

July 12, 2003 and received compensation for lost wages. On May 15, 2004 she began performing a modified mail processor clerk position. On June 9, 2004 appellant filed a claim for a schedule award.

On March 17, 2004 Dr. Leonard R. Smith, a Board-certified orthopedic surgeon and an Office referral physician, reviewed a history of appellant's condition and provided findings on physical examination. He diagnosed improved plantar fasciitis. Dr. Smith noted that appellant experienced pain when standing for long periods of time and walking long distances. He stated:

“Examination of the right foot reveals tenderness overlying the plantar fascia.... Full passive range of motion is present in both ankles and both feet with dorsiflexion 20 degrees, plantar flexion 50 [and] adduction to forefoot to 20 degrees. Inversion and eversion of the heel are possible at 10 degrees. Subjective tenderness is present overlying the plantar fascia with no actual heel tenderness noted.... The circumference of the ankles is 21½ [centimeters] bilaterally, circumference of the bimalleolar diameter of the ankle is 29½ [centimeters] bilaterally. In standing there is a noted flattening of the longitudinal arches. Calf measurements are normal. There is no muscle atrophy or weakness demonstrated. The anterior and posterior tibial pulses are normal. No trophic changes are noted.”

Dr. Smith did not provide any impairment rating.

In an October 2, 2004 report, Dr. Jacob Salomon, an attending Board-certified general surgeon, provided a history of appellant's condition and findings on physical examination. He stated:

“[Appellant] complains of swelling on and off in her ankles, numbness and tingling along the lateral epicondyle, Achilles tendon, and the instep of the foot, and a sharp pain along the instep in the arch of the foot. The pain is worse when she stands long periods of time, walking more than two to three blocks starts increasing the pain. Standing longer than 10 minutes can start increasing the pain.”

* * *

“[O]n inspection of the right and left lower extremities, there [were] no deformities, no atrophies, [no] lacerations noted. Circumference of the instep at the right foot was 23.5 [centimeters] [and] 23 [centimeters] on the left foot. Ankle on the right [and left] was 21 [centimeters], calf on right was 32 [centimeters] [and] on the left 30 [centimeters]. Regarding the ranges of motion for the right ankle, [appellant] had dorsiflexion to 10 [degrees,] normal being 20, plantar flexion to 30[,] normal being 40. Inversion was 20, normal being 30. Eversion was to 15, normal being 20. There was some weakness of muscle strength.... Pinwheel noticed some sensory deficit along the dorsum of the big toe.... [T]he tibialis anterior muscle generates [the] majority of dorsiflexion and inversion. These [dorsiflexion and inversion] were definitely weak 4/5, plantar

flexion was 5/5 and eversion was 5/5 on the right, which corresponds to the diagnosis of the muscles that were injured chronically creating the weakness. There is also no joint instability noted in the right ankle regarding the ATF [anterior talofibular] ligament. On the sole of the foot, there was some tenderness along the plantar fascia with also rebound tenderness noted. There was severe pain in movement of the metatarsal bones and the plantar fascia and severe pain in the plantar fascia on dorsiflexion and inversion.”

Dr. Salomon found that appellant had a 17 percent impairment of the right lower extremity, including 12 percent for a Grade 4 muscle weakness of the right ankle in dorsiflexion and five percent for ankle inversion, according to Table 17-8 at page 532 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.¹

On February 4, 2005 Dr. Eric Berkson, an Office medical adviser, stated that appellant had a 6 percent impairment of the right lower extremity,² including 3 percent for Grade 3 pain (40 percent) in the distribution of the medial plantar nerve and 3 percent for Grade 3 pain (40 percent) in the distribution of the lateral plantar nerve, according to Table 16-10 at page 482 and Table 17-37 at page 552 of the A.M.A., *Guides*. He indicated that decreased strength could not be rated in the setting of pain without a separate etiology and that range of motion was variable by examination and could not therefore be rated.³

On June 28, 2005 the Office granted appellant a schedule award for 17.28 weeks⁴ from May 20 to September 17, 2004 based on a six percent impairment of the right lower extremity. On November 22, 2005 appellant requested reconsideration.

On February 13, 2006 Dr. Ravi K. Ponnappan, an orthopedic surgeon and an Office medical adviser, stated his agreement with the six percent impairment rating. He indicated that a Grade 3 rating of 40 percent adequately represented appellant’s subjective complaints. Dr. Ponnappan noted that the A.M.A., *Guides* at page 508 provided that loss of strength could not be rated in the presence of painful conditions without a separate etiology. He stated that range of motion could not be accurately rated due to the variable measurements between Dr. Smith and Dr. Salomon. Dr. Ponnappan stated that the six percent lower extremity impairment schedule award based on residual pain complaints was accurate and appropriate based on the medical evidence.

¹ A.M.A., *Guides* (5th ed. 2001).

² Dr. Berkson indicated that appellant’s impairment was to her left foot. However, this appears to be an error as the accepted condition is right foot plantar fasciitis.

³ See Federal (FECA) Procedural 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).

⁴ The Federal Employees’ Compensation Act provides for 288 weeks of compensation for 100 percent loss or loss of use of a lower extremity. 5 U.S.C. § 8107(c)(2). Multiplying 288 weeks by 6 percent equals 17.28 weeks of compensation.

On March 20, 2006 the Office denied modification of the June 28, 2005 schedule award decision. Appellant requested reconsideration and submitted an August 30, 2006 report in which Dr. Salomon stated that a July 27, 2006 magnetic resonance imaging (MRI) scan of her right ankle revealed a small tibiotalar and subtalar joint fusion and also an accessory os navicular (navicular bone). Dr. Salomon indicated that the change in the angle of the subtalar joint access caused chronic foot pain. He stated:

“[T]here [were] some biomechanical deviations of the structure of [appellant’s] foot regarding the subtalar joint and on its axis and her gait still being abnormal and her stance being abnormal and tenderness [along] the lateral longitudinal arch.... An unusually large accessory navicular bone ... may cause pain from local pressure. It is frequently associated with weakness in the longitudinal arch and a mild flatfoot deformity. In [appellant’s] case this is true. She does have an enlarged accessory os navicular.... [T]here [are] subjective and objective finding[s] of structural deviation and ... pain and swelling.... When [appellant] stands for prolonged periods of time which is only documented in the recent MRI [scan] showing small ... effusions of these tibiotalar, subtalar joints with the deviation of the subtalar joint axis noted on x-rays. These objective findings along with her subjective findings indicate that there [is] more going on with her foot condition[;] that an impairment rating of six [percent] would not [represent] her conditions correctly. I do feel that the os navicular is creating a persistent pain and also that her other foot is now injured which is also causing more pressure on to her right extremity and with the chronic swelling in the indicated joints.... I would have to respectfully disagree with this 6 [percent] [impairment] at this time and give [appellant] a rating different from the previous [17 percent] impairment rating.... [Appellant] did not have any type of problems previous to the injury with her ambulating until the injury occurred.... [T]he area of the enlarged accessory bone caus[ed] this chronic pain.... I would have to this time go with gait abnormality which I feel [is the rating method] that best represents [appellant’s] condition.... There was no nerve deficit noted.

“So it is my opinion that gait would be the only substantial indication for [appellant] to be rated, so, thereby, the rating would be utilizing gait.... From [T]able 17-5, page 529 ... [s]he did have mild narrowing of the right knee joint and she does have now antalgic limp.... [Appellant] has ... moderate to advanced arthritic changes of the ... ankle. If you would add the decreased joint space due to the navicular and the chronic swelling, I feel that it could be used by the treating physician to [conclude] that she does have arthritis and ongoing swelling and the antalgic limp ... to give her a rating of 5 [percent] whole person from [T]able 17-5 [at page 529], then I would like to convert [the impairment rating] to the lower extremity by [using] [Table] 17-3 to get a total right lower extremity [impairment] of 10 [percent].”

On October 26, 2006 Dr. Benjamin P. Crane, an orthopedic surgeon and an Office medical adviser, stated that he did not understand Dr. Salomon’s impairment rating. He stated that appellant should undergo an independent medical examination by a Board-certified foot and ankle surgeon.

On November 15, 2006 the Office referred appellant to Dr. Richard H. Sidell, Jr., a Board-certified orthopedic surgeon for an examination and evaluation of her right lower extremity.⁵ On December 13, 2006 Dr. Sidell provided a history of appellant's condition and findings on physical examination. He diagnosed a probable mild forefoot osteoarthritis of the right foot and tendinopathy of the tibialis posterior tendon insertion into a probable accessory navicular bone. Dr. Sidell noted that appellant was experiencing pain in the forefoot and plantar area of the right foot. He stated:

“[Appellant] was observed walking for a distance of 40 feet without evidence of an antalgic component to her gait. The lower extremities appeared normal to inspection with no obvious muscle atrophy with side-to-side comparison. The circumference of the calf measured was 14 inches bilaterally. The circumference of the foot at the arch was 9 inches bilaterally. There was no evidence of edema.... There was normal range of motion of both ankles with 20 to 25 degrees of dorsiflexion and 45 to 50 degrees of plantar flexion. There was tenderness over a prominent navicular bone on the right. There was tenderness over the 1st [and 3rd] metatarsophalangeal joint[s] on the right. There was no tenderness over the plantar fascia ... longitudinal arch ... origin of the plantar fascia and off of the calcaneal tuberosity. There was no pain with tensioning of the plantar fascia.... There was no forefoot tenderness noted. The general arch alignment was normal. [Appellant] was able to perform a toe stand and a heel stand and a one-legged stand without difficulty and could perform a vertical hop of six inches without obvious discomfort. Range of motion of all joints of the forefoot was normal. There is no identifiable decrease in strength determined using manual motor testing. No visible sign of muscle atrophy was identified. Neurologic examination was normal.

“No evidence was found at this time to sustain the continuing diagnosis of mild plantar fasciitis, right foot. It is therefore assumed that the condition has resolved. [Appellant's] current complaints are felt to be related to the above-mentioned diagnoses of minimal osteoarthritis involving the metatarsophalangeal joints and tendinopathy involving the tibialis tendon insertion....

“In determining permanent impairment[,] the [A.M.A., *Guides*] is utilized.... The appropriate method to be utilized in this case would be diagnosis based under ligament injuries. This method is selected since there are no anatomic alterations as defined in sections 1 through 9 and no functional alterations under sections 10 through 12 which include range of motion, gait derangement and muscle strength. Table 17-33 on page 547 allows for estimates for certain lower extremity impairments. The closest impairment relating to [appellant's] findings would be under midfoot deformity with mild cavus deformity due to the objective findings of tendinopathy involving the tibialis posterior tendon. This allows for an impairment rating of two percent ... for the [right] lower extremity. Based on my

⁵ Although one page of the referral documents indicates that the referral to Dr. Sidell was for the purpose of resolving a conflict in the medical evidence, the referral letter to appellant states that Dr. Sidell was to provide a second opinion evaluation.

examination of [appellant] and review of the [A.M.A., *Guides*, fifth edition], I can find no justification for an award of 10 percent ... opined by [appellant's] attending physician.”

Although Dr. Sidell based his impairment rating on the diagnosis-based rating method, on January 10, 2007 Dr. Crane stated that appellant had a two percent impairment of her right lower extremity based on Grade 4 pain in the distribution of the medial plantar nerve, according to Table 16-10 at page 482 and Table 16-15 at page 492. Dr. Crane indicated that, as appellant had previously been granted a schedule award for a six percent impairment of the right lower extremity based on pain, she was not entitled to any additional schedule award.

By decision dated January 18, 2007, the Office denied modification of the March 20, 2006 decision.⁶

LEGAL PRECEDENT

The schedule award provision of the Act⁷ and its implementing regulation⁸ 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 A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.⁹

The A.M.A., *Guides* provides for three separate methods for calculating the lower extremity permanent impairment of an individual: anatomic, functional and diagnosis based.¹⁰ The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.¹¹ The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligamentous instability, bursitis and various surgical procedures, including joint replacements and meniscectomies.¹² The functional method is used for conditions when anatomic changes are difficult to categorize, or when functional implications have been documented, and includes

⁶ Subsequent to the January 18, 2007 Office decision, appellant submitted additional evidence. The Board's jurisdiction is limited to the evidence that was before the Office at the time it issued its final decision. See 20 C.F.R. § 501.2(c). The Board may not consider this evidence for the first time on appeal.

⁷ 5 U.S.C. § 8107.

⁸ 20 C.F.R. § 10.404.

⁹ *Id.*

¹⁰ A.M.A., *Guides*, 525.

¹¹ *Id.*

¹² *Id.*

range of motion, gait derangement and muscle strength.¹³ The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.¹⁴ When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.¹⁵ If more than one method can be used, the method that provides the higher impairment rating should be adopted.¹⁶

ANALYSIS

The Office granted appellant a schedule award based on a six percent impairment of the right lower extremity. The Board finds that further development of the medical evidence is necessary to determine whether appellant has more than a six percent right lower extremity impairment.

Dr. Salomon stated that appellant experienced swelling in her ankles, numbness and tingling along the lateral epicondyle, Achilles tendon, and the instep of the foot, and a sharp pain along the instep in the arch of the foot. The pain was worse when she stood for more than 10 minutes or walked more than two or three blocks. Range of motion for the right ankle included dorsiflexion to 10 degrees, plantar flexion to 30, inversion 20 and eversion 15. Dr. Salomon indicated muscle strength weakness in dorsiflexion and inversion. He noted that appellant experienced severe pain in movement of the metatarsal bones and the plantar fascia and severe pain in the plantar fascia on dorsiflexion and inversion. Dr. Salomon found that appellant had a 17 percent permanent impairment of the right lower extremity, including 12 percent for a Grade 4 muscle weakness of the right ankle in dorsiflexion and five percent for ankle inversion, according to Table 17-8 at page 532 of the A.M.A., *Guides*.

Dr. Berkson, an Office medical adviser, stated that appellant had a 6 percent impairment of the right lower extremity, including 3 percent for Grade 3 pain (40 percent) in the distribution of the medial plantar nerve and 3 percent for Grade 3 pain (40 percent) in the distribution of the lateral plantar nerve, according to Table 16-10 at page 482 and Table 17-37 at page 552 of the A.M.A., *Guides*. As noted, Office procedures require that the medical adviser provide rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present. Although Dr. Salomon based his impairment rating on muscle weakness, Dr. Berkson found that appellant had right lower extremity impairment due to pain. Dr. Berkson did not explain how he determined that her pain was a Grade 3. He also did not explain how he selected an impairment of 40 percent from the range of 25 to 60 percent for Grade 3 in Table 16-10. Dr. Ponnappan, another Office medical adviser, stated his agreement with the six percent impairment rating of Dr. Berkson. Both medical advisers indicated that decreased strength could not be rated in the setting of pain without a separate etiology, according

¹³ *Id.* at 525, Table 17-1.

¹⁴ *Id.* at 548, 555.

¹⁵ *Id.* at 526.

¹⁶ *Id.* at 527, 555.

to the text at page 508 of the A.M.A., *Guides*. However, page 508 in Chapter 16 of the A.M.A., *Guides*, pertains to upper extremity impairments. The chapter pertaining to lower extremity impairment, Chapter 17, provides a cross-usage chart, at Table 17-2 at page 526 which sets forth the various methods for rating lower extremity impairment. The chart indicates which impairment rating methods can or cannot be combined. Muscle strength is one of several rating methods for lower extremity impairment. According to Table 17-2, muscle strength cannot be combined with the other methods used by the various physicians in this case, pain (peripheral nerve injury), gait derangement (used in Dr. Salomon's second report), or a diagnosed-based estimate (used by Dr. Sidell). However, muscle weakness, Table 17-8 at page 532, is one method that can be used to determine appellant's right lower extremity impairment. Therefore, the Office medical advisers were incorrect in disallowing the impairment rating of Dr. Salomon based on muscle weakness.

Dr. Salomon provided a second report in which he determined that appellant had a 10 percent impairment of the right lower extremity impairment due to gait derangement according to Table 17-5 at page 529 of the A.M.A., *Guides*. He indicated that he converted a five percent whole person impairment for mild gait derangement to a 10 percent lower extremity impairment using Table 17-3 at page 527. However, the lowest percentage specified in Table 17-5 is seven percent, not five percent. Additionally, even if Table 17-5 provided for a 5 percent whole person impairment, the conversion table, Table 17-3, provides that a 5 percent whole person impairment equals a 12 to 13 percent impairment, not 10 percent.

Dr. Sidell noted that appellant was experiencing pain in the forefoot and plantar area of the right foot. He found no atrophy or decrease in strength. Appellant had normal range of motion. The neurologic examination was normal. Dr. Sidell opined that appellant's accepted mild plantar fasciitis of the right foot had resolved. However, he found a two percent right lower extremity impairment using the diagnosis-based rating method and Table 17-33 at page 547. Dr. Sidell found that appellant had a mild cavus deformity of the midfoot which equaled a two percent impairment according to Table 17-33. He stated that he selected the diagnosis-based rating method because he found no anatomic alterations such as muscle atrophy or peripheral nerve injury and no functional alterations such as range of motion, gait derangement and muscle strength.

The Board finds that there is a conflict in the medical opinion evidence between Dr. Salomon and Dr. Sidell, necessitating referral to an impartial medical specialist. On remand the Office should refer appellant to an appropriate Board-certified medical specialist for an evaluation of her right lower extremity and an impairment rating based on correct application of the A.M.A., *Guides*. The impartial medical specialist should provide medical rationale explaining why a particular rating method was selected. If more than one impairment rating method can be used in evaluating appellant's impairment, the method that provides the higher rating should be adopted.¹⁷

¹⁷ *Id.* at 527.

CONCLUSION

The Board finds that this case is not in posture for a decision. On remand, the Office should refer appellant to an impartial medical specialist for an examination and evaluation of her right lower extremity impairment.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated January 18, 2007 and March 20, 2006 are set aside and the case is remanded for further development consistent with this decision.

Issued: July 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