United States Department of Labor
Employees' Compensation Appeals Board

J.G., Appellant	)	
and	)	**Docket No. 06-1208**
	)	**Issued: December 29, 2006**
U.S. POSTAL SERVICE, POST OFFICE, Pittsburgh, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 24, 2006 appellant filed a timely appeal from the February 3, 2006 merit decision of the Office of Workers' Compensation Programs which found that he was not entitled to an additional schedule award. Under 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the schedule award issue.

ISSUE

The issue is whether appellant has established that he has more than a 39 percent impairment for his right lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On October 18, 1994 appellant, then a 45-year-old letter carrier, filed an occupational disease claim alleging that walking while carrying his mailbag caused him to suffer right heel pain. He underwent surgery on August 26, 1994 for right foot plantar fascia release, returned to limited duty on October 31, 1994 and eventually returned to full duty. The Office accepted that appellant sustained an employment-related right foot plantar fibromatosis and keloid scar and

paid appropriate compensation for periods of disability. The Office also accepted appellant's claim for a recurrence of disability in December 2001 due to this condition and paid for additional medical care. No time was lost from work. On February 12, 2002 appellant had scar tissue excised from his right foot.

The record reflects that appellant has a previous claim under file number 030153791 for a permanent aggravation of his bilateral arthritis of the knees, for which he underwent a total knee replacement to his left knee in March 2003 and a partial knee replacement to his right knee in July 2003. In an April 23, 2004 decision, the Office awarded appellant a schedule award for a 50 percent permanent impairment to his left lower extremity and a 37 percent permanent impairment to his right lower extremity. Appellant also has a work-related carpal tunnel syndrome under file number 032018766 and has received a five percent permanent impairment to his left upper extremity and a five percent permanent impairment to his right upper extremity as a result of this condition.[1] He stopped working on January 17, 2003 due to his carpal tunnel condition and did not return. Appellant retired on January 6, 2004.

Appellant later claimed a schedule award in the present claim. In a report dated July 26, 2004, Dr. James J. Sullivan, Board-certified in physical medicine and rehabilitation, advised that appellant's right foot pain and impaired ambulation constituted a gait derangement. He explained that appellant's obesity and bilateral knee replacement procedures factored into his ambulation deficits. Dr. Sullivan opined that, under the standards of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001), appellant had a mild lower limb impairment due to gait derangement which equated to a 7 percent whole person impairment under Table 17-5, page 529 and a 17 percent right lower extremity impairment under Table 17-3, page 527.[2]

In August 2004, the Office referred appellant's medical record to its Office medical adviser, noting that appellant had previously received a 37 percent lower extremity impairment award.

In a report dated November 17, 2004, the Office medical adviser advised that the request for an additional 17 percent extremity impairment could not be approved. He noted that appellant had prior bilateral knee replacements and advised that Table 17-2, page 526 of the A.M.A., *Guides* precluded gait derangement awards when other awards are made. The Office medical adviser also advised that no award should be based upon right foot plantar fibromatosis as the July 26, 2004 examination indicated "no pain on percussion of the right heel, no pain on palpation of the plantar fascia." The Office medical adviser suggested that a 2 percent impairment due to pain under Table 18-1, page 574 would be appropriate, which would equate to a total right lower extremity award of 39 percent.

[1] Appellant also has nonwork-related conditions. The record indicates that appellant underwent a left shoulder rotator cuff repair in 2002, a ventral abdominal hernia repair in 1991, lumbar discectomies in 1999 and March 2004 and a bladder stone removal in July 2004.

[2] Dr. Sullivan additionally provided impairment ratings for appellant's upper extremities.

By award of compensation dated February 9, 2005, the Office granted appellant a schedule award for a total right lower extremity impairment of 39 percent. The Office deducted that 37 percent permanent impairment of the right lower extremity previously awarded from the total award of 39 percent and paid appellant the remaining 2 percent impairment due.

On February 10, 2005 appellant requested a review of the written record. By decision dated July 22, 2005, an Office hearing representative found that there was a conflict in medical opinion between Dr. Sullivan and the Office medical adviser with regard to the degree and extent of any permanent impairment to the right lower extremity as a result of appellant's work-related knee and foot conditions. The Office hearing representative set aside the Office's February 9, 2005 decision and remanded the case to the Office for referral of appellant to an appropriate impartial medical specialist and the issuance of a *de novo* decision.

By letter dated October 21, 2005, the Office referred appellant, together with a statement of accepted facts, the case record and a list of questions to be addressed to, Dr. Albert G. Liddell, a Board-certified orthopedic surgeon, for an impartial medical examination. In a January 3, 2006 report, Dr. Liddell opined that appellant had reached maximum medical improvement with regards to the right lower extremity in July 2004 and presented his examination findings. He advised that, under the A.M.A., *Guides*, fifth edition, appellant's atrophy was not sufficient to result in a calculation. Dr. Liddell also stated that appellant's quadriceps weakness was not applicable in view of the subjective strength measurements and the fact that appellant "gave way" when he first tested his quad strength. He further stated that appellant did not have an antalgic gait with regard to the right or left foot and that he had equal range of motion of both ankles. Dr. Liddell explained that appellant exhibited a stiff ankle gait bilaterally and attributed his stiffness on both sides to his body habitus and weight, not to any work-related activity. Thus, he disagreed with Dr. Sullivan that there was evidence of gait derangement affecting the right leg compared to the left leg. Utilizing the A.M.A., *Guides*, 547, Table 17-33, Dr. Liddell determined that appellant had a 15 percent impairment of the whole person related to his right unicondylar knee arthroplasty which equated to a 37 percent impairment of the lower right extremity. He stated that appellant has a skin scar in the medial-plantar aspect of the right heel which was slightly tender distally and advised that, under the A.M.A., *Guides*, 574, Table 18-1, the discomfort represented one percent impairment. Thus, Dr. Liddell opined that appellant had a total right leg impairment of 38 percent. He disagreed with the Office medical adviser's award of two percent impairment based on pain under the A.M.A., *Guides*, 574, Table 18-1, as he found no significant tenderness with palpation of the plantar fascia when he deeply palpated the origin of the plantar fascia on the right and left sides. Dr. Liddell additionally explained that appellant has had plantar fascia released from the right calcaneus, which was the area where he complained of this very mild pain with very mild pressure.

By decision dated February 3, 2006, the Office denied appellant's request for an increased schedule award by according special weight to Dr. Liddell's opinion as the impartial medical specialist.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulation[4] sets 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. 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.[5]

When there exist 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 upon a proper factual background, must be given special weight.[6] As a general rule in schedule award cases, the physician should describe the impairment in sufficient detail to permit clear visualization of the impairment and the restrictions and limitations that have resulted.[7]

ANALYSIS

The Office accepted that appellant sustained an employment-related plantar fascial fibromatosis and keloid scar on his right leg and, in a prior claim, accepted a permanent aggravation of his bilateral arthritis of the knees and awarded, in relevant part, a 37 percent permanent impairment to his right lower extremity. He received schedule award compensation for a total impairment of his right lower extremities of 39 percent. Appellant claimed that he was entitled to additional schedule award compensation. The Office found that he was not entitled to such additional compensation based on the opinion of Dr. Liddell, a Board-certified orthopedic surgeon, who served as an impartial medical examiner.

The Board finds, however, a conflict in medical opinion was not created between Dr. Sullivan, appellant's treating physician, and the Office medical adviser, with regard to the extent and degree of permanent impairment to the right lower extremity as a result of appellant's work-related knee and foot conditions. Dr. Sullivan opined that appellant's impaired ambulation constituted a gait derangement for which additional impairment was warranted. However, under Table 17-2, page 526 of the A.M.A., *Guides*, impairment for gait derangement may not be combined with any other evaluation method for rating lower extremity impairment. Thus, since appellant previously was rated for impairment for his knee replacement, Dr. Sullivan's rating is precluded under the A.M.A., *Guides*. The Office medical adviser addressed the fact that an additional schedule award could not be based on gait derangement. Accordingly, a conflict in

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

[4] 20 C.F.R. § 10.404.

[5] *See Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

[6] *Manuel Gill*, 52 ECAB 282 (2001).

[7] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.a(2) (June 2003).

medical opinion does not exist under Chapter 17 of the A.M.A., *Guides* for a rating method that departs from proper application of the A.M.A., *Guides*. Thus, Dr. Liddell's opinion is that of a second opinion physician. Even though the report of Dr. Liddell is thus not entitled to the special weight afforded to the opinion of an impartial medical specialist resolving a conflict of medical opinion, his report can still be considered for its own intrinsic value and can still constitute the weight of the medical evidence.[8] Under the circumstances of the case, the Board finds that Dr. Liddell's opinion establishes that appellant has no more than 37 percent impairment for his right lower extremity.

In a January 3, 2006 report, Dr. Liddell noted appellant's work-related claims regarding his bilateral knee and right foot conditions which had been accepted by the Office and also obtained a medical and factual background from appellant. He provided a clear description of his findings on examination and provided the tables under the A.M.A., *Guides* which the impairment rating was based. Dr. Liddell advised that under the A.M.A., *Guides* appellant's atrophy was not sufficient to result in a calculation and appellant's quadriceps weakness was not applicable in view of the subjective strength measurements and the fact that appellant "gave way" when he first tested his quad strength. He also found no evidence of gait derangement as appellant had equal range of motion of both ankles. Dr. Liddell explained that appellant's stiff bilateral ankle gait was attributed to appellant's stiffness on both sides which is the result of appellant's body habitus and weight and not to any work-related activity. Utilizing the A.M.A., *Guides* 547, Table 17-33, he determined that appellant had a 37 percent right lower extremity impairment related to his right unicondylar knee arthroplasty. Thus, the Board finds that Dr. Liddell properly assigned 37 percent right leg impairment for appellant's unicondylar knee arthroplasty.

Dr. Liddell additionally stated that appellant's skin scar in the medial-plantar aspect of the right heel which was slightly tender distally and advised that, under the A.M.A., *Guides* 574, Table 18-1, the discomfort represented a one percent impairment of the whole person. He additionally noted that his disagreement with the Office medical adviser's finding of two percent impairment based on pain under 574, Table 18-1, was based on his findings that there was no significant tenderness with palpation of the plantar fascia and that the area where appellant complained of mild pain was where the plantar fascia was released from the right calcaneus. However, this was error as Chapter 18 should not be used to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*.[9] Thus, any percentage calculated pursuant to Chapter 18 cannot be affirmed.

The Board finds that the weight of the medical evidence establishes that appellant has no more than 37 percent impairment of the right leg for which he previously received a schedule award. There is no other evidence of record, conforming with the A.M.A., *Guides*, indicating that appellant has any greater impairment.

[8] *Cleopatra McDougal-Saddler*, 47 ECAB 480 (1996).

[9] *See* FECA Bulletin No. 01-05 (issued January 31, 2001); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 Exhibit 4 (June 2003). *See also Philip A. Norulak*, 55 ECAB 690 (2004) (a separate pain calculation under Chapter 18 is not to be used in combination with other methods to measure impairment due to sensory pain as outlined in Chapters 13, 16 and 17 of the fifth edition of the A.M.A., *Guides*).

CONCLUSION

The Board finds that appellant has failed to establish that he has a greater degree of permanent impairment of his right leg than that for which he has previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 3, 2006 is affirmed as modified.

Issued: December 29, 2006
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