



## **FACTUAL HISTORY**

This case was previously before the Board. By decision dated December 1, 2005, the Board affirmed a June 23, 2005 Office decision that denied appellant's claim for a schedule award.<sup>1</sup> The December 1, 2005 Board decision is herein incorporated by reference.

By decisions dated January 27 and March 31, 2006, the Office denied appellant's requests for reconsideration.<sup>2</sup>

Appellant subsequently submitted additional evidence. In an April 21, 2004 report, Dr. Gregory V. Dubay, an attending podiatrist, provided findings on physical examination. He stated:

“Palpation posterior muscle mass did not produce a Homans sign. No evidence of deep or superficial vein thrombophlebitis is noted. Palpable nodes are not seen in the bilateral popliteal fossa. There is one + edema both of the ankles and rear foot bilaterally.

“Motor and sensory functions appear fully intact. Reflexes are equal, active and symmetrical. Babinski, Tinel, ankle clonus indicators and Mulder signs are not noted; although, there is some subjective numbness along the lateral aspect of the left foot following the distal sural nerve and lateral malleolus to the 5<sup>th</sup> left toe.”

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“Muscle tone, bulk and strength are well within normal limits for age and sex. There is a moderate pronatory defect bilaterally that measures six degrees of forefoot varus and four degrees of rear foot varus bilaterally. There is tightness of the plantar fascia with pain at the insertion of the plantar fascia into the medial tubercle of the calcaneus. Attempting to maximally dorsiflex both of the feet produces pain. No signs of mediolateral ankle instability ....

“[Dynamic gait analysis] [r]eveals a moderate pronatory defect associated with high-degree of forefoot and rear foot varus. There is significant delaying of the locking of the midtarsal joint and hypermobility of the first ray. Excessive forefoot peak pressures are evident to sub metatarsal heads two and three bilaterally. Early heel lift is consistent with equinus pattern.”

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<sup>1</sup> Docket No. 05-1490 (issued December 1, 2005). Appellant, a heavy mobile equipment mechanic supervisor, submitted a claim for a schedule award for his accepted bilateral foot conditions, inferior calcaneal spurs, plantar fasciitis and periositis. By decision dated June 23, 2005, the Office denied his schedule award claim.

<sup>2</sup> In support of his requests for reconsideration, appellant submitted no new evidence. He asserted that the medical evidence previously submitted was sufficient to establish his entitlement to a schedule award. Appellant filed an appeal with the Board on March 20, 2006. However, he had intended to file a reconsideration request with the Office and he requested that the Board dismiss his appeal. By order dated June 22, 2006, the Board dismissed appellant's appeal.

In a February 14, 2006 report, Dr. Dubay stated that he was not qualified to perform an impairment evaluation.

On July 24, 2006 Dr. H.P. Hogshead, Board-certified and a district medical adviser, noted that the medical evidence regarding appellant's accepted foot conditions did not reveal any objective findings or limitations that would provide the basis for a finding of permanent impairment. He stated that appellant had no impairment of the right or left lower extremity.

By decision dated November 2, 2006, the Office denied modification of its June 23, 2005 denial of appellant's schedule award claim.

### **LEGAL PRECEDENT**

The schedule award provision of the Federal Employees' Compensation Act<sup>3</sup> and its implementing regulation<sup>4</sup> 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, the Act 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. The American Medical Association, *Guides to the Evaluation of Permanent Impairment* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.<sup>5</sup>

### **ANALYSIS**

Dr. Dubay stated that appellant's motor and sensory functions were fully intact.<sup>6</sup> Reflexes were equal, active and symmetrical. Muscle tone, bulk and strength were well within normal limits. There was numbness along the lateral aspect of the left foot that was subjective. There was a moderate pronatory defect bilaterally that measured six degrees of forefoot varus and four degrees of rear foot varus bilaterally.<sup>7</sup> Dr. Dubay indicated a slight gait defect associated with a high-degree of forefoot and rear foot varus. However, Table 17-5 at page 529 of the A.M.A., *Guides* provides no impairment rating for the gait findings noted by Dr. Dubay.

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<sup>3</sup> 5 U.S.C. § 8107.

<sup>4</sup> 20 C.F.R. § 10.404.

<sup>5</sup> *Id.*

<sup>6</sup> Dr. Dubay found that appellant had pain at the insertion of the plantar fascia into the medial tubercle of the calcaneus. Attempting to maximally dorsiflex both of his feet produced pain. However, as noted above, Dr. Dubay stated that appellant's sensory functions were intact and Dr. Hogshead did not find that appellant had any impairment due to these findings of pain.

<sup>7</sup> There is a provision for impairment due to varus abnormality, in the A.M.A., *Guides*, only for the ankle or hindfoot. See Table 17-13 at page 537. Appellant had a hindfoot (rearfoot) varus of four degrees. There is no impairment for hindfoot varus of less than 10 degrees in Table 17-13. Dr. Dubay indicated that there were no signs of mediolateral ankle instability.

Dr. Hogshead stated that the medical evidence regarding appellant's accepted foot conditions did not reveal any objective findings or limitations that would provide the basis for a finding of permanent impairment based on the A.M.A., *Guides*. He concluded that appellant had no impairment of the right or left lower extremity.<sup>8</sup>

There is no probative medical evidence establishing that appellant has any impairment causally related to his accepted foot conditions. He has the burden of proof to submit medical evidence supporting that he has permanent impairment of a scheduled member of the body.<sup>9</sup> Appellant has not met his burden of proof.

### CONCLUSION

The Board finds that appellant failed to establish that he had any permanent impairment of his feet causally related to his accepted employment related conditions.

### ORDER

**IT IS HEREBY ORDERED THAT** the decisions of the Office of Workers' Compensation Programs dated November 2, March 31 and January 27, 2006 are affirmed.

Issued: April 23, 2007  
Washington, DC

David S. Gerson, Judge  
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge  
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge  
Employees' Compensation Appeals Board

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<sup>8</sup> See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

<sup>9</sup> See *Annette M. Dent*, 44 ECAB 403 (1993).