United States Department of Labor
Employees' Compensation Appeals Board

S.H., Appellant	)	
and	)	
DEPARTMENT OF AGRICULTURE, PITTSBURGH TERMINAL MARKET Pittsburgh, PA, Employer	)	**Docket No. 09-29** **Issued: April 8, 2009**

Appearances:
Edward L. Daniel, for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On October 3, 2008 appellant, through his representative, filed a timely appeal of the Office of Workers' Compensation Programs' merit decisions dated January 8 and August 15, 2008. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this appeal.

ISSUE

The issue is whether appellant has more than a 23 percent impairment of the right lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On May 8, 2006 appellant, then a 65-year-old agricultural commodity grader, filed a claim for an occupational disease. On April 17, 2006 he first became aware of his right Achilles

bursitis with right achillotenotomy.[1] On May 5, 2006 appellant first realized that his right foot condition was caused by standing one to three hours several times a week while performing inspections at work. By letter dated July 20, 2006, the Office accepted the claim for temporary aggravation of right Haglund syndrome. By letter dated September 21, 2006, it accepted that appellant sustained a recurrence of disability on August 21, 2006. Appellant stopped work on August 23, 2006.[2] On October 30, 2006 the Office accepted appellant's claim for right calcaneal spur and Achilles tendinitis. It changed the previously accepted condition of temporary aggravation of right Haglund syndrome to aggravation of right Haglund syndrome based on an October 23, 2006 medical opinion of Dr. Arnold T. Berman, an Office medical adviser. The Office authorized right posterior calcanectomy, excision of the retrocalcaneal bursa and secondary repair of the Achilles tendon which were performed on November 6, 2006 by Dr. Bowman.

On April 27, 2007 appellant filed a claim for a schedule award. By decision dated October 17, 2007, the Office denied the claim. It found the evidence of record insufficient to establish that appellant sustained any permanent impairment causally related to his accepted employment-related conditions.

In a November 21, 2007 letter, appellant, through his representative, requested reconsideration. A September 19, 2007 medical report of Dr. John W. Ellis, a Board-certified orthopedic surgeon, stated that appellant sustained temporary aggravation of Haglund's syndrome, a calcaneal spur and Achilles tendinitis nerve impingement on the medial aspect of the right foot and patellofemoral syndrome of the right knee due to an abnormal gait of the right foot which were causally related to his employment duties. Dr. Ellis opined that he reached maximum medical improvement on March 28, 2007 regarding his right foot. He determined that appellant's diminished range of motion of the right knee resulted in a five percent impairment of the right lower extremity based on Table 17-10 on page 537 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001). Dr. Ellis further determined that appellant's diminished range of motion of the right foot resulted in a 30 percent impairment (A.M.A., *Guides* 537-41, Tables 17-11, 17-12, 17-13, 17-24, 17-25, 17-26, 17-27, 17-28). He determined that appellant sustained a Grade 3 dysesthesia due to impingement on the medical nerve of the right ankle which represented 40 percent impairment. Dr. Ellis multiplied the 40 percent Grade 3 impairment by the maximum 5 percent allowed for impairment of the medial nerve to calculate 2 percent impairment. He added the 30 percent impairment rating for decreased range of motion and 2 percent sensory deficit impairment to calculate a 32 percent impairment of the right foot. Dr. Ellis opined that appellant sustained a 35 percent combined impairment of the right lower extremity due to his right foot employment-related conditions and right knee condition. (A.M.A., *Guides* 604, Combined Values Chart). He further opined that he sustained 31 percent combined impairment due to her employment-related foot conditions.

[1] Appellant underwent right foot surgery on January 6, 2006 which was performed by Dr. Michael W. Bowman, a Board-certified orthopedic surgeon.

[2] Appellant's employment was terminated by the employing establishment effective November 26, 2007 due to his unavailability for duty. On January 22, 2008 he elected to receive retirement benefits from the Office of Personnel Management effective December 1, 2007.

On December 22, 2007 Dr. Berman reviewed Dr. Ellis's September 19, 2007 findings. He stated that the Office had not accepted appellant's claim for a right knee condition and, thus, he could not recommend a five percent impairment rating for the right knee. Dr. Berman applied the tables of the A.M.A., *Guides* to Dr. Ellis's range of motion measurements for the right foot to determine that appellant sustained a 21 percent impairment of the right lower extremity (A.M.A., *Guides* 537, 604, Tables 17-11, 17-12, Combined Values Chart). He noted that Dr. Ellis incorrectly calculated the percentage for eversion, was two percent rather than three percent. Dr. Berman determined that appellant sustained five percent impairment for medial plantar nerve sensory deficit (A.M.A., *Guides* 552, Table 17-37). He multiplied Dr. Ellis's finding that appellant sustained 40 percent impairment for Grade 3 dysesthesia by the 5 percent impairment for sensory deficit to calculate 2 percent impairment for the medial plantar nerve (A.M.A., *Guides* 482, Table 16-10). Dr. Berman combined the 21 percent impairment for decreased motion with the 2 percent impairment for sensory deficit, to calculate a 23 percent impairment of the right lower extremity (A.M.A., *Guides* 604, Combined Values Chart).

By decision dated January 28, 2008, the Office granted appellant a schedule award for a 23 percent impairment of the right lower extremity based on Dr. Berman's December 22, 2007 opinion. In a March 28, 2008 letter, appellant, through his representative, requested reconsideration. Dr. Ellis explained in his March 20, 2008 report that appellant was awarded five percent impairment for decreased range of motion of the right knee due to the abnormal gait of his right foot. He stated that appellant had developed patellofemoral syndrome on the medial aspect of the right knee. If it had not been for the right foot injury, Dr. Ellis stated that there would not have been an abnormal gait of the right foot or patellofemoral syndrome of the right knee with chondromalacia of the right patella. He related that the right knee condition was not due to age as the left knee was normal.

The Office found a conflict in the medical opinion evidence between Dr. Ellis and Dr. Berman as to the extent of appellant's permanent impairment of the right lower extremity. By letter dated May 16, 2008, it referred him, along with a statement of accepted facts, the case record and a list of questions to be addressed, to Dr. Paul A. Liefeld, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a June 2, 2008 report, Dr. Liefeld reviewed a history of appellant's accepted employment-related injuries and medical treatment. He also reviewed a history of his right knee injury and resultant surgery which occurred 25 years ago as a result of a motorcycle accident and his subsequent reinjury of the right knee during a fall which also required surgery. On physical examination of the right ankle, Dr. Liefeld reported, among other things, -10 degrees of active dorsiflexion and 25 degrees of active plantar flexion. He further reported five degrees of passive inversion of the right hindfoot and zero degrees of neutral eversion at rest. Dr. Liefeld stated that there was no fixed motion or ankylosis present anywhere in the right ankle or hindfoot. On x-ray examination of the right ankle, he reported the presence of a modest or a small amount of bone formation in the soft tissues off the posterior surface of the proximal posterior calcaneal surface consistent with slight bone formation or heterotopic ossification in a prior surgical site where appellant had been known to have an Achilles tendon repair. There was a very slight spur along the medial border of the talus. The x-rays were otherwise unremarkable. X-rays of the right knee demonstrated, among other things, the presence of advanced patellofemoral degenerative disease and significant lateral joint space narrowing consistent with degenerative arthritis,

principally in the lateral compartment were also demonstrated. A partial patellaectomy with the lower third of the patella had been resected, such that appellant had a 2.5 centimeter vertical mid-body patellar height of the right patella compared to a 4 centimeter mid-body patellar height on the left.

Dr. Liefeld opined that appellant's severe degenerative post-traumatic arthritis of the right knee and resultant surgeries were caused by his motorcycle accident and not by his accepted established work duties. He stated that Dr. Ellis inappropriately used Tables 17-24 through 17-28 of the A.M.A., *Guides*, as appellant did not have a condition of ankylosis of the right foot. Dr. Liefeld utilized Tables 17-11, 17-12 and 17-13 on page 537 of the A.M.A., *Guides* to determine the extent of permanent impairment related to appellant's right foot. He stated that, while appellant demonstrated 25 degrees of active plantar flexion and active dorsiflexion lacking 10 degrees of a neutral foot ankle posture, he was observed standing with a 0 degree neutral foot ankle posture. Although Dr. Liefeld believed that appellant had a passive range of motion that exceeded both of those endpoints, he utilized those visibly observed endpoints as a basis for a range of motion assessment. Dr. Liefeld stated that appellant did not even qualify for a mild degree of plantar flexion motion loss. He related that even if one were to accept his measured active dorsiflexion position of -10 degrees, he would qualify on that basis for only a mild degree of impairment constituting a 3 percent impairment of the whole person, a 7 percent impairment of the lower extremity and 10 percent impairment of the foot. Dr. Liefeld stated that appellant demonstrated 5 degrees of combined inversion/eversion which represented a 2 percent impairment of the whole person, a 5 percent impairment of the lower extremity and a 7 percent impairment of the right foot. He further stated that appellant did not have a fixed or significant heel varus or valgus based on his direct observation. Dr. Liefeld further stated that none of the ankylosis impairment tables applied to his condition. He determined that the maximum impairment based on these measurements resulted in a 5 percent impairment of the whole person, a 12 percent impairment of the right lower extremity and a 17 percent impairment of the right foot. Dr. Liefeld stated that these impairment ratings overestimated appellant's true impairment as he observed foot and ankle motions that exceeded the measurements observed during the course of his examination.

By letter dated June 25, 2008, the Office requested that Dr. Liefeld clarify his impairment rating. It stated that the Federal Employees' Compensation Act required an impairment rating related to the affected body part and not the whole person. In a June 30, 2008 supplemental report, Dr. Liefeld stated that appellant sustained a 17 percent impairment of the right ankle and foot based on the A.M.A., *Guides*.

On July 28, 2008 Dr. Morley Slutsky, an Office medical adviser, reviewed Dr. Liefeld's June 2 and 30, 2008 findings. He opined that appellant sustained a 12 percent impairment of the right lower extremity. Dr. Slutsky determined that 25 degrees of plantar flexion constituted 0 percent impairment, -- 10 degrees of dorsiflexion constituted 7 percent impairment and 5 degrees of combined inversion and eversion resulted in 5 percent impairment, resulting in 12 percent impairment. He stated that Dr. Liefeld did not document any testing to support two percent impairment for medial plantar nerve sensory deficit. Dr. Slutsky noted that the maximum impairment for this condition was five percent (A.M.A., *Guides* 552, Table 17-37). He stated that, even if appellant was given the maximum impairment value for this condition, his final impairment rating would not exceed 23 percent. Dr. Slutsky combined the 12 percent

impairment for decreased range of motion and the 5 percent impairment for sensory deficit of the medial nerve to calculate a 16 percent impairment of the right lower extremity (A.M.A., *Guides* 604, Combined Values Chart). He stated that, if any further controversy arose regarding appellant's impairment, then a statement should be obtained from Dr. Liefeld as to whether he performed sensory testing for the right medial plantar nerve and whether there was a ratable impairment. Dr. Slutsky concurred with Dr. Liefeld's evaluation and rating examination in this case, noting that he had to provide the best estimate of appellant's actual right ankle active motion during an examination filled with inconsistent actions by appellant.

In an August 15, 2008 decision, the Office denied modification of the January 28, 2008 decision. It found that appellant had no more than a 23 percent impairment of the right lower extremity.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulations[4] set forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[5] However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[6]

In situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[7]

ANALYSIS

The Board finds that the Office properly determined that a conflict in the medical opinion evidence arose between Dr. Ellis, an attending physician, and Dr. Berman, an Office referral physician, as to the extent of permanent impairment of appellant's right lower extremity due to his employment-related right calcaneal spur and Achilles tendinitis, and aggravation of right Haglund syndrome. Dr. Ellis opined that appellant sustained a 31 percent impairment of the right lower extremity based on the A.M.A., *Guides*. Dr. Berman opined that appellant sustained a 23 percent impairment of the right lower extremity based on the A.M.A., *Guides*.

[3] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[4] 20 C.F.R. § 10.404.

[5] 5 U.S.C. § 8107(c)(19).

[6] 20 C.F.R. § 10.404.

[7] *Gloria J. Godfrey*, 52 ECAB 486 (2001).

The Office referred appellant to Dr. Liefeld, selected as the impartial medical specialist.

Dr. Liefeld opined that appellant's severe degenerative post-traumatic arthritis of the right knee and resultant surgeries were caused by his motorcycle accident and not by his accepted established work duties. He determined that the maximum impairment based on his measurements resulted in a 5 percent impairment of the whole person, a 12 percent impairment of the right lower extremity and a 17 percent impairment of the right foot which overestimated appellant's true impairment as he observed foot and ankle motions that exceeded the measurements observed during the course of his examination.

Dr. Liefeld's June 30, 2008 supplemental report stated that appellant sustained a 17 percent impairment of the right ankle and foot based on the A.M.A., *Guides*.

Dr. Liefeld properly applied the A.M.A., *Guides* and provided a detailed and well-rationalized report for rating a 12 percent impairment of the right lower extremity. The Board finds that Dr. Liefeld's opinion is entitled to special weight as the impartial medical specialist.

On July 28, 2008 Dr. Slutsky, an Office medical adviser, reviewed Dr. Liefeld's June 2 and 30, 2008 findings and determined that appellant sustained a 12 percent impairment of the right lower extremity. He combined the 12 percent impairment for decreased range of motion and the 5 percent impairment for sensory deficit of the medial nerve to calculate a 16 percent impairment of the right lower extremity (A.M.A., *Guides* 604, Combined Values Chart). Dr. Slutsky recommended that Dr. Liefeld submit a statement as to whether he performed sensory testing for the right medial plantar nerve and whether there was a ratable impairment if any further controversy arose regarding appellant's impairment.

Dr. Slutsky's determination of appellant's impairment was based on Dr. Liefeld's findings and complies with the A.M.A., *Guides*. He supported Dr. Liefeld's opinion in determining that appellant sustained a 12 percent impairment of the right lower extremity. The Board finds that appellant has no more than a 23 percent impairment of the right lower extremity.

CONCLUSION

The Board finds that appellant has failed to establish that he has more than a 23 percent impairment of the right lower extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the August 15 and January 8, 2008 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: April 8, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board