United States Department of Labor
Employees' Compensation Appeals Board

E.G., Appellant	)	
and	)	**Docket No. 21-0113**
	)	**Issued: October 7, 2022**
DEPARTMENT OF JUSTICE, BUREAU OF ALCOHOL, TOBACCO, FIREARMS & EXPLOSIVES, Houston, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On November 3, 2020 appellant filed a timely appeal from October 6 and 23, 2020 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 met his burden of proof to establish greater than 29 percent permanent impairment of his right lower extremity and 27 percent permanent impairment of his left lower extremity, for which he previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On October 31, 2014 appellant, then a 56-year-old criminal investigator, filed a traumatic injury claim (Form CA-1) alleging that on October 1, 2014 he developed pain and soreness in both feet and knees while participating in exercise sessions as part of the employing establishment's health improvement plan. OWCP accepted the claim for lateral collateral ligament sprain of the knee; bilateral acquired hallux valgus; bilateral acquired hammertoe; pain due to internal orthopedic prosthetic devices, implants, and grafts, initial encounter; bilateral foot primary osteoarthritis; and pseudarthrosis after fusion or arthrodesis.

Appellant underwent authorized right foot bunionectomy and right fifth toe proximal interphalangeal (PIP) joint arthroplasty on February 13, 2015; left foot first metatarsal phalangeal joint arthrodesis, left fifth toe PIP joint arthroplasty, and right third toe distal interphalangeal (DIP) joint arthroplasty on June 19, 2015; and hardware removal from the left foot, arthrodesis of the left foot second PIP joint, tenotomy and capsulotomy of the second metatarsal phalangeal joint on July 27, 2017.

By decisions dated November 23, 2016 and August 29, 2018, OWCP granted appellant schedule awards for a total of 29 percent permanent impairment of the right lower extremity and 27 percent permanent impairment of the left lower extremity.

On July 25, 2019 appellant underwent a bilateral second toe arthroplasty, tenotomy and capsulotomy of the bilateral second metatarsal phalangeal joints, bilateral second digit flexor tenotomy, and resection of left fifth metatarsal phalangeal joint.

OWCP received a November 18, 2019 medical report by a physical therapist who provided examination findings, which included range of motion (ROM) measurements for each lower extremity. The right lower extremity had 15 degrees of dorisflexion, 50 degrees of plantar flexion, 25 degrees of inversion, and 15 degrees of eversion. The left lower extremity also had 15 degrees of dorisflexion, 50 degrees of plantar flexion, 25 degrees of inversion, and 15 degrees of eversion.

In a December 6, 2019 report, Dr. Gabriel A. Maislos, an attending podiatrist, applied the findings from the physical therapist's November 18, 2019 report to the standards of the sixth edition of the American Medical Association, *Guides the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[2] and determined that appellant had an additional two percent permanent impairment of the right lower extremity and one percent permanent impairment of the left lower extremity, totaling three percent bilateral lower extremity permanent impairment due to his bilateral second digit hammertoe deficiencies and right fifth digit dislocation, and tailor's bunion. He advised that appellant reached maximum medical improvement (MMI) on October 10, 2019.

On December 9, 2019 appellant filed a claim for an increased schedule award (Form CA-7).

OWCP, in a December 18, 2019 development letter, requested that appellant submit an impairment evaluation from his attending physician addressing whether he had reached MMI, and

---

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

if so, the extent of any permanent impairment, in accordance with the sixth edition of the A.M.A., *Guides*. It afforded him 30 days to submit the necessary evidence.

On January 22, 2020 OWCP prepared a statement of accepted facts (SOAF) noting that appellant previously was found to have "32 percent and a 24 percent bilateral permanent impairment of the lower extremities." On that same date, OWCP referred appellant's case record along with the SOAF to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), for a review and rating of appellant's permanent impairment of the bilateral lower extremities in accordance with the sixth edition of the A.M.A., *Guides*.

In a January 23, 2020 report, Dr. Harris reviewed the SOAF and the medical record, including the December 6, 2019 report of Dr. Maislos. He first evaluated the permanent impairment of appellant's bilateral lower extremities utilizing the diagnosis-based impairment (DBI) rating method of the sixth edition of the A.M.A., *Guides*. Regarding permanent impairment to the right lower extremity, the DMA used Table 16-2 on page 508, and identified the class of diagnosis (CDX) as correction of right second and fifth digit deformities as a class 1, grade C, which resulted in one percent impairment of each digit. Using the Combined Values Chart, he determined that appellant had two percent permanent impairment of the right lower extremity. The DMA then related that his diagnosed right lower extremity condition did not meet the criteria under Section 16.7 on page 543 to allow application of the ROM rating method. Regarding permanent impairment to appellant's left lower extremity, he again utilized the DBI method under Table 16-2 and identified the CDX as correction of left second digit deformity as a class 1, grade C impairment, which yielded one percent impairment. Using Table 16-2 again, the DMA identified an additional CDX as arthrodesis for the left first metatarsal phalangeal joint as a class 1, grade C impairment, which yielded 10 percent impairment. Using the Combined Values Chart, he determined that appellant had 11 percent permanent impairment of the left lower extremity. The DMA again advised that appellant's left lower extremity diagnosed condition did not allow application of the ROM rating method. He determined that appellant reached MMI on November 18, 2019, the date of Dr. Maislos' impairment evaluation. The DMA commented that he disagreed with Dr. Maislos' left lower extremity impairment rating as he did not rate appellant's impairment due to his left first metatarsal phalangeal joint arthrodesis. He further commented that OWCP's referral memorandum did not specifically identify which lower extremity that appellant previously received a schedule award for a total of "24 percent impairment and 32 percent impairment." The DMA requested clarification on this issue.

On February 11, 2020 OWCP requested that the DMA review the reports of prior DMAs dated May 16 and July 26, 2018 and an impairment rating evaluation dated February 23, 2018 and provide an opinion on the extent of appellant's permanent impairment.

In a supplemental report dated February 15, 2020, DMA Dr. Harris noted his review of April 6, May 16, and July 26, 2018 reports of prior DMAs, which indicated that appellant had 13 percent permanent impairment of the right lower extremity and 11 percent permanent impairment of the left lower extremity, totaling 24 percent bilateral lower extremity permanent impairment. He also noted his review of a prior DMA's October 13, 2016 report which indicated that appellant had 16 percent permanent impairment of each lower extremity, totaling 32 percent bilateral lower extremity permanent impairment. Based on the above, Dr. Harris opined that appellant had no increased permanent impairment of his right lower extremity and left lower extremity.

In a March 18, 2020 decision, OWCP denied appellant's claim for an increased schedule award, finding that the weight of the medical evidence was accorded to DMA Dr. Harris' February 15, 2020 report.

On June 15, 2020 appellant requested reconsideration and submitted additional medical evidence. An unsigned MMI assessment report dated October 10, 2019 noted that appellant had reached MMI. The report also indicated that he had three percent permanent impairment of the right lower extremity due to his ongoing medical treatment.

In a June 2, 2020 report, Dr. Maislos utilized the DBI rating method found at Table 16-2 on page 508 of the A.M.A., *Guides*, to rate impairment of appellant's right lower extremity. He identified the CDX as a class 1 impairment with a default value of 10 percent for right hallux valgus with surgical bunionectomy and pinning. Dr. Maislos did not assign a grade modifier for functional history (GMFH) noting that it was previously stated in his report. He assigned a grade modifier for physical examination (GMPE) of 1 due to loss of ROM for the great toe and noted that a grade modifier for clinical studies (GMCS) was not applicable as the clinical studies were used to identify appellant's diagnosis. Dr. Maislos applied the net adjustment formula (GMPE - CDX) (1 - 1 = 0), which resulted in a net adjustment of zero for a total of 10 percent permanent impairment due to right hallux valgus with surgical bunionectomy and pinning. Regarding permanent impairment to the right second toe, right third toe, and right fourth toe, he identified the CDX as a class 1 impairment with a default value of one percent under Table 16-2 for hammertoe with surgical repair and pinning. He reiterated his previous reason for not assigning a grade modifier for GMFH. Dr. Maislos assigned a grade modifier for GMPE of 1 due to loss of ROM of the right second, third, and fourth toes, and again noted that a grade modifier for GMCS was not applicable as the clinical studies were used to identify appellant's diagnoses. He applied the net adjustment formula (GMPE - CDX) (1 - 1 = 0), which resulted in a net adjustment of zero for a total of one percent permanent impairment each of the right second, third, and fourth toe. Dr. Maislos also rated permanent impairment of appellant's right ankle, identifying the CDX as a class 0 impairment with a default value of zero percent under Table 16-2 on page 507 for osteoarthritis. He applied the net adjustment formula (GMPE - CDX) (0 - 0 = 0) which resulted in a net adjustment of zero for a total of zero percent permanent impairment of the right ankle. Regarding permanent impairment of the left great toe, Dr. Maislos noted that the CDX was a class 1 impairment with a default value of 10 percent according to Table 16-2 on page 508, for left hallux valgus with surgical bunionectomy, pinning, and fusion. He assigned a grade modifier of 1 for GMFH due to pain with weight-bearing activities, grade modifier of 1 for GMPE due to loss of ROM of the left great toe, and indicated that a grade modifier for GMCS was not applicable, for the previously stated reason. Dr. Maislos applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) (1 - 1 = 0) + (1 – 1 = 0) which resulted in a net adjustment of zero for 10 percent permanent impairment of the left great toe. Regarding permanent impairment of the left second toe, he found that the CDX was a class 1 impairment with a default value of one percent under Table 16-2 on page 508 for left second hammertoe with surgical repair and pinning. Dr. Maislos again did not assign a grade modifier for GMFH, for the previously stated reason. He assigned a grade modifier of 1 for GMPE due to loss of ROM of the left second toe and reiterated his prior rationale for not assigning a grade modifier for GMCS. Dr. Maislos applied the net adjustment formula (GMPE - CDX) (1 - 1 = 0) which resulted in a net adjustment of zero for a total of one percent permanent impairment of the left second toe. In rating permanent impairment of appellant's left ankle, he identified the CDX as a class 1 impairment with a default value of zero

percent under Table 16-2 on page 507 for left ankle osteoarthritis. Dr. Maislos assigned a grade modifier of 1 for GMPE due to no significant loss of ROM and restated his rationale as to why a grade modifier for GMCS was not applicable. He applied the net adjustment formula (GMPE - CDX) (0 - 0 = 0) which resulted in a net adjustment of zero for a total of zero percent permanent impairment of the left ankle. Dr. Maislos combined the right toe impairment ratings and left toe and left ankle impairment ratings to calculate 24 percent bilateral lower extremity permanent impairment. He recommended an additional three percent bilateral lower extremity impairment rating based on appellant's ongoing medical treatment. Dr. Maislos determined that he reached MMI on January 4, 2018.

Appellant again filed a Form CA-7 claim for an increased schedule award on June 13, 2020.

On September 14, 2020 OWCP again referred appellant's case record to DMA Dr. Harris, requesting that he review the medical evidence of record and determine whether appellant sustained increased bilateral lower extremity permanent impairment under the sixth edition of the A.M.A., *Guides* due to his authorized July 25, 2019 surgery.

In a September 21, 2020 report, Dr. Harris reviewed the medical record, and agreed with Dr. Maislos' June 2, 2020 impairment ratings of 13 percent for appellant's right lower extremity and 11 percent for his left lower extremity. However, he disagreed with Dr. Maislos' additional three percent bilateral lower extremity impairment rating due to ongoing treatment of appellant's symptoms. The DMA explained that Dr. Maislos failed to provide rationale in support of his impairment rating. He opined that appellant had no increased bilateral lower extremity permanent impairment. The DMA Dr. Harris determined that appellant reached MMI on June 2, 2020, the date of Dr. Maislos' most recent impairment evaluation. He explained that the medical record did not document that MMI was reached on January 4, 2018.

By decision dated October 6, 2020, OWCP denied appellant's June 13, 2020 claim for an increased schedule award.

By decision dated October 23, 2020, OWCP denied modification of OWCP's March 18, 2020 decision, finding that the weight of the medical evidence continued to rest with the DMA's opinion and established that he had no additional bilateral lower extremity permanent impairment.

LEGAL PRECEDENT

It is the claimant's burden of proof to establish permanent impairment of a scheduled member or function of the body as a result of an employment injury.[3]

---

[3] *See T.H.*, Docket No. 19-1066 (issued January 29, 2020); *D.F.*, Docket No. 18-1337 (issued February 11, 2019); *Tammy L. Meehan*, 53 ECAB 229 (2001).

The schedule award provisions of FECA,[4] and its implementing federal regulations,[5] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7]

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).[8] In determining lower extremity impairment, the sixth edition of the A.M.A., *Guides* requires identifying the impairment CDX, which is then adjusted by a grade modifier for functional history, grade modifier for physical examination, and/or grade modifier for clinical studies.[9] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with the DMA providing rationale for the percentage of impairment specified.[11]

ANALYSIS

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

In support of his claim for an increased schedule award, appellant submitted a June 2, 2020 report from Dr. Maislos who determined that appellant reached MMI on January 4, 2018. Using the appropriate tables in the sixth edition of the A.M.A., *Guides*, he opined that appellant had 13 percent permanent impairment of the right lower extremity and 11 percent permanent impairment of the left lower extremity, totaling a combined 24 percent permanent impairment of the bilateral lower extremities. However, while Dr. Maislos found in subsequent evaluations that he had an additional three percent permanent impairment of the bilateral lower extremities due to ongoing

---

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id.* at § 10.404(a).

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

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

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

[10] *Id.* at 515-22.

[11] *See supra* note 7 at Chapter 2.808.6(f) (March 2017); *see S.H.*, Docket No. 20-0253 (issued June 17, 2020).

treatment of his symptoms, he did offer adequate medical rationale based on the A.M.A., *Guides* to support his impairment rating.[12]

OWCP properly routed the report of Dr. Maislos to a DMA, Dr. Harris, and provided him with a January 22, 2020 SOAF, which indicated that appellant previously was found to have a total of "32 percent and a 24 percent bilateral permanent impairment of the lower extremities." In a September 21, 2020 report, the DMA reviewed Dr. Maislos' report and agreed with his impairment ratings of 13 percent permanent impairment of appellant's right lower extremity and 11 percent permanent impairment of his left lower extremity. However, the record indicates that, by decisions dated November 23, 2016 and August 29, 2018, OWCP granted appellant schedule awards for a total of 29 percent permanent impairment of the right lower extremity and 27 percent permanent impairment of the left lower extremity.

It is OWCP's responsibility to provide a complete and proper frame of reference for a physician by preparing a SOAF.[13] OWCP's procedures dictate that when a DMA, second opinion specialist, or referee physician renders a medical opinion based on a SOAF which is incomplete or inaccurate, or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.[14] OWCP did not provide the DMA with an accurate SOAF as it did not accurately list the schedule awards appellant had previously received for his bilateral lower extremities. Thus, the Board finds that September 21, 2020 report of the DMA was not based on an accurate factual framework and cannot represent the weight of the medical evidence.[15]

Once OWCP undertakes to develop the medical evidence, it has the responsibility to do so in a manner that will resolve the relevant issues in the case.[16] Accordingly, the Board finds that the case must be remanded to OWCP. On remand, OWCP shall prepare a complete and accurate SOAF and request that Dr. Harris, the DMA, submit a supplemental report regarding appellant's bilateral lower extremity permanent impairment. Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

---

[12] *See D.B.,* Docket No. 17-1526 (issued April 6, 2018); *Linda Beale,* 57 ECAB 429 (2006).

[13] *C.E.*, Docket No. 19-1923 (issued March 30, 2021); *M.B.*, Docket No. 19-0525 (issued March 20, 2020); *J.N.*, Docket No. 19-0215 (issued July 15, 2019); *Kathryn E. Demarsh*, 56 ECAB 677 (2005)

[14] *R.W.*, Docket No. 19-1109 (issued January 2, 2020); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990).

[15] *M.B., supra* note 13; *G.C.*, Docket No 18-0842 (issued December 20, 2018).

[16] *M.B.,* Docket No. 21-0060 (issued March 17, 2022); *D.S.*, Docket No. 19-0292 (issued June 21, 2019).

ORDER

IT IS HEREBY ORDERED THAT October 6 and 23, 2020 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: October 7, 2022
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board