United States Department of Labor
Employees' Compensation Appeals Board

PHILIP A. NORULAK, Appellant	)	
and	)	**Docket No. 04-817**
	)	**Issued: September 3, 2004**
U.S. POSTAL SERVICE, POST OFFICE, New Providence, 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:
COLLEEN DUFFY KIKO, Member
DAVID S. GERSON, Alternate Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On February 5, 2004 appellant, through his representative, filed a timely appeal from an Office of Workers' Compensation Programs' hearing representative's decision dated October 14, 2003 which affirmed a schedule award for a 16 percent impairment of the right lower extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award in this case.

ISSUE

The issue is whether appellant has established that he has more than a 16 percent permanent impairment of the right lower extremity for which he received a schedule award.

FACTUAL HISTORY

On February 9, 1998 appellant, then a 33-year-old mail carrier, filed an occupational disease claim alleging that he sustained a heel spur and problems with his Achilles tendon which he attributed to factors of his federal employment. Appellant did not stop work. The Office accepted appellant's claim for Achilles tendinitis and plantar fasciitis. On September 2, 1999 the

Office authorized surgery to repair the plantar fasciitis of the right foot. The Office paid appellant for intermittent periods of disability.

On April 29, 2001 appellant filed a claim for a schedule award. By letter dated June 13, 2001, the Office requested that Dr. Walter J. Pedowitz, a Board-certified orthopedic surgeon and appellant's attending physician, provide an impairment rating in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001).

In a report dated January 29, 2001, received by the Office on May 7, 2001, Dr. David Weiss, an osteopath, reviewed appellant's history of injury and listed findings on physical examination. He diagnosed chronic post-traumatic Achilles tendinitis and plantar fasciitis and further noted that appellant was: "status post partial plantar fascial release with removal of [a] large spur and decompression of Achilles insertion to the right foot." On physical examination of the right foot and ankle, Dr. Weiss stated:

> "There is swelling noted over both the Achilles and over the medial aspect of the calcaneus. There is marked tenderness on palpation over the base of the medial malleolus. There is tenderness noted over the deltoid ligament. There is marked tenderness noted over the medial plantar fascia. The Achilles is non-tender; however, there is some thickening noted at the distal 1/3 of the cord. There is tenderness noted over the medial aspect of the calcaneus. Range of motion reveals dorsi-flexion of 5/15 degrees, plantar flexion of 55/55 degrees, inversion of 35/35 degrees, eversion of 20/20 degrees. The Draw sign is negative.
>
> "Motor strength testing reveals a grade of 5/5 involving dorsi-flexion, plantar-flexion, inversion and eversion. The gastrocnemius reveals a grade of 4/5. Thompson's test is negative today in the office.
>
> "The gastrocnemius circumferencial measurements reveal 46.5 cm [centimeters] on the right versus 48 cm on the left. There is softening of the gastrocnemius consistent with measurable atrophy. The ankle joint circumferencial measurements reveal 29.5 cm on the right versus 29 cm on the left."

Dr. Weiss discussed appellant's complaints of right foot pain and stiffness as well as swelling and weakness of the right ankle. He found that, based on the fourth edition of the A.M.A., *Guides*, appellant had a 7 percent impairment due to decreased dorsiflexion, a 3 percent impairment due to pain and a 17 percent impairment due to a motor strength deficit of the right ankle plantar flexion, which he combined to find a total impairment of the right lower extremity of 25 percent. Dr. Weiss opined that appellant achieved maximum medical improvement on January 29, 2001.

In a note dated May 1, 2001, Dr. John L. Moglia, a podiatrist, expressed agreement with Dr. Weiss' finding of a 25 percent right lower extremity impairment.

An Office medical adviser reviewed Dr. Weiss' report on February 25, 2002. He opined that appellant had reached maximum medical improvement on March 12, 2001, the date that he stopped receiving treatment. The Office medical adviser found that dorsiflexion of 5/15

constituted a 7 percent impairment according to Table 17-11 on page 537 of the A.M.A., *Guides*, and that appellant had no loss of flexion or eversion according to Tables 17-11 and 17-12 on page 537 of the A.M.A., *Guides*. He concluded that appellant had a 3 percent impairment due to pain according to Table 18-1 on page 574 and a 6 percent impairment due to loss of 1½ centimeter of circumference of the gastrocnemius. He stated:

> "Dr. Weiss used muscle weakness instead of muscle atrophy. You can[not] use both. Atrophy is more objective. The rest of Dr. Weiss' measurements [and] ratings are accurate."

The Office medical adviser concluded that appellant had a 16 percent impairment of the right lower extremity.

By decision dated May 1, 2002, the Office granted appellant a 16 percent permanent impairment of the right lower extremity. The period of the award ran for 46.08 weeks from March 12, 2001 to January 28, 2002.

On November 21, 2002 appellant, through his attorney, requested a hearing. A hearing was held on July 29, 2003. Appellant submitted a note dated July 29, 2003 from Dr. Pedowitz, who indicated that he agreed with Dr. Weiss' finding of a 25 percent impairment of the right lower extremity.

In a decision dated October 14, 2003, the hearing representative affirmed the Office's May 1, 2002 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,[1] and its implementing federal regulation,[2] 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 for all claimants, the Office has adopted the A.M.A., *Guides* (5th ed. 2001) as the uniform standard applicable to all claimants.[3] The Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001.[4]

The A.M.A., *Guides*, Chapter 17, provides multiple grading schemes and procedures for determining the impairment of a lower extremity due to gait derangement,[5] muscle atrophy,[6]

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404.

[3] 20 C.F.R. § 10.404(a).

[4] *See* FECA Bulletin No. 01-05 (issued January 29, 2001).

[5] A.M.A., *Guides* 529, Table 17-5.

[6] *Id*. at 530, Table 17-6.

muscle weakness,[7] arthritis,[8] nerve deficits[9] and other specific pathologies. The A.M.A., *Guides* also provides impairment ratings of the lower extremities for diagnosis-based estimates, including specific disorders of the knee, such as a torn meniscus or meniscectomy.[10] Section 17.2d of the fifth edition of the A.M.A., *Guides* specifically states that values for atrophy and muscle weakness are not to be combined.[11]

FECA Bulletin No. 01-05 provides that in making an impairment rating for the lower extremities, different evaluation methods cannot be used in combination.[12] Before finalizing any physical impairment calculation, the Office medical adviser is to verify the appropriateness of the combination of evaluation methods with that listed in Table 17-2, the cross-usage chart.[13]

A specific change in the fifth edition of the A.M.A., *Guides* is that it allows for an impairment percentage to be increased by up to three percent for pain by using the pain chapter.[14] A qualitative method for evaluating impairment due to chronic pain is included in Chapter 18. If an individual appears to have a pain-related impairment that has increased the burden on his or her condition slightly, the examiner may increase the percentage up to three percent.[15] If the examiner performs a formal pain-related impairment rating, he or she may increase the percent by up to three percent and then classify the individual's pain-related impairment into one of four categories: mild, moderate, moderately severe or severe.[16] The Office, however, has stated that a separate pain calculation under Chapter 18 is not to be used in combination with other methods to measure impairment due to sensory pain as outlined in Chapters 13, 16 and 17 of the fifth edition of the A.M.A., *Guides*.[17]

ANALYSIS

In a January 29, 2001 report, Dr. Weiss indicated that he used the fourth edition of the A.M.A., *Guides* rather than the fifth edition of the A.M.A., *Guides*, the letter of which is the relevant edition in this case. However, his impairment findings comport to the applicable figures

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

[8] *Id*. at 544, Table 17-31.

[9] *Id*. at 552, Table 17-37.

[10] *Id*. at 545-48, Table 17-33.

[11] *Id*. at 530, section 17.2d. Atrophy ratings should not be combined with any of the other three possible ratings of diminished muscle function (gait derangement, muscle weakness and peripheral nerve injury).

[12] *See* FECA Bulletin No. 01-05 (issued January 29, 2001).

[13] *Id*.

[14] A.M.A., *Guides* 565-91.

[15] *Id*. at 572, Figure 18-1.

[16] *Id*. at 574-575, Figures 18-1, 18-3.

[17] FECA Bulletin No. 01-05 (issued January 29, 2001).

and tables of the fifth edition of the A.M.A., *Guides*. Dr. Weiss found that appellant had subjective complaints of pain and objective findings of swelling, atrophy, loss of range of motion and motor strength testing. Dr. Weiss provided the following range of motion findings for the right ankle, dorsiflexion of 0 to 5/15 degrees which constituted a 7 percent impairment,[18] plantar flexion of 0 to 55/55 degrees which constituted no impairment, inversion of 0 to 35/35 degrees which constituted no impairment and eversion of 0 to 20/20 degrees which constituted no impairment.[19] He further found that appellant had a seven percent impairment due to loss of motor strength of right ankle plantar flexion.[20] Dr. Weiss also accorded appellant an additional three percent impairment due to pain.[21] He combined the 7 percent impairment due to loss of range of motion, the 17 percent impairment due to loss of motor strength of plantar flexion and the 3 percent impairment due to pain to find a total right lower extremity impairment of 25 percent. Dr. Weiss' report, however, does not comply with the instructions found in the A.M.A., *Guides*. The Board notes that Dr. Weiss, in finding a 25 percent right lower extremity impairment, relied upon both loss of range of motion and loss of strength. Table 17-2 of the A.M.A., *Guides* precludes using both range of motion and muscle strength in assessing impairment.[22]

The Office medical adviser reviewed Dr. Weiss' report and concurred with his finding that appellant had a 7 percent impairment due to loss of range of motion and a 3 percent impairment due to pain. He determined, however, that Dr. Weiss should have used the atrophy measurements rather than loss of strength in assessing appellant's impairment because atrophy provided a more objective result. The Office medical adviser properly noted that the A.M.A., *Guides* precluded combining atrophy and muscle weakness in reaching an impairment determination.[23] He opined that a loss of 1½ centimeter of circumference of the gastrocnemius constituted a 6 percent impairment according to Table 17-6 on page 530 of the A.M.A., *Guides*. The Office medical adviser combined the 7 percent impairment due to loss of range of motion, the 6 percent impairment due to atrophy and the 3 percent impairment due to pain and concluded that appellant had a 16 percent impairment of the right lower extremity. However, the Office medical adviser's impairment rating failed to conform to the A.M.A., *Guides* and to the methodologies as outlined in FECA Bulletin No. 01-05. According to Table 17-2 on page 526 of the A.M.A., *Guides*, values for atrophy may not be combined with values for loss of range of motion. FECA Bulletin No. 01-05 provides that the Office medical adviser is to verify the appropriateness of the combination of evaluation methods with the cross-usage chart listed in Table 17-2.

[18] A.M.A., *Guides* 537, Table 17-11. The Board notes that dorsiflexion is another word for extension.

[19] *Id*.

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

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

[22] *Id*. at 526, Table 17-2.

[23] *Id*. at 530, section 17-2d.

Additionally, the Board notes that both Dr. Weiss and the Office medical adviser failed to explain the additional three percent impairment awarded appellant due to pain. Section 18.3b on page 571 of the A.M.A., *Guides* specifically states that examiners should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment rating systems found in the other chapters. Neither Dr. Weiss nor the Office medical adviser addressed why appellant's pain could not be adequately assessed under the protocols of Chapter 17.

Accordingly, the Board finds that the medical evidence of record does not provide a probative medical opinion on the nature and extent of permanent impairment to appellant's right lower extremity. The case, therefore, will be remanded to the Office for further development of the medical evidence, as appropriate, to be followed by a *de novo* decision on appellant's right lower extremity impairment.

CONCLUSION

The Board finds that the case is not in posture for decision. The case will be remanded to the Office for further development of the medical evidence, as appropriate, to determine the extent of permanent impairment in accordance with the A.M.A., *Guides* and FECA Bulletin No. 01-05.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated October 14, 2003 is set aside and the case is remanded to the Office for further proceedings in accordance with this decision by the Board.

Issued: September 3, 2004
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member