U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ROBERT F. PAIGE and DEPARTMENT OF THE AIR FORCE, AIR NATIONAL GUARD, Milford, MA

Docket No. 02-85; Submitted on the Record;
Issued June 24, 2002

DECISION and ORDER

Before ALEC J. KOROMILAS, WILLIE T.C. THOMAS, MICHAEL E. GROOM

The issue is whether appellant sustained any permanent impairment entitling him to a schedule award of the lower extremity.

On May 6, 1997 appellant, then a 52-year-old tools and parts attendant, injured his right ankle during military exercise drills. The Office of Workers' Compensation Programs accepted the claim for right ankle sprain of the medial malleolar region and bilateral aggravation of chronic posterior tibial tendinitis. Appellant stopped work on May 9, 1997 and returned to limited duty on May 16, 1997. Appropriate compensation benefits were paid.

Thereafter, appellant submitted treatment notes from Dr. Thomas Kristiansen, a Board-certified orthopedist, dated June 1997 to March 1998. Dr. Kristiansen noted a history of appellant's right ankle injury which occurred during drill exercises in the National Guard. He diagnosed appellant with a right ankle sprain, chronic posterior tibial tendinitis and long-standing bilateral pes planus with hyperpronation. Dr. Kristiansen indicated that appellant's preexisting bilateral pes planus with hyperpronation were hindering his recovery. He recommended light-duty work.

On June 11, 1998 appellant filed a Form CA-2a, notice of recurrence of disability. He indicated a recurrence of his ankle condition due to employment-related injuries sustained on May 6, 1997. The Office accepted appellant's claim for recurrence of injury and paid appropriate compensation.

On September 24, 1998 appellant filed a claim for a schedule award. He submitted several reports from Dr. Kristiansen dated May 7, 1997 to August 18, 1998. Dr. Kristiansen noted in his report of September 30, 1997 that appellant had an onset of left ankle symptoms with tenderness along the medial malleolus and behind the medial malleolus. His November 25, 1997 note indicated that appellant would not be able to fulfill his employment duties including carrying equipment under potential combat situations. Dr. Kristiansen's report dated June 16, 1998, indicated that the combination of appellant's work-related injury and the decreased activity following the injury led to weakness in both ankles from which appellant has never recovered. He noted that appellant was disabled since the first time he was treated and would not be able to

perform all of his regular duties particularly those involving running and prolonged standing. Dr. Kristiansen's report of August 18, 1998 indicated that appellant's condition was chronic and that appellant's condition would probably deteriorate. He noted appellant's condition was permanent and he must modify his work due to the disability of his feet.

In a letter dated April 10, 2000, the Office requested Dr. Kristiansen evaluate appellant for permanent impairment of the lower extremity in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (4th ed. 1993).

In a letter dated April 18, 2000, Dr. Kristiansen indicated that he did not perform disability impairment evaluations.

Thereafter, the Office referred appellant to a second opinion physician.

In a February 1, 2001 report, Dr. John H. Buckner, a Board-certified orthopedist and office referral physician, diagnosed appellant with status post right ankle sprain and deltoid sprain, resolved and preexisting hyperpronated/flat feet unrelated. Dr. Buckner noted maximum medical improvement had been reached and indicated that there were no permanent residuals of appellant's May 6, 1997 injury. He noted that appellant had normal total ankle range of motion, inversion-eversion were symmetric; there was no anklylosis; and no impairment due to weakness, atrophy, pain or anesthesia. Dr. Buckner indicated that according to the A.M.A., *Guides* (4th ed.) appellant had no ratable impairment of the lower extremity based on the accepted injury.

The Office determined that a conflict of medical opinion had been established between appellant's attending physician, Dr. Kristiansen, who continued to indicate that appellant was disabled due to the employment-related injury and Dr. Buckner, the second opinion doctor, who concluded that appellant's employment-related condition had resolved.

To resolve the conflict, appellant was referred to a referee physician, Dr. Christopher P. FitzMorris, an orthopedist, to resolve the conflict in medical opinion evidence.

The Office provided Dr. FitzMorris with appellant's medical records, a statement of accepted facts as well as a detailed description of appellant's employment duties. In a medical report dated March 28, 2001, Dr. FitzMorris indicated that he reviewed the records provided to him and performed a physical examination of appellant. He noted findings upon physical examination of plantar flexion of 30 degrees on the right;[1] 35 degrees on the left;[2] inversion was 45 degrees bilaterally;[3] eversion was 20 degrees on the right and 30 degrees on the left;[4] there

[1] *See* Table 42, page 78 of the A.M.A., *Guides* (4th ed.); *see also* Table 17-11, page 537 of the A.M.A., *Guides* (5th ed.).

[2] *Id.*

[3] *See* Table 43, page 78 of the A.M.A., *Guides* (4th ed.); *see also* Table 17-12, page 537 of the A.M.A., *Guides* (5th ed.).

[4] *Id.*

were no findings of motor or sensory deficits; no ankylosis was present;[5] no weakness;[6] no atrophy;[7] no anesthesia; however, he noted evidence of pain. Dr. FitzMorris further noted pain was difficult to evaluate and was not considered in the A.M.A., *Guides* (4th ed.) but indicated that a functional capacity evaluation was recommended if pain was to be considered a significant component of disability; however, there was no universally accepted standard, method or instrument for evaluating functional capacity. He indicated that appellant did suffer residuals causally related to his right ankle injury of May 6, 1997 and noted the work-related injury did aggravate appellant's preexisting pes planus and hyperpronation. Dr. FitzMorris further noted that appellant's left foot and ankle problems were related to his right ankle injury on May 6, 1997 and indicated that appellant's residuals were permanent. He indicated, based on the A.M.A., *Guides* (4th ed.), that appellant had zero percent impairment rating for both lower extremities based on Table 42 and 43, page 78 of the A.M.A., *Guides* (4th ed.).

Dr. FitzMorris' report and the case record were referred to the Office's medical adviser who, in a report dated June 18, 2001, used Dr. FitzMorris' findings and determined that appellant had no permanent impairment of the lower extremities.[8] The Office medical adviser utilized Dr. FitzMorris' findings upon examination to determine the impairment rating in accordance with the A.M.A., *Guides* (5th ed. 2001) and determined that appellant sustained zero percent permanent impairment of the lower extremities.[9]

In a decision dated July 2, 2001, the Office denied appellant's request for a schedule award.

The Board finds that appellant did not sustain any permanent disability due to his May 6, 1997 injury.

The schedule award provision of the Act[10] and its implementing regulation[11] 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

[5] *See* Table 55-59, page 80-81 of the A.M.A. *Guides* (4th ed.); *see also* Table 17-24 to 17-28, page 541 of the A.M.A., *Guides* (5th ed.).

[6] *See* Table 39, page 77 of the A.M.A., *Guides* (4th ed.); *see also* Table 17-8, page 532 of the A.M.A., *Guides* (5th ed.).

[7] *See* Table 37-38, page 77 of the A.M.A., *Guides* (4th ed.); *see also* Table 17-6, page 530 of the A.M.A., *Guides* (5th ed.).

[8] *See* Table 17-11, page 537 of the A.M.A., *Guides* (5th ed.); Table 17-12, page 537 of the A.M.A., *Guides* (5th ed.); Table 17-24 to 17-28, page 541 of the A.M.A., *Guides* (5th ed.); and Chapter 18, page 565 of the A.M.A., *Guides* (5th ed.).

[9] In a memorandum dated June 18, 2001, the Office requested that the Office medical adviser revise his findings of May 1, 2001 which was based on the A.M.A., *Guides* (4th ed.), to conform to the A.M.A., *Guides* (5th ed.).

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404 (1999).

all claimants. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.

The Office accepted appellant's claim for right ankle sprain of the medial malleolar region and bilateral aggravation of chronic posterior tibial tendinitis. The Office reviewed the medical evidence and determined that a conflict existed in the medical evidence between appellant's attending physician, Dr. Kristiansen, who disagreed with Dr. Buckner concerning whether appellant had any continuing work-related condition. Consequently, the Office referred appellant to Dr. FitzMorris to resolve the conflict.

Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.[12]

The Board finds that the opinion of Dr. FitzMorris is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight and establishes that appellant's work-related condition has ceased.

Dr. FitzMorris reviewed appellant's history, reported findings and noted an essentially normal physical examination. He indicated that upon physical examination plantar flexion was 30 degrees on the right which resulted in 0 percent rating;[13] 35 degrees on the left which resulted in 0 percent rating;[14] inversion was 45 degrees bilaterally which resulted in zero percent rating;[15] eversion was 20 degrees on the right which resulted in 0 percent rating;[16] eversion of 30 degrees on the left which resulted in 0 percent rating;[17] there were no findings of motor or sensory deficits; no ankylosis was present;[18] no weakness;[19] no atrophy;[20]; no anesthesia; however, he noted evidence of pain. Dr. FitzMorris noted pain was difficult to evaluate and was not considered in the A.M.A., *Guides* (4th ed.) but indicated that a functional capacity evaluation was recommended if pain was to be considered a significant component of disability; however, there was no universally accepted standard, method or instrument for evaluating functional capacity. He indicated, based on the A.M.A., *Guides* (4th ed.), that appellant has 0 percent impairment

[12] *Aubrey Belnavis*, 37 ECAB 206 (1985).

[13] *See* Table 42, page 78 of the A.M.A., *Guides* (4th ed.); *see also* Table 17-11, page 537 of the A.M.A., *Guides* (5th ed.).

[14] *Id.*

[15] *See* Table 43, page 78 of the A.M.A., *Guides* (4th ed.); *see also* Table 17-12, page 537 of the A.M.A., *Guides* (5th ed.).

[16] *Id.*

[17] *Supra* note 15.

[18] *See* Table 55-59, page 80-81 of the A.M.A., *Guides* (4th ed.); *see also* Table 17-24 to 17-28, page 541 of the A.M.A., *Guides* (5th ed.).

[19] *See* Table 39, page 77 of the A.M.A., *Guides* (4th ed.); *see also* Table 17-8, page 532 of the A.M.A., *Guides* (5th ed.).

[20] *See* Table 37-38, page 77 of the A.M.A., *Guides* (4th ed.); *see also* Table 17-6, page 530 of the A.M.A., *Guides* (5th ed.).

rating for both lower extremities based on Table 42 and 43, page 78 of the A.M.A., *Guides* (4th ed.).

The medical adviser reviewed the findings in Dr. FitzMorris' report, and in a report dated June 18, 2001, correlated them to specific provisions in the A.M.A., *Guides* (5th ed.) to determine that appellant sustained no permanent impairment of the lower extremities. He noted normal inversion and eversion figures;[21] and dorsiflexion and plantar flexion figures[22] which resulted in zero permanent impairment of the lower extremities. The Board notes that the Office medical adviser properly utilized the fifth edition of the A.M.A., *Guides* when evaluating Dr. FitzMorris' impairment evaluation and determined that appellant sustained a zero percent permanent impairment of the lower extremities. Upon review of both the fourth and fifth editions of the A.M.A., *Guides* the Board notes that there is no difference in the impairment rating in appellant's case.[23]

The medical adviser properly applied the A.M.A., *Guides* to the information provided in Dr. FitzMorris's report to conclude that there was no impairment. This evaluation conforms to the A.M.A., *Guides* and establishes that appellant has no ratable impairment of the lower extremities.

The decision of the Office of Workers' Compensation Programs dated July 2, 2001 is hereby affirmed.

Dated, Washington, DC
June 24, 2002

Alec J. Koromilas
Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

[21] *See* Table 43, page 78 of the A.M.A., *Guides* (4th ed.); *see also* Table 17-12, page 537 of the A.M.A., *Guides* (5th ed.).

[22] *See* Table 42, page 78 of the A.M.A., *Guides* (4th ed.); *see also* Table 17-11, page 537 of the A.M.A., *Guides* (5th ed.).

[23] *Supra* note 1-7.