# United States Department of Labor
# Employees' Compensation Appeals Board

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| **C.I., Appellant** | ) | |
| | ) | **Docket No. 08-404** |
| **and** | ) | **Issued: June 5, 2008** |
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| **U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Palatine, IL** | ) | |
| **Employer** | ) | |

*Appearances:*
*Appellant, pro se*
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

### ***JURISDICTION***

On November 20, 2007 appellant filed a timely appeal from a November 7, 2007 decision of the Office of Workers' Compensation Programs, adjudicating her claim for a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

### ***ISSUE***

The issue is whether appellant has more than a six percent impairment of her right lower extremity, for which she received a schedule award.

## ***FACTUAL HISTORY***

This is the second appeal in this case.[1] By decision dated July 23, 2007, the Board remanded the case for further development of the medical evidence. The Board found a conflict in medical opinion on the issue of appellant's impairment of her right lower extremity and directed the Office to refer her to an impartial medical specialist. The law and the facts of the previous Board decision are incorporated herein by reference.

The Office referred appellant, together with a statement of accepted facts, a list of questions and the entire case file, to Dr. Steven A. Kodros, a Board-certified orthopedic surgeon, for an examination and evaluation of her right lower extremity impairment in order to resolve the conflict in the medical evidence.

In a September 13, 2007 report, Dr. Jacob Salomon, appellant's attending physician, examined her on August 4, 2007 and found that she had a combined right lower extremity impairment of 16 percent extremity under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), including 12 percent for a Grade 4 muscle weakness of the right ankle in dorsiflexion, based on Table 17-8 at page 532 and a 5 percent impairment for a Grade 4 ankle inversion, based on the same table. Using the Combined Values Chart at page 604, he found that appellant had a 16 percent combined impairment of her right lower extremity.[2]

In an October 31, 2007 report, Dr. Kodros provided findings on examination and the results of x-rays. He determined that appellant had no permanent impairment of her right lower extremity. Dr. Kodros stated:

> "Evaluation of both feet and ankles demonstrates absence of any appreciable soft tissue swelling or deformity…. There is no increased warmth, erythema or sign of any inflammation…. There is perhaps some mild prominence of the navicular tuberosity on the right side, slightly more notable than the left. There is no associated soft tissue swelling overlying this. Palpation produces generalized tenderness on the right…. [Appellant] has some tenderness that extends over the area of the navicular tuberosity, as well. The rest of the foot also demonstrates areas of tenderness that are, again, nonlocalized. [Appellant] actually has relatively little if any tenderness when palpation is applied within the plantar arch and the heel. No palpable nodularities or thickening. No soft tissue masses…. Dorsiflexion [extension] and plantar flexion of the right foot and ankle measure 30 degrees and 50 degrees respectively. [Appellant] notes minimal pain at end-range motion in both directions…. Subtalar inversion and eversion appears normal on the right…. First metatarsophalangeal joint range of motion is about

[1] Docket No. 07-804 (issued July 23, 2007). In 2003, appellant sustained a mild plantar fasciitis of her right foot due to long periods of standing on a concrete floor sorting mail. She was disabled for intermittent dates beginning July 12, 2003 and received compensation for lost wages. On June 28, 2005 the Office granted appellant a schedule award for a six percent impairment of her right upper extremity based on sensory deficit or pain.

[2] Dr. Salomon stated that he was no longer basing appellant's impairment on gait derangement as he had in his August 30, 2006 report previously of record.

30 degrees of dorsiflexion and 20 degrees of plantar flexion bilaterally. Range of motion, however, is limited by [appellant's] pain. She has pain throughout a range of motion in this area and some mild pain with a grind maneuver. Musculotendinitis units about the foot and ankle intact throughout including peroneal and posterior tibial tendons. Neurologic exam[ination] demonstrates motor power to be 5/5 throughout the feet and ankles bilaterally. Sensory exam[ination] is grossly intact to light touch. [Appellant] ambulates about the office today in the hallway barefooted with normal heel-toe gait pattern bilaterally. There is no appreciable limp, antalgia or other gait disturbance. [Appellant] is able to toe-walk and heel-walk bilaterally without difficulty. Circumferences were measured and are found to be equal bilateral[ly] at the level of the calves, ankles and midfoot regions."

* * *

"Assessment: [Appellant] has bilateral foot and ankle pain and complaints … right worse than left. She has been diagnosed in the past as having plantar faciitis on the right…. Differential diagnosis for [appellant's] residual symptoms today might possibly include some symptoms related to os navicular on the right foot and perhaps some mild hallux rigidus (mild osteoarthritis) of the first metatarsophalangeal joints. Furthermore, it should be understood that I do not believe that any or all of these conditions, even in combination, would likely cause the majority of [her] subjective symptoms and/or complaints. I am otherwise unable to offer any readily identifiable organic musculoskeletal explanation for [appellant's] complaints. Neither her subjective symptoms today nor the provocative findings on exam[ination] at this time would support the diagnosis of plantar fasciitis. The same holds true for the presence of posterior or anterior tibial tendinitis. Overall, both of [appellant's] feet and ankles demonstrate excellent function on today's evaluation. Furthermore, the relative severity of [her] subjective complaints, as noted above, are not supported by objective findings or functional deficits on examination. Based on the history provided and the information reviewed today, I do not find significant evidence to indicate a causal relationship with any of these conditions with [appellant's] occupation as described or with prolonged standing on hard surfaces as reported in the history….

"Regarding [permanent impairment] ratings, I do not find any objective criteria based on my evaluation today to support the presence of any [permanent partial impairment] of her lower extremities with respect to the feet and ankles. None of the methods outlined in Table 17-1 [at] page 525 of the [A.M.A., *Guides*] would be applicable in this setting. This is particularly [true] in the light of absence of any readily identifiable objective physical findings or diagnoses. With respect to [maximum medical improvement], based on my review of the medical records, the findings seen today on physical exam[ination] appear to be nearly the same as those noted by Dr. Richard Sidel on his evaluation of [appellant] on [December 13, 2006]."

By decision dated November 7, 2007, the Office found that appellant had no more than a six percent impairment of her right lower extremity, for which she received a schedule award.

## ***LEGAL PRECEDENT***

Section 8107 of the Federal Employees' Compensation Act[3] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified fifth edition of the A.M.A., *Guides*.[4]

Section 8123(a) of the Act provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[5] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[6]

## ***ANALYSIS***

The Board finds that appellant has no more than a six percent impairment of her right lower extremity. Dr. Kodros provided a comprehensive report dated October 31, 2007. He reviewed the factual and medical background in the record and provided detailed findings on physical examination. Dr. Kodros advised that, upon review of the fifth edition of the A.M.A., *Guides*, appellant had no impairment of her right lower extremity. He found no loss of range of motion or loss of strength on examination. Although appellant complained of pain, Dr. Kodros characterized her complaints as subjective and not supported by his findings on examination. He provided thorough medical rationale for his medical opinion that appellant had no right lower extremity impairment at the time of his examination. The Board finds that the report of Dr. Kodros is entitled to the special weight accorded an impartial medical specialist and constitutes the weight of the medical evidence.[7]

The September 13, 2007 report of Dr. Salomon is not sufficient to overcome the weight of Dr. Kodros' report. He found that appellant had a combined right lower extremity impairment of 16 percent extremity under the A.M.A., *Guides*, including 12 percent for a Grade 4 muscle weakness of the right ankle in dorsiflexion and a 5 percent impairment for a Grade 4 ankle inversion. The impairment rating in Dr. Salomon's September 30, 2007 report is the same as in

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th. ed. 2001).

[5] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

[6] *See Roger Dingess*, 47 ECAB 123 (1995); *Glenn C. Chasteen*, 42 ECAB 493 (1991).

[7] *See Sharyn D. Bannick*, 54 ECAB 537 (2003).

his October 2, 2004 report, with the exception that his 2007 report correctly combined the 12 and 5 percent impairments rather than adding them. The Board notes that Dr. Salomon had been on one side of the conflict in medical evidence and the September 30, 2007 report merely reiterates his previous findings. An additional report from a claimant's physician, which essentially repeats earlier findings and conclusions, is generally insufficient to overcome the weight accorded to an impartial medical specialist's report.[8] For these reasons, Dr. Kodros' report remains the weight of the medical opinion evidence.

## ***CONCLUSION***

The Board finds that appellant has no more than a six percent impairment of her right lower extremity.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated November 7, 2007 is affirmed.

Issued: June 5, 2008
Washington, DC

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

[8] *See Roger G. Payne*, 55 ECAB 535 (2004).