

FACTUAL HISTORY

On June 10, 1994 appellant, then a 29-year-old clerk, sustained an injury in the performance of duty when a heavy cart rolled onto her foot. The Office accepted her claim for strain and dislocation of the left ankle and, later, for a consequential fracture of the right tibia. She received compensation for temporary total disability on the periodic rolls.

On December 13, 2001 appellant filed a claim for a schedule award. The Office referred her to Dr. Harold H. Alexander, an orthopedic surgeon, for evaluation. On October 15, 2003 Dr. Alexander addressed the impairment of appellant's left lower extremity:

“The patient had an injury to her left foot when an object rolled over it. X-rays of her left foot show no evidence of fracture dislocation. She has full range of motion of her ankle and subtalar joint. She does have decreased sensation of the plantar medial aspect of her left foot, supplied by the medial plantar nerve. I used Table 17-37, page 552 of the American Medical Association, *Guides to the Evaluation of permanent impairment*, [A.M.A., *Guides*] fifth edition, to compute a 2 [percent] partial lower extremity impairment.”

An Office medical adviser reviewed Dr. Alexander's findings and agreed with the rating reported. On February 4, 2004 the Office issued a schedule award for a two percent permanent impairment of appellant's left leg.

Appellant requested reconsideration. In a decision dated March 23, 2004, the Office denied her request.

LEGAL PRECEDENT -- ISSUE 1

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.² 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*.³

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.⁴ 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

² 5 U.S.C. § 8107; *see id.* § 8107(c)(2) (providing 288 weeks' compensation for a "leg lost").

³ 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001). Chapter 17 of the A.M.A., *Guides* addresses impairment of the "lower extremities."

⁴ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.b(2) (August 2002).

strength or disturbance of sensation or other pertinent description of the impairment.⁵ 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.⁶

ANALYSIS -- ISSUE 1

Table 17-11, page 537, of the A.M.A., *Guides* provides estimates for ankle motion impairment based on goniometer readings obtained during physical examination.⁷ Table 17-12 provides estimates for hindfoot impairment based, again, on recorded arcs of motion. Table 17-13 provides estimates for ankle or hindfoot deformity based on measured angles of position.

Dr. Alexander, the Office referral physician, reported that appellant had “full range of motion” of her ankle and subtalar joint, but he reported no measurements. This prevents the Board from using the tables cited above to determine as a matter of fact whether appellant has an impairment of her left lower extremity due to loss of motion.⁸ The Board cannot confidently interpret Dr. Alexander’s language to mean that active plantar flexion was greater than 20 degrees from the neutral position, as measured by a goniometer or that flexion contracture was less than 10 degrees. And there are five other motions or positions whose measurements should be checked under these tables. A physician’s description of “full” or “normal” range of motion may well be accurate, but as a reviewing and adjudicating body, the Board must be able to determine for itself whether the clinical findings show no impairment under the criteria of the A.M.A., *Guides*. In schedule award cases the Board has observed that “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.”⁹ The Board finds therefore that Dr. Alexander’s description of appellant’s range of motion is not sufficiently detailed to support the Office February 4, 2004 decision on her entitlement to schedule compensation.

This is not the only deficiency in Dr. Alexander’s report. Citing Table 17-37, page 552, of the A.M.A., *Guides*, Dr. Alexander reported that appellant had a two percent permanent impairment of the left lower extremity. This table indicates that a complete sensory loss of the medial plantar nerve represents a five percent impairment of the lower extremity. To derive

⁵ *Id.*, Chapter 2.808.6.c(1).

⁶ *Id.*, Chapter 2.808.6.a (noting exceptions).

⁷ To measure foot dorsiflexion and plantar flexion, for example, 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. A.M.A., *Guides* 535 (Figure 17-5). *See generally id.* at 451 (evaluating abnormal motion).

⁸ If the clinical findings are fully described, any knowledgeable observer may check findings with the criteria of the A.M.A., *Guides*. *Id.* at 17.

⁹ *E.g.*, *Charles Dionne*, 38 ECAB 306 (1986) (noting that the Office has adopted the A.M.A., *Guides* as the standard for evaluating schedule losses and that the Board has concurred in that adoption).

impairment due to partial sensory loss, this percentage is multiplied by the severity of the sensory deficit, as classified in Table 16-10, page 482.¹⁰ Dr. Alexander did not grade the severity of appellant's sensory deficit under this table, but his final rating of 2 percent would indicate the deficit to be approximately 40 percent of the affected nerve, placing it in the Grade 3 classification: "Distorted superficial tactile sensibility (diminished light touch and two-point discrimination), with some abnormal sensations or slight pain, that interferes with some activities." The problem here is that a Grade 3 sensory deficit can range from 26 to 60 percent of the affected nerve and the A.M.A., *Guides* provides that the examiner must use clinical judgment to estimate the appropriate percentage within this range.¹¹ Dr. Alexander did not grade the severity of the sensory deficit, nor did he give any indication whether or how he exercised clinical judgment to select a percentage within the range of values shown in Table 16-10.

Because the medical evidence does not permit a proper application of the A.M.A., *Guides*, the Board will set aside the Office's February 4, 2004 schedule award decision and remand the case for further development. The Office referred appellant to Dr. Alexander for an evaluation of permanent impairment and therefore has the responsibility to obtain an evaluation that will resolve the issue.¹² 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 for her left leg.

CONCLUSION

The Board finds that this case is not in posture for decision. The Office referral physician's use of the phrase "full range of motion," together with his failure to report goniometric findings, prevents the Board from independently determining whether appellant has impairment due to loss of range of motion. The Office referral physician also failed to grade appellant's sensory deficit and to select, using clinical judgment, a percentage deficit within that grade. Further development of the medical evidence is therefore warranted. Because the Office will issue an appropriate final decision on appellant's entitlement to a schedule award for her left leg, the second issue on appeal -- whether the Office properly denied her request for reconsideration -- is moot.

¹⁰ See *id.* at 550 (partial sensory losses are rated according to the grading scheme and procedure set forth in Table 16-10, page 482).

¹¹ *Id.* at 482.

¹² *Mae Z. Hackett*, 34 ECAB 1421, 1426 (1983); see *Milton Lehr*, 45 ECAB 467 (1994) (where the Board remanded the case to the Office for a medical opinion and the opinion obtained from the attending physician was not sufficient to resolve the issue, the Board found that the Office should obtain a supplemental report from the attending physician curing the deficiency and resolving the issue in the case).

ORDER

IT IS HEREBY ORDERED THAT the February 4, 2004 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: August 3, 2005
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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