United States Department of Labor
Employees' Compensation Appeals Board

R.B., Appellant	)	
	)	
and	)	**Docket No. 09-1688**
	)	**Issued: June 4, 2010**
U.S. POSTAL SERVICE, LACKAWANNA POST OFFICE, Buffalo, NY, 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
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 25, 2009 appellant filed a timely appeal of the Office of Workers' Compensation Programs' merit decision dated May 21, 2009. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than 22 percent impairment of his left lower extremity for which he received schedule awards.

FACTUAL HISTORY

On April 4, 1979 appellant, then a 30-year-old letter carrier, filed a traumatic injury claim alleging that he injured his left foot and ankle on that date when he slipped and fell in the performance of duty. On January 21, 1982 he filed a traumatic injury claim alleging that he injured his left foot on that date when a tray of mail fell on his foot. The Office accepted this claim for contusion and hematoma of the left foot. It granted appellant a schedule award for two percent impairment of his left foot on January 21, 1983. On June 27, 1984 appellant sustained a

second employment injury to his left foot, which was accepted for aggravation of fracture of the left fifth metatarsal. He underwent surgery on May 16, 1986 for excision of the proximal portion of the left fifth metatarsal. The Office granted appellant a schedule award for an additional 14 percent impairment of the left foot on August 2, 1988. It granted him a schedule award for an additional six percent impairment of his left lower extremity on February 3, 2005. The Branch of Hearings and Review affirmed this decision on August 8, 2006. Appellant requested reconsideration on January 12, 2007. By decision dated January 25, 2007, the Office declined to reopen his claim for review of the merits on the grounds that he failed to submit evidence or argument in support of his request for reconsideration.

Appellant submitted a report dated June 15, 2007 from Dr. Neil H. Strauss, a podiatrist, addressing his left foot condition. He found clawing of the left fourth and fifth toes which was exacerbated with weight bearing. Dr. Strauss noted that appellant had severe atrophy of the abductor digiti minimi muscle which he attributed to lack of movement since the injury. He also found decreased range of motion in plantar flexion and dorsiflexion with little to no range of motion of the fourth and fifth toes. Dr. Strauss reported severe pain on palpation of the fourth and fifth metatarsals and stated that appellant could not stand on his left forefoot and that his gait was antalgic favoring the left foot. On x-ray he found that appellant had severe degeneration of the bases of the fourth and fifth metatarsals and that the fifth metatarsal demonstrated sclerosis of the peroneus brevis tendon as well as being severely declinated and shortened. Dr. Strauss diagnosed pseudoarthrosis of the left foot with severe muscle weakness, pain and impairment. He provided impairment ratings and found that appellant had moderate plantar flexion capability or 15 percent impairment, mild dorsiflexion or 7 percent impairment, 9 degrees of inversion, 5 percent impairment and 10 degrees of eversion, 2 percent impairment. Dr. Strauss stated that appellant had mild hindfoot deformity, 12 percent impairment. He found five percent impairment of the great toe due to less than 15 degrees and two percent impairment due to severe impairment of the lesser toes. Dr. Strauss awarded 3 percent impairment for ankylosing of the fourth and fifth toes as well as 5 percent impairment for both fracture of the fifth metatarsal and metarasalgia of the fifth metatarsal and 2 percent impairment due to metatarsalgia of the fourth metatarsal for a total impairment of 63 percent of the left lower extremity.

The district medical adviser reviewed this report on September 19, 2007 and stated that Dr. Strauss failed to properly combine the impairment ratings and recommended a second opinion evaluation.

Appellant submitted a report dated May 15, 2006 from Dr. David P. Kalin, a Board-certified family practitioner, noted that his fourth and fifth toes had limited range of motion with constant aching. Dr. Kalin stated that appellant had mild ankylosis of the fourth and fifth toes and inability to plantar flex with mild limited motion of the first, second and third toes. He also found that appellant had loss of range of motion in his ankle with decreases in flexion, extension, inversion and eversion. Dr. Kalin noted loss of strength in the toes. He diagnosed post-traumatic localized dysesthesia with ankylosis of the fourth and fifth toes, metatarsal deformity and mild limited range of motion of the ankle and toes with associated weakness. Dr. Kalin found a 45 percent impairment of the left lower extremity. Appellant filed a claim for compensation requesting a schedule award on December 4, 2007.

The Office referred appellant for a second opinion evaluation with Dr. Jeffrey M. Oettinger, a Board-certified orthopedic surgeon, on January 8, 2008. In a report dated January 24, 2008, Dr. Oettinger described appellant's employment injuries and found 5 to 8 degrees of dorsiflexion and 30 degrees of plantar flexion. He stated that appellant was "stable" to inversion and eversion. Dr. Oettinger noted diffuse pain and tenderness about the base of the fifth metatarsal. He found that appellant had no motion proximally at the metatarsal junction of the fourth and fifth toes as well as dysesthesia radiating to the fourth and fifth toes and no active range of motion of the fourth and fifth toes. Dr. Oettinger diagnosed chronic pain with associated deformity at the base of the fifth metatarsal status post multiple attempts at conservative treatment of operative intervention as well as residual dysesthesia and dysfunctional lateral ray to include the fourth and fifth toes. He agreed with Dr. Strauss' June 15, 2007 report and concluded that appellant had 63 percent impairment. Dr. Oettinger stated that appellant had not reached maximum medical improvement.

The district medical adviser reviewed Dr. Oettinger's report on February 1, 2008 and stated that the rating of 63 percent was not properly itemized under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) and that he did not provide a date of maximum medical improvement. On February 12, 2008 he stated that Dr. Strauss' findings were not consistent with those provided by Dr. Oettinger noting that ankle dorsiflexion of five to eight degrees was seven percent impairment. The district medical adviser also found that based on Dr. Oettinger's report appellant had no impairment due to loss of plantar flexion, no deformity of the hindfoot and no true ankylosis of the toes. He concluded that based on Dr. Oettinger's findings appellant had seven percent impairment due to limited dorsiflexion and two percent for mild impairment of the lesser toes. The district medical adviser concluded that the 63 percent impairment could not be considered valid as it exceeded the A.M.A., *Guides* value for a midfoot amputation which would be 45 percent impairment. He found that appellant had no more than nine percent impairment of his left lower extremity.

The Office requested a supplemental report from Dr. Oettinger and on February 21, 2008 he stated that appellant had mild ankle motion deficiency limited to seven percent. Dr. Oettinger found no true hindfoot deformity and no pain or discomfort. He stated, "Tot impairment is relatively minimal." Dr. Oettinger noted that appellant had postsurgical changes to include ankylosis at the proximal aspect of the tarsal metatarsal region of two percent. He concluded that the district medical adviser's assessment of nine percent impairment of the left lower extremity was appropriate.

By decision dated March 20, 2008, the Office denied appellant's claim for an additional schedule award finding that he had previously received schedule awards totaling 22 percent. It found that his current impairment rating was nine percent based on the second opinion and Office medical adviser. Appellant requested an oral hearing on March 25, 2008. The Branch of Hearings and Review found that the case was not in posture for decision and remanded for the Office to refer appellant for an additional second opinion evaluation by decision dated June 13, 2008.

The Office referred appellant to Dr. David B. Lotman, a Board-certified orthopedic surgeon on August 4, 2008. In a report dated October 8, 2008, Dr. Lotman reviewed appellant's medical history and noted his complaints of foot pain and instability. On physical examination,

he found no gross atrophy, mild hyperemia and no ankle effusion or crepitation. Dr. Lotman stated that appellant demonstrated 0 degrees of dorsiflexion, 55 degrees of plantar flexion, 10 degrees of eversion and 35 degrees of inversion. He found that strength in the left foot and ankle was poor in dorsiflexion and that appellant could only actively dorsiflex to five degrees of plantar flexion. Dr. Lotman recommended additional diagnostic procedures. On November 7, 2008 he reviewed the additional reports and diagnosed status postfracture, fifth metatarsal, left foot with two surgical interventions and idiopathic dysesthesias, left lower extremity. Dr. Lotman concluded that appellant's reported dysesthesias presented symptom magnification. He opined that appellant had two percent impairment of the lower extremity and three percent impairment to the foot as the disability-rating equivalent to ankylosis at the fifth metatarsophalangeal joint.

Appellant filed a notice of occupational disease on November 10, 2008 and alleging that due to his left foot injury he developed conditions in his left knee, lower back, right hip, right shoulder and right knee.

The district medical adviser reviewed these reports on November 19, 2008 and opined that Dr. Lotman was "thorough and thoughtful." He adopted the 2 percent impairment rating for ankylosis of the toes in addition to the 9 percent impairment previously found for a total of 11 percent impairment of the left lower extremity.

By decision dated November 25, 2008, the Office denied appellant's request for an additional schedule award finding that the medical evidence did not establish more than 22 percent impairment of his left lower extremity for which he had previously received schedule awards. Appellant requested an oral hearing on November 26, 2008.

In support of his request, appellant submitted a report dated March 3, 2009 from Dr. Kalin, who reviewed the medical records and diagnosed post-traumatic localized dysesthesia with ankylosis of the fourth and fifth toes, metatarsal deformity and mild limited range of motion of the ankle and toes with associated weakness. Dr. Kalin also found compensatory right lumbosacral sprain and compensatory left knee pain both due to the left foot injury. He opined that appellant had 45 percent impairment of his left lower extremity, based on muscle weakness, loss of range of motion, ankylosis, arthritis and nerve deficits.

Appellant testified at the oral hearing on March 26, 2009. He stated that he could not put pressure on one half of his foot. Appellant stated that he could not walk or stand for long periods. He disagreed with Dr. Lotman's methods and assessment.

By decision dated May 21, 2009, the branch of hearings and review found that appellant had no more than 22 percent impairment of his left lower extremity for which he had received schedule awards and affirmed the Office's November 25, 2008 decision.

On appeal, appellant alleged that the record supported additional impairment as well as consequential injuries.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulations[2] 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 regulations as the appropriate standard for evaluating schedule losses.[3] Effective February 1, 2001, the Office adopted the fifth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[4]

Before the A.M.A., *Guides* can be utilized, a description of appellant's impairment must be obtained from appellant's physician. In obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment including, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation or other pertinent descriptions of the impairment. This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[5]

It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides* his opinion is of diminished probative value in establishing the degree of permanent impairment and the Office may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings reported by the attending physician.[6]

ANALYSIS

Appellant submitted a report dated June 15, 2007 from Dr. Strauss, a podiatrist, opining that appellant had 63 percent impairment of the left lower extremity due to loss of range of motion and diagnosis-based estimates. The Board notes that the district medical adviser properly found that these two evaluation methods could not be combined together under the A.M.A., *Guides*.[7] Appellant also provided a report from Dr. Kalin, a Board-certified family practitioner,

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404 (1999).

[3] *Id.*

[4] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(a) (August 2002).

[5] *Robert B. Rozelle*, 44 ECAB 616, 618 (1993).

[6] *Linda Beale*, 57 ECAB 429, 434 (2006).

[7] A.M.A., *Guides*, 526, Table 17-2. This table provides that range of motion impairments may not be combined with diagnosis-based estimates to reach a permanent impairment rating.

who determined that appellant had 45 percent impairment due to loss of range of motion, ankylosis and loss of strength. The Board notes that impairments for loss of muscle strength cannot be combined with loss of range of motion and ankylosis. Furthermore, Dr. Kalin did not provide detailed findings in support of his impairment ratings such that the impairment could be visualized. As neither Dr. Strauss nor Dr. Kalin provided an impairment rating consistent with the A.M.A., *Guides*, the Board finds that the Office properly referred appellant for a second opinion evaluation.

The Office initially referred appellant to Dr. Oettinger, a Board-certified orthopedic surgeon, for a second opinion evaluation. However, as found by the hearing representative, the Board notes that Dr. Oettinger did not provide any independent impairment rating, but instead adopted the ratings of Dr. Strauss and then the rating of the district medical adviser. As Dr. Oettinger did not provide and support his own impairment rating, the Board finds that the Office properly determined that referral to an additional second opinion physician was appropriate.

The Office referred appellant to Dr. Lotman, a Board-certified orthopedic surgeon, who found on October 8, 2008, no gross atrophy, mild hyperemia and no ankle effusion or crepitation. Dr. Lotman stated that appellant demonstrated 0 degrees of dorsiflexion, 55 degrees of plantar flexion, 10 degrees of eversion and 35 degrees of inversion. He found that strength in the left foot and ankle was poor in dorsiflexion and that appellant could only actively dorsiflex to five degrees of plantar flexion. Dr. Lotman recommended additional diagnostic procedures. On November 7, 2008 he reviewed the additional reports and opined that appellant had two percent impairment of the lower extremity and three percent impairment to the foot as the disability-rating equivalent to ankylosis at the fifth metatarsophalangeal joint. It is the responsibility of the evaluating physician to explain in writing why a particular method to assign the impairment rating was chosen.[8] Dr. Lotman found that this impairment rating was the most appropriate under the A.M.A., *Guides*.[9] The district medical adviser reviewed this report and found that it comported with the A.M.A., *Guides*.

The Board finds that the weight of the medical opinion evidence rests with the report of Dr. Lotman and establishes that appellant has no more than 22 percent impairment of his left lower extremity for which he received schedule awards.

CONCLUSION

The Board finds that the weight of the medical opinion evidence establishes that appellant has no more than 22 percent impairment of his left lower extremity for which he has received schedule awards.

[8] *Tara L. Hein*, 56 ECAB 431 (2005).

[9] A.M.A., *Guides* 542, Table 17-30.

ORDER

IT IS HEREBY ORDERED THAT the May 21, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 4, 2010
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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