

performed surgery to correct the nonunion of the right distal tibia. Appellant received appropriate compensation benefits and retired on August 2, 2000.

On May 29, 2001 appellant filed a claim for a schedule award. He submitted the August 23, 2000 report of Dr. David Weiss, an osteopath, who opined that appellant had a 64 percent impairment of the right lower extremity. On examination, Dr. Weiss noted well-healed surgical scars with edema involving the right ankle joint and tenderness over the medial malleolus. Range of motion of the ankle joint was fused and ankylosed. He described “great capillary refill” on examination.¹ Testing of the gastrocnemius musculature was four of five. Dr. Weiss noted that “[t]he ankle circumference measures 28 centimeters (cm) on the right versus 26 cm on the right [sic].” The gastrocnemius circumference measured 39 cm on the left versus 36 cm on the right and leg circumference from the umbilicus to the base of the medial malleolus measured 92 cm on the left versus 89 cm on the right. Dr. Weiss indicated that he rated appellant’s impairment under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),² as follows: the right leg had a length deficit equal to a 14 percent impairment based on Table 17-4, page 528; Class 1 peripheral vascular disease was equal to a 9 percent impairment based on Table 17-38, page 554; a 4 of 5 motor strength deficit of the right gastrocnemius (ankle plantar-flexion) was equal to a 17 percent impairment based on Table 17-8, page 532; and right ankle ankylosis secondary to varus or abnormal position was equal to a 43 percent impairment based on Table 17-25, page 541 or a combined total of 64 percent impairment of the right lower extremity. He noted that appellant had reached maximum medical improvement on August 22, 2000.

In a report dated June 20, 2001, an Office medical adviser reviewed the report of Dr. Weiss and noted that it could not form the basis for an impairment rating. He stated that he needed to know the exact position of the ankle in the degree of plantar flexion or dorsiflexion and the degree of valgus position. The Office medical adviser also noted that there was no basis for a determination of gastrocnemius strength deficit because the ankle cannot be flexed in the plantar or dorsal direction. On January 22, 2002 the Office requested Dr. Weiss to reply to the June 20, 2001 report of the Office medical adviser. On April 25, 2002 Dr. Weiss stated that appellant’s ankle was fused at a 0 percent angle in all planes at the time of evaluation.

In a report dated October 8, 2002, the Office medical adviser reviewed the additional medical evidence and found a 22 percent impairment of appellant’s right lower extremity. He noted that the ankle was fused in a neutral position, which was 10 percent impairment under the A.M.A., *Guides*, page 541. The 3 cm atrophy of the right calf equaled 13 percent impairment under Table 17-6, page 530. The Office medical adviser combined the 10 percent ankylosis rating with the 13 percent atrophy rating to find a total of 22 percent impairment to the lower extremity. He concurred that the date of maximum medical improvement was August 22, 2000.

¹ Dr. Weiss noted that appellant is diabetic.

² Dr. Weiss stated that he used the fourth edition of the A.M.A., *Guides*, but his references were to the fifth edition of the A.M.A., *Guides*.

On November 5, 2002 the Office granted appellant a schedule award for 22 percent right lower extremity impairment. The award ran for 63.36 weeks, from August 22, 2000 to November 8, 2001.

On November 11, 2002 appellant requested an oral hearing, which was held on October 28, 2003. In a January 24, 2004 decision, an Office hearing representative set aside the November 5, 2002 schedule award and directed that the Office medical adviser provide further opinion on the extent of permanent impairment based on the reported right leg length deficit noted by Dr. Weiss.

On April 7, 2004 Dr. Harry L. Collins, Jr., an Office medical consultant, reviewed the record and noted that appellant's right lower extremity was 89 cm while his left lower extremity was 92 cm or a 3 cm shortening of the right lower extremity. Under Table 35 of the A.M.A., *Guides* (4th ed. 1993) at page 75, this represented a 10 percent permanent impairment of the right lower extremity. This impairment, when combined with the prior 22 percent impairment rating, resulted in a total 30 percent right lower extremity impairment. Appellant's date of maximum medical improvement was noted as August 22, 2000.

On April 13, 2004 the Office granted appellant an additional schedule award for eight percent impairment of his right lower extremity. The period of the award ran from November 9, 2001 to April 19, 2002.

Appellant requested an oral hearing, which was held on February 23, 2005. By decision dated May 20, 2005, an Office hearing representative affirmed the April 13, 2004 schedule award, finding that appellant did not have more than a 30 percent impairment of his right lower extremity.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act³ and its implementing regulation⁴ 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* (5th ed. 2001) has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.⁵

In evaluating lower extremity impairments, Chapter 17 of the A.M.A., *Guides* (5th ed. 2001) notes that alternative methods exist by which impairment may be assessed: anatomic,

³ 5 U.S.C. § 8107.

⁴ 20 C.F.R. § 10.404.

⁵ *Willie C. Howard*, 55 ECAB ____ (Docket No. 04-342 and 04-464, issued May 27, 2004).

functional or diagnosis based estimates.⁶ The evaluator is directed to the cross-usage chart at Table 17-2, page 526, to determine when the methods for evaluating impairment may be combined.

ANALYSIS

The Board finds that the case is not in posture for decision. Appellant was granted schedule awards by the Office for a total 30 percent impairment of his right lower extremity. The rating was based on combining the impairment values for ankylosis in a neutral position (10 percent impairment), 3 cm atrophy of the right calf muscle (13 percent impairment) and a 3 cm leg length discrepancy (10 percent impairment). A review of Table 17-2, the cross-usage chart, reveals that these three lower extremity impairment ratings may be combined. Under the Combined Values Chart at page 604, the Office medical advisers found total impairment to appellant's right lower extremity of 30 percent.

The Office medical advisers properly noted that the fifth edition of the A.M.A., *Guides* at page 541 provides that ankylosis of the ankle in the neutral position represents 10 percent impairment. The Board notes that Dr. Weiss initially allowed 43 percent impairment under Table 17-25, which rates ankle impairment due to ankylosis in the varus position. However, Dr. Weiss did not provide any measurements to support this rating and subsequently clarified on April 25, 2002 that appellant's ankle was fused in the neutral position. Therefore, the 43 percent rating provided in the original report is not supported by the evidence of record. Appellant was properly rated at 10 percent impairment for this deficit by the Office medical adviser.

Dr. Weiss reported finding of a 3 cm leg length deficit, which the Office medical adviser stated was a 10 percent impairment under Table 35, page 75, of the A.M.A., *Guides* (4th ed. 1993). This reference to the fourth edition of the A.M.A., *Guides* was harmless, as the leg length impairment rating is the same at Table 17-4, page 528 of the A.M.A., *Guides* (5th ed. 2001). Table 17-4 provides that a limb length discrepancy of between 3 to 3.9 cm represents a 10 to 14 percent impairment of the lower extremity. Although Dr. Weiss rated appellant's leg length impairment at the maximum 14 percent provided in this range; he did not provide any reason or explanation for doing so in light of the fact that the reported measurement of impairment was 3 cm, at the lower end of the range. The Office medical adviser did not abuse his discretion in allowing the 10 percent impairment rating for this impairment.

Dr. Weiss also reported atrophy of the right calf muscle of three cm; however, the physician did not provide a specific rating of impairment for this deficit. The Office medical adviser properly noted that Table 17-6, page 530, rates impairment for 3 or more cm of the calf muscle as "severe" and provides a 13 percent impairment to the lower extremity. As noted, the Office medical advisers applied the Combined Values Chart to the ankylosis, atrophy and leg length impairments to find a total of 30 percent impairment.

Dr. Weiss also provided several other impairment ratings with regard to appellant's lower extremity. He rated impairment due to peripheral vascular disease under Table 17-38, page 554, allowing nine percent impairment or Class 1. The Board notes that Table 17-2, the cross-usage

⁶ A.M.A., *Guides* (5th ed. 2001) at 17.2, p. 525.

chart, does not prohibit combining a vascular impairment rating with the ankylosis, atrophy and leg length deficits noted above. This impairment, however, was not fully described by Dr. Weiss other than noting some edema and a great capillary refill on examination. In turn, this rating was not discussed by either of the Office medical advisers. The case will be remanded for further development on this aspect of the case. Dr. Weiss also applied Table 17-8, page 532, to allow 17 percent impairment for lower extremity muscle weakness which he described as a 4 to 5 motor strength deficit of the right gastrocnemius. However, a muscle strength estimate of impairment may not be combined with loss due to ankylosis or atrophy under the cross-usage chart at Table 17-2. Dr. Weiss did not address the cross-usage chart in his medical reports or give any recognition to the fact that Chapter 17 limits the methods of impairment that may be combined when rating the lower extremities. For this reason, the case will be returned to the Office for further evaluation of the medical evidence and an appropriate decision on appellant's schedule award claim.

CONCLUSION

The Board finds that the case is not in posture for decision. The case is remanded to the Office for further development of appellant's schedule award claim in conformance with this decision.

ORDER

IT IS HEREBY ORDERED THAT the May 20, 2005 decision of the Office of Workers' Compensation Programs be set aside. The case is remanded for further action in conformance with this decision.

Issued: May 8, 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