U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of TAMMY CRAVEN and U.S. POSTAL SERVICE,
POST OFFICE, Tulsa, OK

Docket No. 01-1307; Submitted on the Record;
Issued January 23, 2002

DECISION and ORDER

Before MICHAEL J. WALSH, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether appellant has more than a three percent impairment of both the left and right lower extremities for which she received a schedule award.

On September 14, 1999 appellant, then a 31-year-old city carrier, filed an occupational injury claim alleging that prolonged walking caused her to develop a bilateral foot condition resulting in surgery. She first became aware of it on or about March 29, 1999 and first realized that it was caused or aggravated by her employment on September 2, 1999. On November 4, 1999 the Office of Workers' Compensation Programs accepted the claim for aggravation of bilateral bunions and a bilateral bunionectomy, which was performed on October 15, 1999. Appellant returned to work on March 17, 2000 in a limited-duty position.[1]

Dr. Steven Smith, a podiatrist, performed the bunionectomy and continued treatment for appellant's accepted foot condition. Following surgery, appellant continued to complain of pain, weakness and numbness in her right foot and was referred to a neurologist. Appellant was later referred to a clinical psychologist for anxiety and depression related to continued problems with her feet.

In a June 13, 2000 work restriction evaluation, Dr. Smith indicated that appellant had reached maximum medical improvement that day and recommended permanent work restrictions of limited walking and standing and weight bearing restrictions.

On July 17, 2000 Dr. Smith evaluated appellant for an impairment rating. He reported her history of injury, discussed her corrective surgery on October 15, 1999 and reported that appellant continued to have pain with her feet despite physical therapy and orthopedics.

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[1] On August 26, 2000 appellant was reemployed with the employing establishment as a modified city carrier. On January 10, 2001 the Office determined that the position fairly and reasonably represented her wage-earning capacity.

Dr. Smith indicated that the degree of appellant's impairment remained consistent and was unlikely to change substantially within the upcoming year. He further stated that appellant underwent examination and he determined her impairment based on the fourth edition of the American Medical Association (A.M.A.), *Guide to Evaluation of Permanent Impairment*. Dr. Smith stated:

> "She has an antalgic limp with shortened stance phase which will require her to use a part-time walking aid such as a cane or crutch for distance walking … Chapter 3.2(b), Table 36, shows a total body impairment of fifteen percent (15 percent). Muscle testing impairment rating was not deemed to be useful due to the pain with testing. In addition, a range of motion testing with the majority of her lower extremity joints showed no impairment except for a mild (2 percent) impairment for limited extension of her great toe joints between 15 to 30 degrees according to Chapter 3.2(e), Table 45. Due to these findings, I would recommend a fifteen percent (15 percent) impairment rating."

On August 15, 2000 appellant filed a Form CA-7 claim for a schedule award.

In a September 13, 2000 report, Dr. H. Mobley, an Office medical adviser reviewed Dr. Smith's report and stated that Dr. Smith reported "bilateral bunions s/p resection, pes planus (flat feet), significant pain, question of RSD, depression and anxiety and a 15 percent whole person impairment based upon an antalgic gait requiring an assistive device for distance walking." He concluded that the report did not meet the requirements of Office regulations for a schedule award determination, because of the discordance between the diagnosis and the amount of the impairment and the questionable use of gait disturbance as the basis for the impairment rating.

On November 18, 2000 the Office referred appellant for a second opinion evaluation in order to determine her schedule award claim. In a report dated December 20, 2000, Dr. Varsha Sikka, a Board-certified physician in physical medicine and rehabilitation, discussed appellant's chief complaints of foot pain, his physical findings, diagnosis, recommendations and disability evaluation. On examination he stated:

> "Ankle dorsiflexion is 20 degrees and plantar flexion is 50 degrees. Subtaler inversion is five degrees, forefoot adduction is 20 degrees and forefoot abduction is 10 degrees. Range of motion of the first metatarsal phalangeal joint is within normal limits. Flexion is 45 degrees and extension is 45 degrees. Pain does increase on range of motion."

Dr. Sikka then stated: "[Appellant] pronates both feet on ambulation, right is worse than left and there is a slight limp. She favors her right foot in gait but gait is functional and speed is normal. Station is normal…." He determined that appellant had moderate to severe bilateral pes

planus feet since birth, status post bilateral bunionectomy and preexisting condition of bilateral bunions. Dr. Sikka concluded:

> "According to A.M.A., *Guides*, 4th Edition, utilizing Table 36, page 76, Chapter 3, [appellant] does not have any impairment rating at this time. Utilizing Table 37 and 39, Impairment for Leg Muscle Atrophy, [appellant] does not have any atrophy or wasting of the muscle groups. Utilizing Tables 55, 56, 57, 58, 59 and 60, range of motion of the ankle is normal. [Appellant] does not have any impairment rating. Utilizing Table 61, [appellant] does not have any arthritis noted from the x-ray. Utilizing Table 64, ankle, hind foot, mid foot and forefoot, [appellant] has normal range of motion and no impairment rating."
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> "According to the A.M.A., *Guides*, 4th Edition, [appellant] does not have any impairment rating from her surgery. Bilateral pes planus and bunions were preexisting and her pain and symptoms were aggravated, requiring surgery but she maintains normal range of motion of the ankle first metatarsal phalangeal joint. There is no gait derangement and there is no atrophy of the musculature noted. Muscle strength and range of motion is within normal limits."

Dr. Sikka concluded that appellant could continue her regular-duty work utilizing her orthopedics and her home exercise program. He indicated in an impairment work sheet that appellant's date of maximum improvement was July 2000.

In a memorandum to the medical adviser dated January 8, 2001, the Office requested that the district medical adviser review Dr. Sikka's report and complete a schedule award work sheet concerning the date of maximum improvement, functional loss of use and percentage of impairment of the lower extremity in accordance with the A.M.A., *Guides*.

In a January 10, 2001 report, Dr. Mobley reviewed Dr. Sikka's impairment evaluation and determined that the maximum medical improvement was December 20, 2000. He reported Dr. Sikka's findings and his conclusion that appellant had no ratable impairment of the lower extremities according to the fourth edition of the A.M.A., *Guides*. Dr. Mobley assessed appellant's nerve deficit of the lower extremity on Table 68, Figure 59 on pages 89-93 where he found five percent bilateral impairment based on sensory impairment and appellant's pain or sensory impairment on Table 11 on page 48, which he determined was a grade 3 or 60 percent. He then calculated 60 percent by 5 percent and indicated that based on the fourth edition of the A.M.A., *Guides*, appellant had 3 percent impairment of the right lower extremity and three percent impairment of the left lower extremity. Dr. Mobley noted that, contrary to the fourth edition of the A.M.A., *Guides*, the Office gave more credence to pain in the consideration of impairment, therefore, he included consideration for pain in his rating.

By decision dated January 18, 2001, the Office issued a schedule award for three percent of the right lower extremity (foot) and three percent of the left lower extremity (foot) for the period December 20, 2000 to March 16, 2001.

Under section 8107 of the Federal Employees' Compensation Act[2] and section 10.404 of the implementing federal regulations,[3] schedule awards are payable for permanent impairment of specified body members, functions or organs. 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 under the law for 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 A.M.A., *Guides* have been adopted by the Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[4]

The Board finds that the case is not in posture for a decision due to an unresolved conflict in the medical opinion

In this case, the probative medical evidence consists of Dr. Smith's opinion regarding gait derangement that appellant had 15 percent lower limb impairment and the second opinion physician Dr. Sikka, who found that appellant did not have any impairment with regard to gait derangement.

Dr. Smith, in his report dated July 21, 2000, deduced that, because appellant had an antalgic limp with shortened stance phase, which required part time use of a walking aid, she had a total body impairment of 15 percent under Chapter 3.2(b), Table 36 of the A.M.A., *Guides*. In a September 13, 2000 report, the Office medical adviser found that Dr. Smith's report did not meet the requirements of Office regulations for a schedule award determination, because of "the discordance between the diagnosis and the amount of the impairment and the questionable use of gait disturbance as the basis for the rating." The Office thereafter referred appellant to Dr. Sikka for evaluation, who in his report dated December 20, 2000, also assessed appellant's lower limb impairment from gait derangement pursuant to the A.M.A., *Guides.* Dr. Sikka found that appellant had a slight limp and that she favored her right foot gait but that the gait was functional. He opined pursuant to Table 36 on page 76 that appellant did not have any impairment in that regard. The Board finds that both Drs. Smith and Sikka utilized Table 36 for determination of appellant's lower limb impairment from gait derangement and each report constitutes probative medical evidence on the issue presented.

Section 8123(a) of the Act provides that, when there is a disagreement between the physician making the examination for the United States and the physician of the employee, a third physician shall be appointed to make an examination to resolve the conflict. When there are opposing medical reports of virtually equal weight and rationale, the case must be referred to an impartial specialist, pursuant to section 8123(a), to resolve the conflict in the medical evidence.[5] Since there is a disagreement between an attending physician, Dr. Smith and a second opinion physician, Dr. Sikka, as to the degree of permanent impairment to the lower limb

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] *James J. Hjort*, 45 ECAB 595 (1994).

[5] *Robert W. Blaine*, 42 ECAB 474 (1991); 5 U.S.C. § 8123(a).

due to gait derangement, a conflict under 5 U.S.C. § 8123(a) is created. On remand the Office should refer appellant to an appropriate impartial specialist for a reasoned opinion as to the degree of permanent impairment, including impairment to the lower limb under the A.M.A., *Guides*.[6] After such further development as the Office deems necessary, it should issue an appropriate decision.

The decision of the Office of Workers' Compensation Programs dated January 18, 2001 is set aside and the case remanded for further action consistent with this decision of the Board.

Dated, Washington, DC
January 23, 2002

Michael J. Walsh
Chairman

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member

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[6] *William C. Bush*, 40 ECAB 1064 (1989).