United States Department of Labor
Employees' Compensation Appeals Board

T.P., Appellant	)	
and	)	**Docket No. 11-2136**
	)	**Issued: July 16, 2012**
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:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge

JURISDICTION

On September 23, 2011 appellant, through his attorney, filed a timely appeal from a June 23, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP) denying his claim for an additional schedule award. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 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.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

This is the third appeal before the Board. In a July 12, 2005 decision, the Board reversed OWCP's October 14, 2004 decision and found that there was a conflict in medical evidence regarding permanent impairment of the legs.[2] The Board found a medical conflict between Dr. Ronald Brisman, a Board-certified neurosurgeon, and Dr. Terry Heiman-Patterson, an attending Board-certified neurologist, on the issue of whether appellant's neuropathy affecting his feet was related to the accepted conditions and whether he had a permanent impairment of the legs related to his accepted conditions. The Board noted that OWCP 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 1997 and 1998. The Board advised that appellant previously received a schedule award for five percent impairment of each leg on June 18, 2002. In a July 20, 2010 decision,[3] the Board set aside OWCP's February 17, 2009 decision finding that a supplemental report from Dr. Dhiraj K. Panda, a Board-certified neurosurgeon selected as the impartial medical examiner, was needed on the issue of whether appellant had a small fiber neuropathy and, if so, whether there was any permanent impairment of the legs pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). The Board noted that any preexisting impairment, whether or not work related, to the scheduled member was to be included in determining entitlement to a schedule award. It advised that the hearing representative in the February 17, 2009 decision had expanded the claim to include the condition of complex regional pain syndrome of both feet. The facts and the medical history of the case are set forth in the Board's prior decisions and incorporated herein by reference.

On remand, following the Board's July 20, 2010 decision, OWCP sent Dr. Panda letters dated August 2 and 23, 2010 requesting a supplemental report on the issues of whether there was a neuropathy and if there was a neuropathy and it was a preexisting condition, to provide an impairment calculation under the sixth edition of the A.M.A., *Guides.* It requested that he submit his report within 3 weeks (21 days). On August 30, 2010 Dr. Panda's former office called OWCP and indicated that Dr. Panda had been retired for over nine months and would not be able to complete the requested report.

On September 17, 2010 OWCP referred appellant, the case record and an updated statement of accepted facts to Dr. Ronald L. Gerson, a Board-certified orthopedic surgeon, to resolve the medical conflict. In a November 15, 2010 report, Dr. Gerson noted the history of injury and appellant's treatment course. He reviewed the medical records, including diagnostic studies and presented findings on physical, motor and neurological examination of the lower extremities. Dr. Gerson diagnosed appellant's employment-related conditions as plantar fasciitis of both feet and stated that appellant was status post bilateral plantar fascia releases and heel spur removals. He indicated that the medical records documented that since undergoing bilateral plantar fascia releases and heel spur removals appellant was diagnosed by August 24, 1998 electromyogram as having a small fiber neuropathy. Dr. Gerson opined that appellant's current symptoms in both feet were a result of a small fiber neuropathy. He opined, however, that the

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

[3] Docket No. 09-1636 (issued July 20, 2010).

small fiber neuropathy was an unassociated condition and had no causal relation to the accepted diagnosis of bilateral plantar fasciitis. Dr. Gerson indicated that, while the most common cause of peripheral neuropathy in the United States was complications from diabetes mellitus, which appellant did not have, there were many other causes for peripheral neuropathy and sometimes the etiology could not be determined. He rationalized that it would be medically impossible for the conditions of plantar fasciitis and heel spurs to cause a small fiber neuropathy. Dr. Gerson also stated that the small fiber neuropathy would not be a ratable condition. He opined that, while he did not have the records concerning the initial plantar fascia release and heel spur removal procedures, appellant reached maximum medical improvement six months after the procedures to both feet. Dr. Gerson stated that, while the medical records mentioned appellant had been diagnosed with complex regional pain syndrome involving both lower extremities, he did not meet the objective criteria under the A.M.A., *Guides* for the diagnosis of complex regional pain syndrome. He indicated that findings of edema, decreased range of motion and trophic changes (hair, nail and skin) were not present; there was no documentation of any imaging study showing radiographic changes compatible with the diagnosis of complex regional pain syndrome and there were no reported findings of trophic bone changes or osteoporosis. Under Table 16-2, page 501 of the sixth edition of the A.M.A., *Guides*, Dr. Gerson assigned Class 1 for appellant's bilateral plantar fasciitis or the class of diagnosis (CDX). Under Table 16-7, page 517, he assigned a grade 1 modifier for the Physical Examination (GMPE) adjustment as there were minimal palpatory findings without observed abnormalities. Under Table 16-8, page 519, Dr. Gerson assigned a grade 2 modifier for the Clinical Studies (GMCS) adjustment based on the July 7, 2008 magnetic resonance imaging scan studies of both ankles. Under Table 16-6, page 516, a grade 1 was provided for the Functional History (GMFH) adjustment due to antalgic gait derangement. Dr. Gerson utilized the net adjustment formula of (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX) (1-1) + (1-1) + (2-1) to find a net adjustment of 1. Under Table 16-2, page 501, he found that as the mid range impairment for plantar fasciitis was 1, the net adjustment of 1 would render a final impairment of two percent for each foot.

On November 29, 2010 an OWCP medical adviser reviewed Dr. Gerson's report. With regard to impairment due to the bilateral peripheral neuropathy, he noted that Dr. Gerson did not include any impairment due to the bilateral peripheral neuropathy as he felt it was not causally related to the accepted condition of bilateral plantar fasciitis and bilateral heel spurs. The medical adviser indicated that Dr. Gerson's examination did not reveal any objective neurological abnormalities; thus, there would be no additional impairment to apply. He further noted that Dr. Gerson found no evidence of a complex regional pain syndrome. The medical adviser concurred with Dr. Gerson that appellant reached maximum medical improvement six months postoperatively. He also stated that Dr. Gerson correctly applied the A.M.A., *Guides* to his examination findings and concurred with the final impairment rating of two percent. However, the medical adviser stated that the impairment rating was two percent for each leg as opposed to each foot.

By decision dated December 14, 2010, OWCP denied an additional schedule award based on the reports of Dr. Gerson and the medical adviser. Appellant disagreed with the decision and requested an oral hearing, which was held by videoconference on April 12, 2011. By decision dated June 23, 2011, an OWCP hearing representative affirmed the December 14, 2010 decision.

LEGAL PRECEDENT

The schedule award provision of FECA 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. FECA, 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 OWCP.[5] 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.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7] 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.[8]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[9] Under the sixth edition, the evaluator identifies 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).[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11] Before applying the A.M.A., *Guides*, however, OWCP must determine whether the claimed impairment of a schedule member is causally related to the accepted work injury.[12]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and

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[4] 20 C.F.R. § 10.404.

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

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

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[8] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); *supra* note 7 at Chapter 3.700.3.b. (June 1993). This portion of OWCP's procedure provides that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

[9] A.M.A., *Guides* (6th ed. 2009), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[10] A.M.A., *Guides* (6th ed. 2009), pp. 383-419.

[11] *Id.* at 411.

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

percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[13]

When there exists an opposing medical opinion 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.[14]

When OWCP 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, OWCP must secure a supplemental report from the specialist to correct the defect in his original report.[15] However, when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, OWCP must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[16]

ANALYSIS

OWCP 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 first appeal, the Board found a conflict in medical opinion 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. On the second appeal, the Board found that a supplemental report from Dr. Panda, a Board-certified neurosurgeon and impartial medical examiner, was needed on the issue of whether appellant had a small fiber neuropathy and, if so, whether there was any permanent impairment of the legs pursuant to the sixth edition of the A.M.A., *Guides*. It noted that any preexisting impairment, whether or not work related, to the scheduled member was to be included in determining entitlement to a schedule award. While OWCP twice requested a supplemental report from Dr. Panda as instructed, his former office advised that he had retired and was unable to provide a report. Thus, it properly referred appellant to Dr. Gerson, a Board-certified orthopedic surgeon, to resolve the conflict in medical opinion.[17]

In his November 15, 2010 report, Dr. Gerson diagnosed employment-related conditions as plantar fasciitis of both feet and stated that appellant was status post bilateral plantar fascia releases and heel spur removals. He found that appellant's current symptoms in both feet were

[13] *See* Federal (FECA) Procedure Manual, *supra* note 7, Chapter 2.808.6(d) (August 2002).

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

[15] *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).

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

[17] *See Nancy Keenan, id.*

the result of a small fiber neuropathy, but opined that the small fiber neuropathy was not causally related to the accepted work-related conditions. Dr. Gerson indicated that there were several causes for peripheral neuropathy and sometimes the etiology could not be determined. He reasoned, however, that it was medically impossible for the conditions of plantar fasciitis and heel spurs to cause a small fiber neuropathy. Dr. Gerson further found that appellant's small fiber neuropathy was diagnosed after he underwent his work-related surgeries; thus, the condition was not a ratable condition in determining his schedule award. He also found that appellant did not meet the objective criteria for the diagnosis of complex regional pain syndrome under the A.M.A., *Guides* and there was no documentation of radiographic changes compatible with complex regional pain syndrome or reported findings of trophic bone changes or osteoporosis. Dr. Gerson stated that appellant reached maximum medical improvement from his plantar fascia release and heel spur removal procedures six months after the procedures to both feet and opined under the A.M.A., *Guides* that he had two percent impairment for each foot from his employment-related bilateral plantar fasciitis. OWCP's medical adviser reviewed Dr. Gerson's report and concurred with the impairment rating, with the exception of noting that the rating was for the lower extremities as opposed to the feet.

In determining that appellant's impairment for the diagnosed condition of plantar fasciitis for each foot, both Dr. Gerson and OWCP's medical adviser referenced Table 16-2, page 508 of the A.M.A., *Guides,* which provides a default impairment of one percent of the lower extremity for the diagnosis of plantar fasciitis. Although the identified impairment involved the diagnosed condition of plantar fasciitis for each foot, the rating under Table 16-2 pertains to the lower extremity, not to each foot as Dr. Gerson noted. Dr. Gerson found under Table 16-6, page 516, the GMFH was 1; under Table 16-7, page 517, the GMPE was 1; and under Table 16-8, page 519, GMCS was 2. He properly applied the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) (1-1) + (1-1) + (2-1) and found a net adjustment of 1. The net adjustment of 1 renders a final lower extremity impairment rating of two percent for each leg. As the two percent impairment rating to each leg is less than the previous award of five percent impairment to each leg, appellant is not entitled to an additional schedule award.

On appeal, appellant's counsel contends that Dr. Gerson's report is insufficient to carry the weight of the medical evidence. While he asserts Dr. Gerson's physical examination was deficient, a review of Dr. Gerson's report indicates that he performed detailed testing of appellant, including findings on physical, motor and neurological examination, which were essentially normal with a bilateral short stance phase at both legs. Counsel also argues that Dr. Gerson did not resolve the conflict in medical evidence with regard to the small fiber neuropathy. However, Dr. Gerson clearly noted the presence of the small fiber neuropathy and presented rationale as to why he believed that it was not employment related. He also specifically indicated that the small fiber neuropathy should not be considered in the impairment rating as it occurred subsequent to appellant's work-related surgeries. As noted, any preexisting impairment to the schedule member, whether or not work related, was to be included in determining entitlement to a schedule award. The evidence does not show that this condition was preexisting. Counsel next contends that the medical adviser resolved the conflict in medical evidence by disagreeing with Dr. Gerson's opinion that two percent impairment to each foot was appropriate and instead two percent impairment to each lower extremity should apply. The Board notes that the medical adviser was merely applying Dr. Gerson's findings to the protocols of the A.M.A., *Guides* and Table 16-2 clearly indicates that the impairment under that Table is

for the lower extremity.[18] The medical adviser properly applied the A.M.A., *Guides* in advising that the impairment was for the lower extremities and not for the foot.[19] Accordingly, Dr. Gerson's report is sufficiently detailed and well reasoned to constitute the weight of the medical evidence. He based his report on a proper history of injury, detailed physical findings and provided medical reasoning for his conclusions. Dr. Gerson's medical report represents the weight of the medical evidence. Thus, appellant did not establish his entitlement to an additional schedule award.

CONCLUSION

The Board finds that appellant did not establish that he sustained any permanent impairment causally related to his accepted conditions thereby entitling him to an additional schedule award under 5 U.S.C. § 8107.

ORDER

IT IS HEREBY ORDERED THAT the June 23, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 16, 2012
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

[18] A.M.A., *Guides* at 501.

[19] *See* Federal (FECA) Procedure Manual, *supra* note 7, *Developing and Evaluating Medical Evidence*, Chapter 2.810.8.k (September 2010) (if a case has been referred for a referee evaluation to resolve the issue of permanent impairment, it is appropriate for the OWCP medical adviser to review the calculations to ensure the referee physician appropriately used the A.M.A., *Guides*).