United States Department of Labor
Employees' Compensation Appeals Board

B.W., Appellant	)	
	)	**Docket No. 07-1060**
and	)	**Issued: August 17, 2007**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Wisconsin Rapids, WI, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 12, 2007 appellant filed a timely appeal from August 14, 2006 and January 5, 2007 decisions of the Office of Workers' Compensation Programs, adjudicating her schedule award claim. 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 is whether appellant has more than a one percent permanent impairment of her left lower extremity.

FACTUAL HISTORY

On March 13, 2003 appellant, then a 46-year-old letter carrier, filed a traumatic injury claim alleging that on March 12, 2003 she injured her left foot when she slipped on ice and her foot "came down hard." The Office accepted her claim for a left foot strain. The Office subsequently accepted an April 1, 2004 recurrence of disability. On December 23, 2004 appellant filed a claim for a schedule award.

In reports dated December 16 and 20, 2004, Dr. Douglas P. Galuk, an attending Board-certified orthopedic surgeon, stated that appellant had no gross swelling in her left foot but there was mild tenderness of the first metatarsophalangeal (MTP) joints. X-rays revealed no change from previous x-rays in joint space narrowing at the cuboid/cuneiform joint. Dr. Galuk diagnosed first MTP joint arthrosis of the left foot, degenerative disease of the fourth metatarsal and cuneiform joints of the left foot, a pronated left foot and a left midfoot sprain with continued pain. He indicated that appellant had a three percent impairment. However, Dr. Galuk did not indicate whether she had a three percent impairment of the foot or of the lower extremity. He also did not explain how he determined appellant's impairment rating with reference to specific tables in the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment.*[1]

On February 2, 2005 the Office asked Dr. Galuk to provide an impairment rating for appellant based on the A.M.A., *Guides*. The Office provided a list of factors to be considered which included loss of function due to pain, sensory alteration, limitation of motion of joints, muscle weakness or atrophy (with reference to specific affected muscles) or causalgia. Dr. Galuk was asked to describe any foot or toe pain, sensory loss or alteration of sensation and explain whether it was localized to a specific peripheral nerve or particular area. The Office indicated that measurements for range of motion should be provided for the toes. The Office asked Dr. Galuk to explain his impairment rating with reference to applicable tables in the A.M.A., *Guides*. In an April 8, 2005 report, Dr. Galuk stated:

> "Restriction of motion includes 11 degrees of hyperpronation as well as [a seven] degree reduction in supination based on active motion. Passive motion is retained at full, however. There is a decrease in supinatory strength as well as eversion primarily due to pain. There is the aforementioned ankylosis and arthrofibrosis due to the continued midfoot chronic sprain. There is a dorsal deformity at the base of the first metatarsal and cuneiform joints. X-rays confirm decreased joint space at the cuboid cuneiform joint. [Appellant] experiences aching, tenderness and occasional sharp pain with any appreciable time on her feet. The percentage of impairment as directed by the [A.M.A., *Guides*] has been assigned as a [three] percent permanent partial disability compared to an amputation at the ankle."

[1] A.M.A., *Guides* (5th ed. 2001).

On July 12, 2006 Dr. Benjamin P. Crane, an Office medical adviser,[2] found that appellant had a one percent impairment of the left lower extremity, based on Grade 4 pain in the distribution of the superficial peroneal nerve, according to Table 16-10 at page 482 and Table 17-37 at page 552 of the A.M.A., *Guides*, fifth edition. He stated:

> "[Appellant] was diagnosed with a left foot sprain [and] was treated [with] pain medications, custom arch supports and rest. [She] ultimately returned to work with minimal restrictions.
>
> "Currently [appellant] reports mild foot pain made worse with strenuous activity. There is not a physical examination, provided in the medical narrative, which clearly describes [appellant's] current condition. There is decreased supinator and eversion strength secondary to pain. Radiographs are read by Dr. Galuk as demonstrating decreased joint space at the cuboid cuneiform joint, cartilage level is not documented.
>
> "It should be noted [that] decreased strength cannot be rated in the presence of decreased [range of] motion, painful conditions, deformities or absence of parts that prevent effective application of maximal force in the region being evaluated (Paragraph 1, [page] 508)."

On August 14, 2006 the Office granted appellant a schedule award for 2.88 weeks[3] from October 1 to 21, 2004 based on a one percent impairment of her left lower extremity. On September 5, 2006 appellant requested a review of the written record and submitted another copy of Dr. Galuk's April 8, 2005 report.

By decision dated January 5, 2007, the Office denied modification of the August 14, 2006 decision.

LEGAL PRECEDENT

The schedule award provision of the Act[4] and its implementing regulation[5] 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

---

[2] *See* Federal (FECA) Procedural Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

[3] The Federal Employees' Compensation Act provides for 288 weeks of compensation for 100 percent loss or loss of use of a lower extremity. 5 U.S.C. § 8107(c)(2). Multiplying 288 weeks by one percent equals 2.88 weeks of compensation.

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

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.[6]

The A.M.A., *Guides* provides for three separate methods for calculating the lower extremity permanent impairment of an individual: anatomic, functional and diagnosis based.[7] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[8] The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligamentous instability, bursitis and various surgical procedures, including joint replacements and meniscectomies.[9] The functional method is used for conditions when anatomic changes are difficult to categorize or when functional implications have been documented and includes range of motion, gait derangement and muscle strength.[10] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[11] When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.[12] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[13]

ANALYSIS

The Board finds that this case is not in posture for a decision. Further development of the medical evidence is necessary to determine whether appellant has more than a one percent left lower extremity impairment.

Dr. Galuk's impairment rating included the following findings:

> "Restriction of motion includes 11 degrees of hyperpronation as well as [a] 7 degree reduction in supination based on active motion. Passive motion is retained at full, however. There is a decrease in supinatory strength as well as eversion primarily due to pain. There is the aforementioned ankylosis and arthrofibrosis due to the continued midfoot chronic sprain. There is a dorsal deformity at the base of the first metatarsal and cuneiform joints. X-rays confirm decreased joint

[6] *Id.*

[7] A.M.A., *Guides* 525.

[8] *Id.*

[9] *Id.*

[10] *Id.* at 525, Table 17-1.

[11] *Id.* at 548, 555.

[12] *Id*. at 526.

[13] *Id*. at 527, 555.

> space at the cuboid cuneiform joint. [Appellant] experiences aching, tenderness and occasional sharp pain with any appreciable time on her feet. The percentage of impairment as directed by the [A.M.A., *Guides*] has been assigned as a [three] percent permanent partial disability compared to an amputation at the ankle."

There are several deficiencies in Dr. Galuk's impairment rating. He did not clearly state whether appellant's three percent impairment was for her lower extremity or for her foot. Dr. Galuk did not include all of the information requested by the Office such as complete range of motion measurements. He did not provide a thorough analysis of any loss of function due to pain, sensory alteration, limitation of motion of joints, causalgia or muscle weakness or atrophy, with reference to specific affected muscles. Dr. Galuk did not provide a complete description of any foot or toe pain, sensory loss or alteration of sensation and explain whether it was localized to a specific peripheral nerve or particular area. He noted that x-rays revealed decreased joint space at the cuboid and cuneiform joints but he did not provide cartilage level measurements as shown on x-ray. Dr. Galuk did not explain his impairment rating with reference to applicable tables in the A.M.A., *Guides*.

Dr. Crane noted that appellant had mild foot pain made worse with strenuous activity. He determined that appellant had a one percent impairment of the left lower extremity for pain or sensory loss based on Grade 4 pain in the distribution of the superficial peroneal nerve, according to according to Table 16-10 at page 482 and Table 17-37 at page 552 of the A.M.A., *Guides*, fifth edition.

There is no medical evidence of record with a complete physical description of appellant's left lower extremity condition and a thorough discussion of her impairment with reference to applicable tables in the fifth edition of the A.M.A., *Guides*. As noted, after obtaining all necessary medical evidence is obtained, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present. Dr. Galuk did not provide complete measurements and descriptions of all the factors to be considered in determining appellant's foot or lower extremity impairment. Because Dr. Crane based his impairment rating on Dr. Galuk's report, his impairment rating is likewise insufficient to establish appellant's left lower extremity impairment.

Although the claimant has the burden of establishing entitlement to compensation, the Office shares responsibility in the development of the evidence.[14] On remand, the Office should refer appellant to an appropriate medical specialist for a complete and thorough evaluation of her left lower extremity and an impairment rating based on correct application of the A.M.A., *Guides*. The physician should provide medical rationale explaining why a particular rating method was selected. If more than one impairment rating method can be used in evaluating appellant's impairment, the method that provides the higher rating should be adopted.[15]

[14] *Willie James Clark*, 39 ECAB 1311 (1988).

[15] A.M.A., *Guides* 527.

CONCLUSION

The Board finds that this case is not in posture for a decision. On remand, the Office should refer appellant to an appropriate medical specialist for an examination and evaluation of her left lower extremity impairment.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated January 5, 2007 and August 14, 2006 are set aside and the case is remanded for further development consistent with this decision.

Issued: August 17, 2007
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board