



Dr. Jason Stewart, a Board-certified orthopedic surgeon, performed a right ankle traumatic arthropathy in March 25, 2004.<sup>1</sup> The Office accepted the additional conditions of right unspecified enthesopathy and right articular cartilage disorder of the ankle and foot.

On June 27, 2006 Dr. Stewart performed right ankle arthropathy with hardware removal, arthrodesis and implantation of internal growth stimulator. In a report dated November 29, 2006, he found that appellant had reached maximum medical improvement and awarded 4 percent impairment of the whole person, 10 percent impairment of the lower extremity and 14 percent impairment of the right foot based on the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*<sup>2</sup> (A.M.A., *Guides*). Dr. Stewart noted that appellant experienced occasional mild foot pain. Appellant requested an additional schedule award on December 4, 2006.

By decision dated February 5, 2007, the Office found that appellant's wages as a light-duty position of modified sheet metal mechanic fairly and reasonably represented his wage-earning capacity and that he had no loss of wages.

The Office referred Dr. Stewart's impairment evaluation to the district medical adviser on July 24, 2007. In a note dated August 14, 2007, Dr. H. Mobley, a Board-certified orthopedic surgeon, found that Dr. Stewart's report lacked sufficient descriptive details and the rating was based on the fourth edition rather than the fifth edition of the A.M.A., *Guides*. He requested that the Office refer appellant for a second opinion evaluation to properly determine the extent of his permanent impairment for schedule award purposes.

On December 29, 2008 the Office referred appellant to Dr. Patricia A. Knott, a Board-certified orthopedic surgeon. In a February 10, 2009 report, Dr. Knott found that appellant reported ankle discomfort in the morning which became unbearable by the end of the day. She found swelling in the ankle on physical examination, two centimeters of calf atrophy, normal motor strength, but no ankle movement in the lower extremity on examination. Dr. Knott also reported decreased sensation to the right foot and lateral aspect of appellant's right leg. She stated that appellant's ankle was fused in a neutral position. Dr. Knott concluded that appellant had 10 percent impairment due to ankle ankylosis<sup>3</sup> and 8 percent impairment due to atrophy,<sup>4</sup> for a combined rating of 17 percent impairment of the right lower extremity.

The district medical adviser reviewed Dr. Knott's report on March 26, 2009 and noted impairment for that atrophy and range of motion or ankylosis could not be combined under the cross-usage chart in the A.M.A., *Guides*.<sup>5</sup> He concluded that appellant was entitled to the greater

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<sup>1</sup> The surgical report indicates that appellant's left ankle was involved, but the majority of the reports from Dr. Stewart, indicating that this surgery was to the right ankle.

<sup>2</sup> A.M.A., *Guides*, 4<sup>th</sup> ed. (1993).

<sup>3</sup> *Id.* at 541.

<sup>4</sup> *Id.* at 530, Table 17-6.

<sup>5</sup> *Id.* at 526, Table 17-2.

of the two impairments, 10 percent for ankylosis. The district medical adviser noted that appellant had previously received a schedule award for 14 percent impairment of the right lower extremity and was therefore not entitled to an additional award.

By decision dated April 10, 2009, the Office denied appellant's request for an additional schedule award finding that he had no more than 14 percent impairment to his right lower extremity.

### **LEGAL PRECEDENT**

The schedule award provision of the Federal Employees' Compensation Act<sup>6</sup> and its implementing regulations<sup>7</sup> 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. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.<sup>8</sup> In evaluating lower extremity impairments, Chapter 17 of the A.M.A., *Guides* notes that alternative methods exist by which impairment may be assessed: anatomic, functional or diagnosis-based estimates.<sup>9</sup> The evaluator is directed to the cross-usage chart at Table 17-2 on page 526 to determine when the methods for evaluating impairment may be combined. The Office's procedure manual also provides, "Before finalizing any physical impairment calculation that requires the combination of evaluation factors, the [Office medical adviser] should verify the appropriateness of the combination in Table 17-2."<sup>10</sup>

In determining which evaluation method to follow, the A.M.A., *Guides* provide the following instruction:

"The evaluator's first step is to establish the diagnosis(es) and whether or not the individual has reached MMI [maximum medical improvement]. The next step is to identify each part of the lower extremity that might possibly warrant an impairment rating (pelvis, hip, thigh, etc., down to the toes). Figure 17-10 lists potential methods for each lower extremity part. The evaluator determines whether ROM [range of motion] impairment or other regional impairments are present for each relevant part and records the impairment values in the appropriate

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<sup>6</sup> 5 U.S.C. § 8107.

<sup>7</sup> 20 C.F.R. § 10.404.

<sup>8</sup> Effective February 1, 2001, schedule awards are determined in accordance with the fifth edition of the A.M.A., *Guides*. *Rose V. Ford*, 55 ECAB 449 (2004).

<sup>9</sup> A.M.A., *Guides* 525.

<sup>10</sup> Federal Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

locations on the worksheet. The selection of the most specific method(s) and the appropriate combination are later considerations.

“After all potentially impairment conditions have been identified and the correct ratings recorded, the evaluator should select the clinically most appropriate (*i.e.*, most specific) method(s) and record the estimated impairment for each. The **cross-usage chart** (Table 17-2) indicates which methods and resulting impairment ratings may be combined. It is the responsibility of the evaluating physician to explain why a particular method(s) to assign the impairment rating was chosen. When uncertain about which method to choose, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.”<sup>11</sup> (Emphasis in the original.)

### ANALYSIS

The Office accepted that appellant sustained a right ankle fracture and resulting surgeries. It granted appellant a schedule award for 14 percent impairment of his right lower extremity. Appellant requested an additional schedule award on December 4, 2006 and submitted a report from Dr. Stewart, a Board-certified orthopedic surgeon, who found that, under the fourth edition of the A.M.A., *Guides*, appellant had 4 percent impairment of the whole person,<sup>12</sup> 10 percent impairment of the right lower extremity or 14 percent impairment of the right foot.<sup>13</sup> As noted, appellant’s impairment rating should have been based on the fifth edition of the A.M.A., *Guides*. As noted by the district medical adviser, Dr. Stewart did not provide sufficient findings from the physical examination in support of his impairment rating. The Board has held that before the A.M.A., *Guides* can be utilized, a description of a claimant’s impairment must be obtained from the claimant’s physician. In obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment including, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, as well as any decreases in strength or disturbance of sensation or other pertinent descriptions of the impairment. This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.<sup>14</sup> Dr. Stewart’s impairment rating did not comport with the appropriate edition of the A.M.A., *Guides* or provide sufficient detail regarding appellant’s impairments. The Board finds that the Office properly

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<sup>11</sup> A.M.A., *Guides* 525-26.

<sup>12</sup> The Act and the implementing regulations do not allow for a schedule award due to impairments of the whole person. No schedule award is payable for a member, organ or function of the body that is not specified in the Act or the implementing regulations. *Tania R. Keka*, 55 ECAB 354 (2004). Therefore appellant is not entitled to schedule award based on an impairment rating to the whole person.

<sup>13</sup> The Board has held that where the residuals of an injury to a scheduled member of the body extend into an adjoining area of a member also enumerated in the schedule, such as an injury of a finger into a hand, or 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. *Dennis R. Stark*, 57 ECAB 306 (2006).

<sup>14</sup> *J.C.*, 58 ECAB 258 (2007).

referred appellant to a second opinion physician to determine the extent of permanent impairment.

In a February 10, 2009 report, Dr. Knott, a Board-certified orthopedic surgeon, found that appellant experienced pain and swelling in his right ankle. His ankle was ankylosed in the neutral position and there were two centimeters of right calf atrophy. Dr. Knott properly determined that ankle ankylosis in the neutral position was 10 percent impairment to the lower extremity.<sup>15</sup> He properly found that two centimeters of calf atrophy was eight percent impairment of the lower extremity.<sup>16</sup> However, as noted by the Office medical adviser, these two impairments cannot be combined.<sup>17</sup> The A.M.A., *Guides* provide that ratings from muscle atrophy cannot be combined with range of motion or ankylosis. Therefore appellant is only entitled to the greater of the two impairments, 10 percent impairment of the right lower extremity for ankylosis. As he had already received a schedule award for 14 percent impairment of his right lower extremity, he has not established greater impairment to warrant an additional schedule award.<sup>18</sup>

### CONCLUSION

The Board finds that appellant has no more than 14 percent impairment of the right lower extremity for which he received a schedule award.

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<sup>15</sup> A.M.A., *Guides* 541.

<sup>16</sup> *Id.* at 530, Table 17-6.

<sup>17</sup> *Id.* at 526, Table 17-2.

<sup>18</sup> *Rose V. Ford*, 55 ECAB 449, 455 (2004).

**ORDER**

**IT IS HEREBY ORDERED THAT** the April 10, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 7, 2010  
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