United States Department of Labor
Employees' Compensation Appeals Board

T.R., Appellant	)	
	)	**Docket No. 08-1916**
and	)	**Issued: March 23, 2009**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Albuquerque, NM, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 30, 2008 appellant filed a timely appeal from decisions of the Office of Workers' Compensation Programs dated January 24 and June 5, 2008 denying his request for an increased schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this appeal.

ISSUE

The issue is whether appellant has more than 18 percent permanent impairment of his right lower extremity.

FACTUAL HISTORY

On May 3, 2001 appellant, a 52-year-old supervisor, filed an occupational disease claim alleging that he sustained injuries to his right foot as a result of federal employment duties. The Office accepted his claim for right foot strain. Subsequently, appellant underwent 1st metatarsal phalangeal joint (MPJ) fusion and exostectomy of the 2nd metatarsal of the right foot. His claim was expanded to include localized primary osteoarthritis of the right ankle and foot. On December 17, 2004 appellant filed a claim for a schedule award.

Appellant submitted a report dated January 9, 2006 from his treating physician, Dr. Nathan D. Ivey, a podiatrist, who noted the history of appellant's accepted right foot condition, which resulted in a fusion of his 1st metatarsal joint. Dr. Ivey indicated that appellant experienced pain under the ball of his foot with every step of every day and had an antalgic, painful gait, requiring the use of a cane. Vascular examination revealed palpable pulses with immediate capillary filling time to digits bilaterally. Neurologically, sensation was grossly intact on the basis of the Semmes-Weinstein test, and to light touch bilaterally. Deep tendon reflexes were within normal limits. There was mild tingling, but no burning or parasthesias along the incision line, with decreased sensation along the dorsal and plantar aspect of right hallux. Musculoskeletal examination revealed pain with range of motion of the 2nd to the 4th MPJs on the right; digital contractures (2nd to 5th MPJs on the right); and a palpable underlying plate on the l st MPJ. There was no pain with palpation of plate and no hallux purchase in the right foot. Hallux position was 35 degrees fixed dorsiflexion, 10 degrees abduction, with valgus rotation of the hallux. The first metatarsal was locked into a dorsiflexed position with no purchase of the l st metatarsal head in stance. Dr. Ivey observed an antalgic gait with no supination and pronation on the right. Radiology reports showed 1st MPJ fusion with five-hole cloverleaf-type plate, shortening of the 1st ray, and significant elevation. The hallux was fused at a 55 degree dorsiflexion position in relation to the 1st metatarsal. Some lucency was noted on the oblique view at the level of the 1st MPJ.

Dr. Ivey recommended an impairment rating of 38 percent of the right lower extremity, or 15 percent of the whole person, according to Table 17-5 at page 529 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment.* He indicated that the range of motion analysis, which would entitle appellant to only a four to six percent whole person impairment, only took into account the pathology at the hallux and did not address the dorsiflexed position of the 1st metatarsal, which caused the medial foot to be in the air and caused significant gait abnormalities and a significant shift of weight to the lateral foot. Noting that there were no methods of impairment that evaluate the fixed position of the metatarsal and the chronic pain and inflammation in the lateral MPJs, Dr. Ivey opined that the most appropriate method would be gait derangement under Table 17-5. He concluded that appellant's symptoms, including an antalgic gait, shortened stance, arthritic changes of the ankle, as well as his need for a cane for distance walking, placed him in the mild, "class c," category of lower limb impairment due to gait derangement, which would warrant 15 percent whole person impairment rating, or 38 percent lower extremity impairment rating. Dr. Ivey opined that appellant was at maximum medical improvement (MMI).

In a report dated February 14, 2006, Dr. Pamela Black, a Board-certified physiatrist, provided an assessment of "status post arthrodesis of right Dl with abnormal gait pattern." She disagreed with Dr. Ivey's 38 percent impairment rating. The record contains an April 26, 2006 functional capacity evaluation.

The Office forwarded the medical record and a statement of accepted facts to the district medical adviser, requesting an evaluation of appellant's right lower extremity impairment resulting from his accepted conditions, and an opinion as to whether he had reached MMI and, if so, when. In a September 21, 2006 report, the medical adviser indicated that, in order for him to complete his assessment, it would be necessary for Dr. Black to evaluate the degree of

appellant's right lower extremity impairment resulting from the accepted conditions, and to render an opinion as to the date of MMI.

On December 28, 2006 the Office asked Dr. Black to examine appellant and to provide an opinion on the date of MMI, and as to the degree of impairment to his right lower extremity. In a report dated January 23, 2007, Dr. Black observed that appellant had an abnormal gait and walked with a cane, which he reportedly used on a regular basis. Results of range of the motion examination for the right lower extremity were as follows: knee flexion -- (104 degrees); knee extension -- (-17 degrees); varus deformity -- (5 degrees); ankle dorsiflexion from neutral -- (10 degrees); plantar flexion -- (28 degrees); eversion (20 degrees); and inversion (20 degrees).[1] Dr. Black noted decreased sensation to pinprick of the right Dl digit proximal to the metacarpophalangeal (MCP), both on the dorsal and plantar surfaces, and ankylosis of Dl MCP at 0 degrees. She agreed that the date of MMI was January 9, 2006, but disagreed with Dr. Ivey's impairment rating of 38 percent. Referring to Table 17-30 of the A.M.A., *Guides*, Dr. Black concluded that appellant should receive a 10 percent lower extremity impairment rating for ankylosis of the great toe. Pursuant to appropriate tables on page 537, she awarded seven percent lower extremity impairment for loss of dorsiflexion; zero percent impairment for loss of plantar flexion; zero percent impairment for loss of eversion; and two percent impairment for loss of inversion. Dr. Black stated that impairments at the ankle were added to result in nine percent lower extremity impairment. She opined that appellant was entitled to 20 percent impairment rating for loss of knee flexion. Dr. Black indicated that appellant's total combined impairment rating was 34 percent.

The Office again referred the case to the district medical adviser for review and an opinion as to the degree of appellant's permanent impairment. In a report dated April 12, 2007, the medical adviser opined that appellant had reached MMI on January 23, 2007, the date of his evaluation by Dr. Black. Referring to Table 17-11 at page 537 of the A.M.A., *Guides*, he determined that appellant had seven percent permanent impairment of the right ankle for loss of motion (dorsiflexion, 10 degrees, mild). Under Table 17-12 at page 537, the medical adviser found two percent impairment for loss of motion in the hindfoot (inversion 20 degrees, mild), resulting in a total combined impairment for loss of motion of nine percent, pursuant to the Combined Values Chart on page 604 of the A.M.A., *Guides*. Under Table 17-30, he awarded 10 percent impairment rating for ankylosis of the right great toe. The medical adviser concluded that, under the Combined Values Chart, appellant had a total combined right lower extremity impairment of 18 percent.[2]

[1] Dr. Black also provided measurements relating to appellant's left lower extremity, which was not relevant to the schedule award determination.

[2] The medical adviser did not include Dr. Black's rating as it related to appellant's right knee, as the diagnosed knee conditions were not accepted in this case.

On June 8, 2007 the Office granted appellant a schedule award for 18 percent impairment of his right lower extremity. The period of the award was from January 23 through October 8, 2007. The Office determined that the date of MMI was January 23, 2007.

On June 21, 2007 appellant requested a telephonic hearing, which was conducted on November 8, 2007. He argued that greater weight should be given to the opinion of Dr. Ivey, who is a foot surgeon, and that his report established that appellant had 38 percent permanent impairment of the right lower extremity. Appellant submitted a July 3, 2007 report from Dr. Ivey, who contended that Dr. Black's impairment rating was deficient, in that it failed to address any issue other than range of motion. Noting that there was no other specific method that could be used under the A.M.A., *Guides* that would take into account the degree and origin of appellant's pain, Dr. Ivey opined that Table 17-5 at page 529, which evaluates impairment based on gait derangement, is the appropriate table to use.

By decision dated January 24, 2008, an Office hearing representative affirmed the June 8, 2007 decision, finding that the weight of the medical evidence rested with the district medical adviser, who utilized Dr. Black's examination findings. Stating that Dr. Ivey did not provide measurements or calculations to support his opinion, the representative found that the only medical evidence of record which contained complete measurements, citations and calculations using the A.M.A., *Guides* was the April 12, 2007 report of the district medical adviser.

On March 6, 2008 appellant requested reconsideration. In support of his request, he submitted a February 11, 2008 report from Dr. Ivey, who stated that there were no measurements or calculations that could be used to support the rating he provided under the section of the A.M.A., *Guides* on gait derangement. Dr. Ivey indicated that appellant qualified under "mild class 'c'" of Table 17-5 at page 529, due to his use of a cane for distance walking, and that this was the only calculation that was necessary. In a report dated March 4, 2008, Dr. Steve S. Wrege, a treating physician, concurred with Dr. Ivey's January 9, 2006 impairment rating.

By decision dated June 5, 2008, the Office denied modification of the January 24, 2008 decision, finding that Dr. Black's January 23, 2007 impairment rating met the requirements of the Act, and carried the weight of the medical evidence.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,[3] and its implementing regulations,[4] 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. The A.M.A., *Guides*

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[5]

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.[6] 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.[7]

ANALYSIS

The Board finds that this case is not in posture for a decision due to a conflict in medical opinion between Dr. Ivey and the district medical adviser as to the extent of appellant's right lower extremity impairment.

In his January 9, 2006 report, Dr. Ivey recommended an impairment rating of 38 percent of the right lower extremity, pursuant to Table 17-5 at page 529 of the A.M.A., *Guides*. He noted that appellant experienced pain under the ball of his foot with every step of every day and had an antalgic, painful gait, requiring the use of a cane. Dr. Ivey provided findings of vascular, neurological and musculoskeletal examinations and reviewed radiology reports. He indicated that the range of motion analysis, which would entitle appellant to only four to six percent whole person impairment, only took into account the pathology at the hallux and did not address the dorsiflexed position of the 1st metatarsal, which caused the medial foot to be in the air and caused significant gait abnormalities and a significant shift of weight to the lateral foot. Noting that there were no methods of impairment that evaluated the fixed position of the metatarsal and the chronic pain and inflammation in the lateral MPJs, he opined that the most appropriate method of evaluation was gait derangement under Table 17-5. Dr. Ivey concluded that appellant's symptoms, including an antalgic gait, shortened stance, and arthritic changes of the ankle, as well as his need for a cane for distance walking, placed him in the mild, "class c," category of lower limb impairment due to gait derangement, which would warrant 15 percent whole person impairment rating, or 38 percent lower extremity impairment rating and opined that appellant was at MMI.

On January 23, 2007 Dr. Black opined that appellant had 34 percent impairment of his right lower extremity. Referring to Table 17-30 of the A.M.A., *Guides*, she concluded that appellant should receive 10 percent lower extremity impairment rating for ankylosis of the great toe. After providing range of motion measurements, Dr. Black concluded that appellant had seven percent lower extremity impairment for loss of ankle dorsiflexion, and two percent impairment for loss of inversion, pursuant to appropriate tables on page 537, for a total ankle impairment of nine percent. She opined that appellant was entitled to 20 percent impairment

[5] *See id*.; *Jacqueline S. Harris*, 54 ECAB 139 (2002).

[6] 5 U.S.C. § 8123(a).

[7] *Id. See also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

rating for loss of knee flexion, resulting in a total combined impairment rating of 34 percent, under the combined values guideline on page 604.

Based on Dr. Black's report, an Office medical adviser opined that appellant had 18 percent impairment of his right lower extremity, and that he had reached MMI on January 23, 2007, the date of Dr. Black's evaluation. Referring to Table 17-11 at page 537 of the A.M.A., *Guides*, he determined that appellant had seven percent permanent impairment of the right ankle for loss of motion (dorsiflexion, 10 degrees, mild). Under Table 17-12 at page 537, the medical adviser found two percent impairment for loss of motion in the hindfoot (inversion 20 degrees, mild), resulting in a total combined impairment for loss of motion of nine percent, pursuant to the Combined Values Chart on page 604 of the A.M.A., *Guides*. Under Table 17-30, he awarded 10 percent rating for ankylosis of the right great toe. Noting that appellant was not entitled to a schedule award for his knee condition, which was not accepted by the Office, he concluded that, under the Combined Values Chart, appellant had a total combined right lower extremity impairment of 18 percent.

The Board finds that there is a conflict between the medical opinions of Dr. Ivey, appellant's treating physician, and the Office medical adviser.[8] Dr. Ivey explained that he evaluated appellant's right lower extremity impairment based on gait derangement under Table 17-5 to arrive at a 38 percent impairment rating, because he believed that it most appropriately measured appellant's total impairment. On the other hand, applying Dr. Black's calculations, the medical adviser referred to Tables 17-11 and 12, which measure range of motion impairment, and Table 17-30, which measures impairment due to ankylosis of the toes, to arrive at 18 percent impairment rating. The Board finds that the case must be remanded to the Office for an impartial medical examination to resolve the conflict as to the degree of permanent impairment to appellant's right lower extremity, followed by an appropriate *de novo* decision.[9]

[8] The Board notes that the evidence of record does not reflect that Dr. Black was selected by the Office to examine appellant. Therefore, a conflict cannot exist between Dr. Black and Dr. Ivey pursuant to 5 U.S.C. § 8123(a). However, a disagreement between a district medical adviser and a treating physician can create a conflict. *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.7(g) (April 1993) (providing that, while a district medical adviser may create a conflict in medical opinion, he or she may generally not resolve it); *id.* at 2.810.11(c)(2) (April 1993) (the referee specialist's report, once received, must actually fulfill the purpose for which it was intended, *i.e.*, it must resolve the conflict in medical opinion).

[9] The Board notes that the medical adviser did not include Dr. Black's rating as it related to appellant's right knee condition, because those conditions were not accepted by the Office. However, it is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included. *See Carl J. Cleary*, 57 ECAB 563 (2006). *See also Dale B. Larson*, 41 ECAB 481, 490 (1990); *Pedro M. DeLeon, Jr.*, 35 ECAB 487, 492 (1983). Therefore, in determining whether appellant is entitled to a schedule award, the Office must consider any preexisting condition affecting the right leg. *See Walter R. Malena*, 46 ECAB 983 (1995) (the Office, in considering a schedule award due to permanent impairment of the right ankle must also take into account any preexisting permanent impairment affecting the right knee). *See also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b (June 1993) (the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function).

CONCLUSION

The Board finds that this case is not in posture for a decision due to a conflict in the medical opinion evidence between the district medical adviser and Dr. Ivey as to the degree of appellant's right lower extremity impairment. On remand, the Office should refer appellant, together with a statement of accepted facts and the case record, to an appropriate impartial medical specialist, for an examination and evaluation in order to resolve the conflict.

ORDER

IT IS HEREBY ORDERED THAT the June 5 and January 24, 2008 decisions of the Office of Workers' Compensation Programs are set aside and remanded to the Office for action in accordance with the terms of this decision.

Issued: March 23, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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