

a left ankle arthrodesis on June 30, 2003, and on December 5, 2003 he underwent an ankle and subtalar joint fusion. The Office subsequently accepted deformity of the left ankle and a closed fracture of the medial malleolus.

On July 26, 2004 Dr. Cynthia Carter, a podiatric surgeon, reported that appellant had reached the point of maximum medical benefit, and she discharged him with a diagnosis of post-traumatic arthritis with valgus deformity, left ankle, and status post arthrodesis with tibial osteomyelitis, left ankle.¹ She reported that he had ankylosis of the left ankle and subtalar joint. Dr. Carter also reported a one centimeter loss of length in the left lower extremity. Appellant had daily pain, increased with activity and limiting activities of daily living. Dr. Carter added: "Atrophy gastrocnemius left -- 41½ right -- 40½."

An Office medical adviser reviewed Dr. Carter's findings and determined that appellant had a 19 percent permanent impairment of his left lower extremity due to ankle arthrodesis and subtalar joint fusion. Appellant filed a claim for a schedule award.

On July 9, 2007 the Office issued a schedule award for a 19 percent permanent impairment of appellant's left lower extremity. In a decision dated March 31, 2008, an Office hearing representative affirmed.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act² authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.³

A claimant seeking compensation under the Act has the burden of establishing the essential elements of his claim by the weight of the reliable, probative and substantial evidence.⁴

ANALYSIS

In her July 26, 2004 evaluation of appellant's left lower extremity, Dr. Carter, the treating podiatric surgeon, reported ankylosis in both the ankle (tibia-talus) and subtalar (talus-calcaneus) joints. Ankylosis of the ankle joint in the neutral position⁵ is a 10 percent impairment of the

¹ Dr. Carter made clear that appellant did not currently suffer from osteomyelitis. She indicated that he was hospitalized on August 30, 2003 and subsequently completed six weeks of antibiotics without complication to treat the staph aureus found in bone cultures of the distal medial tibia. Repeat bone cultures were negative for osteomyelitis on December 5, 2003, and his postoperative course progressed without incident. Dr. Carter reported that the condition "may recur in the future" and that appellant might need further surgery if that were to happen.

² 5 U.S.C. § 8107.

³ 20 C.F.R. § 10.404.

⁴ *Nathaniel Milton*, 37 ECAB 712 (1986); *Joseph M. Whelan*, 20 ECAB 55 (1968) and cases cited therein.

⁵ Dr. Carter did not report otherwise.

lower extremity.⁶ Likewise, ankylosis of the hindfoot in the neutral position is a 10 percent impairment of the lower extremity.⁷ Because the impairments of different joints are combined, not added together,⁸ appellant has a 19 percent total impairment of his left lower extremity due to ankylosis of his ankle and hindfoot.⁹

A claimant may receive an award for both ankylosis and leg length discrepancy.¹⁰ Dr. Carter reported a leg length loss of about one centimeter but this is too small to represent an impairment of the lower extremity.¹¹ A claimant may not receive an award for both ankylosis and arthritis.¹² Dr. Carter offered a discharge diagnosis of post-traumatic arthritis, but she provided no basis for rating any impairment due to arthritis.¹³

Neither may a claimant receive an award for both ankylosis and atrophy.¹⁴ Dr. Carter's notation on atrophy raises more questions than it answers, not only because of the size of the calf circumferences reported (over a meter in length), but also because it indicates the calf on the injured left side is one inch *larger* than the calf on the unaffected right side. If true, that would indicate no impairment due to atrophy.

On appeal, appellant contends that the Office failed to rate impairment due to pain, prior injuries, the knee, the hindfoot, right sciatica and post-traumatic arthritis. Dr. Carter evaluated appellant's impairment, which the Office reviewed and compared to the tables in the A.M.A., *Guides*. Appellant's schedule award does reflect impairment due to an ankylosed hindfoot and it does reflect impairment due to pain. As the A.M.A., *Guides* explains: "The impairment ratings in the body organ system chapters make allowance for any accompanying pain."¹⁵ There is a separate chapter for chronic pain syndrome, but if an examining physician determines that an individual has such a pain-related impairment, she must address whether or not that impairment has already been adequately incorporated into the rating the person has received on the basis of

⁶ A.M.A., *Guides* 541 (5th ed. 2001).

⁷ *Id.* at 542. Dr. Carter offered no measure of valgus position, and so there is no basis to rate an additional impairment due to hindfoot deformity. *See id.* at 541 (Table 17-26).

⁸ *Id.* at 538.

⁹ *Id.* at 604 (Combined Values Chart).

¹⁰ *Id.* at 526 (Table 17-2, Guide to the Appropriate Combination of Evaluation Methods).

¹¹ *Id.* at 528 (Table 17-4).

¹² *Id.* at 526 (Table 17-2, Guide to the Appropriate Combination of Evaluation Methods).

¹³ *See id.* at 544 (Table 17-31, Arthritis Impairments Based on Roentgenographically Determined Cartilage Intervals).

¹⁴ *Id.* at 526 (Table 17-2, Guide to the Appropriate Combination of Evaluation Methods).

¹⁵ *Id.* at 20.

other chapters of the A.M.A., *Guides*.¹⁶ Dr. Carter gave no indication that appellant should receive any increased rating for pain.

Appellant's schedule award does reflect prior injury to the ankle and subtalar joints, but it does not reflect any impairment due to the knee. Dr. Carter offered no clinical findings on the left knee. Appellant's schedule award also does not reflect his right sciatica, which is not shown to impair his left lower extremity. If he believes his accepted employment injury has caused a permanent impairment to his right lower extremity, he may file such a claim. As noted, the cross-usage chart of the A.M.A., *Guides* precludes combining impairment for both ankylosis and arthritis.

The Board finds that the medical evidence of record establishes a 19 percent impairment to appellant's left lower extremity.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he has more than a 19 percent impairment of his left lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the March 31, 2008 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 21, 2009
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

¹⁶ *Id.* at 570.