerve and superficial peroneal nerve was not causally related to appellant's accepted employment injury or medically necessary.

By *de novo* decision dated January 28, 2020, OWCP granted appellant a schedule award for one percent permanent impairment of the left lower extremity. The period of the award ran for 2.88 weeks from March 5 to 25, 2019.

On February 24, 2020 appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review. In a statement dated February 24, 2020, she questioned why OWCP had not accepted the impairment rating of her physician, Dr. Mechrefe.

[5] Appellant submitted progress reports regarding her continued treatment with Dr. Mechrefe for left foot and ankle pain and low back pain.

On February 14, 2020 OWCP referred appellant to Dr. John Golberg, a Board-certified orthopedic surgeon, for an opinion regarding whether the proposed left foot release of the sural nerve and superficial peroneal nerve with implantation surgery was medically necessary and causally related to her accepted employment injury.

In a report dated March 9, 2020, Dr. Golberg discussed appellant's history of the October 2, 2003 employment injury and complaints of hypersensitivity of the foot. He noted that she had an antalgic gait. Dr. Golberg related, "Examination of the lower extremities demonstrates scarring over the lateral aspect of the foot. There is extreme sensitivity in the region of the scar. There is allodynia with referred pain that affects [appellant] all the way to the mid-calf and she states that she has episode of radiating pain as far as the hip." He opined that appellant had a neuropathic pain response most likely due to the surgery "undertaken to try to correct [appellant's] condition of peroneal tendon abnormality and bone spurs over the lateral foot area." Dr. Golberg advised that the findings on examination showed symptom magnification. Regarding the diagnosis, he related, "There seems to have developed chronic peroneal tendinopathy subsequently as well as the development of post-traumatic exostosis of the lateral forefoot. [Appellant] has neuralgic pain over the lateral foot and neuropathic pain syndrome resulting in chronic pain of the left lateral foot and possibly secondary to previous surgical exploration." Dr. Golberg found that it was uncertain whether surgery would improve appellant's symptoms or allow her to resume work.

In a supplemental report dated April 23, 2020, Dr. Golberg opined that appellant had developed reflex sympathetic dystrophy (RSD) or complex regional pain syndrome (CRPS) of the lower extremity. He noted that she had "allodynia and hypersensitivity over the region of the lateral aspect of the foot and radiating above the ankle area as well as a positive Tinel's sign and extreme sensitivity over the region of the sural nerve." Dr. Golberg found that the proposed surgery was clinically indicated, but might not be successful.

By decision dated May 5, 2020, OWCP's hearing representative affirmed the January 28, 2020 decision.

On June 11, 2020 OWCP authorized left foot and ankle surgery.

In a progress report dated June 15, 2020, Dr. Mechrefe diagnosed left ankle pain and chronic regional pain syndrome of the left lower extremity due to the accepted employment injury. On examination he found full ROM and strength, normal sensation, an antalgic gait, severe left foot and ankle pain with palpation, and hypersensitivity of the lateral side of the left foot and ankle. Dr. Mechrefe recommended against surgical intervention. He advised that appellant had a "significant lower extremity impairment as relates to this work-related injury. This is somewhat on the order of 25 [percent] lower extremity impairment."

On July 6, 2020 Dr. Mechrefe provided similar findings and diagnoses as in his June 15, 2020 report. He again recommended against surgery as it could increase appellant's symptoms. Dr. Mechrefe asserted that she had reached MMI. He found hypersensitivity along the lateral side of the foot and ankle and severe pain with palpation and normal sensation, strength, and motion. Dr. Mechrefe opined that appellant had an employment-related peroneal nerve injury causing pain and an antalgic gait, which resulted in issues with her knee, hip, and back. He found that she had

five percent permanent impairment of the peroneal nerve under Table 16-12 and five percent impairment of the medial and lateral plantar nerves, for a combined lower extremity impairment of nine percent.

On August 14, 2020 appellant requested reconsideration.

On September 2, 2020 Dr. Herbert White, Jr., a Board-certified occupational medicine specialist serving as a DMA, reviewed the evidence of record. He noted that Dr. Golberg had found symptom magnification at the time of his March 9, 2020 examination. Dr. White related that the August 1, 2018 EMG/NCV study of the left ankle had "revealed no response of the left peroneal nerve at the ankle" but that the other nerves were normal. He identified the CDX of left common peroneal nerve and left medial and lateral plantar nerves as a class 0 according to Table 16-12 on page 535-36, which yielded no impairment. Dr. White advised that appellant had normal sensory and motor findings and thus no impairment. He noted that an impairment due to ROM could not be used in rating peripheral nerve impairments according to page 513 of the A.M.A., *Guides*. Dr. White found that appellant had reached MMI on July 6, 2020. He concluded that she was not entitled to an additional schedule award.

In a letter dated September 4, 2020, OWCP requested that Dr. Mechrefe review Dr. White's findings and submit an addendum report with additional comments.

In an undated note received October 1, 2020, Dr. Mechrefe reiterated his prior determination that appellant had a combined rating of nine percent due to five percent lower extremity impairment of the peroneal nerve and medial lateral plantar nerves.

By decision dated October 27, 2020, OWCP denied appellant's claim for an increased schedule award.

On December 11, 2020 appellant requested reconsideration. She submitted an undated report from Dr. Mechrefe. Dr. Mechrefe again found nine percent left lower extremity impairment due to five percent permanent impairment of the common peroneal nerve and medial and lateral plantar nerves according to Table 16-12.

In a report dated February 26, 2021, Dr. White found that appellant had no impairment of the peroneal or medial and lateral plantar nerves as she had normal motor and sensory findings.

By decision dated March 11, 2021, OWCP denied modification of its October 27, 2020 decision.

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. FECA,

[6] *Supra* note 1.

[7] 20 C.F.R. § 10.404.

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.[8] 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.[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] Under the sixth edition, the evaluator identifies 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] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[13]

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*.[14]

ANALYSIS

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

By decision dated January 28, 2020, OWCP granted appellant a schedule award for one percent permanent impairment of the left lower extremity. Subsequent to its decision, it further developed the issue of whether it should authorize a release of the sural nerve and superficial peroneal nerve of the left foot. In a report dated March 9, 2020, Dr. Golberg, an OWCP referral physician, found allodynia with referred pain. He attributed appellant's neuropathic pain response to her prior surgery to repair the peroneal tendon. Dr. Golberg opined that the examination revealed evidence of symptom magnification. He diagnosed chronic peroneal tendinopathy and

[8] 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 Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also* Chapter 3.700, Exhibit 1 (January 2010).

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

[10] 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*.

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

[12] *Id*. 411.

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

[14] *Supra* note 8 at Chapter 2.808.6(f) (March 2017); *B.B.*, Docket No. 18-0782 (issued January 11, 2019).

post-traumatic exostosis of the lateral forefoot and chronic pain of the left lateral foot. In an April 23, 2020 report, Dr. Golberg diagnosed RSD and CRPS of the lower extremity. He indicated that appellant had normal muscle function of the foot and ankle with allodynia, hypersensitivity, and a positive Tinel's sign over the sural nerve.

In a report dated July 6, 2020 Dr. Mechrefe diagnosed left ankle pain and CRPS of the left lower extremity causally related to the accepted employment injury. He found hypersensitivity of the lateral side of the left foot on examination and severe pain with palpation, but normal motion, sensation, and strength. Dr. Mechrefe advised that appellant had sustained a peroneal neve injury causing an antalgic gait. Referencing Table 16-12 of the A.M.A., *Guides*, he opined that she had five percent permanent impairment of the peroneal nerve under Table 16-12 and five percent impairment of the medial and lateral plantar nerves, for a combined lower extremity impairment of nine percent.

Consistent with its procedures, OWCP properly referred the matter to a DMA for an opinion regarding appellant's permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*.[15]

On September 2, 2020 Dr. White, a DMA, noted that Dr. Golberg had found symptom magnification and that the August 1, 2018 EMG/NCV study of the left ankle had "revealed no response of the left peroneal nerve at the ankle" but that the other nerves were normal. He identified the CDX of left common peroneal nerve and left medial and lateral plantar nerves as a class 0 according to Table 16-12 of the A.M.A., *Guides*, which yielded no impairment. Dr. White noted that appellant had normal motor and sensory findings. In a report dated February 26, 2021, he again found that she had no impairment of the peroneal, medial, or lateral plantar nerves due to normal sensory and motor findings. However, Dr. White failed to explain his finding that appellant had no impairment of the peroneal nerve given that electrodiagnostic testing performed August 1, 2018 had showed no response from the left peroneal nerve. Additionally, while he noted that Dr. Golberg had found symptom magnification, he did not discuss Dr. Golberg's findings on examination of a positive Tinel's sign of the sural nerve and allodynia and hypersensitivity of the lateral aspect of the foot or his finding of additional employment-related conditions, including chronic peroneal tendinopathy, post-traumatic exostosis of the lateral forefoot, and RSD or CRPS of the lower extremity. Consequently, the Board finds that the DMA's report requires clarification.

It is well established that, proceedings under FECA are not adversarial in nature and, while the employee has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[16] Once OWCP undertook development of the evidence by referring appellant's case file to a DMA, it had an obligation to do a complete job and obtain a proper evaluation and report that would resolve the issue in this case.[17]

[15] *See S.C.*, Docket No. 20-0769 (issued January 12, 2021).

[16] *See W.W.*, Docket No. 18-0093 (issued October 9, 2018); *William J. Cantrell*, 34 ECAB 1233 (1983).

[17] *See P.T.*, Docket No. 21-0138 (issued June 14, 2021).

The case is, therefore, remanded to OWCP for referral of the case record and a SOAF to the DMA for a proper analysis under the A.M.A., *Guides* in order to determine the extent of appellant's permanent impairment of the left lower extremity. OWCP should also determine, on remand, whether it should expand the acceptance of her claim based on the opinion of Dr. Golberg, its referral physician. After this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision on appellant's schedule award claim.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the October 27, 2020 and March 11, 2021 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: June 10, 2022
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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