U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JOHN A. TURNER and PEACE CORPS,
St. Lucia, Eastern Caribbean

Docket No. 98-2636; Submitted on the Record;
Issued November 15, 2000

DECISION and ORDER

Before WILLIE T.C. THOMAS, A. PETER KANJORSKI,
VALERIE D. EVANS-HARRELL

The issue is whether appellant has more than a 56 percent permanent impairment of the left leg, for which he received a schedule award.

The case has been on appeal previously.[1] In a May 2, 1997 decision, the Board noted that appellant had fallen from a height of approximately 25 feet and sustained a compound fracture and dislocation of the left ankle which became infected. Appellant underwent several operations, which included repeated debridements of the infected ankle, talectomy and calcaneotibial and naviculotibial fusions of the left ankle. The Office of Workers' Compensation Programs issued a schedule award for a 56 percent permanent impairment of the left leg. The Board noted that Dr. Loy E. Cramer, a Board-certified orthopedic surgeon, and Dr. William A. Kelly, a Board-certified neurosurgeon, had concluded that appellant had a 50 percent permanent impairment of the left leg based on a 30 percent permanent impairment for ankle fusion, 10 percent permanent impairment for subtalar fusion and 10 percent permanent impairment for loss of the talus. An Office medical adviser concluded that appellant had an 80 percent permanent impairment of the foot, based on dorsiflexion, plantar flexion, inversion and eversion fused at 0 degrees in range of motion. The medical adviser then reduced the permanent impairment to a 56 percent permanent impairment of the leg. The Board pointed out that a permanent impairment for fusion of the ankle was a permanent impairment of the leg, not the foot. The Board also found that the Office medical adviser had not taken into account appellant's pain, numbness, osteoporosis, and atrophy in calculating the schedule award. The Board, therefore, set aside the Office's decision and remanded the case for further development.

In a May 30, 1997 memorandum, an Office medical adviser indicated that the Combined Values Chart of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[2] should have been used in calculating appellant's permanent impairment. He also

[1] Docket No. 95-1747 (issued May 2, 1997).

[2] (3d ed. rev., 1990).

noted that it was a procedural error to award permanent impairment for both loss of flexion and loss of dorsiflexion when the ankle was fused at 0 degrees. The medical adviser commented that it was also an error, in an ankylosis of the hindfoot at 0 degrees, to duplicate percentages of permanent impairment for the loss of inversion and eversion. He pointed out that the A.M.A., *Guides* also provided that when there was ankylosis of the ankle and the subtalar joints, the larger percentage of impairment represented the permanent impairment of the leg. The medical adviser concluded, therefore, that appellant had a 30 percent permanent impairment of the leg due to the fusions of the ankle and subtalar joints. He accepted that appellant had a 10 percent permanent impairment for loss of the talus which was to compensate for appellant's shortened leg length. The medical adviser indicated that there were no objective findings reported that would form a basis for an impairment rating for pain or sensory deficit. He, therefore, concluded, using the Combined Values Chart, that appellant had a 37 percent permanent impairment of the leg due to fusions in the left leg and loss of the talus.

In a June 6, 1997 decision, the Office denied appellant's claim for an increased schedule award on the grounds that further development of the case showed appellant had only a 37 percent permanent impairment of the leg and, therefore, was not entitled to a greater schedule award. Appellant requested a hearing before an Office hearing representative. In a November 21, 1997 decision, the Office hearing representative, without a hearing, set aside the Office's June 6, 1997 decision. The hearing representative found that the medical evidence of record showed that appellant had pain, atrophy and tenderness in the foot and ankle which would support a finding of permanent impairment due to pain and weakness. She remanded the case for referral of appellant to a physician for a second opinion, noting that appellant had not been evaluated for a permanent impairment in four years. The hearing representative also indicated that, under the Office's procedures, schedule awards calculated according to any previous version of the A.M.A., *Guides* should be evaluated using the edition used, and if an error in computation was found, the award should be recomputed using the original edition.[3]

The Office referred appellant, together with a statement of accepted facts and the case record, to Dr. Michael Bidgood, a Board-certified orthopedic surgeon, for an examination and opinion on the extent of the permanent impairment of the left leg. In a January 26, 1998 report, Dr. Bidgood indicated that appellant had a short leg limp on the left and a one-inch pelvic tilt towards the left. He reported that the left leg was one inch shorter than the right leg. Dr. Bidgood found that the circumference of the thigh was 15 inches on the left and 16 inches on the right. The circumference at mid-calf was 13 inches on the right and 14 inches on the left. He noted appellant had decreased sensation around the surgical incisions and skin grafts. Dr Bidgood stated that the metatarsophalangeal joint of the great toe had a full, painless range of motion. He indicated that the ankle and subtalar joints were fused in the neutral position. Dr. Bidgood found a slight decrease in sensation over the dorsal and plantar aspects of the left foot. He detected no evidence of sudomotor or vasomotor abnormalities in his examination as well as no swelling and no joint crepitation. Dr. Bidgood concluded that appellant had a 30 percent permanent impairment of the left leg due to ankylosis of the ankle and hind foot in the neutral position, a 10 percent permanent impairment for talectomy and resulting one-inch leg

[3] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Hearings and Reviews of the Written Record*, Chapter 2.1601.8(c) (January 1999).

shortening, and a 10 percent permanent impairment due to ankylosis of the subtalar level in neutral position. He stated that, although appellant had localized alterations in sensation over the surgical incisions and skin graft, there were no peripheral and nervous system neuropathies present. He indicated that the sensory changes were locally related to the debridements and arthrodesis. Dr. Bidgood also found a chronic one-inch atrophy of thigh and calf due to the arthrodesis. He stated that, under the edition of the A.M.A., *Guides* used, the atrophy was incorporated as part of the impairment expected for fused joints. He concluded that appellant had a 50 percent permanent impairment of the leg.

In a March 9, 1998 memorandum, the Office medical adviser concurred with Dr. Bidgood's report. He stated, however, that the Combined Values Chart should be used which yielded a permanent impairment of 43 percent. In a March 18, 1998 memorandum, the Office medical adviser indicated that the fourth edition of the A.M.A., *Guides* only gave a 10 percent permanent impairment rating for ankylosis of the ankle in the neutral position. Ankylosis of the subtalar joint in the neutral position also equaled a 10 percent permanent impairment. Talectomy and loss of leg length equaled an additional 10 percent permanent impairment of the left leg. The medical adviser concluded that appellant's schedule award should be based on the revised third edition of the A.M.A., *Guides*.

In a March 23, 1998 decision, the Office denied appellant's claim for an increased schedule award on the grounds that the evidence of record showed he had no additional permanent impairment of the left leg.[4]

The Board finds that in this case the Office properly determined that appellant had no more than a 56 percent permanent impairment of the left leg.

The schedule award provision of the Federal Employees' Compensation Act[5] and its implementing regulation[6] set forth the number of weeks of compensation to be paid for permanent loss, or loss of use, of members or functions of the body listed in the schedule award. However, neither the Act nor its regulations specify the manner in which the percentage loss of a member shall be determined. For consistent results and to ensure equal justice to all claimants, the Board has authorized the use of a single set of tables in evaluating schedule losses, so that there may be uniform standards applicable to all claimants seeking schedule awards. The American Medical Association, *Guides to the Evaluation of Permanent Impairment*[7] has been adopted by the Office as a standard for evaluating schedule losses and the Board has concurred in such adoption.[8]

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[4] In an April 23, 1998 letter, appellant requested a review by the Board. The Office treated the request as a request for a hearing before an Office hearing representative and issued a decision on July 2, 1998, denying appellant's request for a hearing before an Office hearing representative. This decision is null and void because it denied a hearing where appellant had not requested one.

[5] 5 U.S.C. § 8107(c).

[6] 20 C.F.R. § 10.304.

[7] (4th ed., 1993).

[8] *Thomas P. Gauthier*, 34 ECAB 1060, 1063 (1983).

Dr. Bidgood and the Office medical adviser properly used the third edition revised of the A.M.A., *Guides* to determine that appellant had a 30 percent permanent impairment of the left leg due to ankylosis of the ankle and a 10 percent permanent impairment due to ankylosis of the subtalar joint. He and the Office medical adviser also properly concluded that appellant had a 10 percent permanent impairment due to the talectomy which resulted in a one-inch shortening of the left leg. Dr. Bidgood did not give a permanent impairment rating for pain and weakness because he did not find any peripheral or nervous system neuropathies. He and the Office medical adviser took into consideration all the relevant medical evidence in determining the extent of appellant's permanent impairment. The medical evidence of record does not show a permanent impairment greater than the 56 percent permanent impairment of appellant's left leg for which he has already received a schedule award.[9]

The decision of the Office of Workers' Compensation Programs, dated March 23, 1998, is hereby affirmed.

Dated, Washington, DC
November 15, 2000

Willie T.C. Thomas
Member

A. Peter Kanjorski
Alternate Member

Valerie D. Evans-Harrell
Alternate Member

[9] The Board notes that appellant submitted additional evidence after the Office's March 23, 1998 decision. The scope of the Board's review is limited to the evidence that was before the Office at the time of its final decision. The Office, therefore, cannot consider new evidence on appeal. 20 C.F.R. § 501.2(c).