

**United States Department of Labor
Employees' Compensation Appeals Board**

A.E., Appellant

and

U.S. POSTAL SERVICE, POST OFFICE,
Cleveland, OH, Employer

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**Docket No. 15-0496
Issued: May 23, 2016**

Appearances:

*Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director*

Case Submitted on the Record

DECISION AND ORDER

Before:

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

JURISDICTION

On January 6, 2015 appellant, through counsel, filed a timely appeal from a December 2, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 met her burden of proof to establish permanent impairment of her left lower extremity due to her accepted employment injury.

FACTUAL HISTORY

On April 26, 2005 appellant, then 46-year-old mail processor, filed an occupational disease claim alleging left heel pain and left ankle pain in the performance of duty. She stopped work on April 26, 2005. By decision dated September 15, 2005, OWCP accepted appellant's claim for left ankle tendinitis and aggravation of heel spur, left foot. Appellant received compensation benefits on the supplemental rolls. On February 21, 2006 she returned to full-duty work with restrictions, but remained eligible for medical benefits.

By letter dated May 1, 2007 OWCP referred appellant for a second opinion examination to determine whether she continued to have any residuals related to the accepted conditions and whether the work restrictions remained. Dr. Sheldon Kaffen, a Board-certified orthopedic surgeon and second opinion physician, provided results on examination in a June 13, 2007 report. He found appellant's accepted conditions to have completely resolved; however, he found that the proper accepted condition should have been plantar fasciitis rather than heel spur. Dr. Kaffen found that appellant was capable of returning to full duty without restrictions.¹

Dr. Kaffen also provided an impairment rating of one percent under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment, hereinafter* (A.M.A., *Guides*). He found that appellant had no deficit in range of motion of either the left ankle or left foot. In a clarification report dated July 19, 2007, Dr. Kaffen noted that the one percent impairment was based on tenderness over the plantar aspect of the heel and subjective complaints of pain on weight bearing.

Appellant continued to work in a light-duty capacity until September 24, 2010 when her light-duty position was withdrawn under the National Reassessment Process. She was provided only two hours of work a day and effective September 17, 2010 and was returned to the supplemental compensation rolls for partial disability.

In 2010 OWCP referred appellant for a second opinion examination with Dr. Robert J. Nickodem, Jr., a Board-certified orthopedic surgeon. In his October 26, 2010 report, Dr. Nickodem found appellant continued to be partially disabled due to her work conditions, but determined that she could work full time in a sedentary position with restrictions on standing and walking for no more than two hours a day.

Appellant continued to submit medical reports to OWCP as a result of his continuing receipt of compensation. In an April 13, 2011 treating physician report, Dr. Patrick Landers, a podiatrist, noted that appellant had presented for evaluation of left heel pain and for an injection. He diagnosed calcaneal spur and plantar fasciitis. Appellant reported a dull ache on the plantar central heel area that radiated to the arch at times which was aggravated by prolonged weight bearing. Dr. Landers found normal range of motion and muscle strength, squeeze test of the heel was negative, and noted an antalgic gait. He recommended physical therapy.

On July 5, 2011 appellant's counsel requested a schedule award and submitted medical evidence. In a June 24, 2011 report, Dr. William N. Grant, a Board-certified internist, noted appellant's history of injury and treatment and diagnosed tenosynovitis foot/ankle and calcaneal spur. Utilizing the sixth edition of the A.M.A., *Guides*, he referred to Table 16-22 and found that range of motion of the left ankle/foot with plantar flexion was limited to 10 degrees which was 15 percent left lower extremity impairment and dorsiflexion limited to 8 degrees was 7 percent left leg impairment.² Dr. Grant referred to Table 16-20³ and found inversion limited to 8 degrees

¹ On June 7, 2011 appellant retired.

² A.M.A., *Guides* 549.

³ *Id.*

was five percent left lower extremity impairment and eversion limited to 10 degrees was two percent left lower extremity impairment. He combined the values to find 27 percent left leg impairment.

In an October 26, 2011 report, OWCP's medical adviser noted the discrepancies between the reports of Drs. Landers and Grant. Dr. Landers had found no strength deficit or loss of range of motion in his April 13, 2011 report whereas in his July 5, 2011 report Dr. Grant had found range of motion deficits. He recommended referral to a second physician.

On August 10, 2012 OWCP again referred appellant, along with a statement of accepted facts and the medical record, to Dr. Nickodem for another second opinion examination to determine the extent of impairment.

In an August 23, 2012 report, Dr. Nickodem noted appellant's history of injury and treatment. Appellant was able to ambulate without assistive devices, other than orthotics, and with mild discomfort in the left heel. The left ankle measured one centimeter larger than the right ankle. Dr. Nickodem noted left ankle ranges of motion. He also found tenderness to palpation of a plantar fascial origin on the left and no appreciable masses or skin changes. Dr. Nickodem determined that appellant had tenderness to function of the peroneal or posterior tibialis tendon as well as the Achilles tendon or the anterior tibialis tendon. He indicated a normal motor and sensory examination in the left leg.

Dr. Nickodem stated that the most appropriate way to rate impairment was based upon the range of motion of the ankle and subtalar joint which were mildly limited. He referred to Table 16-6⁴ and determined that appellant's functional history adjustment would most appropriately be in the mild problem range based on minimal limping using footgear. Dr. Nickodem referred to Table 16-7⁵ and determined that appellant had mild limitation on range of motion, which qualified for a grade modifier of one based on physical examination. He also referred to the clinical studies adjustment in Table 16-8⁶ and placed her at a grade modifier of one as the x-ray studies revealed a calcaneal spur, which he believed was the cause of her symptoms. Dr. Nickodem referred to Table 16-22⁷ and determined that dorsiflexion limited to 10 degrees of the left ankle was equal to seven percent impairment. Referring to Table 16-20,⁸ he found eversion limited to 8 degrees was two percent impairment and inversion limited to 10 degrees was two percent impairment. Dr. Nickodem found a total of 11 percent impairment for the lower left extremity. He advised that appellant had reached maximum medical improvement in 2005.

⁴ *Id.* at 516.

⁵ *Id.* at 517.

⁶ *Id.*

⁷ *Supra* note 2.

⁸ *Id.*

In a report dated October 1, 2012, the medical adviser questioned if it was proper to rate impairment based on loss of range of motion. He opined that, for the diagnosis of plantar fasciitis, appellant had one percent impairment.

On February 15, 2013 OWCP referred appellant along with a statement of accepted facts, and the medical record to Dr. William Bohl, a Board-certified orthopedist for an impartial medical evaluation to resolve the conflict in opinion between Drs. Nickodem and Grant regarding the extent of appellant's left lower extremity impairment.

In a February 27, 2013 report, Dr. Bohl noted appellant's history and provided results on examination. Appellant ambulated without any limp or apparent discomfort. Left ankle examination revealed plantar flexion to 50 degrees and dorsiflexion to 15 degrees. Palpation of the left foot and ankle showed a slight degree of tenderness over the posterior calcaneal area at the insertion of the Achilles tendon, tenderness over the lateral aspect of the posterior calcaneus, and tenderness over the anterolateral and distal lateral ligaments of the ankle with a palpable defect in the anterolateral ligaments distally. Dr. Bohl found a positive anterior drawer sign and 1 to 2+ positive Talar tilt of the ankle with no such findings in the opposite ankle. There was no tenderness medially and no tenderness over the ball of the heel or at the plantar fascia insertion of the heel which would support any diagnosis of an ongoing posterior tibial tendinitis or plantar fasciitis. There was no tenderness over the peroneal ligaments laterally. Tenderness was limited to the posterior body of the calcaneus and lateral ligamentous structures. Appellant had slightly decreased sensation to touch over the dorsum of the left foot.

Dr. Bohl reviewed a July 29, 2005 x-ray and found a prominent plantar spur, and no posterior calcaneal spur. He advised that this was the spur which was aggravated by appellant's work injury. Dr. Bohl diagnosed a second to third degree sprain of her lateral ankle ligaments, which was now a chronic left ankle sprain. He opined that there was no evidence of any residual of plantar fasciitis or tenderness in the area of the plantar spur. There was no evidence of any ongoing tendinitis of the ankle other than the posterior Achilles tendinitis of a mild degree, which Dr. Bohl did not believe was what was originally recognized as appellant's work injury. Maximum medical improvement occurred shortly after April 22, 2005.

Regarding degrees of retained active motion, Dr. Bohl found that a comparison of the left ankle with the presumed normal right ankle, which revealed that the only notable loss in range of motion was approximately 10 degrees of dorsiflexion in the right ankle which was unrelated to the allowed diagnoses. He opined that there were no other significant objective findings except the positive anterior drawer sign and Talar tilt indicating a chronic ankle sprain which was appellant's main source of symptoms and not part of her allowed conditions.

Dr. Bohl explained that range of motion could not be utilized to evaluate foot impairment, since the symptomatology from a plantar fasciitis would not cause any loss of range of motion either in the foot or ankle and was not an appropriate evaluation. He utilized the A.M.A., *Guides* and referred to Table 16-2, the Foot and Ankle Regional Grid.⁹ Under the criteria of soft tissue, which included plantar fasciitis and plantar fibromatosis, Dr. Bohl advised

⁹ *Id.* at 501.

that appellant had no pain or tenderness at the insertion of plantar fascia. He determined the class would be zero and the impairment would be zero percent of the leg. Dr. Bohl explained that, with regard to the allowed diagnosis of tendinitis of the ankle, the same Table 16-2 applied under the category muscle/tendon. He noted that the allowed diagnosis of ankle tendinitis was somewhat nonspecific, so he found a reference to posterior tibial tendinitis, which would be consistent with some of the findings by other physicians of tenderness over the medial aspect of the ankle. Dr. Bohl explained that there was no mention in the medical evidence of any Achilles tendinitis and advised that, since there was no tenderness whatsoever over the posterior tibial tendon at this time, this would also represent class zero and no impairment of the leg. He concluded that the only impairments currently noted were those attributable to appellant's chronic left ankle sprain and instability, which were not part of her allowed diagnosis, and therefore not ratable for her work-related impairment.

In a May 2, 2013 report, the medical adviser noted appellant's history and his review of the medical file. He confirmed that Dr. Bohl correctly utilized the A.M.A., *Guides* and concurred with Dr. Bohl that appellant had a zero percent impairment.

On May 15, 2013 OWCP denied appellant's claim for a schedule award.

On May 20, 2013 counsel requested a telephonic hearing, which was held on October 8, 2013.

By decision dated December 23, 2013, OWCP's hearing representative affirmed the May 15, 2013 decision. The hearing representative found that the weight of the medical evidence resided with Dr. Bohl, the impartial medical examiner.

On November 19, 2014 counsel requested reconsideration and submitted new medical evidence. In a November 6, 2014 report, Dr. Catherine Watkins Campbell, Board certified in occupational medicine and family medicine, noted appellant's history and provided results on examination. Under the A.M.A., *Guides*, Dr. Campbell noted that maximum medical improvement had been previously recognized as of October 1, 2012. She referred to Table 16-2 of the A.M.A., *Guides*, Foot and Ankle Regional Grid, under the criteria of soft tissue for plantar fibromatosis, and selected class 1 due to (significant, consistent palpatory findings). Dr. Campbell selected a functional modifier of 1 based upon the presence of an antalgic gait with the use of orthotics. She also selected a physical examination grade modifier of 2, based on moderate palpatory findings of tenderness and thickened soft tissue. Dr. Campbell selected a clinical studies modifier of 2 based upon a calcaneal spur present on x-ray and moderate soft tissue pathology of a chronic nature. She opined that appellant had a two percent left leg impairment.

By decision dated December 2, 2014, OWCP denied modification of the December 23, 2013 decision finding that Dr. Bohl continued to carry the weight of the medical evidence.

LEGAL PRECEDENT

Section 8107 of FECA¹⁰ sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.¹¹ FECA however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.¹² The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.¹³ For decisions issued after May 1, 2009, the sixth edition will be used.¹⁴

In addressing lower extremity impairments, the sixth edition requires identifying the impairment Class of Diagnosis condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).¹⁵ The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).¹⁶

Section 8123(a) of FECA provides, in pertinent part: “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.”¹⁷ Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.¹⁸

ANALYSIS

The Board finds this case is not in posture for decision. OWCP accepted left ankle tendinitis and aggravation of left heel spur. It had determined that there was a conflict in the medical opinion between Dr. Grant, a treating physician, who found 27 percent impairment of the lower left extremity, and Dr. Nickodem, a second opinion physician, who found 11 percent

¹⁰ 5 U.S.C. §§ 8101-8193.

¹¹ *Id.* at § 8107.

¹² *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

¹³ 20 C.F.R. § 10.404.

¹⁴ FECA Bulletin No. 09-03 (issued March 15, 2009).

¹⁵ A.M.A., *Guides* 494-531; *see J.B.*, Docket No. 09-2191 (issued May 14, 2010).

¹⁶ *Id.* at 521.

¹⁷ 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207, 210 (1993).

¹⁸ *See Roger Dingess*, 47 ECAB 123, 126 (1995); *Juanita H. Christoph*, 40 ECAB 354, 360 (1988); *Nathaniel Milton*, 37 ECAB 712, 723-24 (1986).

impairment of the lower left extremity. In order to resolve the conflict, OWCP referred appellant, pursuant to section 8123(a) of FECA, to Dr. Bohl for an impartial medical examination and an opinion on the matter.

OWCP found that the weight of the medical evidence with respect to appellant's left leg impairment rested with the well-rationalized February 27, 2013 opinion of Dr. Bohl which was based on a complete and accurate factual and medical history and properly applied the standards of the sixth edition of the A.M.A., *Guides* to find that appellant had a zero percent permanent impairment of her left leg.¹⁹

In his February 27, 2013 report, using Table 16-2,²⁰ the Foot and Ankle Regional grid for soft tissue, which included plantar fasciitis and plantar fibromatosis, Dr. Bohl found that, for her aggravation of left ankle tendinitis and left ankle spur, appellant had sustained a class 0 impairment of her left leg, resulting in no impairment because appellant did not have any pain or tenderness at the insertion of the plantar fascia. He explained that, with regard to the allowed diagnosis of tendinitis of the ankle, the same Table 16-2 applied under the category muscle/tendon. Dr. Bohl advised that this category was not specific; however, he found posterior tibial tendinitis, which was consistent with some of his findings of tenderness over the medial aspect of the ankle. He determined that there was no "tenderness whatsoever over the posterior tibial tendon." Dr. Bohl concluded that this represented a class 0 or a zero percent impairment of the leg. He explained why range of motion would not apply, advising that planar fasciitis would not cause loss of range of motion either in the foot or ankle and in his opinion that was not an appropriate method of evaluation. Dr. Bohl explained the only impairments found on his examination were attributable to her chronic left ankle sprain and instability, which were not work related. He determined that appellant did not qualify for impairment. On May 2, 2013 the medical adviser reviewed Dr. Bohl's impairment rating and found that it properly applied the A.M.A., *Guides*.²¹

Subsequent to the report of Dr. Bohl, appellant submitted a November 6, 2014 detailed, well-rationalized impairment evaluation of her accepted ankle and foot condition report from Dr. Campbell. Dr. Campbell concurred with Dr. Bohl that range of motion was not an appropriate method of evaluating the conditions. Utilizing the sixth edition of the A.M.A., *Guides*, she recommended two percent permanent impairment of the left leg. Dr. Campbell's findings differed from those of Dr. Bohl based on her physical examination on September 22, 2014. She referred to Table 16-2 of the A.M.A., *Guides*, Foot and Ankle Regional Grid, under the criteria of soft tissue for plantar fibromatosis, and selected class 1 due to (significant, consistent palpatory findings). Dr. Campbell selected a functional modifier of 1 based upon the presence of an antalgic gait with the use of orthotics and a physical examination grade modifier of 2, based on moderate palpatory findings of tenderness and thickened soft tissue. She selected a clinical studies modifier of 2 based upon a calcaneal spur present on x-ray

¹⁹ *Id.*

²⁰ *Supra* note 9.

²¹ The medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist. *V.G.*, 59 ECAB 635 (2008); *Thomas J. Fragale*, 55 ECAB 619 (2004); *see also Richard R. LeMay*, 56 ECAB 341 (2005).

and moderate soft tissue pathology of a chronic nature. She opined that appellant had a two percent left leg impairment.

The Board finds that these reports of Dr. Bohl and Dr. Campbell are of equal weight, are based on the same diagnosis-based estimate under the A.M.A., *Guides*, and are sufficient to create a new conflict as to the degree of permanent impairment of appellant's accepted conditions.²² The case will be remanded for a new independent medical examination to resolve the outstanding conflict.

CONCLUSION

The Board finds that the case is not in posture for decision as there remains an outstanding conflict of medical opinion as to whether appellant has established permanent impairment to a scheduled member.

ORDER

IT IS HEREBY ORDERED THAT the December 2, 2014 decision of the Office of Workers' Compensation Programs is hereby set aside and remanded for further proceedings consistent with this decision of the Board.²³

Issued: May 23, 2016
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

²² *Supra* note 17.

²³ James A. Haynes, Alternate Judge, participated in the original decision but was no longer a member of the Board effective November 16, 2015.