United States Department of Labor
Employees' Compensation Appeals Board

R.L., Appellant	)	
and	)	**Docket No. 09-367**
	)	**Issued: September 16, 2009**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Cincinnati, OH, 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
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On November 17, 2008 appellant filed a timely appeal from March 31 and October 27, 2008 decisions of the Office of Workers' Compensation Programs, adjudicating his claim for a schedule award. 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 18 percent permanent impairment of the left lower extremity for which he received a schedule award.

FACTUAL HISTORY

On February 21, 2003 appellant, then a 54-year-old letter box mechanic, filed a claim for a traumatic injury on February 1, 2003 when he struck his left ankle on the corner of a wooden cart while he was moving a collection box. The Office accepted his claim for a left ankle contusion and a left leg peroneal tendon tear. On September 4, 2003 appellant underwent repair

of a left peroneal rupture performed by Dr. Robert A. Raines, Jr., his attending Board-certified orthopedic surgeon. He returned to full work duties on October 20, 2003. On August 24, 2004 appellant filed a claim for a schedule award.[1]

In reports dated August 23, September 14 and December 17, 2004, Dr. Raines provided findings on physical examination and diagnosed a left peroneal tendon tear with long-term residual pain occurring primarily in the evening after appellant finished work. There was some stiffness in appellant's left ankle but swelling was decreasing. He had pain and significant soreness proximal to the tip of the lateral malleolus. Appellant was able to evert his foot and had no peroneal tendon dislocation. Dorsiflexion was 0 degrees, plantar flexion 30 degrees, inversion 20 degrees and eversion 10 degrees. Subjective symptoms included pain and moderate to severe discomfort around the surgical site and a slight limp. Dr. Raines stated that appellant had reached maximum medical improvement. He calculated 3 percent whole body impairment, 7 percent left lower extremity impairment and 10 percent left foot impairment due to decreased range of motion.

On February 5, 2005 an Office medical adviser calculated 11 percent impairment of appellant's left lower extremity, including 7 percent for 0 degrees of dorsiflexion, based on Table 17-11 at page 537 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), 2 percent for 20 degrees of inversion and 2 percent for 10 degrees of eversion, based on Table 17-12 at page 537. Plantar flexion of 30 degrees was normal based on Table 17-11.

By decision dated June 27, 2008, the Office granted appellant a schedule award based on 11 percent impairment of the left lower extremity for 31.68 weeks, from August 23, 2004 to April 1, 2005.[2] Appellant requested a telephonic hearing before an Office hearing representative that was held on November 29, 2005.

By decision dated February 14, 2006, the Office hearing representative affirmed the June 27, 2005 decision on the grounds that the evidence established that appellant had no more than 11 percent impairment of his left upper extremity.

On June 21, 2007 appellant filed a claim for an additional schedule award. In reports dated April 23 and June 14, 2007, Dr. Raines reviewed the medical history and provided findings on physical examination. He stated that appellant continued to have left ankle problems following surgery, including rolling and instability. There was intermittent left ankle pain. Appellant's left ankle felt very weak and the weakness worsened with increased activity and walking. Dorsiflexion was 10 degrees, plantar flexion 30 degrees, inversion 25 degrees and eversion 15 degrees.[3] There was no left foot swelling, no angular deformity, no ulcers or

[1] Appellant has a separate claim under File No. xxxxxx165 accepted for a lumbar sprain and strain, a displaced lumbar disc and radiculopathy.

[2] The Federal Employees' Compensation Act provides for 288 weeks of compensation for 100 percent loss or loss of use of the lower extremity. 5 U.S.C. § 8107(c)(2). Multiplying 288 weeks by 11 percent total for the left lower extremity equals 31.68 weeks of compensation.

[3] The plantar flexion, inversion and eversion range of motion measurements are all normal based on Table 17-11 and 17-12 at page 537.

calluses and no crepitus. Palpation revealed tenderness over the lateral ligaments. There was minimal tenderness over the peroneal ligaments and ankle laxity with guarding. X-rays revealed no pathology. Dr. Raines diagnosed left ankle instability and opined that appellant had seven percent whole person impairment based on the A.M.A., *Guides*. On July 3, 2007 the Office requested additional information from Dr. Raines.

In a July 20, 2007 report, Dr. Raines stated that appellant had seven percent whole person impairment for mild left lower extremity gait derangement based on Table 17-5 at page 529 of the A.M.A., *Guides*. He had atrophy of his left calf with soreness and diminished circumference of 1 centimeter (cm). There were no significant sensory changes. Appellant had a significant problem with instability; he was prone to inversion injuries because of weakness of the restraining ligaments and tendons and pain on the lateral side of his left foot. Range of motion was unchanged from his June 14, 2007 visit.

In a December 12, 2007 report, an Office medical adviser calculated 18 percent left lower extremity impairment for mild gait derangement, based on Table 17-5 at page 529 and Table 17-3 at page 527 (comparing lower extremity impairment to whole person impairment) of the A.M.A., *Guides* based on Dr. Raines' July 20, 2007 report. He noted that restricted ankle range of motion and 1 cm of atrophy of the calf muscles could not be combined with impairment due to gait derangement, according to Table 17-2 at page 526, the cross-usage chart.

By decision dated March 31, 2008, the Office granted appellant an additional schedule award for seven percent impairment to his left lower extremity for 20.16 weeks from April 2 to August 21, 2005. Combined with the 11 percent previously awarded, appellant received schedule awards totaling 18 percent left lower extremity impairment.[4]

Appellant requested a telephonic hearing that was held on August 14, 2008. He subsequently submitted an August 25, 2008 report from Dr. Raines, which was identical to his July 20, 2007 report with the exception that it did not contain the first sentence in the 2007 report, "I am responding to your letter dated July 3, 2007 and will provide the information that you need." In a separate August 25, 2008 report, Dr. Raines stated that appellant's right and left ankle range of motion included 20 degrees of left ankle dorsiflexion, 50 degrees plantar flexion, 35 degrees inversion and 15 degrees eversion. Appellant had daily soreness and muscle cramps at night. His ankle was not 100 percent stable but he walked without gait assistance.

By decision dated October 27, 2008, an Office hearing representative affirmed the January 2, 2008 decision on the grounds that the evidence established that appellant had no more than 18 percent impairment to his left lower extremity.[5]

[4] The Office did not combine the 18 percent impairment for gait derangement with the 11 percent impairment for loss of range of motion because, as noted, gait derangement impairment cannot be combined with range of motion impairment according to Table 17-2 of the A.M.A., *Guides.* It deducted the 11 percent impairment previously awarded for loss of range of motion from the 18 percent impairment for gait derangement, resulting in 7 percent additional impairment.

[5] Subsequent to the October 27, 2008 Office decision, additional evidence was associated with the file. The Board's jurisdiction is limited to the evidence that was before the Office at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c). The Board may not consider this evidence for the first time on appeal.

LEGAL PRECEDENT

Section 8107 of the Act[6] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[7]

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.[8] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[9] 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.[10] 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.[11] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[12] 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.[13] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[14]

ANALYSIS

The impairment calculations for appellant's left lower extremity are based on the functional method for calculating lower extremity impairment. In 2004, Dr. Raines calculated three percent whole body impairment and seven percent left lower extremity impairment due to decreased range of motion which included dorsiflexion of 0 degrees, plantar flexion of 30 degrees, inversion of 20 degrees and eversion of 10 degrees. Chapter 15 provides for determination of impairment based on the "whole person;"[15] however, the Act does not provide

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

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

[9] *Id.*

[10] *Id.*

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

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

[13] *Id.* at 526.

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

[15] *See id* at section 15.12, Nerve Root and/or Spinal Cord.

for a schedule award based on permanent impairment of the whole person.[16] An Office medical adviser applied appellant's left ankle range of motion measurements to the applicable section of the A.M.A., *Guides* and correctly calculated 11 percent impairment of appellant's left lower extremity, including 7 percent for 0 degrees of dorsiflexion (extension), based on Table 17-11 at page 537, 2 percent for 20 degrees of inversion and 2 percent for 10 degrees of eversion, based on Table 17-12 at page 537.[17]

On June 21, 2007 appellant filed a claim for an additional schedule award. In reports dated April through July 2007, Dr. Raines stated that appellant continued to have left ankle problems following surgery, including rolling and instability. Appellant's left ankle felt very weak and the weakness worsened with increased activity and walking. Dr. Raines diagnosed left ankle instability and opined that appellant had seven percent whole person impairment for mild left lower extremity gait derangement based on Table 17-5 at page 529 of the A.M.A., *Guides*. Table 17-5 provides for whole person impairment from 7 to 15 percent for whole person impairment due to mild gait derangement. Dr. Raines determined that the lowest impairment percentage of seven percent was appropriate based on appellant's physical findings. Whole person impairment of 7 percent equals a maximum of 18 percent lower extremity impairment according to Table 17-3 at page 527. Appellant had a 1 cm atrophy of his left calf. Measurement of his ankle range of motion revealed that he had increased range of motion since 2004 and no longer had impairment due to loss of range of motion. An Office medical adviser calculated 18 percent left lower extremity impairment for mild gait derangement, based on Table 17-5 at page 529 and Table 17-3 at page 527 of the fifth edition of the A.M.A., *Guides*. He noted that impairment due to decreased range of motion and atrophy could not be combined with impairment due to gait derangement, according to Table 17-2 at page 526, the cross-usage chart.

On March 31, 2008 the Office granted appellant an additional schedule award for seven percent impairment to his left lower extremity for gait derangement. It deducted the 11 percent impairment previously awarded because, as noted, impairment due to gait derangement cannot be combined with impairment due to loss of range of motion.

Appellant submitted an August 25, 2008 report from Dr. Raines, which was substantially identical to his July 20, 2007 report. Dr. Raines calculated seven percent whole person impairment based on mild gait derangement. This report is not sufficient to establish that appellant has more than 18 percent impairment already awarded because it is virtually identical to the July 20, 2007 report, which the Office medical adviser used in calculating appellant's 18 percent left lower extremity impairment. In the second August 25, 2008 report, Dr. Raines stated that appellant's right and left ankle range of motion included 20 degrees of left ankle dorsiflexion, 50 degrees plantar flexion, 35 degrees inversion and 15 degrees eversion. These range of motion measurements are all normal based on Tables 11 and 12 at page 537 of the A.M.A., *Guides*. Dr. Raines stated that appellant had daily soreness and muscle cramps at night. Appellant's ankle was not 100 percent stable but he walked without gait assistance. Dr. Raines did not, however, provide an impairment calculation in the second report, therefore, it does not establish that appellant has more than 18 percent left lower extremity impairment.

[16] *Tania R. Keka*, 55 ECAB 354 (2004); *Guiseppe Aversa*, 55 ECAB 164 (2003).

[17] As noted, plantar flexion of 30 degrees was normal based on Table 17-11.

The Board finds that appellant failed to establish that he has more than 18 percent impairment of his left lower extremity, for which he received schedule awards.

On appeal, appellant states that he experiences pain and cramps in his lower left leg which wakes him up at night, weakness in his left ankle which causes instability and other problems which he addressed at the August 14, 2008 telephonic hearing, including increased pain and rolling over of his ankle. His left ankle symptoms were thoroughly addressed by Dr. Raines. Appellant's testimony regarding his left ankle symptoms in the August 14, 2008 telephonic hearing is contained in the hearing transcript which is of record. There is no information in appellant's appeal letter that has not been considered by the Board in this decision.

CONCLUSION

The Board finds that appellant failed to establish that he has more than 18 percent impairment of his left lower extremity, for which he received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated October 27 and March 31, 2008 are affirmed.

Issued: September 16, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board