United States Department of Labor
Employees' Compensation Appeals Board

M.G., Appellant	)	
and	)	**Docket No. 06-520**
	)	**Issued: October 13, 2006**
SOCIAL SECURITY ADMINISTRATION, Philadelphia, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On January 3, 2006 appellant filed a timely appeal from a merit decision of the Office of Workers' Compensation Programs dated December 20, 2005, which found that she had no more than a 43 percent impairment of the left lower extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the schedule award.

ISSUE

The issue is whether appellant has more than a 43 percent impairment to her left lower extremity, for which she received a schedule award.

FACTUAL HISTORY

On August 15, 2001 appellant, then a 43-year-old service representative, filed a claim alleging that she injured her left elbow and knee when she tripped over a telephone cord at work. The Office accepted the claim for contusion to the elbow and forearm, tenosynovitis of the left foot and ankle, contusion of the left knee, left sprain and strain of the ankle and aggravation of preexisting deep venous thrombosis (DVT) resulting in permanent restrictions. It authorized

medical treatment, including a July 21, 2003 arthroscopic surgery to evaluate the cause of appellant's ankle swelling and pain. Appellant was paid appropriate compensation benefits for temporary total disability. She returned to her preinjury position on February 14, 2005.

On December 2, 2005 appellant filed a claim for a schedule award and submitted an April 19, 2005 report from Dr. George L. Rodriguez, a Board-certified physiatrist, who performed an impairment rating evaluation. Dr. Rodriguez opined that appellant had DVT -- left lower extremity (recurrent with pulmonary embolus and persistent lymphedema), adhesive capsulitis -- left ankle (per surgical resection), degenerative joint disease -- left ankle (severe -- as per direct surgical visualization), synovitis -- left ankle, hemorrhage -- left ankle (chronic and acute; with debridement), tarsal tunnel syndrome -- lateral (left foot) and gait abnormality, which were attributable to her August 15, 2001 work-related injuries. He noted that appellant did not use any assistive devices to walk. Dr. Rodriguez opined that appellant reached maximum medical improvement on March 31, 2004 and that she suffers from significant left leg and ankle pain. The left knee evaluation was noted to be within normal limits with a showing of trophic, pitting edema from the infrapatellar area to the metatarsophalangeal joint with mild tenderness diffusely on palpation of the left calf. Left ankle examination revealed full plantar flexion, inversion and eversion; however, dorsiflexion was limited to zero degrees or the neutral position. Sensation was noted to be intact both medially and laterally in both feet with normal strength for both lower extremities. Appellant's stance was noted to be wide-based with unloading on the left lower extremity and a slight left antalgia on ambulation. Under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[1] Dr. Rodriguez opined that appellant had a 77 percent total left lower extremity impairment. He classified the peripheral vascular impairment as a Class 3 impairment, which resulted in 69 percent impairment[2] and found that the ankle range of extension at 0 degrees or neutral position resulted in 7 percent impairment.[3] Dr. Rodriguez found that the ankle arthritis was of high severity, which resulted in 20 percent impairment.[4] He additionally found that the plantar nerve had a Grade 4 or 25 percent sensory deficit[5] which, when multiplied by the maximum percent deficit of 5 percent,[6] resulted in 1 percent impairment. Dr. Rodriguez used the Combined Values Chart on page 605 and combined the 69 percent peripheral vascular impairment with the total impairments of appellant's ankle, which equated to 28 percent and found a combined left lower extremity impairment value of 77 percent.

On November 14, 2005 an Office medical adviser reviewed the medical record. He stated that appellant's DVT resulted from a complication of her hysterectomy in 1999; therefore, the diagnosis was an aggravation of the preexisting thrombosis. The Office medical adviser

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

[2] *Id.* at 554, Table 17-38.

[3] *Id.* at 537, Table 17-11.

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

[5] *Id*. at 482, Table 16-10.

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

applied the findings of Dr. Rodriguez to the A.M.A., *Guides* to find that appellant had a 43 percent total left lower extremity impairment. Under Table 17-38 page 554, the Office medical adviser found that appellant had a Class 2 peripheral vascular (venous) disease impairment of 39 percent. Under Table 17-11, page 537, he agreed with Dr. Rodriguez' finding that an ankle with zero degree dorsiflexion equated to a seven percent lower extremity impairment. The Office medical adviser noted that Dr. Rodriguez did not provide any findings in his report to support the impairment ratings based on arthritis and sensory nerve deficits. Therefore, he excluded Dr. Rodriguez' 20 percent left lower extremity impairment for an arthritis impairment and 1 percent left plantar nerve sensory impairment. Utilizing the Combined Values Chart on page 605, the Office medical adviser combined the 39 percent peripheral vascular (venous) disease impairment with the 7 percent ankle dorsiflexion impairment to find a total left lower extremity impairment of 43 percent. The Office medical adviser noted that the date of maximum medical improvement was April 19, 2005, based on Dr. Rodriguez' report.

By decision dated December 20, 2005, the Office granted appellant a schedule award for a 43 percent left lower extremity impairment. The period of the award ran for 123.84 weeks from April 19, 2005 to September 2, 2007.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[7] and its implementing regulation[8] sets 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.[9]

ANALYSIS

The Office found a 43 percent left lower extremity impairment based on the November 14, 2005 report of the Office medical adviser.[10] The Office medical adviser reviewed the findings of Dr. Rodriguez to find that appellant had lower extremity impairments due to peripheral vascular (venous) disease and ankle motion impairment arising from her accepted work-related conditions. He excluded Dr. Rodriguez' impairment ratings based on ankle arthritis and a plantar nerve sensory deficit. The Office medical adviser agreed with Dr. Rodriguez that

[7] 5 U.S.C. § 8107(a)(c).

[8] 20 C.F.R. § 10.404.

[9] *See Mark A. Holloway*, 55 ECAB ___ (Docket No. 03-2144, issued February 13, 2004).

[10] The Office's procedures indicate that referral to an Office medical adviser is appropriate when a detailed description of the impairment from the attending physician is obtained. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (August 2002). *See Thomas J. Fragale*, 55 ECAB ___ (Docket No. 04-835, issued July 8, 2004).

appellant's ankle extension was limited to the neutral position, resulting in seven percent left lower extremity impairment.[11] The record supports that appellant has a seven percent left lower extremity impairment due to ankle extension.

With respect to a lower extremity impairment resulting from arthritis in the ankle, Dr. Rodriguez opined that appellant's arthritis was of high severity and opined, under Table 17-31 of the A.M.A., *Guides*, that she had a 20 percent impairment.[12] The Office medical adviser excluded Dr. Rodriguez' impairment rating on the basis that he did not provide evidence of ankle arthritis. Table 17-2 of the A.M.A., *Guides*, specifically excludes the combination of a range of motion impairments, of which appellant was accorded a seven percent impairment due to loss of ankle extension, with impairment for arthritis.[13] The Office medical adviser properly excluded Dr. Rodriguez' 20 percent impairment determination due to ankle arthritis.

The Office medical adviser also rejected Dr. Rodriguez' impairment findings with respect to a sensory deficit resulting from the plantar nerve. Dr. Rodriquez opined that appellant had one percent impairment, but offered no description regarding appellant's sensory deficit pursuant to the grading scheme for Table 16-10 of the A.M.A., *Guides*.[14] Dr. Rodriguez' examination revealed intact sensation both medially and laterally in both feet, which is contrary to a finding of a distorted or diminished touch. As there is insufficient evidence to support a sensory deficit or pain resulting from a peripheral nerve disorder, the Board finds that the Office medical adviser properly excluded this impairment determination.

With respect to the impairment rating based on a vascular impairment, the Board notes that Dr. Rodriguez classified appellant with a Class 3 impairment representing a 69 percent peripheral vascular impairment. The Office medical adviser classified appellant with a Class 2 impairment, representing a 39 percent peripheral vascular impairment. Table 17-38 of the A.M.A., *Guides*[15] sets forth criteria for rating impairments due to peripheral vascular disease. The table is divided into five classes, in which a higher class rating represents a greater impairment to the lower extremity. In interpreting Table 17-38, individuals in a Class 2 category have intermittent claudication on walking at least 100 yards at an average pace or persistent edema of a moderate degree, incompletely controlled by elastic supports or vascular damage as evidenced by a sign such as a healed, painless stump of an amputated digit showing evidence of persistent vascular disease or healed ulcer. Class 2 individuals are assigned a 10 to 39 percent impairment of the lower extremity. Individuals in a Class 3 category have intermittent claudication on walking as few as 25 yards and no more than 100 yards at average pace or have marked edema that is only partially controlled by elastic supports or have vascular damage as evidenced by a sign such as healed amputation of two or more digits of one extremity, with evidence of persisting vascular disease or superficial ulceration. Those individuals are assigned

[11] A.M.A., *Guides* 537, Table 17-11.

[12] *Id.* at 544.

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

[14] *Id.* at 482.

[15] *Id.* at 554, Table 17-38.

40 to 69 percent impairment. The Board has recognized that the selection of a percentage from the range of values allowed by the A.M.A., *Guides* involves a subjective judgment.[16] The application of Table 17-38 of the A.M.A., *Guides* requires a subjective judgment as it allows for selection of a value between a range of percentages between classes of impairment when an impairment rating is assigned due to peripheral vascular disease.

The Board finds that the Office medical adviser did not sufficiently explain the reasons why he assigned a Class 2, as opposed to a Class 3, as noted by Dr. Rodriquez with regard to appellant's vascular impairment.[17] In view of this, the Board finds that further development of the medical evidence is warranted regarding the extent of appellant's permanent impairment pursuant to the A.M.A., *Guides*.

While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.[18] On remand, the Office should further develop the medical evidence as to the extent of appellant's left leg permanent impairment under the A.M.A., *Guides.* Following this and any other further development as deemed necessary, the Office shall issue an appropriate merit decision on appellant's schedule award claim.

CONCLUSION

The Board finds that this case is not in posture for decision regarding whether appellant has greater than a 43 percent left lower extremity impairment, for which she received a schedule award.

[16] *John Keller*, 39 ECAB 543, 547 (1988).

[17] The Board has recognized that an attending physician, who has an opportunity to examine appellant, is often in a better position to make certain judgments regarding schedule awards *see Richard Giordano*, 36 ECAB 134, 139 (1984); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(c) (August 2002). The procedure manual notes that, when the A.M.A., *Guides* ask for a percentage within a range, the physician may be asked why he assigned a particular percentage of impairment.

[18] *See John W. Butler*, 39 ECAB 852 (1988).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated December 20, 2005 is set aside and the case remanded to the Office for proceedings consistent with this opinion of the Board.

Issued: October 13, 2006
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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