United States Department of Labor
Employees' Compensation Appeals Board

THOMAS A. SHEEDY, Appellant	)	
and	)	**Docket No. 03-2305**
	)	**Issued: July 20, 2004**
DEPARTMENT OF THE NAVY, NAVAL SHIPYARD, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
WILLIE T.C. THOMAS, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On September 25, 2003 appellant, through counsel, filed a timely appeal from an Office of Workers' Compensation Programs' merit decision dated January 16, 2003. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue on appeal is whether appellant has more than a 24 percent permanent impairment of his right lower extremity for which he received a schedule award. On appeal his counsel argues that the report of Dr. Andrew Collier, the impartial medical specialist, upon which the Office relied in denying further compensation, is deficient in several regards and should not represent the weight of the medical evidence in this case. Appellant's counsel argues that Dr. Collier failed to give any motor strength or sensory deficit ratings, although he found appellant to have such impairments and further that he failed to give a rating for arthrodesis of the great toe, although he found that appellant had limited range of motion there. He further asserts that Dr. Collier failed to consider appellant's preexisting peripheral vascular disease and diabetes because he felt they were not work related, although preexisting conditions must be considered in determining impairment.

FACTUAL HISTORY

This case has been before the Board previously. By decision dated November 27, 2001, the Board found that the Office had not properly developed whether appellant was entitled to more than 24 percent permanent impairment to his right lower extremity and set aside Office decisions dated June 10, 1999 and February 2, 2000.[1] Upon remand, the Office was to further develop and evaluate appellant's permanent impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* and provide the impartial medical specialist selected on the case a complete statement of accepted facts for impairment evaluation. The law and the facts as set forth in the previous Board decision is incorporated herein by reference.

On remand the Office referred appellant for a reevaluation with the impartial medical specialist selected previously, Dr. Collier. He was requested to determine the extent of impairment residual causally related to the accepted work injury in accordance with the fifth edition of the A.M.A. *Guides*. The Office provided the physician with an amended statement of accepted facts dated December 13, 2001.

In a report dated January 23, 2002, Dr. Collier discussed that since the 1981 work injury appellant has had three surgeries to his right foot and one surgery medial to the ankle for his tarsal tunnel. He outlined that appellant had cheilectomies of the first metatarsophalangeal (MTP) joint, which led to an eventual silastic implant and admission for a post operative infection. Dr. Collier stated that appellant also had arthrodesis of the second and third interphalangeal (IP) joints, although the third was not fused and had metatarsal osteotomy of toe number two. He further stated that appellant had a tarsal tunnel release on the right. Dr. Collier noted that he reexamined appellant that day and found no change in his foot or lower extremity; that, as before, appellant had slight pain in areas of his right foot and some difficulty with prolonged walking or standing. The physician determined that appellant had reached maximum medical improvement.

[1] Docket No 00-1958 (issued November 27, 2001). Appellant sustained hallux limitus of the first metacarpophalangeal joint (MPJ) of his right foot due to a fall at work on February 6, 1981. He underwent several Office authorized surgeries, including a right MPJ osteotomy and arthroplastic repair on December 1, 1981; a right MPJ arthroplasty and total implant insertion and distal interphalangeal joint arthroplasty, right second digit, on July 25, 1990; a partial metatarsal head resection of the second metatarsal, dorsiflexory valgus osteotomy of the third metatarsal and arthroplasty of the interphalangeal joints of the second and third toes with k-wire fixation of the right foot on February 27, 1991; and tarsal tunnel release surgery on December 1, 1992. The Office authorized orthopedic shoes and orthotic devices and accepted his cellulitis, metarsalgia and tarsal tunnel syndrome conditions as employment related. By decision dated October 21, 1997, the Office granted appellant a 24 percent schedule award for permanent impairment of his right leg. On April 7, 1999 the Office referred appellant to Dr. Collier for an impartial medical examination to further evaluate his right leg impairment. The Board determined that the statement of accepted facts provided to him was deficient because it only referred to appellant's work-related February 6, 1981 hallux limitus condition and his December 1, 1981 surgery and that Dr. Collier and the Office medical adviser did not adequately explain their opinions regarding appellant's impairment.

Regarding the impairment rating of appellant's right lower extremity, Dr. Collier stated:

> "[I]t is henceforth muscle atrophy none, rating 0; gait derangement [T]able 36, there is no applicable rating due to no evidence of degenerative arthritis; motor weakness, he has weakness of the extensor hallucis longus and the flexor of the great toe on the right. They are both 4+/5. The extensor hallucis longus, [T]able 17.8, page 532, 1 percent whole person, 2 percent lower extremity, 3 percent of foot. Loss of flexor strength of whole person 2 percent, lower extremity 5 percent and of foot 7 percent, same table. All other motors were normal. Range of motion of the ankle is full, 0. Hindfoot is full, 0. Toe impairments, [T]able 17-14, page 537; great toe extension less than 15 degrees, 2 percent whole person, 5 percent lower extremity and 7 percent foot. IP joint is normal, 0. Lesser toes MTP extension, 0. Impairment due toe ankyloses, [T]able 17-30, page 543, ankle is normal, 0. Subtalar joint is normal, 0. Ankyloses first, second and third toes in extension, although not full extension, 6 percent of the whole person, 14 percent of the lower extremity and 20 percent of the foot. [Appellant] has had tarsal tunnel syndrome on the right. He is status-post release with full resolution of symptoms. [Appellant] has no sensory deficits whatsoever of the medial or lateral plantar nerves from the tarsal tunnel. There is a negative Tinel's also. He does have decreased sensation in the tips of the first, second and third toes which correspond to the digital nerves. These are not ratable. [Appellant] does have mild pain under the second, third and forth metatarsal heads, again not ratable. Henceforth, [appellant] has a grand total of 11 percent impairment of the whole person, 24 percent of the lower extremity and 33 percent of the foot."

In a report dated February 19, 2002, Dr. Michael Quinlan, the Office medical adviser reviewed Dr. Collier's January 23, 2002 report and stated that Dr. Collier used the appropriate tables of the A.M.A., *Guides,* fifth edition, including the Combined Values Chart. The Office medical adviser noted that impairment does not extend to the ankle and indicated that appellant had 33 percent impairment to the right foot.

By decision dated February 19, 2002, the Office denied that appellant had greater than a 24 percent permanent impairment to his right lower extremity as a result of the work injury. In a letter dated February 25, 2002, appellant, through counsel, requested a hearing which was held October 23, 2002.

During the hearing, appellant's counsel argued that appellant continued to have loss of motion, sensory deficit, numbness and tingling which he stated was indicated in Dr. Collier's January 23, 2002 report. He argued that the physician again only concentrated on loss of motion and did not provide adequate ratings for sensory deficit, although there is numbness and tingling along the metatarsal joints and toes; loss of motor strength, despite the findings of weakness in the extensor hallucis longus and flexor of the great toe and ankle arthrodesis, despite the fact that the district medical adviser previously found impairment pursuant to the fourth edition of the A.M.A., *Guides*.

By decision dated January 16, 2003, the Office hearing representative determined that the January 23, 2002 report of Dr. Collier was complete and well rationalized and represented the

weight of the medical evidence that appellant had no more than 24 percent impairment to the right lower extremity. The Office hearing representative affirmed the prior decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulation[3] 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 regulation as the appropriate standard for evaluating schedule losses.

ANALYSIS

In the instant case, Dr. Collier correctly applied the tables of the fifth edition of the A.M.A., *Guides* to determine appellant's permanent impairment. Regarding muscle weakness, he outlined that appellant had weakness of the extensor hallucis longus and the flexor of the great toe on the right which were both at Grades 4+/5. Dr. Collier stated that according to Table 17.8 on page 532 the extensor hallucis longus of the great toe showed impairment of 1 percent whole person, 2 percent lower extremity and 3 percent of foot. He indicated further that, according to the same table, loss of flexor strength showed impairment of two percent whole person, five percent lower extremity and seven percent of foot. Regarding toe impairments, Dr. Collier outlined that according to Table 17-14 on page 537 appellant's great toe extension was less than 15 degrees which yielded an impairment of 2 percent whole person, 5 percent lower extremity, and 7 percent of the foot. Dr. Collier stated that according to Table 17-30 on page 543 ankyloses found at the first, second, and third toes in extension yielded 6 percent impairment of the whole person, 14 percent of the lower extremity and 20 percent of the foot. He found that appellant's IP joint and the lesser toes MTP extension were normal and that his tarsal release resulted in full resolution of those symptoms including sensory deficits of the medial or lateral plantar nerves from the tarsal tunnel. Dr. Collier found decreased sensation in the tips of the first, second and third toes and mild pain under the second, third and forth metatarsal heads, but determined that the decreased sensation and pain were not ratable. He correctly used the Combined Values Chart on page 604 of the A.M.A., *Guides* to combine the separate impairment ratings for appellant's right lower extremity, listed above, to determine that he had a total right lower extremity impairment of 24 percent.

Dr. Collier is the only physician of record who has provided a thorough evaluation in conformance with the proper edition of the A.M.A., *Guides*. His finding was also approved by

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

the Office medical adviser.[4] Although appellant, through counsel, argues that he had additional impairment based on sensory deficit, decreased motor strength and arthrodesis of the right ankle joint, he has not provided medical evidence supporting additional impairment in conformance with the fifth edition of the A.M.A., *Guides*, nor has he adequately explained how the existing evidence of record would support such additional impairment ratings. Furthermore, while appellant's counsel argues that Dr. Collier failed to consider appellant's preexisting conditions when determining impairment, the Board disagrees. It is well established that in calculating a schedule award for a member of the body that sustained an employment-related impairment, preexisting impairments of that member must be included.[5] Dr. Collier, in his January 23, 2002 report, acknowledged that appellant had minor peripheral disease in his right lower extremity more than the left due to his nonoccupational smoking and diabetes. He did not calculate any impairment of the lower extremity considering appellant's preexisting peripheral disease and diabetes because he stated that the work-related injury here would not have affected the peripheral vascular system which is the system involved with appellant's preexisting conditions. The Board finds that Dr. Collier took into account his nonoccupational preexisting impairments and determined them inconsequential when calculating his schedule award.[6]

The weight of the medical evidence establishes that appellant has no greater than a 24 percent permanent impairment of the right lower extremity.

CONCLUSION

The Board finds that appellant has no more than a 24 percent permanent impairment of his right lower extremity for which he is entitled to a schedule award.

[4] The Office medical adviser noted that appellant's impairment did not extend to the ankle and indicated that he had a 33 percent impairment to the right foot. The Board notes that combining the right foot impairment values provided by Dr. Collier using the Combined Values Chart does, in fact, equal a 33 percent impairment of the right foot. The Board has held that where the residuals of an injury to a member of the body specified in the schedule award provisions of the Act extend into an adjoining area of a member also enumerated in the schedule, such as an injury of the finger into the hand, of a hand into the arm or of a foot into the leg, the schedule award should be made on the basis of the percentage of loss of use of the larger member. *See Tonya D. Bell*, 43 ECAB 845, 849 (1992). In the present case, it is not clear that residuals of appellant's injury extend from his right foot into his right leg, but it does not appear that basing appellant's schedule award on an impairment rating limited to his right foot would provide him with compensation greater than that already received. An impairment rating of 33 percent of the right foot (33 percent times 205 weeks for total foot impairment) equals 67.65 weeks of compensation, whereas an impairment rating of 24 percent of the right leg (24 percent times 288 weeks for total leg impairment) equals 69.12 weeks of compensation. *See* 5 U.S.C. § 8107(2), (4).

[5] *See Dale Larson*, 41 ECAB 481 (1990); *Pedro M. De Leon, Jr.*, 35 ECAB 487 (1983).

[6] *See Raymond E. Gwynn*, 35 ECAB 247 (1983) (finding that preexisting arthritis had to be considered along with present knee conditions in determining the degree of impairment); *see also Pedro M. De Leon, Jr., supra* note 6, (finding that an impairment rating for an accepted knee contusion injury must include consideration of preexisting degenerative knee changes).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated January 16, 2003 is affirmed.

Issued: July 20, 2004
Washington, DC

Colleen Duffy Kiko
Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member