U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of MICHAEL J. KEARINS and U.S. POSTAL SERVICE,
POST OFFICE, Dallas, Tex.

Docket No. 96-909; Submitted on the Record;
Issued March 19, 1998

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether appellant has greater than a 66 percent permanent impairment of his right lower extremity, for which he has received a schedule award.

The Office of Workers' Compensation Programs accepted that on March 20, 1991 appellant, after tripping, sustained right ankle sprain and required surgery for a posterior tibial tendon repair and a decompression of his right Achilles tendon. He received appropriate compensation for all periods of wage loss.

On May 21, 1992 appellant's treating orthopedic surgeon, Dr. Neal C. Small, indicated that appellant could stand, walk, kneel, bend, stoop and twist for four hours per day and could drive a vehicle. Thereafter, on June 8, 1992 appellant returned to work at the employing establishment for four hours per day with intermittent standing and walking.

On August 25, 1993 Dr. Small evaluated appellant for impairment rating purposes. He found that appellant had 103 degrees of dorsiflexion, or a 4 percent lower extremity impairment, 104 degrees of plantar flexion, or a 0 percent impairment, 45 degrees in inversion, or a 0 percent impairment and 0 degrees of eversion, for a 4 percent, impairment, which when combined equaled an 8 percent impairment of his right lower extremity. Dr. Small calculated this total impairment in accordance with the Third Edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. In an October 4, 1993 medical narrative, Dr. Small indicated that appellant has essentially normal range of ankle motion without sensory changes and that the eight percent permanent impairment was for his small amount of range of motion restriction, but noted that appellant also had discomfort in the Achilles tendon region and in the posterior tibial tendon region which he had not rated.

On October 18, 1993 appellant requested a schedule award for impairment due to his right ankle injury. He enclosed postoperative photographs of his surgical scars and claimed that

his impairment in strength was at least 50 percent as documented by an enclosed report from a physical therapist providing the numerical results of strength testing in degrees per second.

On December 19, 1993 an Office medical adviser, Dr. R. Meador, opined that appellant had a two percent impairment for loss of motion in eversion, and noted that strength testing needed to be repeated using the comparison specified by the A.M.A., *Guides*. The Office requested such a comparison and rating from Dr. Small in accordance with the Fourth Edition of the A.M.A., *Guides*.

By office medical progress note dated January 26, 1994, Dr. Small replied:

> "[Appellant] does have weakness. His plantar flexion strength is grade 4; therefore his impairment for ankle plantar flexion is 17 percent lower extremity…. He has only 1+ dorsiflexion which is 25 percent lower extremity…. He has 1+ inversion which is 12 percent lower extremity…. He has grade 3 eversion which is 12 percent lower extremity…. He has plantar flexion capability limitations which are moderate which is 15 percent lower extremity…. Dorsiflexion is severely restricted with on[ly] 95 degrees of dorsiflexion, 5 degrees beyond neutral. This amounts to 30 percent lower extremity. Inversion and eversion restrictions are moderate with 5 percent lower extremity … in each direction. Using these criteria, adding together all of the impairment based on muscle weakness and range of motion deficiencies, the total impairment is 121 percent of the involved lower extremity…. Because of the maximum allowable being 62 percent lower extremity impairment ... this patient would qualify for the maximum ankle impairment."

No particular references to the A.M.A., *Guides* were given and no explanation as to why this evaluation result was so different from the August 25, 1993 rating was provided.

On April 12, 1994 another Office medical adviser relied on Dr. Small's one set of numerical findings and calculated that according to the A.M.A., *Guides* appellant had a 62 percent impairment of his right lower extremity. The Office medical adviser, Dr. H. Mobley, noted that according to page 75, Chapter 3.2, para. 1, only one evaluation method should be used to evaluate a specific impairment, that according to page 88, Chapter 3.2k para. 2, estimates for peripheral nerve impairments may be combined with those for other types of extremity impairments, *except those for muscle weakness and atrophy.* He concluded that, therefore, he would use either weakness impairment or motion limitation but not both, with no allowance for pain in the impairment rating. Using the A.M.A., *Guides* (Fourth Edition 1993), Tables 38 and 39, page 77, and Dr. Small's single set of values for muscle weakness testing results, Dr. Mobley calculated that a 17 percent impairment plus a 25 percent impairment plus a 12 percent impairment plus a 12 percent impairment equaled a 66 percent total permanent impairment of the right lower extremity due to muscle weakness. The Board notes, however, that Chapter 3.2d, "Manual Muscle Testing," notes that because of muscle testing results being subject to a patient's conscious and unconscious control, measurements should be consistent between two trained observers, or that if measurements were made by one examiner, they should be consistent on different occasions. The Board notes that in this case the Office determined appellant's muscle weakness impairment based upon only one set of results and that previous results by a

physical therapist were markedly different from those determined by Dr. Small. The Office did not seek an explanation for these differences, did not require Dr. Small to describe his testing procedures or explain how he obtained his measurements, and did not require further verification and corroboration of testing results. These were errors in appellant's favor. Dr. Mobley also calculated appellant's impairment due to loss in range of motion using the one set of results presented in his January 26, 1994 report. The Board notes that Dr. Small's January 26, 1994 range of motion testing results were markedly different from the August 25, 1993 loss in range of motion results but that the Office did not require verification of the most recent results, despite the fact that the 1993 results showed that appellant had only an 8 percent total permanent for losses in range of motion, yet the 1994 results showed a 55 percent impairment. According to Chapter 3.2d neither of these sets of results would, therefore, be valid as they differed by such a significant amount. Using Dr. Small's 1994 invalid range of motion results Dr. Mobley calculated that appellant had a 52 percent impairment for losses in range of motion. As the 66 percent impairment due to muscle weakness was the greater, Dr. Mobley then chose to rely on that impairment rating, but he reduced it to 62 percent because total amputation of the foot was only a 62 percent impairment of the lower extremity, and appellant still had use of his right foot.

On May 5, 1994 the Office granted appellant a schedule award for a 62 percent permanent impairment of his right lower extremity.

On May 26, 1994 appellant requested a hearing on his schedule award, claiming that no consideration had been given for pain and suffering, or for loss of his metatarsal arch, and alleging that Dr. Small had stated that he should receive the maximum award for the foot and the leg. The Board notes that the maximum award for the right lower extremity would include the foot and would only be awarded for complete amputation of the right lower extremity at the hip, which was not the case in appellant's impairment.

On October 6, 1994 the hearing representative remanded the case to the Office, finding it not in posture for decision, for Dr. Mobley to discuss the additional evidence that appellant had a two percent impairment of the lower extremity due to a rocker bottom foot and to explain the comparison with foot and lower extremity impairments.

On November 2, 1994 Dr. Mobley noted Dr. Small's assessment of a two percent lower extremity impairment for a rocker bottom foot, but misstated Dr. Small's findings erroneously claiming that Dr. Small found an additional two percent impairment of appellant's *foot*, rather than of his lower extremity, and then erroneously calculated that this equated with a five percent impairment of the lower extremity. These errors were not significant, however, as Dr. Mobley indicated that the 62 percent lower extremity impairment was made on the basis of complete amputation of the foot and that, after amputation of the foot, additional impairment of the missing member would be irrelevant and excessive duplication. However, the Board notes that appellant did not have amputation of his right foot, and therefore was not entitled to a 100 percent impairment of his right foot, or the corresponding 62 percent impairment of his lower extremity based upon supposition of a 100 percent impairment of his foot, such that the 62 percent lower extremity impairment must be based upon other testing criteria, and that the additional two percent impairment was actually given as a lower extremity impairment by Dr. Small, which needed to be considered. On November 2, 1994 Dr. Mobley incorrectly opined

that appellant had a 62 percent impairment of his right lower extremity or a 100 percent impairment of his right foot.

On January 3, 1995 the Office incorrectly granted appellant a schedule award for a 100 percent impairment of his right foot, even though the foot had not been amputated and he had right foot weight bearing and some range of motion, and was standing and walking at work for 6 hours per day at that time.

By letter dated January 31, 1995, appellant requested another hearing, objecting to his schedule award, claiming that he deserved an award for his foot and for his lower extremity, based upon Dr. Small's comment that appellant had a 121 percent impairment of his right lower extremity. The Board notes that the most impairment that anyone can get is a 100 percent impairment of the lower extremity which would be awarded with complete amputation at the hip. The Board notes that this was not the case here, where appellant had ankle surgery, residual discomfort and weakness, but kept his foot and his lower extremity and could bear weight, stand, and walk enough to work six hours a day. Therefore, the Board finds that appellant had less than a 100 percent impairment of his right lower extremity.

A hearing was held on July 27, 1995 at which appellant testified. The hearing representative used Dr. Mobley's reported data on muscle weakness testing based upon Dr. Small's unverified, uncorroborated numerical values, but not considering the additional two percent lower extremity impairment found by Dr. Small for rocker bottom foot. By decision dated October 10, 1995, the hearing representative modified the January 3, 1995 award, finding that appellant was entitled to a 66 percent impairment of his right lower extremity, as that was the total of the impairment values Dr. Small had found. The hearing representative noted that Dr. Virginia Miller, the Director of the Branch of Medical Standards and Rehabilitation, reviewed the case and opined that the 62 percent rating based on a 100 percent impairment of the foot should not be used as appellant did not have an amputated foot, such that the 66 percent lower extremity impairment rating was correct. Dr. Miller then stated that the additional two percent lower extremity impairment for a rocker bottom foot was duplicative but did not explain why, since the 66 percent lower extremity impairment rating was based solely upon ankle weakness measurements, and did not include consideration of separate foot impairment, such as loss of metatarsal arch, and since Dr. Mobley's rationale of duplicity, with which she agreed without explanation, was based upon his assumption of a prior 100 percent impairment of the foot, which appellant did not have.

On December 14, 1995 the Office granted appellant an additional 4 percent award for a total of 66 percent permanent impairment of his right lower extremity.

The Board finds that this case is not in posture for decision due to incomplete medical evaluation of all of appellant's impairments.

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulation[2] set forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage loss of use.[3] However, neither the Act nor its regulations specify the manner in which the percentage of loss of a member is to be determined. For consistent results and to insure equal justice under the law to all claimants, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants seeking schedule awards. The A.M.A., *Guides* (Fourth Edition) have been adopted by the Office for evaluating schedule losses, and the Board has concurred in such adoption.[4]

Although the standards for evaluating the permanent impairment of an extremity under the A.M.A., *Guides* are based primarily on loss of range of motion, all factors that prevent a limb from functioning normally, including pain and loss of strength, should be considered, together with loss of motion, in evaluating the degree of permanent impairment.[5] In the instant case, appellant's 66 percent lower extremity impairment was based upon ankle joint weakness which restricted range of motion. Appellant did not submit proof supporting that he had further functional impairment due to pain, rather his reports addressing his pain refer to nighttime sensory leg discomfort, rather than to losses in range of motion or diminished use or function due to pain. However, appellant did submit evidence of a further lower extremity impairment separate and apart from his ankle tendon repairs, due to metatarsal arch loss in his foot. If the medical evidence supports that this metatarsal arch loss is a permanent impairment and is due to his accepted employment ankle strain or resulting tendon surgeries, any further lower extremity impairment, or foot impairment translated into lower extremity terms, would additionally be compensable under the schedule award provisions of the Act, as this foot impairment is separate from the ankle weakness impairments upon which appellant's 66 percent impairment rating was based.

Upon remand, appellant should be fully reevaluated by a different examiner to verify the accuracy of the determinations of weakness measurements made by Dr. Small, and any such resulting weakness impairments should be added to any other impairments arising in a part of the body other than the affected ankle, which are due to appellant's accepted ankle strain or to his tendon surgeries. When all of appellant's permanent impairments causally related to his accepted ankle strain and tendon surgeries are determined and added together, if the result is in excess of the 66 percent permanent total right lower extremity impairment award already received by appellant, the balance shall be granted to appellant.

[1] 5 U.S.C. § 8101 *et seq.*; *see* 5 U.S.C. § 8107(c).

[2] 20 C.F.R. § 10.304.

[3] 5 U.S.C. § 8107(c)(19).

[4] *James J. Hjort*, 45 ECAB 595 (1994); *Thomas D. Gauthier*, 34 ECAB 1060 (1983).

[5] *See Paul A. Toms*, 28 ECAB 403 (1987).

Consequently, the decisions of the Office of Workers' Compensation Programs dated December 14 and October 10, 1995 are hereby set aside and the case is remanded for further development in accordance with this decision and order of the Board.

Dated, Washington, D.C.
March 19, 1998

George E. Rivers
Member

David S. Gerson
Member

Willie T.C. Thomas
Alternate Member