United States Department of Labor
Employees' Compensation Appeals Board

S.T., Appellant	)	
and	)	**Docket No. 11-502**
	)	**Issued: March 17, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Charlottesville, VA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On April 6, 2010 appellant filed a timely appeal of December 17, 2009 and March 29, 2010 Office of Workers' Compensation Programs' merit decisions. Pursuant to the Federal Employees' Compensation Act[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.

ISSUE

The issue is whether appellant has more than 10 percent impairment of his right lower extremity for which he received a schedule award.

FACTUAL HISTORY

On August 13, 2007 appellant, then a 45-year-old letter carrier, filed a occupational disease claim alleging that he developed swelling in his feet and constant foot pain due to

[1] 5 U.S.C. § 8101 *et seq.*

walking and standing in the performance of duty. The Office accepted his claim for aggravation of bilateral *pes planus*.[2]

Dr. Jimmy Downing, a podiatrist and appellant's attending physician, recommended a medial cuneiform-navicular fusion and repair of the posterior tibialis tendon on the right. He performed this surgery on January 25, 2008. The Office entered appellant on the periodic rolls on April 9, 2008. Appellant returned to limited work on June 19, 2008.

In a note dated February 5, 2009, Dr. Downing examined appellant's computed tomography (CT) scan and found that there was not an osseous union of the medial cuneiform navicular joint. He stated that appellant might require additional surgery. On February 24, 2009 Dr. Downing stated that appellant's diagnosis of bilateral *pes planus* deteriorated due to the nature of his employment and that appellant developed arthritis prior to 2005. He concluded, "It is my medical opinion that the arthritis in [appellant's] navicular-cuneiform joint is due to his original condition of *pes planus*."

Appellant returned to a light-duty position working eight hours a day on March 31, 2009. He requested a schedule award on April 7, 2009. In a letter dated May 1, 2009, the Office requested that appellant provide medical evidence in support of his request for a schedule award in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment.*[3]

Dr. Downing opined that appellant had reached maximum medical improvement (MMI) on April 6, 2009. He stated that he could not provide an impairment rating. Appellant submitted his January 29, 2009 CT scan report which demonstrated loosening of a portion of the screw within the medial cuneiform and no definitive region of osseous fusion traversing the navicular and medial cuneiform.

The Office referred appellant for a second opinion evaluation with Dr. Visespong Punyanitya, a Board-certified orthopedic surgeon, on September 14, 2009. In a report dated September 22, 2009, Dr. Punyanitya reported mild tenderness on palpation at the middle of the scar on appellant's right foot. He found 11 degrees of dorsiflexion and 30 degrees of plantar flexion, with inversion of 11 degrees and eversion of 0 degrees. Dr. Punyanitya found fixed *pes planus* deformity and absence of midfoot passive motion with pain on dorsiflexion and plantar flexion of the midfoot area. He noted that appellant had mild weakness of plantar flexion of the right foot, Grade 4/5. In regards to appellant's left foot, Dr. Punyanitya found 10 degrees of dorsiflexion of the left ankle and 32 degrees of plantar flexion with 18 degrees of inversion and 5 degrees of eversion. He noted tenderness without swelling along the posterior tibial tendon and at the mid-arch area with no weakness of plantar flexion. Dr. Punyanitya found flexible *pes planus* deformity but no pain on passive motion of the mid foot or toes. He also noted mild hypoesthesia on palpation and pinprick on the medial border of the left foot. Dr. Punyanitya

[2] Appellant had previously filed a traumatic injury on November 7, 2000 alleging that on November 4, 2000 he injured his low back lifting a heavy volume of mail and twisting in the performance of duty.

[3] A.M.A., *Guides* (6th ed. 2009).

diagnosed bilateral *pes planus*, bilateral rupture of the ankle and foot tendon and nonunion of medial cuneiform-navicular joint fusion, right foot.

Dr. Punyanitya found that appellant continued to experience residuals of his flat feet and tendinitis which was compounded by the failure of healing of the fusion of the cuneiform-navicular joint. He concluded that appellant had permanent impairment due to persistent tendinitis, derangement of the tarsal bone causing limited motion and pain on motion, as well as pain from the nonunion which impaired the ability to bear weight, stand and walk. Dr. Punyanitya found appellant had 49 percent of the lower extremities stating, "Reference Table 16.2, Table 16.6, Table 16.7 and Table 16.8" of the A.M.A., *Guides*. He found appellant reached MMI on January 29, 2009.

The Office referred appellant's claim to Dr. Willie E. Thompson, an Office medical adviser. On December 1, 2009 Dr. Thompson reviewed the medical evidence on behalf of the Office and found that under the sixth edition of the A.M.A., *Guides* a double arthrodesis in the neutral position was 10 percent impairment of the right lower extremity. He provided a citation to Table 16-2 of the A.M.A., *Guides*.[4] Dr. Thompson stated, "In regards to the left foot there is no basis for a rating of permanency for a flat foot. There is no criteria set forth in the fourth edition of the A.M.A., *Guides*. I am unable to provide a basis for a rating of permanency to the left foot; therefore, the impairment rating to the left foot is zero percent." Dr. Thompson concluded that appellant reached MMI on January 28, 2009.

By decision dated December 17, 2009, the Office granted appellant a schedule award for 10 percent impairment of his right lower extremity and 28.8 weeks of compensation. Appellant disagreed with this decision and requested that he receive 49 percent impairment as found by Dr. Punyanitya. He resubmitted Dr. Downing's June 3, 2008 note and requested reconsideration on December 28, 2009.

Appellant submitted several physical therapy notes. In notes dated January 19 and 26, 2010, Dr. Downing recommended treatment for appellant's left foot diagnosis of capsulitis of the left foot navicular cuneiform joint.

By decision dated March 29, 2010, the Office denied modification of the December 17, 2009 decision finding that Dr. Thompson's report was entitled to the weight of the medical evidence as he specifically correlated the diagnosed condition with the appropriate table of the A.M.A., *Guides*.

LEGAL PRECEDENT

The schedule award provision of the Act[5] and its implementing regulations[6] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss or loss of use, of scheduled members or functions of the body. The Act, however, does not

[4] A.M.A., *Guides* 508, Table 16-2.

[5] 5 U.S.C. §§ 8101-8193, 8107.

[6] 20 C.F.R. § 10.404.

specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the discretion of the Office. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[7]

In addressing lower extremity impairments, the sixth edition requires identification of the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE) and clinical studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[8]

ANALYSIS

The Board finds that this case is not in posture for decision. While Dr. Punyanitya's September 22, 2009 report includes detailed findings regarding appellant's lower extremities, he did not correlate these findings with the specific requirements of the A.M.A., *Guides*. His report references "Table 16.2,[9] Table 16.6,[10] Table 16.7[11] and Table 16.8[12]" of the A.M.A., *Guides*, but does not explain how he used these tables and does not employ the lower extremity formula set out in the sixth edition of the A.M.A., *Guides*. This formula requires that Dr. Punyanitya determine the class of diagnosis (CDX) and apply the appropriate grade modifiers for functional history, (GMFH) physical examination(GMPE) and clinical studies (GMCS) and apply the following formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) to reach the appropriate grade within the class of diagnosis.[13] He did not offer any explanation of how he reached his impairment rating of 49 percent. Dr. Punyanitya's report also addresses appellant's lower extremities without differentiating the impairment rating between the right and left lower extremity. It is unclear whether he believes that appellant has right and left lower extremity impairments totaling 49 percent or whether he is attributing the 49 percent impairment rating to appellant's right lower extremity alone.

The Office medical adviser, Dr. Thompson, also failed to provide an explanation of how he reached appellant's impairment rating. He cited one table of the A.M.A., *Guides*, but did not

[7] For new decisions issued after May 1, 2009 the Office began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6a (January 2010); *Id*. at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[8] A.M.A., *Guides* 521. *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

[9] *Id.* at 501, Table 16-2, Foot and Ankle Regional Grid -- Lower Extremity Impairments.

[10] *Id*. at 516, Table 16.6, Functional History Adjustment -- Lower Extremities.

[11] *Id*. at 517, Table 16-7, Physical Examination Adjustment -- Lower Extremities.

[12] *Id*. at 519, Table 16-8, Clinical Studies Adjustment -- Lower Extremities.

[13] *Id*. at 521.

apply the formula as mentioned above and did not mention any of the listed modifiers which could have resulted in an impairment rating from 7 to 13 percent for a double arthrodesis in the neutral position.

As neither Dr. Punyanitya nor Dr. Thompson provided a detailed and thorough report which comports with the provisions of the sixth edition of the A.M.A., *Guides*, the Board finds that this case is not in posture for a decision. On remand, the Office should develop the medical evidence which could include a supplemental report from Dr. Punyanitya explaining his impairment rating in terms of the stated formula of the A.M.A., *Guides* and a more thorough review of the medical evidence and application of the A.M.A., *Guides* by Dr. Thompson. After this and such other development of the medical evidence as the Office deems necessary, the Office should issue an appropriate decision.

CONCLUSION

The Board finds that the case is not in posture for decision and requires additional development of the medical evidence consistent with this decision of the Board.

ORDER

IT IS HEREBY ORDERED THAT the March 29, 2010 and December 17, 2009 decisions of the Office of Workers' Compensation Programs are set aside and remanded for additional development.

Issued: March 17, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board