U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ALBERT A. CARRILES and DEPARTMENT OF THE NAVY, NAVAL AIR STATION, Pensacola, Fla.

Docket No. 96-692; Submitted on the Record;
Issued August 20, 1998

DECISION and ORDER

Before MICHAEL E. GROOM, BRADLEY T. KNOTT,
A. PETER KANJORSKI

The issue is whether appellant met his burden of proof to establish that he had more than a 40 percent permanent impairment of his left lower extremity for which he received a schedule award.

On March 16, 1987 the Office of Workers' Compensation Programs accepted that appellant sustained an employment-related permanent aggravation of a congenital foot problem on February 4, 1987. By award of compensation dated February 3, 1994, the Office granted appellant a schedule award for a 40 percent permanent impairment of his left lower extremity and subsequently authorized triple arthrodesis surgery which was performed on June 17, 1992. On January 7, 1994 appellant filed a claim for an additional schedule award of compensation benefits.

In support of his claim that he has more than a 40 percent permanent impairment of his left lower extremity, appellant submitted a December 2, 1994 report from Dr. John C. McAndrew, III, a Board-certified orthopedic surgeon and his treating physician. In this report, Dr. McAndrew stated:

> "I have reviewed the [fourth] edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment.* In reading on page 81 under the paragraph involving the foot with regards to arthrodesis, in reference to Table 57, it is apparent that he would have a 4 [percent] impairment due to fusion in a perfect position, but with 10 (degrees) of eversion, one would add 10 [percent] to that. Making it a total of 14 [percent] to the whole person or 35 [percent] to the lower extremity. We had previously rendered him a 50 [percent] impairment to the lower extremity. It is apparent that on restudy that number is too high and that his rating should be 35 [percent] to the lower extremity, secondary to his arthrodesis. The remainder of his impairment rating would be the same -- that is, 7 [percent] to the lower extremity due to loss of dorsiflexion and 11 [percent] due

to loss of plantar flexion. This would come out to a total of 53 [percent] to the lower extremity as opposed to the previously stated 68 [percent]."[1]

On April 18, 1995 an Office medical adviser reviewed Dr. McAndrew's report. With respect to Dr. McAndrew's 53 percent permanent impairment rating, the Office medical adviser stated:

"Dr. McAndrew incorrectly added the impairment (in Table 57) for neutral position (4 [percent] of the whole person or 10 [percent] of the lower extremity) to the impairment at 10 (degrees) valgus (10 [percent] of whole person or 25 [percent] of the lower extremity). Instead, it is correct to use only the impairment at the degree valgus, 10 (degrees), which claimant has, namely 25 [percent] ppi of the lower extremity.

"Dr. McAndrew has not reported claimant's ankle range of motion since the last surgery, on November 7, 1994. The values on the physical capacity evaluations of 1993 are not valid at this time…."

By letter dated April 19, 1995, the Office forwarded the Office medical adviser's report to Dr. McAndrew for his comment. In his response dated May 4, 1995, Dr. McAndrew explained his earlier impairment rating, stating:

"As you are probably aware, [appellant] has a fusion to his hind foot, not a fusion to his ankle. Although we related to Table 57, Table 57 has to do with ankle impairment, not subtalor joint and hind-foot impairment. Because of his triple arthrodesis, he actually would fall under the category of the hind foot and the way it is evaluated is noted in that paragraph. I have used that evaluation according to the paragraph under hindfoot, midfoot and forefoot, to come up with the 25 [percent]. Because he does have limitation of ankle motion in addition to the fusion of the subtalor motion and since that is a totally different joint, apart from that which was surgically fused, I do feel it is appropriate to rate him, also, for the limitation of the motion of the ankle joint that exists. That is why additional impairment was added onto that rendered for the subtalor joint alone and this is how I came up with the percentage that I did.

"In short, I stand by my impairment rating, albeit high, but he has problems at two different levels and those really should not be ignored in my opinion, if one is to be appropriate and I think that if Dr. Collins [the Office medical adviser] was to look at the manual carefully, he would realize that we were really evaluating the patient based upon two different joints involved, not just one. Had it been ankle arthrodesis, then his statement would be correct, with a 25 [percent] impairment, although with subtalor arthrodesis and loss of motion in the ankle joint, his

[1] Dr. McAndrew additionally found appellant to have a five percent impairment of the left lower extremity secondary to chondromalacia of the patella. However, this condition was not accepted by the Office as employment related.

percentage would be higher, since it involves both joints and both of them need to be considered.

"I do agree that the physical capacity evaluation done over a year ago is outdated. The patient's functional ability is greater than it was then…."

At the request of the Office, the Office medical adviser reviewed Dr. McAndrew's explanation and stated:

"I agree with Dr. McAndrew, generally. We need, however, claimant's ankle range of motion on or after December 2, 1994, so we can combine it with the hindfoot impairment."

By letter dated September 19, 1995, the Office notified Dr. McAndrew that the Office medical adviser had agreed with his findings and asked that he provide the measurements and calculations for the range of motion of appellant's left ankle, so that these impairment could be combined with the hindfoot impairment, to arrive at a total lower extremity impairment rating.

In a letter dated October 2, 1995, Dr. McAndrew responded, stating:

"I have reviewed my impairment rating on [appellant] again and as per your request concerning the ankle only, he has a 7 [percent] impairment to the lower extremity due to loss of dorsiflexion of the ankle and 11 [percent] to the lower extremity due to loss of plantar flexion. This comes to a total of 18 [percent] impairment to the lower extremity due to loss of motion of the ankle. The specific range of motion of the ankle was done in an office visit prior to December 2, 1994 and was not redone at that date, but his ankle motion has not changed subsequent to his last surgery and these impairment ratings still hold."

The Office once again forwarded Dr. McAndrew's findings to the Office medical adviser and asked for his comments. In a report dated November 8, 1995, the Office medical adviser stated that he could not agree with the 18 percent impairment rating for the loss of motion for the ankle as this rating was based on an examination before December 2, 1994 which could not be found in the file.

On November 16, 1995 the Office contacted the Office medical adviser and, noting that the record contained the results of a January 24, 1995 physical capacity evaluation performed at the request of Dr. McAndrew, asked whether these results could be used to calculate a valid impairment rating for range of motion of the ankle.

In his response dated November 20, 1995, the Office medical adviser stated that the January 24, 1995 physical capacity evaluation reflected that appellant had ankle dorsiflexion of zero degrees, which equated to a seven percent impairment, and ankle plantar flexion of 16 degrees, which equated to a seven percent impairment, for a total of 14 percent permanent impairment pursuant to Table 42, page 78 of the A.M.A., *Guides.* The Office medical adviser further noted that appellant had a 25 percent permanent impairment for subtalor fusion in 10 degrees valgus, pursuant to table 57 and paragraph "foot" on page 81 of the A.M.A., *Guides*. He

concluded that combining these percentages using the combined values chart on page 322 of the *Guides* yielded a total impairment of 36 [percent] of the left lower extremity.

In a decision dated December 8, 1995, the Office denied appellant's claim for an additional schedule award on the grounds that his impairment at the time of his claim, 36 percent, was less than the 40 percent schedule award previously awarded to him, and therefore he was not entitled to an additional award.

The Board finds that this case is not in posture for decision.

An employee seeking compensation under the Federal Employees' Compensation Act[2] has the burden of establishing the essential elements of his claim by the weight of the reliable, probative, and substantial evidence,[3] including that he sustained an injury in the performance of duty as alleged and that his disability, if any, was causally related to the employment injury.[4] Section 8107 of the Act provides that if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[5] Neither the Act nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants, the Office has adopted the A.M.A., *Guides*, fourth edition 1993 as a standard for evaluating schedule losses and the Board has concurred in such adoption.[6]

The Office has based its assessment of appellant's left lower extremity impairment on the evaluation of an Office medical adviser. On November 20, 1995 the Office medical adviser applied the standards of the fourth edition of the A.M.A., *Guides* to the findings of appellant's attending Board-certified orthopedic surgeon, Dr. McAndrew, in order to determine that appellant had a 36 percent permanent impairment of his left lower extremity. The Office medical adviser arrived at this conclusion by combining the 25 percent permanent impairment of the hind foot, with the 14 percent impairment associated with appellant's loss of ankle dorsiflexion and plantar flexion. In his earlier report dated September 8, 1995, however, the Office medical adviser indicated that he agreed with Dr. McAndrew that, in addition to appellant's dorsiflexion and plantarflexion range of motion impairment and a 25 percent impairment for triple arthrodesis of the hind foot, appellant had an additional ankle impairment of 10 percent due to the triple arthrodesis of the hind foot which also affected the ankle joint. The Board notes that the Office medical adviser's November 20, 1995 report and the final impairment rating does not address this impairment. In the absence of clear description of the impairment and a full explanation of how the percentage of permanent impairment was calculated using the A.M.A., *Guides*, the Board will remand the case for further development of

[2] 5 U.S.C. §§ 8101-8193.

[3] *Donna L. Miller*, 40 ECAB 492, 494 (1989); *Nathanial Milton*, 37 ECAB 712, 722 (1986).

[4] *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[5] 5 U.S.C. § 8107(a).

[6] *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989); *Charles Dionne*, 38 ECAB 306, 308 (1986).

the medical evidence to resolve the issue in this case. After such development as the Office deems necessary, it should issue an appropriate decision.

The decision of the Office of Workers' Compensation Programs dated December 8, 1995 is set aside and the case remanded for further action consistent with this decision of the Board.

Dated, Washington, D.C.
August 20, 1998

Michael E. Groom
Alternate Member

Bradley T. Knott
Alternate Member

A. Peter Kanjorski
Alternate Member