United States Department of Labor
Employees' Compensation Appeals Board

M.J., Appellant	)	
	)	**Docket No. 10-35**
and	)	**Issued: July 20, 2010**
U.S. POSTAL SERVICE, POST OFFICE, St. Louis, MO, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 5, 2009 appellant filed a timely appeal of the August 17, 2009 decision 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 the case.

ISSUE

The issue is whether appellant has greater than 11 percent impairment to each lower extremity.

FACTUAL HISTORY

On November 10, 2005 appellant, then a 57-year-old supervisor, filed an occupational disease claim alleging that she developed an injury to her lower extremities caused by frequent standing and walking required in her job. On December 20, 2005 the Office accepted bilateral plantar nerve lesions. On February 24 and April 21, 2006 appellant underwent surgery on her left and right lower extremities, respectively, for excision of neuromas. The surgery was performed by Dr. Seth M. Anderson, an attending podiatrist. Appellant returned to limited duty

on August 31, 2006 with standing restricted to five hours a day. On December 19, 2006 the Office accepted the additional condition of bilateral tarsal tunnel syndrome. Appellant underwent a left tarsal tunnel release on December 20, 2006. She returned to limited duty on March 25, 2007 with standing restricted to two hours a day. On December 10, 2007 appellant filed a claim for a schedule award. In 2008 she advised the Office that Dr. Anderson did not provide impairment ratings. Appellant requested a referral to a physician who could provide an impairment rating for her lower extremities.

On April 21, 2008 Dr. Jack C. Tippett, a Board-certified orthopedic surgeon, reviewed the medical history and provided findings on physical examination. Appellant advised that she had pain in both ankles and feet. Dr. Tippett stated that her feet were normal in appearance with healed scars between the second and third toes on the dorsum of both feet. Posteromedially over the left ankle there was also a healed incisional scar that was mildly tender to external pressure. There was mild tenderness in both ankles with assisted inversion, eversion and dorsiflexion. There was no swelling. There were areas of hypesthesia between the second and third toes of both feet. These areas were checked with the two-point discrimination test in which there was little duplication of response to the two points adjusted to one centimeter differences. Range of motion was mildly decreased. Left ankle extension was decreased at 8 degrees and flexion was normal at 40 degrees which constituted seven percent lower extremity impairment for mildly decreased extension according to 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*). Inversion of the left ankle was decreased at 11 degrees and eversion was decreased at 7 degrees which constituted four percent impairment based on Table 17-12 at page 537 (two percent each for mildly decreased inversion and eversion). Right ankle extension was mildly decreased at 0 degrees and flexion was normal at 40 degrees which constituted seven percent impairment. Right ankle inversion was mildly decreased at 12 degrees and eversion was mildly decreased at 5 degrees. Dr. Anderson found that appellant's chronic pain did not appear to be significantly intense, particularly when she wore her orthotics and used reasonable restraint in standing and walking. He calculated 11 percent combined impairment to each lower extremity for decreased range of motion.

On May 3, 2008 an Office medical adviser noted that Dr. Anderson found no impairment due to pain, sensory change or weakness. His calculation of 11 percent impairment to each left lower extremity was correct based on the fifth edition of the A.M.A., *Guides*.

By decision dated May 15, 2008, the Office granted appellant a schedule award based on 11 percent impairment of each lower extremity for 63.36 weeks, from August 27, 2007 to November 12, 2008.[1]

On May 12, 2009 appellant requested reconsideration. She contended that she had impairment to both lower extremities due to chronic pain in both ankles and feet. In a June 10, 2008 report, Dr. Anderson noted that appellant had pain in her left medial rearfoot caused by scar tissue. On July 14, 2009 he stated that she had continuing pain to the balls and rear area of both

[1] 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 for each lower extremity equals 63.36 weeks of compensation.

feet. Dr. Anderson discussed possible pain management evaluation if she decided to decline further surgery. December 23, 2008 magnetic resonance imaging (MRI) scan reports of the left and right foot were unremarkable. December 30, 2008 x-ray reports of the feet were essentially negative.

On August 13, 2009 an Office medical adviser indicated that Dr. Anderson's reports did not establish that appellant had greater than 11 percent impairment to each lower extremity.

By decision dated August 17, 2009, the Office affirmed the May 15, 2008 decision.

LEGAL PRECEDENT

The schedule award provision of the Act[2] and its implementing regulations[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* (5th ed.) has been adopted by the Office as the appropriate standard for evaluating schedule losses.[4]

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.[5] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[6] 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.[7] 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.[8] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[9] When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] *Id.*.

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

[6] *Id.*

[7] *Id.*

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

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

combination of methods that gives the most clinically accurate impairment rating.[10] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[11]

ANALYSIS

The Board finds that this case is not in posture for a decision.

Dr. Tippett noted that appellant had pain in both ankles and feet. He stated that her feet were normal in appearance with healed scars between the second and third toes on the dorsum of both feet. Posteromedially over the left ankle there was a healed incisional scar that was mildly tender to external pressure. There was mild tenderness in both ankles with assisted inversion, eversion and dorsiflexion. There were areas of hypesthesia between the second and third toes of both feet. Left ankle extension was decreased at eight degrees which constituted seven percent lower extremity impairment for mildly decreased extension according to Table 17-11 at page 537 of the fifth edition of the A.M.A., *Guides*. Inversion of the left ankle was decreased at 11 degrees and eversion was decreased at 7 degrees which constituted four percent impairment based on Table 17-12 at page 537. Right ankle extension was mildly decreased at zero degrees which constituted seven percent impairment. Right ankle inversion was mildly decreased at 12 degrees and eversion was mildly decreased at 5 degrees. Dr. Anderson found that appellant's chronic pain did not appear to be significantly intense, particularly when she wore her orthotics and used reasonable restraint in standing and walking. He correctly calculated 11 percent impairment to each lower extremity based on the range-of-motion measurements and the fifth edition of the A.M.A., *Guides*.

The Board finds that Dr. Tippett did not provide sufficient explanation for excluding impairment due to chronic pain. Dr. Anderson noted that appellant had chronic pain to the balls and rear area of both feet. He discussed the possibility of pain management if she decided to decline further surgery. Dr. Tippett found that appellant's chronic pain was not "significantly intense." The fifth edition of the A.M.A., *Guides* does not require that pain be significant to constitute impairment. It provides that sensory deficit or pain be rated using Table 16-10 at page 482.[12] This table includes six grades of sensory deficit or pain, ranging from Grade 5 (no impairment) to Grade 0 (complete sensory loss or severe pain). Grades 4 through 1 include varying degrees of sensory loss or pain. Dr. Anderson failed to explain why not one of the grades in Table 16-10 was applicable to appellant's chronic pain level. Therefore, his opinion as to appellant's lower extremity impairment requires additional explanation. On remand the Office should ask Dr. Tippett to provide a supplementary report addressing the issue of whether appellant has any impairment to her lower extremities due to sensory loss or pain based on Table 16-10 and any other applicable sections of the fifth edition of the A.M.A., *Guides*. After such further development as the Office deems necessary, it should issue an appropriate decision.

[10] *Id*. at 526.

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

[12] *Id*. at 550, 17.2l (Peripheral Nerve Injuries).

CONCLUSION

The Board finds that this case is not in posture for a decision. On remand the Office should obtain a supplementary report from Dr. Tippett explaining whether appellant has any impairment to her lower extremities due to sensory loss or pain.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 17, 2009 is set aside and the case is remanded for further action consistent with this opinion.

Issued: July 20, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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