U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of MICHAEL J. KEARINS and U.S. POSTAL SERVICE,
POST OFFICE, Dallas, TX

Docket No. 98-2551; Submitted on the Record;
Issued July 10, 2000

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether appellant has greater than a 66 percent permanent impairment of his right lower extremity, for which he has received a schedule award.

This is appellant's second appeal before the Board on this issue. In the prior decision, the Board remanded the case to the Office of Workers' Compensation Programs for further development, including reevaluation by a different examiner and for recalculation of appellant's total right lower extremity impairment. The facts and circumstances of the case are laid out in the prior Board decision and are hereby incorporated by reference.[1]

Upon remand on April 17, 1998 the Office referred appellant for a second opinion evaluation to Dr. M. Louis Frazier, a Board-certified orthopedic surgeon.

By report dated May 6, 1998, Dr. Frazier noted:

> "[Appellant] complains of pain with standing greater than one hour, pain in the medial retromalleolar area and Achilles tendon area with fasciculations in the medial foot and longitudinal arch. He has intermittent numbness in digits two through four, with some associated paresthesias since the posterior tib[ial] surgery on January 14, 1992. He externally rotates his foot to decrease the amount of pain. He has permanent use of a shoe insert and has multiple stabilizing braces which he has used."
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> "To the best of my physical examination, the following muscle grades were obtained: plantar flexion of the ankle Grade 3, dorsiflexion Grade 4, both with

[1] Docket No. 96-909 (issued March 19, 1998).

associated pain in the ankle medially. Ankle inversion is 4+, eversion is 3+. Range of motion: 30 degrees plantar flexion, 4 degrees dorsiflexion, 10 degrees each inversion and eversion. There is some mild loss of the medial longitudinal arch perceived and [appellant] stands with both of his feet facing forward. He has a positive Tinel's over the tarsal tunnel. No fixed sensory deficit. Temperature in the feet are the same. No focal swelling. There is no palpable defect in the Achilles tendon or the tibialis posterior tendon. [Appellant] walks in a gait with his foot externally rotated about 70 degrees bearing weight on the lateral aspect of the foot and the heel failing to step off through the hallux.

"[Appellant] has the following impairment: His foot impairment is rated based on weakness only as weakness and range of motion cannot both be rated. Looking at Table 38, page 77, plantar flexion foot impairment is 53, dorsiflexion 17, inversion in 7, eversion 17 percent foot impairment. Combining these on the Combined Values Chart leads to a 71 percent foot impairment. Looking at Table 64, page 86, for the rocker bottom foot this is a 7 percent foot impairment which brings the total up to 78 percent foot impairment. The continuing pain, standing intolerance and gait abnormality should be awarded an additional 22 percent foot impairment bringing the total foot impairment to 100 percent.

"In my medical opinion there is no leg impairment separate from the impairments I have above noted which are calculated in terms of foot impairment. To take the above calculations in terms of lower extremity impairment one would take the same Table 38, page 77 and apply the following impairments for plantar flexion weakness 37 percent, dorsiflexion 12 percent, inversion 5 percent, eversion 12 percent. Combining these using the Combined Values Chart it is a 55 percent lower extremity impairment. The 5 percent on Table 64, page 86, for the mild rocker bottom foot would bring the total to 60 percent lower extremity impairment. The additional pain, activity intolerance and paresthesias would bring it up to the level of 62 percent lower extremity."

Dr. Frazier opined that the calculated impairment was due to the March 20, 1991 work injury and that there was no additional right lower extremity impairment due to any subsequent injury, including the August 8, 1995 fall.

On May 29, 1998 the district medical adviser, Dr. H. Mobley, calculated appellant's permanent impairment using atrophy/decreased strength determinations rather than loss of motion measurements, and opined that appellant had a 54 percent impairment for atrophy/decreased strength, a 13 percent impairment due to pain/ subjective complaints and a 5 percent for a rocker bottom foot. Dr. Mobley opined that combining these percentages resulted in a right lower extremity (RLE) permanent impairment rating of 62 percent. Dr. Mobley opined that the date of appellant's maximum medical improvement was May 6, 1998.

In an accompanying narrative report that date, Dr. Mobley noted Dr. Frazier's findings of pain, losses in degrees of range of motion, weakness and the presence of a 'rocker bottom' foot; he noted Dr. Frazier's impairment percentages and opined that there were "errors in his final calculations when he adds a consideration for pain and the 'rocker bottom' percentages rather than combining with the previous impairments." Dr. Mobley noted:

> "Based upon the Fourth Edition [American Medical Association,] *Guides* [*to the Evaluation of Permanent Impairment*] and the available medical evidence, I am able to make the following determination: Muscle weakness -- lower extremity (pg 77, Table 38, 39) Right ankle -- flexion -- Grade 3 [2] = 37 percent RLE, extension -- Grade 4 -- 12 percent RLE, inversion -- Grade 4 -- 5 percent RLE, eversion -- Grade 3 -- 12 percent RLE. Combine (pg 322) 37 percent and 12 percent is 45 percent and 12 percent is 52 percent and 5 percent is 54 percent RLE. Diagnosis-based estimate (pg 85, Table 64) Midfoot deformity -- 'Rocker Bottom' -- mild -- 5 percent. Other musculoskeletal system defects (pg 63-64)
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> "If the examiner determines that the estimate for the anatomic impairment does not sufficiently reflect the severity of the patient's condition, the examiner may increase the impairment percent, explaining the reason for the increase in writing.
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> "Pain -- 13 percent RLE (Dr. Frazier awarded 2 percent). Combine (pg 322) 54 percent and 13 percent is 60 percent and 5 percent is 62 percent RLE.
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> "There are errors in Dr. Frazier's figures and in the application of the A.M.A., *Guides*. However, it is clear from his report that he believes that the claimant has a 100 percent impairment of the foot and ankle (62 percent lower extremity) and he has used 'adjustment factors' *i.e.*, pain, adding instead of combining, etc. to produce his final outcome of 100 percent of the foot (62 percent lower extremity). In my opinion, this determination represents an accurate interpretation of the physician's clinical intent and impression and the application of this through the Fourth Edition, A.M.A., *Guides*."

By decision dated June 2, 1998, the Office found that appellant had no greater than a 66 permanent impairment of his right lower extremity. The Office noted that, based upon Dr. Frazier's May 6, 1998 second opinion report, appellant was entitled to a schedule award for a 62 percent permanent impairment of the right lower extremity. The Office further noted that the Office medical adviser concurred with the 62 percent permanent impairment as being in agreement with the standards set by the fourth edition of the A.M.A., *Guides*.

By letter dated June 16, 1998, appellant requested reconsideration of the June 2, 1998 decision. Appellant alleged that he was entitled to a 73 percent right lower extremity impairment, claiming that the calculations stood on their own merits. He added a 37 percent impairment for plantar flexion weakness with a 12 percent impairment for dorsiflexion weakness, then added 5 percent for inversion weakness, added 12 percent for eversion weakness,

[2] Dr. Mobley used Grade 2 to correspond with the percentage award.

added 5 percent for mild rocker bottom foot and added 2 percent for additional pain, activity intolerance and paresthesias, to arrive at a total right lower extremity impairment of 73 percent.

On July 20, 1998 Dr. Mobley responded, noting that the A.M.A., *Guides* maximum award for the foot is 100 percent which is equivalent to 62 percent of the lower extremity. He noted that this was determined by the amputation table, Table 63, p. 83, for the Syme operation, which was amputation just above the ankle. Dr. Mobley noted that appellant's requested 73 percent lower extremity impairment would be greater than 100 percent of the foot. He opined that, although appellant arrived at a 73 percent permanent impairment by adding figures from the muscle weakness chart, Table 39, p. 77, these figures from this chart should be combined. Dr. Mobley agreed with Dr. Frazier that appellant had a 62 percent permanent impairment of his right lower extremity as related to his accepted employment-related conditions.

By decision dated July 22, 1998, the Office denied modification of the June 2, 1998 decision finding that the evidence submitted in support was insufficient to warrant modification. The Office noted that both Drs. Frazier and Mobley found that appellant had a 62 percent permanent impairment of his right lower extremity in accordance with the A.M.A., *Guides* and, therefore, that the medical evidence of record established that the values for individual measurements of muscle weakness should be combined rather than added to calculate appellant's total right foot impairment.

The Board finds that appellant has no greater than a 66 percent permanent impairment of his right lower extremity, for which he has received a schedule award.

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulations[4] set forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage loss of use.[5] However, neither the Act nor its regulations specify the manner in which the percentage of loss of a member is to be determined. For consistent results and to insure equal justice under the law to all claimants, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants seeking schedule awards. The A.M.A., *Guides* (4th ed.) have been adopted by the Office for evaluating schedule losses and the Board has concurred in such adoption.[6]

Although the standards for evaluating the permanent impairment of an extremity under the A.M.A., *Guides* are based primarily on loss of range of motion, all factors that prevent a limb from functioning normally, including pain and loss of strength, should be considered, together with loss of motion, in evaluating the degree of permanent impairment.[7] In the instant case,

[3] 5 U.S.C. § 8101 *et seq.*; *see* 5 U.S.C. § 8107(c).

[4] 20 C.F.R. § 10.304.

[5] 5 U.S.C. § 8107(c)(19).

[6] *James J. Hjort*, 45 ECAB 595 (1994); *Thomas D. Gauthier*, 34 ECAB 1060 (1983).

[7] *See Paul A. Toms*, 28 ECAB 403 (1987).

appellant received a schedule award for a 66 percent permanent impairment of his right lower extremity based upon ankle joint weakness. This impairment award was actually greater than the amount of lower extremity impairment currently calculated by both the second opinion examiner and the Office medical adviser, such that appellant already received an award greater than that to which the current medical evidence of record supported that he was entitled.

Further, appellant submitted no current medical evidence supporting that he was entitled to any greater award than that for the 62 percent lower extremity impairment, which represented a 100 percent impairment of his right foot. Consistent with the A.M.A., *Guides*, there is no impairment beyond 100 percent that any particular enumerated bodily member can sustain, such that appellant cannot have greater than a 100 percent impairment of his right foot, as would be represented by a complete amputation at the level of the ankle.[8] The A.M.A., *Guides* is explicit in indicating that the lower extremity impairment, as represented by a complete amputation of the foot at the ankle level, is not greater than a 62 percent impairment of the lower extremity.[9] Therefore, in determining impairment related to appellant's accepted ankle and foot injury, in terms of a lower extremity impairment, it cannot be greater than 62 percent of the lower extremity, unless impairment to other parts of appellant's lower extremity is also included. In this case, however, no such additional injury has been accepted by the Office and no such impairment has been established by the medical evidence of record.

Appellant alleges that he is entitled to a 73 percent permanent right lower extremity impairment, but he presents no medical evidence to support such a proposition. As it would be impossible for appellant to have greater than a 62 percent permanent right lower extremity impairment due to injuries to his ankle and foot, as explained above, to be entitled to a 73 percent right lower extremity impairment award, appellant must prove that he is also impaired, due to his accepted employment injuries and their sequelae, in some other part of his right lower extremity. Appellant has not done this through the submission of rationalized medical opinion evidence supporting such contention and his mere, unsupported allegation regarding his total right lower extremity impairment is not probative medical evidence.[10]

The Board notes that, although the A.M.A., *Guides'* section regarding manual muscle testing, (pp. 76-77), does not specifically address whether impairment percentages for multiple impairments of a single bodily member should be added or combined, in all other sections of the A.M.A., *Guides, (*4th ed., 1993), when separate structures of an impaired entity are involved, they are always combined. The two exceptions to this principle, multiple finger impairments and multiple impairments of the thumb, both of which are to be added to determine total hand impairment, are clearly and explicitly noted in the applicable sections of the A.M.A., *Guides*. The Board notes, however, no such explicit exception related to the application of Table 39.

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[8] One hundred percent is total and there is nothing greater than the total, by definition; *see* The Random House *College Dictionary*, Revised Edition, 1980, p.1388, (total is defined as constituting or comprising the whole of something; entire").

[9] A.M.A., *Guides*, 83, Table 63 (4th ed., 1993).

[10] *See Sheila Arbour (Victor E. Arbour)*, 43 ECAB 779 (1992) (lay individuals are not competent to render a medical opinion).

Additionally, the Board notes that the A.M.A., *Guides* clearly instructs that motor weakness impairments from multiple nerves should be combined (p. 56, column 1, no. 6). Therefore, if the impairment due to weakness of the lower extremity was calculated by determining the impairment of each individual nerve involved, the total weakness impairment values should be combined rather than added.

Moreover, the Board notes that the A.M.A., *Guides* assigns a value for a total structure and its separate parts in order to arrive at a general figure for impairment of one of the parts or of a total of that entity. Overlying the establishment of these separate values is the principle that the total of all of these separate values must not exceed the total value of the bodily member involved.[11] This is the basis for the Combined Values Chart, which ensures that a total of separate impairments does not exceed the total (100 percent) value of the structure.

[11] *See* A.M.A., *Guides*, p. 84, column 1, para. 4 (the final lower extremity impairment must not exceed the impairment estimate for amputation of the extremity, (100 percent, or 40 percent of the whole person impairment)) and p. 88 (motor, sensory and dysesthesia estimates should be combined, but impairments from multiple peripheral nerve injuries should not exceed the whole-person impairment estimate for complete loss of the lower extremity (40 percent)).

Accordingly, the decisions of the Office of Workers Compensation Programs dated July 22 and June 2, 1998 are hereby affirmed.

Dated, Washington, D.C.
July 10, 2000

Michael J. Walsh
Chairman

David S. Gerson
Member

Willie T.C. Thomas
Alternate Member