U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of WILMA KOESTER and DEPARTMENT OF THE AIR FORCE, SHEPPARD AIR FORCE BASE, TX

Docket No. 99-661; Submitted on the Record;
Issued May 18, 2000

DECISION and ORDER

Before MICHAEL J. WALSH, WILLIE T.C. THOMAS, MICHAEL E. GROOM

The issue is whether appellant has more than a 22 percent permanent impairment to her right leg.

In the present case, the Office of Workers' Compensation Programs accepted that appellant sustained a fractured right ankle as a result of a fall in the performance of duty on January 11, 1995. By decision dated January 6, 1998, the Office issued a schedule award for a 22 percent impairment to the right leg. By decision dated September 30, 1998, the Office denied modification.

The Board has reviewed the record and finds that the case requires further development of the evidence.

Section 8107 of the Federal Employees' Compensation 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.[1] 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the uniform standard applicable to all claimants.[2]

In this case, Dr. Griffith C. Miller, a family practitioner, provided a history and results on examination in a report dated August 25, 1997. With respect to the degree of permanent

[1] 5 U.S.C. § 8107. This section enumerates specific members or functions of the body for which a schedule award is payable and the maximum number of weeks of compensation to be paid; additional members of the body are found at 20 C.F.R. § 10.304(b).

[2] *A. George Lampo*, 45 ECAB 441 (1994).

impairment, Dr. Miller referred to both Table 39 of the A.M.A., *Guides*, which provides impairments for muscle weakness, as well as Table 42, providing impairments for loss of motion.[3] In a report dated November 17, 1997, an Office medical adviser determined that appellant's impairment should be based solely on the range of motion impairment, resulting in a 22 percent impairment under Table 42. The medical adviser opined that "the determination of impairment resulting from injury to the ankle should be done using either measurement of range of motion *or* loss of strength and atrophy, not both. Please see the last paragraph on page 78 regarding this matter." (Emphasis in the original.)

The paragraph referred to by the medical adviser is a comment with respect to a hypothetical example of a fractured tibia that resulted in loss of half of the ankle flexion and extension motion, with permanent stiffness in the toes. The comment notes that by comparing the tables, "one can see that the estimated impairment for loss of motion of the ankle and toes would exceed any estimated impairment for weakness or atrophy of the leg muscles. If the impairment is estimated on the basis of ankle and toe loss of motion, it should not be estimated on the basis of muscle atrophy also. Manual muscle testing is difficult to assess because of the lower leg muscles' limited range of motion of the ankles and toes."[4] In a prior comment, involving an example of a healed tibia fracture with loss of ankle extension power and muscle atrophy, the A.M.A., *Guides* notes that "the impairment from weakness is judged to be of greater significance to the patient than the atrophy impairment. Thus, manual muscle testing (Tables 38 and 39, below) is the better approach to estimating the patient's impairments."

In reviewing these comments, it would appear that the medical adviser correctly indicated that when there are impairments for loss of motion, weakness or atrophy, it is not appropriate to combine these impairments. The medical adviser apparently also concluded that when there are impairments for loss of motion and weakness, the loss of motion impairment is always applied. A reading of the above comments, however, suggests that the A.M.A., *Guides* recommend application of the method producing the greater estimated impairment. In both examples, the degree of impairment was determined by application of the table for that impairment that would exceed the other impairment.

According to Dr. Miller, appellant had a Grade 3 impairment for plantar flexion weakness and dorsiflexion weakness. Under Table 39, this would clearly result in a greater impairment than the 22 percent for loss of range of motion.[5] The medical adviser did not clearly explain why the A.M.A., *Guides* would preclude the use of Table 39 under these circumstances. Accordingly, the case will be remanded to the Office for further development. The medical evidence should be sent to an Office medical adviser for a reasoned opinion as to the degree of permanent impairment in the right leg under the A.M.A., *Guides*. After such further development as the Office deems necessary, it should issue an appropriate decision.

[3] A.M.A., *Guides* (4th ed. 1993) at 77, Table 39, 78, Table 42.

[4] A.M.A., *Guides* at 78.

[5] The leg impairment for a Grade 3 plantar flexion impairment is 37 percent and for dorsiflexion is 25 percent.

The decisions of the Office of Workers' Compensation Programs dated September 30 and January 6, 1998 are set aside and the case remanded to the Office for further proceedings consistent with this decision.

Dated, Washington, D.C.
May 18, 2000

Michael J. Walsh
Chairman

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member