United States Department of Labor
Employees' Compensation Appeals Board

S.W., Appellant	)	
and	)	**Docket No. 15-1740**
	)	**Issued: January 28, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Coppell, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 18, 2015 appellant filed a timely appeal of a May 8, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) 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 met her burden of proof to establish more than one percent permanent impairment of her left lower extremity for which she received a schedule award.

FACTUAL HISTORY

On March 3, 2007 appellant, then a 46-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that she sustained a left ankle strain or sprain on that date when she

[1] 5 U.S.C. § 8101 *et seq.*

had a misstep from a curb, lost her balance, and fell in the performance of duty. OWCP accepted her claim for left ankle sprain on March 30, 2007.

Appellant filed a recurrence of disability claim (Form CA-2a) on February 28, 2010 and alleged that she sustained a recurrence of her ankle condition on December 29, 2009. She alleged that she had developed a heel spur as a result of her 2007 employment injury. A left heel x-ray on January 21, 2010 demonstrated a small heel spur. OWCP accepted the recurrence claim on April 6, 2010.

Appellant underwent a left ankle magnetic resonance imaging (MRI) scan on May 10, 2010 which demonstrated peritendinitis and tenosynovitis of the posterior tibialis and peroneus tendons. The MRI scan also demonstrated narrow edema in the calcaneus at the insertion of the plantar fascia with thickening of the plantar fascia.

Dr. John T. Wey, a Board-certified orthopedic surgeon, examined appellant on June 16, 2010 and described her history of injury. He diagnosed chronic plantar fasciitis left foot, plantar heel spur left foot, and distal tarsal syndrome left foot. Dr. Wey opined that appellant had been hurting for three years and recommended surgery. Appellant underwent partial plantar fasciectomy surgery on February 23, 2011.

Dr. Diane S. Litke, a Board-certified orthopedic surgeon, examined appellant on November 18, 2011 and relayed her history of injury. She noted appellant's surgery on February 23, 2011 and reported appellant's complaints of pain. Dr. Litke found palpatory tenderness over the left foot and ankle as well as full range of motion of the left ankle and foot.

OWCP accepted plantar fibromatosis, calcaneal spur, tarsal tunnel syndrome, and mononeuritis on the left on April 6, 2012. Appellant returned to work on July 14, 2014.

Dr. Litke examined appellant on November 21, 2013 and repeated her earlier findings. She recommended physical therapy.

Dr. Wey examined appellant on October 13, 2014 and found no signs of muscle atrophy in the left ankle and foot. He reported swelling in appellant's anterolateral ankle with tenderness in the lateral gutter and peroneal. Dr. Wey listed appellant's range of motion as 14 degrees of dorsiflexion, 68 degrees of plantar flexion, 14 degrees of inversion, and 28 degrees of eversion. He found that strength testing was normal as was stability testing. Dr. Wey reported normal gait, no signs of rheumatoid arthritis, and symmetrical reflexes. Sensory testing for light touch was decreased in the lateral dorsal left foot. Appellant demonstrated a positive Tinel's sign in the superficial peroneal nerve and the deep peroneal nerve in the left ankle. Dr. Wey diagnosed plantar fasciitis and mononeuritis unspecified. Appellant filed a claim for compensation (Form CA-7) requesting a schedule award on October 14, 2014.

Dr. Les Benson, Board-certified in emergency medicine, examined appellant on October 24, 2014 and found that she had reached maximum medical improvement. He described appellant's history of injury. Dr. Benson provided appellant's left ankle range of motion as 17 degrees of plantar flexion, 12 degrees of dorsal flexion, 20 degrees of inversion and 7 degrees of eversion. He diagnosed left plantar fibromatosis, left calcaneal spur, left tarsal tunnel syndrome, and left mononeuritis. Dr. Benson opined that appellant's permanent impairment was best

determined by range of motion impairment. He found that less than 20 degrees of plantar flexion was seven percent impairment,[2] 20 degrees of any inversion was two percent impairment,[3] and that less than 10 degrees of ankle eversion was two percent impairment.[4] Dr. Benson also found that appellant's 12 degrees of ankle extension was equivalent to less than 10 degrees and awarded her two percent impairment.[5] He totaled these impairments and found that appellant had 11 percent impairment based the American Medical Association, *Guides to the Evaluation of Permanent Impairment.*[6]

An OWCP medical adviser reviewed the record on November 13, 2014 and disagreed regarding appellant's physical findings between Dr. Litke and Benson. He recommended a second opinion evaluation.

On February 18, 2015 OWCP referred appellant for a second opinion evaluation with Dr. James E. Butler, III, a Board-certified orthopedic surgeon.

Dr. Butler completed an examination on February 18, 2015 and reviewed the statement of accepted facts. He found that palpation of the left ankle revealed tenderness. Dr. Butler found that appellant had reached maximum medical improvement and diagnosed left ankle sprain, left plantar fasciitis, and left foot tarsal tunnel release. He found that appellant's range of motion was within normal limits with plantar flexion of 22, 25, and 23 degrees and dorsiflexion of 12, 13, and 12 degrees. Appellant demonstrated inversion of 22, 26, and 24 degrees as well as eversion of 13, 12, and 13 degrees. Dr. Butler utilized the diagnosis-based estimates and found that appellant had a class 1 impairment[7] with grade 1 functional history,[8] physical examination,[9] and clinical studies grade modifiers.[10] After applying the net adjustment formula, Dr. Butler determined that appellant had a default grade C or one percent impairment of the left lower extremity.

On February 25, 2015 appellant submitted a report by Dr. Wey, who examined appellant on February 2, 2015 and provided range of motion figures including 10 degrees of dorsiflexion, 66 degrees of plantar flexion, 20 degrees of ankle inversion and 30 degrees of ankle eversion. Only 20 degrees of ankle inversion is a ratable impairment under the A.M.A., *Guides*.[11] Dr. Wey

[2] A.M.A., *Guides* 549, Table 16-22.

[3] *Id.* at Table 16-20.

[4] *Id.*

[5] *Supra* note 2.

[6] *Id.* at 529 (6th ed. 2009).

[7] *Id.* at 501, Table 16-2.

[8] *Id.* at 516, Table 16-6.

[9] *Id.* at 517, Table 16-7.

[10] *Id.* at 519, Table 16-8.

[11] *Supra* note 3.

continued to report positive Tinel's sign at the superficial peroneal nerve and deep peroneal nerve in the left ankle as well as tarsal tunnel syndrome in the left foot.

An OWCP medical adviser reviewed this report on April 2, 2015 and agreed with Dr. Butler's assessment. He noted that Dr. Butler's measurements of ankle and hind foot motion would result in no impairment for loss of range of motion.

By decision dated May 8, 2015, OWCP granted appellant a schedule award for one percent permanent impairment of her left lower extremity.

LEGAL PRECEDENT

The schedule award provision of FECA[12] and its implementing regulations[13] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of use of scheduled members or functions of the body. FECA, however, does not 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 OWCP. 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. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[14]

In addressing lower extremity impairments, the sixth edition requires identifying the impairment Class of Diagnosis (CDX) condition, 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).[15]

ANALYSIS

Appellant sustained an ankle sprain, plantar fibromatosis, calcaneal spur, tarsal tunnel syndrome, and mononeuritis on the left due to her March 3, 2007 employment injury. She submitted a report from Dr. Benson, dated October 24, 2014, finding that she had reached maximum medical improvement. Dr. Benson provided appellant's left ankle range of motion as 17 degrees of plantar flexion, 12 degrees of dorsal flexion, 20 degrees of inversion, and 7 degrees of eversion. He provided an impairment rating based on range of motion based on his findings. The Board notes that Dr. Benson's range of motion deficits for the left ankle and hind foot far exceeded those provided by appellant's other attending physicians, Drs. Litke and Wey.

[12] 5 U.S.C. §§ 8101-8193, 8107.

[13] 20 C.F.R. § 10.404.

[14] For new decisions issued after May 1, 2009 OWCP 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 2.808.5a (February 2013); *see also*, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

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

Dr. Litke found that appellant had normal range of motion, while Dr. Wey, reported limited inversion of 20 degrees, two percent impairment.[16] Dr. Benson also awarded two percent impairment due to 12 degrees of ankle extension a nonratable impairment under the A.M.A., *Guides*.[17] For these reasons, the Board finds that Dr. Benson's report is of diminished probative value and does not establish 11 percent permanent impairment of the left lower extremity.

The Board finds, however, a conflict of medical opinion regarding the extent of appellant's permanent impairment between Drs. Butler and Wey. As previously noted, Dr. Wey's findings support that appellant had two percent permanent impairment due to loss of range of motion of 20 degrees of inversion. Dr. Butler, the second opinion physician, found that appellant had inversion of 22, 26, and 24 degrees, not a ratable impairment under the range of motion method and accorded appellant one percent permanent impairment based on the diagnosis-based estimates. Due to the disagreement between the objective findings submitted by appellant's physician and a physician for OWCP, the Board finds a conflict of medical evidence on the extent of appellant's permanent impairment for schedule award purposes. When there are opposing reports of virtually equal weight and rationale, the case will be referred to an impartial medical specialist pursuant to section 8123(a) of FECA which 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 and resolve the conflict of medical evidence.[18] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[19] On remand, OWCP should refer appellant to an appropriate physician to resolve the existing conflict of medical evidence. Following this and any necessary further development, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for a decision. There is an existing conflict of medical evidence regarding the extent of appellant's permanent impairment for schedule award purposes.

[16] *Supra* note 3.

[17] *Supra* note 2.

[18] 5 U.S.C. §§ 8101-8193, 8123; *M.S.*, 58 ECAB 328 (2007); *B.C.*, 58 ECAB 111 (2006).

[19] *R.C.*, 58 ECAB 238 (2006).

ORDER

IT IS HEREBY ORDERED THAT the May 8, 2015 decision of the Office of Workers' Compensation Programs is set aside and remanded for further development consistent with this opinion of the Board.

Issued: January 28, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board