

On October 11, 2002 appellant filed a claim for a schedule award.¹ Her attending physician, Dr. Neil R. Fried, a podiatric surgeon, expected permanent effects from the employment injury, including pain over the surgical plate and weakness of the flexor hallucis longus muscle. The Office asked Dr. Fried to evaluate permanent impairment according to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.

On May 5, 2003 Dr. Fried reported appellant's work-related diagnosis to be ankle fracture with residual internal derangement, painful hardware and weak hallux. He stated that she reached maximum medical improvement in February 2003. On an impairment evaluation worksheet, Dr. Fried recorded ranges of motion for the ankle: 0 degrees dorsiflexion,² 10 degrees plantar flexion,³ 20 degrees inversion and 10 degrees eversion. From this he wrote that total foot impairment due to loss of motion was 21 percent or 15 percent for the lower extremity. Weakness, he reported, accounted for an additional 24 percent impairment of the foot or 17 percent of the lower extremity.

Dr. Fried also evaluated appellant's left great toe. He reported 60 degrees metatarsophalangeal dorsiflexion and 0 degrees interphalangeal plantar flexion. Dr. Fried indicated that total foot impairment due to loss of motion was 7 percent; or 5 percent for the lower extremity. Weakness provided an additional impairment of 17 percent; or 12 percent for the lower extremity.

Dr. Fried concluded that appellant had a 62 percent impairment of the foot or a 49 percent impairment of the lower extremity. The Office asked its medical adviser to review the medical records and calculate appellant's permanent impairment under the A.M.A., *Guides*.

On June 26, 2003 the Office medical adviser reviewed findings from a July 6, 1999 report of a second opinion physician, whom the Office had asked to address the extent of any employment-related residuals and disability for work. The Office medical adviser determined from this report that appellant had a four percent impairment due to loss of ankle motion and a one percent permanent impairment due to dysesthesia in the distribution of the superficial peroneal nerve. Using the Combined Values Chart at page 604 of the A.M.A., *Guides*, he concluded that appellant had a five percent total impairment of the left lower extremity. The Office medical adviser reported that the date of maximum medical improvement was October 1, 1999.

On September 29, 2003 the Office issued a schedule award for a five percent permanent impairment of the left lower extremity. On appeal appellant noted the difference between the 62 percent impairment as found by her physician and the 5 percent impairment awarded by the Office.

¹ Appellant previously filed a claim for a schedule award on August 10, 2000. The Office attempted to develop the medical evidence, but no evaluation of permanent impairment was forthcoming.

² It appears Dr. Fried initially recorded five degrees dorsiflexion, but corrected this to zero degrees.

³ It appears Dr. Fried initially recorded 20 degrees plantar flexion, but corrected this to 10 degrees.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act authorizes the payment of schedule awards for the loss or loss of use, of specified members, organs or functions of the body.⁴ 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*.⁵

To support a schedule award, the file must contain competent medical evidence that describes the impairment in sufficient detail for the adjudicator to visualize the character and degree of disability.⁶ The report of the examination must always include a detailed description of the impairment which includes, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation or other pertinent description of the impairment.⁷ The Office should advise any physician evaluating permanent impairment to use the fifth edition of the A.M.A., *Guides* and to report findings in accordance with those guidelines.⁸

ANALYSIS

The Office asked Dr. Fried to evaluate permanent impairment, but his May 5, 2003 report does not allow a proper application of the fifth edition of the A.M.A., *Guides*. It is difficult to read the range of motion he recorded for dorsiflexion and plantar flexion of the ankle, as he appears to have overwritten his initial measurements. Dr. Fried also gave no indication that he evaluated range of motion according to the method described in Figure 17-5, page 535:

“The goniometer’s pivot is centered over the ankle and one arm parallels the tibia. The examiner reads the angles subtending the maximum arcs of motion for dorsiflexion and plantar flexion. The test is repeated with the knee flexed to 45 degrees. The averages of the maximum angles represent dorsiflexion and plantar flexion ranges of motion.”

Dr. Fried did not explain how he used Table 17-11 and Table 17-12, page 537, to determine a 15 percent impairment of the lower extremity due to loss of ankle motion. He did not explain how he used Table 17-8, page 532, to determine impairment due to muscle weakness. The A.M.A., *Guides* provides criteria for grading muscle function of the lower extremity⁹ and

⁴ 5 U.S.C. § 8107.

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

⁶ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.b(2) (August 2002).

⁷ *Id.*, Chapter 2.808.6.c(1).

⁸ *Id.*, Chapter 2.808.6.a (with noted exceptions).

⁹ A.M.A., *Guides* 531, Table 17-7 (5th ed. 2001).

provides a table of impairments for different muscle groups.¹⁰ Dr. Fried's impairment evaluation worksheet does not disclose the grade of muscle function or the muscle group affected.

The same general deficiencies exist with respect to Dr. Fried's ratings for range of great toe motion and great toe weakness. He did not report the reason he was evaluating appellant's left great toe. To compound matters, the Office medical adviser did not review Dr. Fried's report. Rather, he calculated appellant's impairment based on a report that was nearly four years old and obtained from a physician who did not evaluate appellant for a schedule award. The medical adviser provided no reason for using this report or for determining a much earlier date of maximum medical improvement than that reported by Dr. Fried.

The Board will set aside the Office's September 29, 2003 decision and remand the case for a proper evaluation of permanent impairment under the fifth edition of the A.M.A., *Guides*. After such further development of the evidence as may be necessary, the Office shall issue an appropriate final decision on appellant's entitlement to a schedule award.

CONCLUSION

The Board finds that this case is not in posture for decision on whether appellant has more than a five percent permanent impairment of her left lower extremity. Further development of the medical evidence is warranted.

¹⁰ *Id.* at 532, Table 17-8. But the A.M.A., *Guides* cautions that individuals whose performance is inhibited by pain or the fear of pain are not good candidates for manual muscle testing and other evaluation methods should be considered. *Id.* at 531.

ORDER

IT IS HEREBY ORDERED THAT the September 29, 2003 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: November 9, 2004
Washington, DC

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member