

On April 15, 2002 appellant filed a notice of recurrence of disability which he attributed to his original injury. Appellant explained that his injury never healed correctly and was causing discomfort in his daily activities. On August 7, 2002 the Office accepted appellant's claim and authorized surgery. Appellant underwent an authorized terminal syme amputation of the left great toe on August 23, 2002, which was performed by Dr. Clyde W. Parsons, a Board-certified orthopedic surgeon. He indicated that two incisions were made at the corner of each base of the great toenail and, after removal of the nail bed, the nail bed matrix was removed and cauterized. Dr. Parsons indicated that the distal phalanx was shortened to allow the tip of the great toe to be pulled up to the area to be sutured on the cuticle. Appellant returned to light duty on October 22, 2002.

In a January 9, 2003 disability certificate, Dr. Parsons advised that appellant could return to work on that date, with restrictions of no lifting with some standing and walking.

In an April 28, 2003 report, Dr. Jeffrey L. Woodward, Board-certified in physical medicine and rehabilitation and a second opinion physician, noted appellant's history of injury and treatment and advised that appellant had chronic right great toe pain. He indicated that the most current pain originated from the right great toe joint with mild motion restriction. Dr. Woodward advised that appellant continued treating with Dr. Parsons. He authorized full-time modified duty with restrictions of frequent lifting, pushing, pulling, from 0 to 30 pounds, and occasional lifting, pushing, pulling, with a maximum of 0 to 50 pounds. He returned to regular duty on September 3, 2003.

On July 7, 2004 appellant filed a claim for a schedule award.

In an August 23, 2004 report, the Office medical adviser indicated that appellant was eligible for an impairment rating due to the partial amputation of his right big toe. He advised that the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001), should be utilized to determine an impairment rating.

By letter dated August 26, 2004, the Office referred appellant for an examination to determine whether appellant was eligible for a schedule award.

In a September 17, 2004 report, Dr. Woodward advised that appellant had a partial amputation of the great toe in 2002. He advised that the left toenail was absent, and that appellant had a healed surgical scar and distal stump, with mild diffuse erythema and distal bulbous swelling, and that the capillary refill was normal. Dr. Woodward indicated that appellant had mild pain on deep palpation of the diffuse dorsal and distal great toe. He utilized a goniometer and advised that he had great toe metatarsophalangeal extension of 20 degrees and flexion of 15 degrees and active range of motion of the great toe with interphalangeal extension of 5 degrees and flexion of 5 degrees. Dr. Woodward noted that appellant had sensation of altered light touch which was moderate over 90 percent of the distal great toe. He opined that appellant had chronic left great toe pain from distal fracture and subsequent partial amputation and a residual range of motion and sensory deficits and reached maximum medical improvement in August 2003. Dr. Woodward advised that appellant had great toe metatarsal extension and

interphalangeal flexion which was mild and a two percent lower extremity impairment pursuant to Table 17-14.¹

By letter dated October 4, 2004, the Office medical adviser reviewed Dr. Woodward's September 17, 2004 report and requested an addendum, explaining that appellant was also entitled to impairment for his amputation, if applicable.

In an October 18, 2004 addendum, Dr. Woodward advised that appellant was entitled to an impairment for his amputation. He referred to Table 17-32,² and advised that appellant had a great toe interphalangeal joint amputation of five percent of the lower extremity impairment combined with a previous two percent impairment recommendation based on the Combined Values Chart, which was equal to a seven percent lower extremity impairment.

On November 13, 2004 the Office medical adviser reviewed Dr. Woodward's October 18, 2004 report and advised that he had reviewed the operative report of August 23, 2002 and determined that appellant actually had an amputation at the top of the nail bed. He opined that this would mean that two thirds of the great toe was amputated. Dr. Woodward noted that appellant still had range of motion at the interphalangeal joint, although the range of motion was not quite normal. He explained that the interphalangeal joint was not affected by the symes amputation. However, Dr. Woodward noted that it should still be treated as an amputation at the interphalangeal (IP) level. The Office medical adviser also explained this would cause the rating at the IP joint level to be deleted. He indicated that Dr. Woodward offered the rating as a lower extremity rating, but explained that the rating must be maintained as a great toe rating. The Office medical adviser indicated that the A.M.A., *Guides*, fifth edition, did not have a conversion table where a foot impairment could be converted to a great toe rating. He explained, however, that the third edition revised of the A.M.A., *Guides* at page 59 contained such a table. He noted a 7 percent impairment of the foot was equal to 41 percent of the great toe.³ The Office medical adviser opined that the maximum award for a symes amputation of the left great toe was 41 percent.

On November 16, 2004 the Office granted appellant a schedule award for 41 permanent impairment of the left great toe. The award covered a period of 15.58 weeks from August 31 to December 18, 2003.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act⁴ sets forth the number of weeks of compensation to be paid for the permanent loss or loss of use of specified members,

¹ A.M.A., *Guides* 537, Table 17-14.

² A.M.A., *Guides* 545, Table 17-32.

³ The medical adviser's report noted use of the third edition. However, a review of his reference to the A.M.A., *Guides* indicates that he was actually referring to the third edition revised.

⁴ 5 U.S.C. §§ 8101-8193.

functions and organs of the body.⁵ The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.⁶ The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.⁷

Where the residuals of an injury to a member of the body specified in the schedule⁸ extend into an adjoining area of a member also enumerated in the schedule, such as an injury of a finger into the hand, of a hand into the arm or of a foot into the leg, the schedule award should be made on the basis of the percentage loss of use of the larger member.⁹

The fifth edition does not provide a method of assigning a percentage of impairment to individual toes. Rather, it addresses such impairment in terms of the whole person, the foot or the lower extremity. Since the Act specifically provided for payment of schedule awards for individual toes, Office procedures state that the third edition revised of the A.M.A., *Guides*¹⁰ should be used to compute impairment of toes alone.¹¹

ANALYSIS

The relevant medical evidence includes Dr. Woodward's September 17, 2004 report in which he indicated that appellant reached maximum medical improvement in August 2003 and advised that the left toenail was absent, and that appellant had a healed surgical scar and distal stump, with mild diffuse erythema and distal bulbus swelling. He noted mild pain and deep palpation of the diffuse dorsal and distal great toe and advised that appellant had active range of motion of the great toe with interphalangeal extension of 5 degrees and flexion of 5 degrees. Dr. Woodward noted that appellant had sensation of altered light touch which was moderate over 90 percent of the distal great toe and indicated that appellant had chronic left great toe pain from distal fracture and subsequent partial amputation and a residual range of motion and sensory deficits. Dr. Woodward advised that appellant had great toe metatarsal extension and interphalangeal flexion which was mild and indicated that appellant had a two percent lower extremity impairment pursuant to Table 17-14.¹² The Office medical adviser concurred with the rating and added that Dr. Woodward needed to determine whether appellant was entitled to a rating for the amputation.

⁵ 5 U.S.C. § 8107.

⁶ *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

⁷ 20 C.F.R. § 10.404.

⁸ 5 U.S.C. § 8107.

⁹ *Asline Johnson*, 42 ECAB 619 (1991); *Manuel Gonzales*, 34 ECAB 1022 (1983).

¹⁰ American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (3^d ed.) (revised 1990).

¹¹ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

¹² A.M.A., *Guides* at 537, Table 17-14.

In an October 18, 2004 addendum, Dr. Woodward advised that appellant was also entitled to impairment for his amputation. He referred to Table 17-32¹³ and advised that appellant had a great toe IP joint amputation which would entitle him to a rating of five percent of the lower extremity. He concluded that this combined with the previous two percent impairment recommendation, based on the Combined Values Chart,¹⁴ was equal to a seven percent lower extremity impairment.

The Office medical adviser subsequently reviewed Dr. Woodward's October 18, 2004 report and advised that, upon review of the operative report of August 23, 2002, only two thirds of the great toe was amputated. He noted that appellant had range of motion at the IP joint, although it was not normal and opined that the IP joint was not affected by the symes amputation. However; the Office medical adviser indicated that it should still be treated as an amputation at the IP level; but specifically advised that this would cause the rating at the IP joint level to be deleted. He indicated that Dr. Woodward offered the rating as a lower extremity rating, but explained that the rating must be maintained as a great toe rating. The Office medical adviser referred to Table 27 in the third edition revised of the A.M.A., *Guides* at page 59 and noted that 41 percent of the great toe was equal to 7 percent of the foot. The Board notes that when the residuals of an injury to a member of the body specified in the schedule¹⁵ extend into an adjoining area of a member also enumerated in the schedule, the schedule award should be made on the basis of the percentage loss of use of the larger member.¹⁶ The Board notes that Table 17-32 of the fifth edition¹⁷ specifically provides ratings for the great toe at the IP joint to the lower extremity in the amount of five percent for the lower extremity or seven percent for the foot.

However, the issuance of the schedule award based on toe impairment instead of leg or foot impairment has not prejudiced appellant in this case. If the leg was used, according to 5 U.S.C. § 8107(c)(2), the compensation for total loss of a leg is equal to 288 weeks. Whereas under 5 U.S.C. § 8107(c)(4) the compensation for total loss of a foot is equivalent to 205 weeks. Thus, if appellant were entitled to 5 percent of the leg, he would be entitled to 14.40 weeks of compensation.¹⁸ If he were entitled to 7 percent of the foot, he would only be entitled to 14.35 weeks of compensation. Appellant would not be entitled to more than the 15.58 weeks he has already received for the impairment to his great toe. He has not submitted any other medical evidence to suggest entitlement to a greater award.

¹³ A.M.A., *Guides* at 545, Table 17-32.

¹⁴ A.M.A., *Guides* 604.

¹⁵ 5 U.S.C. § 8107.

¹⁶ *Supra* note 9.

¹⁷ A.M.A., *Guides* 545.

¹⁸ As noted above, the Office medical adviser specifically noted that the IP joint was not affected by the symes amputation, and explained that they would still treat it as a symes amputation, but it would cause the rating for the IP joint level to be deleted.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he has more than a 41 percent permanent impairment of his left great toe.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 16, 2004 is affirmed.

Issued: August 25, 2005
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