United States Department of Labor
Employees' Compensation Appeals Board

T.P., Appellant	)	
and	)	**Docket No. 09-1636**
	)	**Issued: July 20, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Glassboro, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 20, 2009 appellant filed a timely appeal from a February 17, 2009 merit decision of the Office of Workers' Compensation Programs denying his claim for an additional schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant has more than five percent impairment of the left lower extremity and more than five percent impairment of the right lower extremity, for which he received a schedule award.

FACTUAL HISTORY

This is the second appeal before the Board. In a July 12, 2005 decision, the Board reversed the Office's October 14, 2004 decision finding that there was a conflict in the medical evidence regarding permanent impairment of the legs.[1] In particular, the Board found a conflict

[1] Docket No. 05-706 (issued July 12, 2005).

in the medical evidence between Dr. Ronald Brisman, a Board-certified neurosurgeon, and Dr. Heiman-Patterson, an attending Board-certified neurologist, on the issue of whether appellant's neuropathy affecting his feet was related to the accepted work-related conditions and whether he had a permanent impairment of the lower extremities related to his accepted conditions. The Board noted that the Office had accepted the claim for an aggravation of plantar fasciitis and bilateral heel spurs and that he had bilateral plantar fasciotomies and heel spur excision in 1996. It advised that appellant previously received a schedule award for five percent impairment of each leg on June 2, 2002. The facts and the medical history of the case are set forth in the Board's prior decision and incorporated herein by reference.

On August 15, 2005 the Office referred appellant, the case record and a statement of accepted facts to Dr. Chandra Sharma, a Board-certified neurologist, to resolve the medical conflict regarding whether appellant's foot neuropathy was work related and, if so, whether there was permanent impairment to his legs under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) due to the accepted conditions. In an August 24, 2005 report, Dr. Sharma opined that appellant had polyneuropathy involving both legs and both hands of the small fiber type, which was of idiopathic or undetermined cause and not due to his accepted conditions. He stated that the cause of appellant's foot pain was polyneuropathy that was not caused or aggravated by plantar fasciitis, bone spurs and tarsal tunnel compression or to surgery for bone spurs and plantar fasciitis. However, Dr. Sharma stated that the accepted conditions of fasciitis and heel spurs coexisted with polyneuropathy and added to the severity of the pain. He further opined under the A.M.A., *Guides* that appellant had 5 percent permanent impairment of his legs due to the accepted conditions of fasciitis and bone spurs and an additional 15 percent impairment of each leg due to unrelated polyneuropathy. After the Office requested a supplemental report discussing how he arrived at his impairment rating based on the A.M.A., *Guides*, Dr. Sharma, on September 3, 2005, indicated that he assigned 5 percent permanent impairment of each lower extremity on the report of a prior orthopedic consultant and he assigned 15 percent permanent impairment of each lower extremity for polyneuropathy based on weakness he observed but not found on any specific pages of the A.M.A., *Guides*.

In a September 15, 2005 report, an Office medical adviser indicated that Dr. Sharma had found that appellant's neuropathy was not work related and his only work-related condition was fasciitis. The medical adviser opined that appellant had five percent permanent impairment of each leg due to fasciitis under Table 17-37, page 552 of the A.M.A., *Guides*.

In an October 18, 2005 decision, the Office denied an additional schedule award based on the reports of Dr. Sharma and the Office medical adviser. On January 25, 2006 an Office hearing representative set aside the October 18, 2005 decision finding that Dr. Sharma did not resolve the medical conflict and a new medical referee was needed.

On June 28, 2006 the Office referred appellant to Dr. Maria Carta, a Board-certified neurologist, for an impartial medical examination. In a July 25, 2006 report, Dr. Carta provided her findings. She indicated that appellant's history and clinical findings were consistent with iatrogenic complex regional pain syndrome of both feet due to multiple surgical procedures with resultant trauma effect and anatomical disruption. Dr. Carta opined that his chronic pain was due

to his accepted diagnosis and opined that he had 11 percent permanent impairment for sensory impairment under Table 13-23, page 346, of the A.M.A., *Guides.*

On September 28, 2006 an Office medical adviser indicated that he did not understand the basis of Dr. Carta's impairment findings. He advised that generalized stocking hypesthesias just above the ankle to pinprick and light touch was not usually considered objective since many nerve roots were involved. Additionally, Dr. Carta's diagnosis of complex regional pain syndrome gave an ill-defined pain and diffuse sensory pattern and she did not show the necessary calculations under the A.M.A., *Guides.* The Office requested that Dr. Carta provide a supplemental report responding to the issues raised by its Office medical adviser. It also referred appellant back to Dr. Carta.

In a May 14, 2007 report, Dr. Carta provided her findings and diagnosed peripheral sensory neuropathy and iatrogenic complex regional pain syndrome due to multiple surgical procedures performed on his feet. She opined that appellant had 11 percent permanent impairment under Table 13-23 of the A.M.A., *Guides*, stating that he had Class 3 impairment with normal sensation except for pain or decreased sensation with or without pain present during activity.

On May 25, 2007 an Office medical adviser noted Table 13-23 of the A.M.A., *Guides* was for peripheral nerve disorder, not for complex regional pain syndrome. He stated that the 11 percent impairment bilaterally was not based on objective data, proper calculations or instructions of the A.M.A., *Guides* per Table 13-23.

By decision dated May 31, 2007, the Office denied an additional schedule award based on the Office medical adviser's report. Appellant requested a hearing.

In a September 5, 2007 decision, an Office hearing representative vacated the May 31, 2007 decision and remanded the case to Office for referral of appellant to a new impartial medical specialist to resolve the medical conflict regarding whether his neuropathy affecting his feet was related to the accepted work-related conditions and whether he had permanent impairment of his lower extremities related to his accepted conditions.

On February 11, 2008 the Office referred appellant, the case record, a February 7, 2008 addendum to statement of accepted facts and a list of questions, to Dr. Dhiraj K. Panda, a Board-certified neurosurgeon, for an impartial medical examination. In a February 20, 2008 report, Dr. Panda reviewed the medical record and presented his examination findings. He diagnosed a small fiber neuropathy unrelated to the work injury of August 31, 1993. Dr. Panda noted the electromyogram (EMG) studies in 1996 were normal. He advised that the neurological examination including sensory examination of both feet was essentially normal. Dr. Panda stated that he could not detect any sensory loss or alteration of sensation in both of his feet and legs. He opined that appellant's chronic pain and discomfort did not interfere with his daily activities. Dr. Panda's examination revealed a normal range of motion in both feet with no weakness or atrophy detected in both lower extremities. He also stated that he could not find any neurological deficit. Dr. Panda opined that appellant reached maximum medical improvement from his work injury and that his chronic pain in both feet was due to nonwork-related

conditions. Under the A.M.A., *Guides*, he opined that appellant had eight percent permanent impairment of both lower extremities under Table 17-37, page 552.

On March 11, 2008 an Office medical adviser reviewed the medical evidence and found that Dr. Panda's report did not resolve the medical conflict. The medical adviser advised that Dr. Panda's report noted essentially normal findings or findings due to nonwork-related conditions. Yet he observed that Dr. Panda found eight percent permanent impairment of each leg. The Office medical adviser stated that it was unclear how Dr. Panda used the A.M.A., *Guides.* He also advised that Dr. Panda found that appellant's pain was nonwork related and did not interfere with appellant's activities.

In a March 7, 2008 report, Dr. Heiman-Patterson stated that appellant had complex regional pain syndrome in the legs due to previous plantar fasciitis and bone spurs along with surgery that was causally related to his work. Appellant's examination showed evidence of reflex sympathetic disorder (RSD) with swelling along with sweating and color changes in his leg associated with sensory loss and significant pain, even to touch. He had recurrent allodynia to pressure and some atrophic changes. Dr. Heiman-Patterson opined that the pain syndrome was a direct result of appellant's plantar fasciitis, bone spurs and surgeries.

On April 24, 2008 the Office medical adviser responded to the Office's April 15, 2008 inquiry about information needed from Dr. Panda to resolve the medical conflict. He advised that no further information was needed as Dr. Panda's examination was thorough but normal, but Dr. Panda needed to explain how he arrived at eight percent permanent impairment of both legs under Table 17-37 of the A.M.A., *Guides*. Furthermore, Dr. Panda opined that the chronic pain was due to nonwork-related conditions.

In a May 12, 2008 letter, the Office requested Dr. Panda provide a supplemental report clarifying the discrepancies identified by the Office medical adviser and to indicate whether he reviewed the January 3, 1997 statement of accepted facts as well as the subsequent addenda to the statement of accepted facts. Dr. Panda was asked to provide a reasoned medical explanation of appellant's permanent impairment of the legs due to the accepted conditions.

In a May 29, 2008 report, Dr. Panda stated that he saw appellant on February 18, 2008. He indicated that he reviewed the January 3, 1997 statement of accepted facts as well as the addenda to the statements of accepted facts during the preparation of his report. Dr. Panda stated that his diagnosis was small fiber neuropathy, which was not due to his August 31, 1993 work injury. He further stated that his examination did not show any motor or sensory defect. Dr. Panda advised that appellant's chronic pain in both feet was not related to the August 31, 1993 work injury. However, it could be related to scar tissue due to multiple surgeries. Dr. Panda advised that due to pain and dysesthesia in lateral and medial plantar nerves distribution of both feet using Table 17-37, page 552, he arrived at an impairment of eight percent for appellant's nonwork-related small fiber neuropathy. He noted that small fiber neuropathy had been reported on August 23, 1998. Dr. Panda noted, however, a March 31, 1997 EMG study of the lower extremity was reported as normal. He opined that, on the basis of motor and sensory examinations, appellant had no permanent impairment.

On June 11, 2008 the Office medical adviser stated that Dr. Panda's May 29, 2008 report clarified discrepancies. He indicated that Dr. Panda found no motor and no sensory impairment and thus there was no permanent impairment bilaterally for the legs. The Office medical adviser advised that, while Dr. Panda found eight percent impairment due to chronic pain and paresthesias in both feet, he stated that it was due to an unrelated condition.

In a June 23, 2008 decision, the Office found that appellant was not entitled to an additional schedule award. It noted that Dr. Panda, the impartial medical specialist, found that appellant had eight percent permanent impairment to the bilateral lower extremities but that this was not related to the work injury.

On July 2, 2008 appellant requested a hearing, which was held November 19, 2008. He submitted a July 7, 2008 magnetic resonance imaging (MRI) scan report, a July 2, 2008 report from Dr. Robert J. Schwartzman, a Board-certified neurologist and internist, and a September 18, 2008 report from Dr. Heiman-Patterson. Dr. Schwartzman diagnosed chronic regional pain syndrome in both lower extremities. He recommended an MRI scan to rule out neuromas on the plantar nerves, worse on the right than the left. Dr. Heiman-Patterson opined that appellant has symptoms referable to complex regional pain syndrome that was likely secondary to his chronic foot trauma with resultant bone spur and plantar fasciitis requiring surgery that was related to his work activities. He noted that appellant had some small fiber sensory loss which might be an evolution of the RSD or represent a separate small fiber neuropathy.

By decision dated February 17, 2009, an Office hearing representative affirmed the June 23, 2008 decision that appellant had no additional impairment of the bilateral lower extremities causally related to the accepted conditions based on the opinion of Dr. Panda, the impartial medical specialist. The hearing representative further expanded the claim to include the condition of complex regional pain syndrome of both feet.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations[3] 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. The Act, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of the Office.[4] 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 regulations as the appropriate standard for evaluating schedule losses.[5] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to

[2] 5 U.S.C. §§ 8101-8193.

[3] 20 C.F.R. § 10.404.

[4] *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

[5] *Ronald R. Kraynak*, 53 ECAB 130 (2001).

calculate schedule awards.[6] For decisions issued after May 1, 2009, the sixth edition will be used.[7] Before applying the A.M.A, *Guides*, the Office must determine whether the claimed impairment of a scheduled member is causally related to the accepted work injury.[8]

When there exist opposing medical opinions 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 and medical background, will be given special weight.[9]

When the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in the original report.[10] However, when the impartial specialist is unable to clarify or elaborate on the original report or if a supplemental report is also vague, speculative or lacking in rationale, the Office must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining a rationalized medical opinion on the issue.[11]

ANALYSIS

The Board finds that this case is not in posture for decision. The case must be remanded for further development of the medical evidence.

The Office accepted that appellant sustained aggravation of plantar fasciitis, bilateral heel spurs and bilateral complex regional pain syndrome of both feet. On June 18, 2002 it issued a schedule award for five percent permanent impairment to each leg. Appellant requested an additional schedule award. On the prior appeal, the Board found a conflict in medical opinion between Dr. Brisman, a Board-certified neurosurgeon, for the Office, and Dr. Heiman-Patterson, an attending physician, on the issue of whether the neuropathy affecting his feet was causally related to his accepted conditions and whether he had a permanent impairment of the lower extremities related to his accepted conditions. The Office first referred appellant to Dr. Sharma to resolve the conflict. Dr. Sharma opined that appellant's neuropathy was not work related. However, after two requests from the Office, he failed to explain his calculation of five percent permanent impairment of each lower extremity under the A.M.A., *Guides.* The Office then referred appellant to Dr. Carta for a second impartial examination to resolve the conflict.

[6] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[7] FECA Bulletin No. 09-03 (issued March 15, 2009).

[8] *Michael S. Mina*, 57 ECAB 379, 385 (2006).

[9] *R.C.*, 58 ECAB 238 (2006); *Bernadine P. Taylor*, 54 ECAB 342 (2003).

[10] *Raymond A. Fondots*, 53 ECAB 637, 641 (2002); *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232 (1988); *Ramon K. Ferrin, Jr.*, 39 ECAB 736 (1988).

[11] *Nancy Keenan*, 56 ECAB 687 (2005); *Roger W. Griffith*, 51 ECAB 491 (2000); *Talmadge Miller*, 47 ECAB 673 (1996).

However, after two requests, Dr. Carta failed to provide a detailed explanation as to how she arrived at her 11 percent permanent impairment rating for each lower extremity. Thus, the Office properly referred appellant to Dr. Panda, to resolve the conflict in medical opinion.[12]

In his February 20, 2008 report, Dr. Panda reviewed the record, presented findings and diagnosed a small fiber neuropathy unrelated to the August 31, 1993 work injury. The neurological examination, including sensory examination of both feet, was essentially normal. Dr. Panda further related that his examination revealed a normal range of motion in both feet with no weakness or atrophy in both leg and no neurological deficit. He opined that appellant reached maximum medical improvement and that his chronic pain in both feet was due to nonwork-related conditions. Dr. Panda opined that appellant had eight percent permanent impairment of each leg under Table 17-37, page 552. In his May 29, 2008 report, he reiterated that the small fiber neuropathy was not due to appellant's work-related injury. Dr. Panda noted that small fiber neuropathy had been reported in a medical record on August 23, 1998 but a March 31, 1997 EMG study of the lower extremity was normal. He further stated that his examination did not show any motor or sensory defect and appellant had no permanent impairment on this basis. Dr. Panda indicated that, due to pain and dysesthesia in lateral and medial plantar nerves distribution of both feet, under Table 17-37, page 552, he had arrived at an impairment of eight percent for appellant's nonwork-related small fiber neuropathy.

The Board finds that Dr. Panda's report requires clarification regarding appellant's small fiber neuropathy. Dr. Panda found that appellant had a nonwork-related small fiber neuropathy, which caused chronic pain and awarded eight percent bilaterally for that condition under Table 17-37, page 552 of the A.M.A., *Guides.* However, he advised that there was no neurological deficit. This does not appear to be consistent. It is difficult to determine whether there is a neuropathy and, if it does exist, how Dr. Panda reached an eight percent bilateral impairment as the A.M.A., *Guides* do not seem to reflect an eight percent impairment for that condition. The Board further notes that the Office medical adviser discounted the additional eight percent impairment Dr. Panda gave for this condition as being nonwork related. Even assuming the small fiber neuropathy is a preexisting condition, any preexisting impairment (even if not work related) to the scheduled member is to be included in determining entitlement to a schedule award.[13] As noted, when an impartial specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the deficiency in his original report.[14] Here, additional information is required from Dr. Panda on whether there is neuropathy. If there is neuropathy and it is a preexisting condition, then he needs to provide an explanation for his impairment calculation under the sixth edition of the A.M.A., *Guides.*

The Board will set aside the February 17, 2009 decision and remand the case for further development. The Office should seek a supplemental report from Dr. Panda. If Dr. Panda is unavailable or unwilling to clarify his opinion, the case should be referred to another impartial

[12] *See id.*

[13] *Michael C. Milner*, 53 ECAB 446, 450 (2002).

[14] *Raymond A. Fondots, supra* note 10.

medical specialist.[15] After such further development as the Office deems necessary, an appropriate decision should be issued regarding this matter.

The Board notes that, subsequent to the receipt of Dr. Panda's reports, appellant submitted additional medical evidence. This evidence did not include a physician's opinion addressing whether appellant sustained permanent impairment to his lower extremities in accordance with the A.M.A., *Guides.* Therefore, the Board finds these medical reports are of diminished probative value.[16]

On appeal, appellant's attorney questioned why Dr. Brisman could create a conflict as he was the first impartial medical examiner in this case and was disqualified. The Board, on the prior appeal, found that Dr. Brisman's opinion created a conflict with that of Dr. Heiman-Patterson. It noted that, while Dr. Brisman was originally selected to resolve a medical conflict regarding appellant's ability to work, there was no prior conflict regarding his permanent impairment. Appellant's attorney also contends that the Office should have asked Dr. Panda directly to determine whether appellant has chronic regional pain syndrome as a result of the accepted conditions and authorized surgeries. The Board notes, however, that the conflict in medical opinion evidence between Dr. Brisman and Dr. Heiman-Patterson pertained to the issue of whether the neuropathy affecting appellant's feet was related to his accepted conditions and whether he had a permanent impairment of the lower extremities related to his accepted conditions. Thus, Dr. Panda addressed the matters that were in conflict.[17] Furthermore, upon return of the case record, he will be asked to calculate appellant's permanent impairment of the legs pursuant to the A.M.A., *Guides*.

CONCLUSION

The Board finds that this case is not in posture for a decision.

[15] *Nancy Keenan, supra* note 11.

[16] *See A.L.*, 60 ECAB ___ (Docket No. 08-1730, issued March 16, 2009).

[17] Nevertheless, in the February 17, 2009 decision, the Office hearing representative expanded the claim to include the condition of complex regional pain syndrome of both feet.

ORDER

IT IS HEREBY ORDERED THAT the February 17, 2009 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this opinion.

Issued: July 20, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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