United States Department of Labor
Employees' Compensation Appeals Board

T.M., Appellant	)	
and	)	**Docket No. 08-971**
	)	**Issued: November 18, 2008**
U.S. POSTAL SERVICE, POST OFFICE, 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
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On February 19, 2008 appellant filed a timely appeal from an August 14, 2007 merit decision of the Office of Workers' Compensation Programs that granted him a schedule award for 13 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 issue.

ISSUE

The issue is whether appellant met his burden of proof in establishing that he had greater than 13 percent impairment of the right lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On April 15, 2005 appellant, then a 50-year-old letter carrier, filed a traumatic injury claim stating that he sustained an injury in the performance of duty when his right foot was run over by a motor vehicle. He did not initially stop work but worked in a limited-duty capacity. In an April 15, 2005 report, Dr. Robert B. Swain, a Board-certified anesthesiologist, diagnosed right foot contusion with no complicating sequelae and explained that appellant's foot was run

over by a car while he was on duty. The Office initially accepted appellant's claim for a right foot contusion and later accepted a fracture, first metatarsal distal head, traumatic arthropathy, right foot/ankle and osteoarthritis, right foot/ankle.

In a July 1, 2005 report Dr. Steven M. Raikin, a Board-certified orthopedic surgeon, diagnosed cystic changes in the right first metatarsal head consistent with degenerative joint disease and possible osteonecrosis. He concluded that appellant's condition was likely exacerbated by his April 15, 2005 employment injury. On July 8, 2005 Dr. Gouri Atri, a Board-certified preventative medicine specialist, diagnosed right foot crush injury, degenerative joint disease and avascular necrosis. On September 2, 2005 he diagnosed right fracture sesamoid with chronic foot pain and advised that appellant was scheduled for surgery on September 20, 2005.

Appellant stopped work on September 20, 2005 and underwent a right first metatarsophalangeal joint (MPJ) fusion on the same day. Dr. Raikin performed the procedure and diagnosed crush injury of right first MPJ and right first MPJ arthritis. On December 12, 2005 he advised that at status post 12 weeks following surgery appellant had returned to limited-duty work. Dr. Raikin noted that appellant had some gravity-dependent swelling and residual pain. On February 6, 2006 he reported that appellant was fully recovered at 19 weeks status post right first MPJ fusion. Dr. Raikin stated that appellant could return to full-duty work effective February 20, 2006.

On February 27, 2006 appellant filed a recurrence of disability claim alleging that he had returned to full-duty work but had continued to experience severe pain. He stopped work on the same day.

In a March 6, 2006 report, Dr. Benson Weinstock, a podiatrist, noted severe swelling and extreme tenderness to palpation over the surgical area. X-rays showed a partial fusion of the right first MPJ with an irregular joint space and two compression screws, one of which extended into the first interspace and soft tissues. Dr. Weinstock noted appellant's complaints of right foot swelling and pain since his September 20, 2005 surgery and diagnosed nonunion and/or pseudoarthrosis of the right first MPJ with traumatic arthritis and soft tissue inflammation due to the improper placement of the fixation screw during surgery. On May 4, 2006 he explained that diagnostic testing revealed a failed fusion of the right first MPJ, due to failed surgery and advised that appellant may require either a second fusion or a joint implant. In a June 22, 2006 report, Dr. Edward L. Chairman, a podiatrist, noted appellant's complaints of residual pain from his September 20, 2005 surgery and diagnosed pain and discomfort in the interspace, first and second metatarsals, due to irritation from the elongated screw. On July 10, 2006 he explained that appellant's residual pain was related to the elongated screw and concluded that the screw must be removed. In an October 10, 2006 operative report, Dr. Chairman diagnosed painful hardware of the right foot and performed a removal of hardware from the right first MPJ.

Appellant returned to full-time limited-duty work effective November 14, 2006.

In a March 15, 2007 x-ray report, Dr. Howard C. Hutt, a Board-certified diagnostic radiologist, diagnosed no obvious fracture or dislocation at the ankle but noted evidence of prior internal fixation along the great toe with screw fixation and areas of sclerosis within the proximal phalanx of the right great toe.

In a March 15, 2007 report and impairment rating, Dr. George L. Rodriguez, a Board-certified physiatrist, noted appellant's history of injury on April 15, 2005, right first MPJ fusion by Dr. Raikin and ultimate removal of a loose screw by Dr. Chairman. He noted that appellant experienced intermittent episodes of pain and swelling in the right foot, ankle and great toe. Dr. Rodriguez explained that appellant's pain was occasionally severe and involved the sole of his foot. On examination, appellant had full range of motion in plantar flexion, extension, internal rotation and external rotation, but had pain in the dorsum of the right foot at the proximal crease during extreme extension of the ankle. Dr. Rodriguez noted diffuse edema along the sole of the foot and a well-healed midline surgical scar overlying the right first MPJ, which was mildly tender to palpation. He diagnosed right foot contusion, right first metatarsal distal head fracture and status post fusion, traumatic arthropathy of the ankle, right ankle osteoarthritis and chronic pain. Dr. Rodriguez concluded that appellant had significant right foot and ankle pain related to the April 15, 2005 work injury and had reached maximum medical improvement on March 31, 2006. He found that appellant had 10 percent impairment of the right leg based on Table 17-30 on page 543 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[1] (A.M.A., *Guides*) for great toe ankylosis. Dr. Rodriguez recommended an additional three percent impairment for pain, based on Chapter 18 of the A.M.A., *Guides*.[2] He characterized the three percent for pain as a whole person impairment and converted it to an additional five percent impairment of the right lower extremity based on Office procedures and Table 17-32 of the A.M.A., *Guides*.[3] Dr. Rodriguez added the values to determine that appellant had a total of 15 percent impairment of the right leg.

On April 25, 2007 appellant claimed a schedule award. On July 20, 2007 the Office referred appellant's schedule award claim to the Office medical adviser.

In a July 27, 2007 report, the Office medical adviser noted the results of Dr. Rodriguez' report and impairment rating. He agreed with the recommended 10 percent right lower extremity impairment for great toe ankylosis pursuant to Table 17-30 on page 543 of the A.M.A., *Guides*.[4] However, the medical adviser explained that appellant was entitled to only three percent additional impairment for pain and stated that he did not understand why Dr. Rodriguez found that the three percent was a whole person impairment which must be converted into five percent lower extremity impairment before adding the impairment rating values. He stated that Dr. Rodriguez appeared to use Office procedures to convert a lower extremity rating unnecessarily, as "we are only dealing with the lower extremity anyway." The medical adviser

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

[2] *See* A.M.A., *Guides* § 18.3, 573.

[3] Federal (FECA) Procedure Manual, Part 3, Medical -- *Schedule Awards*, Chapter 3.0700.4(c)(2)(b) (March 2005); A.M.A., *Guides* 545, Table 17-32.

[4] A.M.A., *Guides* 543, Table 17-30.

determined that appellant had 13 percent impairment of the right leg, with 10 percent impairment for great toe ankylosis based on Table 17-30 and 3 percent impairment for pain based on Chapter 18.

On August 14, 2007 the Office granted appellant a schedule award for 13 percent impairment of the right leg.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[5] and its implementing regulation[6] 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.[7] The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[8]

ANALYSIS

The Office accepted appellant's claim for a right foot contusion, a fracture of the first metatarsal distal head, traumatic arthropathy of the right foot/ankle and osteoarthritis of the right foot/ankle. Appellant underwent a right first metatarsal joint fusion on September 20, 2005 and a right foot hardware removal on October 10, 2006. In a March 15, 2007 impairment rating, Dr. Rodriguez found that appellant had 15 percent impairment of the right lower extremity.

Dr. Rodriguez' impairment rating was based on right great toe ankylosis and pain. He applied Table 17-30 on page 543 of the A.M.A., *Guides*[9] to find that appellant had 10 percent right lower extremity impairment for great toe ankylosis. Pursuant to Table 17-30, ankylosis of the great toe with full extension, which Dr. Rodriguez measured on physical examination, corresponds to 10 percent lower extremity impairment.[10] The Office medical adviser agreed that Dr. Rodriguez properly rated appellant's lower extremity impairment for right great toe ankylosis. The Board finds that Dr. Rodriguez' 10 percent right lower extremity impairment rating for ankylosis comports with the A.M.A., *Guides*.

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *V.G.*, 59 ECAB __ (Docket No. 07-2179, issued July 14, 2008).

[8] *See id.*

[9] A.M.A., *Guides* 543, Table 17-30.

[10] *Id.*

Dr. Rodriguez also found that appellant had five percent impairment for pain pursuant to Chapter 18 of the A.M.A., *Guides*.[11] The Board notes that the A.M.A., *Guides* account for pain in the general body and organ systems impairment ratings.[12] Therefore, physicians generally should not use pain impairment rating system under Chapter 18 to rate impairments for which pain can be adequately measured through other impairment rating methods.[13] The A.M.A., *Guides* instructs physicians to first evaluate the claimant according to the appropriate body or organ impairment rating system.[14] The Board has held 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 given in other chapters of the A.M.A., *Guides*.[15] The Board has also noted that impairment ratings in the body organ system chapters of the A.M.A., *Guides* make allowance for any accompanying paint.[16] Dr. Rodriguez did not explain why the lower extremity rating system outlined in Chapter 17, for which appellant's impairment for ankylosis was based, did not make proper allowance for accompanying pain. Likewise, the Office medical adviser did not explain why appellant's pain could not be adequately rated under other chapters of the A.M.A., *Guides*. Therefore, the Board finds that Dr. Rodriguez and the Office medical adviser improperly applied three percent impairment under Chapter 18 of the A.M.A., *Guides*.

Accordingly, the Board finds that appellant has not established that he has greater than 13 percent right lower extremity impairment, for which he received a schedule award.

CONCLUSION

The Board finds that appellant has not met his burden of proof in establishing that he had more than 13 percent right lower extremity impairment, for which he received a schedule award.

[11] *Supra* note 2. Dr. Rodriguez characterized impairment rating for pain as three percent whole person impairment that he converted to impairment of the leg. The A.M.A., *Guides* do not contemplate that pain impairment under Chapter 18 be considered whole person impairment. *See* A.M.A., *Guides* at 570 ("because percentages for pain-related impairment have not been used and tested on a widespread basis … it was decided that impairment ratings for pain disorders would not be expressed as percentages of whole person impairment"). Likewise, Office procedures cited by Dr. Rodriquez to support converting whole person pain impairment to leg impairment actually pertain to converting whole person impairment of internal organs, for which the A.M.A., *Guides* do not provide a specific organ rating, into a percentage of impairment of the particular organ. *See supra* note 3.

[12] A.M.A., *Guides* at 570.

[13] *Id.* at 571; *P.C.*, 58 ECAB __ (Docket No. 08-410, issued May 31, 2007).

[14] *Supra* note 12.

[15] *See P.C.*, *supra* note 13.

[16] *L.H.*, 58 ECAB ___ (Docket No. 06-1691, issued June 18, 2007).

ORDER

IT IS HEREBY ORDERED THAT the August 14, 2007 decision of the Office of Workers' Compensation Programs is affirmed, as modified.

Issued: November 18, 2008
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board