United States Department of Labor
Employees' Compensation Appeals Board

V.G., Appellant	)	
and	)	**Docket No. 07-2179**
	)	**Issued: July 14, 2008**
U.S. POSTAL SERVICE, POST OFFICE, Southeastern, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 27, 2007 appellant, through her attorney, filed a timely appeal from the February 23, 2007 decision of an Office of Workers' Compensation Programs' hearing representative who affirmed the denial of an additional schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than eight percent impairment of the left foot, for which she received schedule awards.

FACTUAL HISTORY

Appellant's February 15, 2000 occupational disease claim was accepted by the Office for a neuroma of the third left interspace and stress fractures of the third and fourth metatarsals of

the left foot. She did not stop work but continued in a light-duty position. The Office paid appropriate compensation benefits.[1]

On December 11, 2003 appellant filed a claim for a schedule award. In an August 14, 2003 report, Dr. David Weiss, an osteopath Board-certified in family medicine, advised that appellant had reached maximum medical improvement that date. Examination of her left foot revealed focal tenderness over the subtalar joint, posterior tibial tendon and common peroneal tendon, tenderness over the head of the metatarsal phalangeal joints of the great toe, second, third, fourth and fifth toes, fullness between the second and third and third and fourth webs, tenderness over the lateral gutter and a positive Tinel's sign over the tarsal tunnel. Dr. Weiss diagnosed cumulative and repetitive trauma disorder with diffuse degenerative joint disease of the metatarsal-phalangeal joints and bilateral tarsal tunnel syndrome. Under the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[2] he rated appellant's impairment as 15 percent of the left leg. Dr. Weiss found 12 percent impairment for Grade 4/5 motor strength deficit, left foot dorsiflexion,[3] and 3 percent for pain.[4]

On October 3, 2004 an Office medical adviser reviewed the medical evidence and found that appellant had six percent impairment of the left leg under the A.M.A., *Guides*. He noted that Table 17-33 allowed two percent impairment for forefoot deformity due to metatarsal fracture of the third and fourth metatarsal joints, a total of four percent impairment.[5] The medical adviser then combined an additional two percent pain-related impairment.[6] He noted that the evidence did not support any impairment for sensory deficit and that there was no injury to the ankle. The medical adviser agreed that appellant reached maximum medical improvement on August 24, 2003.

On January 11, 2005 the Office granted appellant a schedule award for six percent permanent impairment of the left foot. The period of the award was from August 24 to November 18, 2003.

Appellant requested an oral hearing which was held on May 23, 2005. She contended that the Office erroneously relied upon the impairment rating of the Office medical adviser.

In an August 12, 2005 decision, an Office hearing representative set aside the January 11, 2005 schedule award and remanded the case for further development of the medical evidence.

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[1] The record reflects that appellant has a claim accepted for right carpal tunnel syndrome, No. 03-2003692, and for a left foot contusion, No. 03-0247106. She also had a claim accepted for left shoulder bursitis, left carpal tunnel syndrome and cervical thoracic strain, which was previously before the Board in Docket No. 07-1549 (issued April 24, 2008). These claims are not before the Board in the present appeal.

[2] A.M.A., *Guides* (5th ed. 2001).

[3] *Id*. at 532, Table 17-8.

[4] *Id*. at 574, Figure 18-1.

[5] *Id.* at 546, Table 17-33.

[6] *Id*. at 574, Figure 18-1.

On November 8, 2003 the Office medical adviser revised his prior rating to find a total eight percent impairment of appellant's left leg. He indicated that he applied Table 17-33 to allow three percent impairment for forefoot deformity, due to metatarsal fracture, of the third and fourth metatarsal joints, or a total of six percent impairment for the left foot.[7] The medical adviser reiterated that appellant had two percent pain-related impairment.[8]

In a decision dated November 15, 2005, the Office found that appellant had eight percent impairment of the left foot. It granted an additional schedule award of two percent permanent impairment of the left foot.

On November 18, 2005 appellant requested an oral hearing.

In a January 17, 2006 decision, a hearing representative found a conflict in medical opinion arising in the impairment ratings of Dr. Weiss and the Office medical adviser. The case was remanded to refer appellant to an impartial medical specialist.

The Office referred appellant to Dr. Christopher M. Aland, a Board-certified orthopedic surgeon, selected as the impartial medical specialist. In an April 21, 2006 report, Dr. Aland reviewed appellant's history of injury and medical treatment and set forth findings on examination of the left leg. He found no limitation of mobility of the hip, knee and ankle, global tenderness to palpation throughout the foot, ankle and leg with no gross deformity. Sensation was intact to light touch; capillary filling was good with no evidence of dependent edema or lymphademopathy. Dr. Aland noted that, although appellant's claim had been accepted for stress fracture of her third and fourth metatarsals, a bone scan did not confirm this diagnosis. Based on appellant's complaint of pain, he rated impairment as three percent. He noted a rating for the metatarsals was not appropriate as there was no evidence of bony pathology. Dr. Aland noted that appellant could return to work full time with restrictions.

On May 17, 2006 the Office requested that Dr. Aland clarify his medical opinion and reference the tables of the A.M.A., *Guides* used to calculate appellant's impairment. On June 8, 2006 he stated that appellant had developed arthritis of the left foot and metatarsal region and that her impairment was best rated under Table 17-31, page 544, under the joint category of "other metatarsals," which allowed for 7 percent lower extremity impairment or 10 percent foot impairment.

On July 30, 2006 Dr. Morley Slutsky, an Office medical consultant in occupational medicine, advised that osteoarthritis of the left foot was not an accepted condition. In applying Table 17-31, he noted that Dr. Aland had not referred to any x-rays used to assess the joints involved. He recommended a supplemental opinion from Dr. Aland.

In an August 2, 2006 report, Dr. Aland again diagnosed osteoarthritis of the left foot which he stated should be added to the statement of accepted facts. He stated that this was based on a review of appellant's bone scan which revealed osteoarthritis of the first

[7] *Id*. at 546, Table 17-33.

[8] *Id*. at 574, Figure 18-1.

metatarsophalangeal joint. Dr. Aland noted that appellant's injury was consistent with excessive walking and standing activities. He reiterated that the diagnostic studies did not support that she sustained a stress fracture to her third or fourth metatarsal and that the impairment rating assigned was based on arthritic pain not on any specific narrowing of the joint. Based on this opinion, the Office accepted aggravation of osteoarthritis of the left foot.

On August 22, 2006 Dr. Slutsky found that appellant had three percent impairment of the left foot secondary to pain for her left foot neuroma and left foot osteoarthritis pain. He advised that Chapter 17 of the A.M.A., *Guides* did not provide an adequate method for rating impairment for the accepted left foot neuroma. For this reason, Dr. Slutsky utilized Chapter 18 of the A.M.A., *Guides*. He concurred with Dr. Aland's determination that appellant did not sustain a metatarsal stress fracture and did not warrant an impairment rating for this condition. Appellant was not eligible for an impairment rating related to arthritis because there was no specific narrowing noted secondary to the diagnosed osteoarthritis.

In an August 30, 2006 decision, the Office denied an additional schedule award on the grounds that the weight of the medical evidence did not establish more than eight percent impairment.

Appellant requested an oral hearing which was held on December 11, 2006. She contended that the reports of Dr. Aland were not well rationalized.

In a decision dated February 23, 2007, an Office hearing representative affirmed the August 30, 2006 decision.[9] The hearing representative found that Dr. Slutsky's opinion represented the weight of the medical evidence.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[10] and its implementing regulation[11] 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 regulation as the appropriate standard for evaluating schedule losses.

ANALYSIS

The Office accepted appellant's claim for neuroma of the third left interspace, stress fractures of the third and fourth metatarsals and aggravation of osteoarthritis of the left foot. It

[9] The hearing representative indicated that appellant had previously been issued schedule awards totaling eight percent for the left leg. However, the schedule awards in this case were for eight percent impairment of the left foot.

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404 (1999).

found that a medical conflict arose between Dr. Weiss and an Office medical adviser regarding the extent of permanent impairment. The Office referred appellant to Dr. Aland to resolve the conflict.

Where there exists a conflict of medical opinion 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 background, is entitled to special weight.[12]

The Board has reviewed the impairment rating by Dr. Aland and finds that, while he rated a 7 percent permanent impairment of the left lower extremity or a 10 percent impairment of the left foot under Table 17-31, he did not adequately explain his rating in accordance with the relevant standards of the A.M.A., *Guides*.[13] On April 21, 2006 Dr. Aland noted general findings upon physical examination of the left lower extremity of global tenderness to palpation throughout the foot, ankle and leg, with no gross deformity and no loss of strength. He found no evidence of metatarsal fracture or bony pathology. He initially rated three percent permanent impairment for pain. However, Dr. Aland did not cite to any tables or charts in support of his rating determination. In his supplemental reports, Dr. Aland advised that he rated impairment under Table 17-31, which allows 7 percent impairment to the lower extremity or 10 percent impairment to the foot for osteoarthritis.[14] He based his diagnosis on a bone scan which revealed osteoarthritis of the first metatarsophalangeal joint. However, the A.M.A., *Guides* require that ratings under Table 17-31 be supported by an x-ray. Chapter 17.2h Arthritis, page 544, A.M.A., *Guides*, provides that an arthritis impairment rating of a foot joint requires a lateral view for the hindfoot and an anterior-posterior view for the midfoot and forefoot.[15] Dr. Aland failed to specifically identify the cartilage interval for the metatarsophalangeal joint in Table 17-31. For these reasons, his impairment rating is of diminished probative value.[16] Because Dr. Aland did not adequately explain how his impairment rating conforms to the A.M.A., *Guides*, his opinion does not resolve the conflict in medical opinion and is not entitled to special weight afforded a referee physician.[17]

Dr. Slutsky reviewed the medical evidence of record and opined that appellant sustained a three percent impairment of the left foot for pain pursuant to Chapter 18-1 of the A.M.A., *Guides*. The Board notes that, generally, an impairment rating for pain is not appropriate under Chapter 18. The Office has advised its staff that Chapter 18 is "not to be used in combination

[12] *Aubrey Belnavis*, 37 ECAB 206 (1985). *See* 5 U.S.C. § 8123(a).

[13] *See Tonya R. Bell*, 43 ECAB 845, 849 (1992).

[14] Dr. Aland did not address whether residuals of appellant's accepted condition extended from the foot into the leg.

[15] *See* A.M.A., *Guides* 544, Chapter 17.2h; *see also Thomas L. Iverson*, 50 ECAB 515 (1999).

[16] *See Paul R. Evans, Jr.*, 44 ECAB 646 (1993); *John Constantin*, 39 ECAB 1090 (1988) (medical report not explaining how the A.M.A., *Guides* are utilized is of little probative value).

[17] *See Aubrey Belnavis*, *supra* note 12.

with other methods to measure impairment due to sensory pain…."[18] However, Dr. Slutsky specifically noted that the nature of appellant's accepted neuroma condition was difficult to rate under Chapter 17 and that an impairment rating for pain under Chapter 18 was therefore appropriate.

The Board notes, however, that the Office hearing representative improperly determined that the weight of the evidence rested with Dr. Slutsky, the Office medical consultant. Section 10.502 of implementing federal regulation,[19] in addition to the Offices procedures;[20] provide that when the Office directs an employee to undergo a referee examination to resolve a conflict, it is to rely on the opinion of the medical referee in determining the issue. To properly resolve the conflict of medical opinion in this case, it is the impartial medical specialist who should provide a reasoned opinion as to the extent of permanent impairment. An Office medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.[21] Consequently, the hearing representative erred in finding that the weight of the medical evidence rested with Dr. Slutsky as the conflict in medical opinion was not resolved by Dr. Aland.

The case will be remanded so that appellant may be referred to another impartial medical specialist to resolve the conflict regarding the extent of permanent impairment to her left lower extremity.[22] The Board will set aside the Office's February 23, 2007 decision and remand the case for further development of the medical evidence.

[18] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4, Use of Fifth Edition of A.M.A., *Guides* (November 2002).

[19] 20 C.F.R. § 10.502.

[20] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.7(g) (April 1993) (provides that "while a district medical adviser may create a conflict in medical opinion, he or she may generally not resolve it"); *id*. at 2.810.11(c)(2) (April 1993) (the referee specialist's report, once received, must actually fulfill the purpose for which it was intended, *i.e.*, it must resolve the conflict in medical opinion).

[21] *Richard R. LeMay*, 56 ECAB 341 (2005).

[22] *See L.R. (E.R.)*, 58 ECAB ___ (Docket No. 06-1942, issued February 20, 2007) (when the Office 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, the Office must secure a supplemental report from the specialist to correct the defect; however, when the impartial specialist is unable to clarify the original report or if the supplemental report is also vague, speculative or lacking in rationale, the Office must refer the matter to a second impartial specialist for the purpose of obtaining a proper opinion on the issue).

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the February 23, 2007 decision of the Office of Workers' Compensation Programs be set aside and the case remanded for further action consistent with this opinion.

Issued: July 14, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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