United States Department of Labor
Employees' Compensation Appeals Board

A.P., Appellant	)	
	)	
and	)	**Docket No. 22-1246**
	)	**Issued: April 25, 2023**
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, COLEMAN FEDERAL CORRECTIONAL COMPLEX, Coleman, FL, 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
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On August 22, 2022 appellant filed a timely appeal from a July 25, 2022 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.

ISSUE

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

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On September 12, 2015 appellant, then a 35-year-old correctional officer, filed a traumatic injury claim (Form CA-1) alleging that on that date he sustained injuries to his right hip buttock, back, neck, left shoulder, and feet, as well as a mild concussion, blurred vision, and dizziness, when a hatch door gave way causing him to slip and fall in the performance of duty. He stopped work that day. OWCP accepted the claim for concussion with loss of consciousness, cervical, lumbar and pelvic sprains, L4-5 intervertebral disc displacement, lumbar herniated disc with radiculopathy, herniated cervical discs at C4-5 with radiculopathy, right knee chondromalacia, and right ankle tibiofibular ligament sprain.[2]

In an August 14, 2020 report, Dr. William Dinenberg, a Board-certified orthopedic surgeon serving as a second opinion physician, noted appellant's accepted conditions. Regarding appellant's right ankle, he reported that appellant had chronic thinning of the anterior talofibular ligament noted on magnetic resonance imaging scan and tenderness over the anterior talofibular ligament to palpation.

In a permanent impairment rating examination report dated December 22, 2020, Dr. Mark A. Seldes, a Board-certified family practitioner, noted appellant's accepted conditions, reviewed appellant's diagnostic testing reports, and related appellant's physical examination findings. He advised that appellant reached maximum medical improvement (MMI) in regard to his lumbar radiculopathy and right ankle injury as of December 22, 2020. Dr. Seldes used Table 16-2, page 501 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[3] to rate appellant's right ankle permanent impairment for the diagnosis of anterior talofibular ligament strain. He for the class of diagnosis (CDX) of anterior talofibular ligament strain, appellant had a class 1 impairment. Dr. Seldes assigned a grade modifier for functional history (GMFH) of 2 and a grade modifier for physical examination (GMPE) of 2. He noted that a grade modifier for clinical studies (GMCS) was not assigned. Using the net adjustment formula resulted in a net adjustment of +2 or grade severity E. This resulted in seven percent permanent impairment for a class 1 diagnosis with grade E severity. Using Table 16-20 and Table 16-22, page 549, Dr. Seldes he also calculated appellant's impairment using range of motion (ROM) methodology. He found 18 degrees plantar flexion resulted in 7 percent lower extremity permanent impairment, 8 degrees dorsiflexion resulted in 7 percent lower extremity permanent impairment, 10 degrees eversion resulted in 2 percent lower extremity permanent impairment, and 7 degrees inversion resulted in 5 percent lower extremity permanent impairment, resulting in a total 21 percent right lower extremity permanent impairment. Next, Dr. Seldes calculated appellant's permanent impairment for the diagnosis of lumbar spine with radiculopathy in the right S1 nerve root using *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment* (July/August 2009) (*The Guides Newsletter*). He identified the CDX as S1 radiculopathy and assigned a class 1 impairment. Dr. Seldes assigned a GMFH of 2 as appellant

[2] OWCP assigned the present claim OWCP File No. xxxxxx572. Under OWCP File No. xxxxxx666, it accepted the occupational disease claim for lumbar intervertebral disc displacement and lumbar intervertebral disc disorders with radiculopathy. In a letter dated December 8, 2017, OWCP informed appellant that it had administratively combined OWCP File Nos. xxxxxx666 and xxxxxx572, with the latter serving as the master file.

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

had an American Academy of Orthopedic Surgeons lower limb questionnaire scoring in the moderate deficit range. He further found that a GMPE was not used. Dr. Seldes reported a GMCS of 2 as the nerve conduction velocity and electromyography tests showed evidence of lumbar radiculopathy with right S1 nerve root involvement. He applied the net adjustment formula, resulting in a net adjustment of +2, which raised the default CDX grade value of C to E, corresponding to four percent permanent impairment of the lower extremity for sensory impairment. Dr. Seldes noted that there was mild motor deficit at Grade E, which equaled five percent permanent impairment. He added the percentages for a total of nine percent permanent impairment of the right lower extremity due to S1 radiculopathy. Lastly, Dr. Seldes combined the two lower extremity impairments of 21 percent right lower extremity impairment for right ankle and foot loss of ROM with 9 percent permanent impairment for right S1 lumbar radiculopathy, resulting in a total of 28 percent right lower extremity permanent impairment.

Appellant elected to receive benefits from the Office of Personnel Management in lieu of FECA compensation, effective May 1, 2021.

On May 8, 2021 appellant filed a claim for compensation (Form CA-7) for a schedule award.

On July 13, 2021 OWCP referred appellant's case, along with a statement of accepted facts (SOAF), for a schedule award impairment rating to Dr. Michael Katz, a Board-certified orthopedic surgeon, serving as the district medical adviser (DMA). In a July 14, 2021 report, Dr. Katz reviewed the medical record and SOAF. He recommended that OWCP obtain a second opinion permanent impairment evaluation by a Board-certified physiatrist for an assessment of appellant's right ankle ROM and spinal nerve deficits.

On April 20, 2022 OWCP referred appellant along with a SOAF, to Dr. Omar David Hussamy, a Board-certified orthopedic surgeon, for a second opinion examination and rating of permanent impairment using the sixth edition of the A.M.A., *Guides*.

In a May 6, 2022 report, Dr. Hussamy summarized the medical reports of record. He provided findings following physical examination of appellant's right ankle/foot and right lower extremity. Dr. Hussamy noted radiation of pain to the right lower extremity and right ankle pain, otherwise no right ankle objective findings. He referred to Table 16-2 of the Foot and Ankle Regional grid,[4] and determined that, for the CDX of joint instability/ligamentous laxity, appellant had a class 0 impairment due to no significant objective abnormal muscle or tendon injury findings, resulting in a zero percent permanent impairment. Next, Dr. Hussamy found a zero percent permanent impairment using the ROM method and Table 16-22.[5] Regarding right S1 radiculopathy, he noted that, based on *The Guides Newsletter*, appellant had a class 1 spinal nerve impairment for S1 mild motor deficit with a default value of three percent. Dr. Hussamy assigned a GMFH of 2, a GMPE of 1, and a GMCS of 1. Using the net adjustment formula, he calculated a net adjustment of +1, which moved the default value from Grade C to Grade D, which equaled four percent permanent impairment for motor deficits and a one percent permanent impairment for

[4] A.M.A., *Guides* 502.

[5] *Id.* at 549.

sensory deficits. Combining the sensory and motor deficits for the S1 nerve root resulted in a total of five percent right lower extremity permanent impairment.

On May 24, 2022 OWCP referred the case back to DMA Dr. Katz for a permanent impairment rating. In a report dated May 27, 2022, Dr. Katz reviewed the SOAF and Dr. Hussamy's May 6, 2022 report. Using Table 16-2, page 501 of the A.M.A., *Guides*, for the CDX of joint instability/ligamentous laxity, he identified a class 0 impairment for no significant abnormal objective right ankle findings with a default value 0. Dr. Katz found no net adjustment and result of 0 percent right lower extremity permanent impairment. Next, using the DBI method of *The Guides Newsletter,* he identified class 1 impairment for the S1 spinal nerve with mild sensory deficit for a default value of one percent. Dr. Katz assigned a GMFH of 2, a GMPE of 1, and a GMCS of 1. Using the net adjustment formula, he calculated a net adjustment of +1, which moved the default value from Grade C to Grade D, which equaled a one percent permanent impairment. Next, Dr. Katz identified a class 1 impairment for S1 mild motor deficit with a default value of three percent. He assigned a GMFH of 2, a GMPE of 1, and a GMCS of 1. Using the net adjustment formula, Dr. Katz calculated a net adjustment of +1, which moved the default value from Grade C to Grade D, which equaled four percent permanent impairment for motor deficits and one percent impairment for sensory deficits. Combining the sensory and motor deficits for the S1 nerve root resulted in a total of five percent right lower extremity permanent impairment. Dr. Katz noted that the ROM methodology was not applicable, and indicated that appellant reached MMI on May 6, 2022, the date of Dr. Hussamy's report. He concurred with Dr. Hussamy's assessment of no permanent impairment for appellant's right foot/ankle, and five percent permanent impairment for S1 spinal nerve right lower extremity permanent impairment.

By decision dated June 6, 2022, OWCP granted appellant a schedule award for five percent right lower extremity permanent impairment. The period of the award ran from May 6 to August 14, 2022.

In a follow-up medical evaluation dated June 20, 2022, Dr. Seldes reiterated examination findings from his prior report.

In a June 21, 2022 report, Dr. Seldes reviewed Dr. Hussamy's May 6, 2022 report and appellant's assertion that Dr. Hussamy did not use a goniometer in measuring appellant's right ankle ROM. He noted his disagreement with Dr. Hussamy's, finding no right ankle ROM deficits.

On June 27, 2022 appellant requested reconsideration of the June 6, 2022 schedule award decision.

On July 11, 2022 OWCP again referred the case to DMA Dr. Katz for review of the newly submitted medical evidence. In a July 14, 21022 report, Dr. Katz reviewed the medical record and SOAF. He opined that Dr. Hussamy's measurement of a right ankle normal arc of motion would not necessitate subsequent measurement as it was normal, and therefore, would be the best of any 3 measurements used in the calculation. Dr. Katz also opined that Dr. Hussamy's examination findings were more consistent with the examination findings of Dr. Dinenberg. He therefore opined that his earlier opinion regarding impairment remained unchanged.

By decision dated July 25, 2022, OWCP denied modification of its June 6, 2022 decision denying appellant's schedule award claim.

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. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, good administrative practice necessitates 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)): A Contemporary Model of Disablement*.[10] In determining permanent impairment of the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the ankle, the relevant portion of the leg for the present case, reference is made to Table 16-2 (Foot and Ankle Regional Grid) beginning on page 501.[11] After the CDX is determined from the Foot and Ankle Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating of choices, including choices of diagnoses from regional grids and calculations of modifier scores.[13]

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[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 2.808.5(a) (March 2017); *see also id*. at Chapter 3.700, Exhibit 1 (January 2010).

[9] *D.M.*, Docket No. 21-1209 (issued March 24, 2022); *L.E.*, Docket No.20-1505 (issued June 7, 2021); *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.

[11] *See* A.M.A., *Guides* 501-08, Table 16-2.

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

[13] *Id.* at 23-28.

Neither FECA, nor its implementing regulations, provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[14] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[15] The sixth edition of the A.M.A., *Guides* provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*. It was designed for situations in which a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. The FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the Federal (FECA) Procedure Manual.[16]

Section 8123(a) of FECA provides in part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[17] In situations where there exist opposing medical reports of virtually equal weight and rationale, and the case is referred to an IME for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[18]

ANALYSIS

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

Regarding appellant's right ankle permanent impairment, the Board notes that the A.M.A., *Guides* caution that most lower extremity impairments are rated based on the DBI methodology if the impairment class is described by the diagnosis. ROM is primarily used as a physical examination adjustment factor and is only used to determine actual impairment values when it is not possible to otherwise define impairment.[19]

With regard to appellant's accepted right anterior talofibular ligament strain, Dr. Seldes, in his December 22, 2020 report, found that under Table 16-2 appellant had a class 1 impairment for the diagnosis. Dr. Seldes assigned a GMFH of 2 and a GMPE of 2. He noted that no grade modifier was assigned for GMCS. Using the net adjustment formula Dr. Seldes related that a net adjustment of +2 resulted in a grade severity E, seven percent permanent impairment. He also opined that appellant had 21 percent permanent impairment of the right lower extremity right anterior talofibular ligament strain based on the ROM methodology. In a report dated May 6, 2022, Dr. Hussamy, OWCP's referral physician, calculated zero percent permanent impairment

[14] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *C.S.*, Docket No. 19-0851 (issued November 18, 2019).

[15] *Supra* note 8 at Chapter 2.808.5c(3) (March 2017).

[16] *Supra* note 8 at Chapter 3.700, Exhibit 4 (January 2010); *B.M.*, Docket No. 19-1069 (issued November 21, 2019).

[17] 5 U.S.C. § 8123(a).

[18] *D.C.*, Docket No. 20-0897 (issued August 11, 2021); *D.M.*, Docket No. 18-0746 (issued November 26, 2018); *R.H.*, 59 ECAB 382 (2008); *James P. Roberts*, 31 ECAB 1010 (1980).

[19] A.M.A., *Guides* 497.

using the DBI method under Table 16-2, page 502. He determined that appellant had a class 0 impairment due to no significant objective abnormal muscle or tendon injury findings, resulting in zero percent permanent impairment. Next, Dr. Hussamy found zero percent permanent impairment using the ROM method and Table 16-22.[20]

With regard to right S1 nerve root impairment, Dr. Seldes found four percent permanent impairment of the right lower extremity for sensory deficit and five percent permanent impairment for motor deficit, resulting in nine percent permanent impairment of the right lower extremity due to S1 radiculopathy. However, Dr. Hussamy calculated four percent permanent impairment of the lower extremity for motor deficit and one percent permanent impairment for sensory deficit, resulting in a total of five percent right lower extremity permanent impairments of right anterior talofibular ligament strain.

The Board therefore finds that a conflict in the medical evidence exists between Dr. Seldes, appellant's treating physician, and Dr. Hussamy, OWCP's referral physician, regarding whether appellant had permanent impairment of the right lower extremity greater than the five percent previously awarded.

Therefore, the case must be remanded to OWCP for referral of appellant to an independent medical examiner for resolution of the conflict in medical opinion evidence in accordance with 5 U.S.C. § 8123(a). After such further development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

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

[20] *Id.* at 549.

ORDER

IT IS HEREBY ORDERED THAT the July 25, 2022, decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: April 25, 2023
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board