United States Department of Labor
Employees' Compensation Appeals Board

W.E., Appellant	)	
and	)	**Docket No. 09-2196**
	)	**Issued: August 9, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Magnolia, AR, 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
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 31, 2009 appellant filed a timely appeal of an April 20, 2009 schedule award decision of the Office of Workers' Compensation Programs and a June 18, 2009 decision denying his request for reconsideration without a merit review. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUES

The issues are: (1) whether appellant has greater than 19 percent impairment of his left leg for which he received a schedule award; and (2) whether the Office properly denied appellant's reconsideration request without a merit review under 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On January 29, 2004 appellant, then a 48-year-old rural carrier, fractured his pelvis in a motor vehicle accident while in the performance of duty. He stopped work on January 30, 2004 and returned to modified duty on December 5, 2005. The Office accepted his claim for fractured pelvis.

In a February 5, 2004 report, Dr. Johannes Gruenwald, an orthopedic surgeon, diagnosed left acetabular fracture and performed an open reduction internal fixation of the left acetabulum. In a February 13, 2004 report, Dr. Mayra Alfonso, a physiatrist, noted that, after appellant's surgery for pelvic fracture, he developed myocardial infarction, acute renal failure, shock liver and right middle and lower lobe pneumonia. He also developed left foot drop secondary to peroneal neuropathy. On February 13, 2004 Dr. Moises Menendez, a Board-certified surgeon, diagnosed pressure ulcer of the left heel and performed full thickness debridement of the pressure ulcer. On February 24, 2004 Dr. Alfonso performed an angioplasty to treat a lesion in the left superficial femoral artery. She also treated appellant for thromboembolus in the popliteal artery that was partially obstructing the tibioperoneal trunk orifice.

On June 21, 2004 the Office accepted otitic barotraumas, acute myocardial infarction and chronic osteomyelitis of the left foot and ankle. It also accepted an ulcer of the left heel and midfoot.

On October 10, 2006 appellant filed a schedule award claim.

On October 27, 2006 the Office requested that Dr. John Alexander, Board-certified in family medicine, provide an opinion on the extent of appellant's permanent impairment based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*).

In a May 2, 2007 report, Dr. Alexander rated appellant's impairment using whole person impairment based on the fourth edition of the A.M.A., *Guides*. He found 30 percent whole person impairment for use of a cane and ankle-foot orthosis (AFO) according to Table 36 on page 76 of the A.M.A., *Guides*. Dr. Alexander also found 13 percent impairment for leg atrophy as the right thigh showed greater than three centimeters than the left thigh, citing Table 37 on page 77. He rated five percent impairment for 10 centimeter atrophy of the left calf, citing Table 37 on page 77. Dr. Alexander also found 10 percent impairment for significant dorsiflexion left foot drop according to Table 39 on page 77. He found four percent moderate impairment range based on Table 40 on page 78. Dr. Alexander combined 32 percent whole person impairment for atrophy, dorsiflexion and restricted movement with 30 percent whole person impairment for use of a cane and AFO to derive a total of 52 percent whole person impairment due to the left lower extremity. He noted that appellant reached maximum medical improvement on February 20, 2007.

In a November 1, 2007 report, an Office medical adviser reviewed Dr. Alexander's report noting that his ratings were based on the fourth edition of the A.M.A., *Guides*. Under the fifth edition of the A.M.A., *Guides*, he determined 30 percent whole person impairment for moderate gait abnormality according to Table 17-5 on page 529 of the A.M.A., *Guides*. The medical adviser also noted that 30 percent whole person impairment converted to 75 percent impairment of the leg. He found 13 percent left lower extremity impairment for 6 centimeter thigh atrophy citing Table 17-6 on page 530, 25 percent impairment for Grade 0 foot drop ankle dorsiflexion weakness citing Table 17-8 on page 532 and 10 percent lower extremity impairment for moderate loss of hip motion according to Table 17-9 on page 537. The medical adviser noted that the A.M.A., *Guides* advised using gait abnormality only in cases where more specific methods are not available and it stands alone. He noted that appellant had multiple left lower

extremity problems and that Dr. Alexander's report was inadequate to allow recommendation for impairment. He requested that the Office obtain an impairment evaluation from an appropriate Board-certified physician.

On March 20, 2008 the Office referred appellant with a statement of accepted facts to Dr. Robert Holladay IV, a Board-certified orthopedic surgeon, for a second opinion. In an April 10, 2008 report, Dr. Holladay provided a detailed summary of the history of injury. He noted appellant's complaint of numbness in appellant's left hip and left lower extremity. Dr. Holladay's examination revealed left foot drop and no tenderness to palpation of the thoracic or lumbar spine. He diagnosed left acetabulum and left pelvis fracture, open reduction internal fixation of the left acetabulum, left heel pressure ulcer, left footdrop and left hip osteoarthritis. Dr. Holladay noted that appellant ambulated with a left footdrop with a right ankle brace and used a cane on his right. He measured range of motion of the left hip as 60 degrees flexion for 5 percent lower extremity impairment, 0 degrees extension for 0 percent impairment, 30 degree abduction for 0 percent impairment, 10 degrees adduction for 5 percent impairment, 10 degrees internal rotation for 5 percent impairment and 20 degrees external rotation for 5 percent impairment, totaling 20 percent impairment for hip range of motion, citing Table 17-9 on page 537 of the fifth edition of the A.M.A., *Guides*. Dr. Holladay measured range of motion of the left ankle as 10 degrees dorsiflexion for seven percent left lower extremity impairment and 30 degrees plantar flexion for zero percent impairment, according to Table 17-11 on page 537. He also measured left hindfoot motion as 10 degrees inversion of the left ankle for two percent impairment and 5 degrees eversion for two percent impairment, which totaled four percent impairment, citing Table 17-12 on page 537. Dr. Holladay used the Combined Values Chart on page 604 of the A.M.A., *Guides* to combine the dorsiflexion and plantar values with the inversion and eversion values to determine 11 percent left lower extremity impairment due to loss of motion of the left ankle secondary to drop foot. For peripheral nerve injury, he noted that the maximum impairment due to motor loss of the common peroneal nerve was 42 percent impairment of the leg and 15 percent of the whole person, according to Table 17-37 on page 552. Dr. Holladay assigned Grade 3 for a 50 percent motor deficit, citing Table 16-11 on page 484, which he multiplied by 15 percent, representing the maximum motor loss for the common peroneal nerve, to derive 7.5 percent whole person impairment that he rounded to 8 percent. He found that this equated to 18.5 percent of the lower extremity which was round to 19 percent impairment. Dr. Holladay noted that the A.M.A., *Guides* did not combine peripheral nerve loss with range of motion loss and, as appellant's peripheral nerve injury had a higher impairment, he would use that value instead of the ankle range of motion loss value. He used the Combined Values Chart to combine 20 percent loss of hip range of motion with 19 percent motor loss of the common peroneal nerve to derive a total of 35 percent left lower extremity impairment as a residual of the accepted work injury.[1]

In an undated statement, appellant indicated that he had endured "a long list of physical abuses" since returning to work. He submitted an undated report from Dr. Alexander who noted seeing appellant on January 27, 2009 at which time he complained of his working conditions.

[1] Dr. Holladay also provided whole person impairment calculations for each individual lower extremity impairment percentage.

Dr. Alexander advised that appellant must work in a normal atmosphere of central heat and air due to health reasons.

In an April 10, 2009 report, an Office medical adviser reviewed Dr. Holladay's report and noted that appellant reached maximum medical improvement on April 10, 2008, the date of Dr. Holladay's report. The medical adviser noted that an August 5, 2005 statement of accepted facts indicated accepted conditions included left foot drop secondary to peroneal neuropathy and a pressure ulcer affecting the left heel. The medical adviser determined that appellant had 19 percent left leg impairment explaining that this represented appellant's total impairment as the common peroneal nerve condition due to left foot weakness was the only accepted condition that Dr. Holladay rated. The medical adviser noted that Dr. Holladay correctly indicated that nerve deficit loss could not be combined with loss of ankle range of motion, according to Table 17-2 of the A.M.A., *Guides* and that ankle range of motion rating was less advantageous to appellant.

In an April 20, 2009 decision, the Office granted appellant a schedule award for 19 percent permanent impairment of the left lower extremity. He received 54.72 weeks of compensation from April 10, 2008 to April 28, 2009.

On May 19, 2009 appellant requested reconsideration based on Dr. Alexander's report rating 52 percent impairment. He also asserted that Dr. Holladay only examined him for 45 minutes, but that Dr. Alexander had observed appellant walking, shopping and attending social events. Appellant submitted Dr. Alexander's May 2, 2007 report. He also submitted several documents from Dr. Alexander including a May 18, 2009 duty status report noting that appellant could perform his regular work full time and prescription notes dated May 17 and 29, 2009 prescribing a new replacement brace and diagnosing footdrop, pelvic fracture and neuropathy. The record also contains a May 26, 2009 nurse's note indicating that appellant required new shoes that needed to be fitted to his brace.

In a June 18, 2009 decision, the Office denied appellant's request for reconsideration without a merit review finding that he failed to provide any new and relevant medical evidence.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations 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. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of the Office. For consistent results and to ensure equal justice, the Board has authorized 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 Office for evaluating schedule losses and the Board has concurred in such adoption.[3]

[2] 5 U.S.C. §§ 8101-8193. *See* 5 U.S.C. § 8107.

[3] *See* 20 C.F.R. § 10.404; *R.D.*, 59 ECAB ___ (Docket No. 07-379, issued October 2, 2007).

ANALYSIS

Appellant contends that he has greater than 19 percent impairment of the left lower extremity. He submitted reports from Dr. Alexander, including a May 2, 2007 report that rated 52 percent whole person impairment under the fourth edition of the A.M.A., *Guides*. The Board finds that this report is insufficient to establish appellant's impairment as the physician did not use the proper edition of the A.M.A., *Guides.* Effective February 1, 2001, the Office designated the fifth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[4] Therefore, the report using the fourth edition did not apply the proper standard for evaluating impairment. Dr. Alexander's impairment determination was also in error because whole person impairment is not awarded under the Act.[5] Other reports from Dr. Alexander did not rate appellant's impairment under the fifth edition of the A.M.A., *Guides*. Consequently, Dr. Alexander's reports are an insufficient basis on which to establish appellant's permanent impairment and the Office properly referred appellant to Dr. Holladay for an evaluation.

Dr. Holladay's April 10, 2008 report provided the values for appellant's loss of hip range of motion and the corresponding calculations. Based on Table 17-9 on page 537 of the A.M.A., *Guides*, his findings included 60 degrees of flexion for 5 percent leg impairment, 0 degrees of extension for no impairment, 30 degrees of abduction for no impairment, 10 degrees of adduction for 5 percent impairment, 10 degrees of internal rotation for 5 percent impairment and 20 degrees of external rotation for 5 percent impairment. Dr. Holladay's totaled these values to equal 20 percent leg impairment for loss of hip motion. However, the Board notes that 60 degrees of flexion actually equates to 10 percent impairment under Table 17-9. Therefore, leg impairment due to hip loss of motion totals 25 percent impairment based Dr. Holladay's measurements.

For loss of ankle motion, Dr. Holladay found 10 degrees of dorsiflexion for seven percent leg impairment and 30 degrees of plantar flexion for seven percent impairment, citing Table 17-11 on page 537 of the A.M.A., *Guides*. For left hindfoot motion, he also measured 10 degrees of inversion for two percent impairment and 5 degrees of eversion for two percent impairment according to Table 17-12 on page 537. Dr. Holladay combined the ankle motion impairment values using the Combined Values Chart on page 604 of the A.M.A., *Guides* to determine 11 percent leg impairment from ankle loss of motion.[6]

Regarding appellant's peripheral nerve injury secondary to the footdrop, Dr. Holladay determined that under Table 17-37 on page 552, the common peroneal afforded a maximum of 42 percent impairment of the leg, or 15 percent whole person impairment, for motor loss.

---

[4] *See* FECA Bulletin No. 01-05 (issued January 29, 2001). On appeal, appellant asserts that his schedule award should have been based on the 6th edition of the A.M.A., *Guides*. At the time of the Office's April 20, 2009 schedule award decision, the 5th edition of the A.M.A., *Guides* was applicable to appellant's claim. The Office's use of the 6th edition of the A.M.A., *Guides* did not become effective until May 1, 2009. *See* FECA Bulletin No. 09-03 (issued March 15, 2009).

[5] *B.P.*, 60 ECAB ___ (Docket No. 08-1457, issued February 2, 2009).

[6] The Board notes that, as all these values pertain to the ankle, they should be added together, not combined. *See* A.M.A., *Guides* 533. However, in this case, both methods yield 11 percent impairment.

Dr. Holladay also assigned appellant Grade 3 and 50 percent motor deficit, citing Table 16-11 on page 484 of the A.M.A., *Guides*. He concluded that appellant's peripheral nerve loss impairment was 18.5 percent, rounded to 19 percent lower extremity impairment.[7] However, Dr. Holladay apparently multiplied the maximum whole person impairment, 15 percent, instead of the maximum impairment for the leg, 42 percent, by the 50 percent motor deficit grade. The Board notes that the calculation should have been performed with respect to the leg since whole person impairment is not awarded under the Act.[8] Under the process set forth in Table 16-11, the 50 percent deficit multiplied by the 42 percent maximum impairment of the leg for motor loss in the common peroneal nerve would yield 21 percent impairment. This miscalculation also affected Dr. Holladay's total left leg impairment calculation as he determined 35 percent total left lower extremity impairment by combining 19 percent common peroneal nerve impairment with 20 percent impairment for loss of hip range of motion.

Additionally, Dr. Holladay indicated that the A.M.A., *Guides* do not permit peripheral nerve loss to be combined with loss of range of motion. Therefore, he did not include ankle loss of range of motion in his impairment calculation but he included hip loss of range of motion. However, he incorrectly interpreted the A.M.A., *Guides*, as Table 17-2 on page 526 provides that that peripheral nerve injury and range of motion impairments can be combined.[9] Thus, Dr. Holladay did not properly combine impairment ratings for left hip loss of range of motion and motor loss in the common peroneal nerve with left ankle loss of range of motion.

After receiving Dr. Holladay's report, the Office referred the matter to its Office medical adviser. The medical adviser generally determined that appellant had a total left lower extremity impairment of 19 percent. He did not fully support his impairment rating with any calculations or citations to any tables, figures or pages of the A.M.A., *Guides* to explain the basis of his impairment rating.[10] The medical adviser noted that appellant's common peroneal nerve condition was the only accepted condition that Dr. Holladay rated and, therefore, this was the sole basis for appellant's permanent impairment. He did not acknowledge that the Office accepted appellant's claim for other conditions such as a fractured pelvis, chronic osteomyelitis of the left foot and ankle and an ulcer of the left heel and midfoot -- conditions that involved the left hip, ankle and hindfoot.[11] The medical adviser did not explain why Dr. Holladay's inclusion of impairment for loss of left hip range of motion was improper in rating appellant's total left leg

[7] *See J.P.*, 60 ECAB ___ (Docket No. 08-832, issued November 13, 2008) (in rounding to the nearest whole number, fractions are rounded up from .50).

[8] *B.P.*, *supra* note 6.

[9] *See also* A.M.A., *Guides* 533 (estimates for peripheral never impairments may be combined with those for other types of lower extremity impairments, except for muscle weakness, atrophy and gait derangement).

[10] *See C.J.*, 60 ECAB ___ (Docket No. 08-2429, issued August 3, 2009) (the Office medical adviser is responsible for reviewing the file, particularly the medical report on which the award is to be based, and then calculating the award).

[11] The Board also notes that, once it is established that a claimant has impairment due to accepted conditions, any preexisting impairment also must be included. *See B.P.*, *supra* note 6.

impairment. The Board will set aside the April 20, 2009 schedule award and remand the case for appropriate further development.[12]

CONCLUSION

The Board finds that the case is not in posture as to the impairment to appellant's left leg.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated April 20, 2009 is set aside and the case is remanded for further development consistent with this decision.

Issued: August 9, 2010
Washington, DC

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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

[12] In light of the Board's disposition of the first issue, the second issue is moot.