

FACTUAL HISTORY

On November 18, 2005 appellant, then a 49-year-old city letter carrier, filed a claim for an occupational disease alleging that when she stepped down on her left leg she felt soreness in her left hip radiating down to her left knee.¹ On August 21, 2006 the Office accepted her claim for temporary aggravation of preexisting strains of the left hip and thigh and temporary aggravation of preexisting enthesopathy of the left hip.² On October 25, 2006 appellant filed a claim for a schedule award.

In reports dated July 12 and September 7, 2006, Dr. James Weir, an attending Board-certified orthopedic surgeon, indicated that appellant was partially disabled due to her left lower extremity condition.

In an August 10, 2006 report, Dr. Bruce D. Abrams, a Board-certified orthopedic surgeon and an Office referral physician, reviewed appellant's medical history and provided findings on physical examination. He found that appellant had no residuals of her left hip condition.

In reports dated February 12 to August 14, 2007, Dr. Weir stated that appellant had permanent work restrictions and disability due to her left hip condition.

Due to the conflict in medical opinion between Dr. Weir and Dr. Abrams as to whether appellant had any residual disability or medical condition causally related to her November 17, 2005 employment injury, the Office referred her to Dr. Rodney K. McFarland, a Board-certified orthopedic surgeon, for an examination and evaluation in order to resolve the conflict.

In a January 17, 2008 report, Dr. McFarland reviewed the medical history, including diagnostic test reports and provided findings on physical examination. He stated that appellant moved about during the examination without difficulty or complaint. Dr. McFarland ambulated at a normal speed without using an assistive device but with a barely noticeable limp on the left side. Appellant was unable to stand on her left lower extremity without using her hand for support and was a little unsteady when attempting heel-to-toe gait. There was full and equal motion of both hip joints but some pulling sensation on the left hip at 90 degrees flexion which was the maximum flexion for both hips. Appellant experienced some mild left lateral thigh cramping on adduction. She noted pain on the greater trochanter of the left hip with resisted abduction and to a lesser extent with resisted extension. However, appellant exhibited normal and symmetrical strength of all motion of her hips except for 5 to 4+5 weakness associated with discomfort on abduction of the left hip. Faber test on the left resulted in discomfort in the greater trochanter and the left S1 joint. Patrick's maneuver resulted in more lateral hip pain. Appellant had normal strength and unrestricted motion of the remainder of both lower extremities. Measured circumference of both lower extremities revealed mild atrophy of the left thigh which

¹ Under OWCP File No. xxxxxx519, appellant has an accepted claim for an injury on November 4, 2004 when she tripped on a wire and fell onto a driveway. The Office accepted a left groin strain, left shoulder strain and right knee abrasion. Appellant returned to full duty on February 14, 2005. On August 22, 2006 the Office expanded the claim to include a left gluteus medius tendon rupture and left trochanteric bursitis.

² Enthesopathy is a disorder of a muscular or tendinous attachment to bone. See DORLAND'S, *Illustrated Medical Dictionary* (30th ed. 2003) 622.

measured 68 centimeters at the thigh and 47 centimeters at the calf. The right lower extremity measured 69 and 47 centimeters, respectively, at the thigh and calf. Appellant could perform a moderate squat and had full painless motion of her lumbar and thoracic spine.

Dr. McFarland advised that appellant had residual pain from her left hip sprain and enthesopathy. An October 24, 2007 MRI scan indicated persistent inflammation which suggested that the cause of her continued pain might be residual enthesopathy from incomplete healing of the avulsed tendon to bone. Continued pain at that site, exacerbated by use, could significantly contribute to continued weakness and overall impairment of the hip. Dr. McFarland noted that appellant had residual weakness from the left hip sprain and enthesopathy. The persistent muscle atrophy of the left hip abductor muscles as shown on the October 24, 2007 MRI scan, in spite of what appeared to be a successful repair, correlated with her continued fatigue with extended use of the left hip. Dr. McFarland calculated 3 to 8 percent impairment of the left lower extremity for muscle atrophy measured at 10 centimeters above the patella, a 1 centimeter decrease, based on Table 17-6 at page 530 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). The table provides from 3 to 8 percent impairment for 1 to 1.9 centimeters of atrophy. Dr. McFarland noted that the cross-usage chart at page 526, Table 17-2, precludes the combination of impairment rating due to atrophy with impairment due to loss of muscle strength.

On May 13, 2008 Dr. Jason D. Eubanks, an orthopedic surgeon and an Office medical adviser, stated that appellant had three percent impairment of the left lower extremity for one centimeter of left thigh atrophy based on Table 17-6 at page 530 of the A.M.A., *Guides*, fifth edition and the findings of Dr. McFarland.

By decision dated July 25, 2008, the Office granted appellant a schedule award for three percent impairment of the left lower extremity for 8.64 weeks, from January 31 to March 31, 2008.³ In a July 23, 2008 file memorandum, it noted that, although the date of maximum medical improvement was determined to be January 17, 2008, the date of Dr. McFarland's report, the schedule award would begin on January 31, 2008 because appellant was paid compensation for lost wages through January 30, 2008.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act⁴ 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

³ The 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 three percent equals 8.64 weeks of compensation. Subsequent to the July 25, 2008 Office decision, appellant submitted additional evidence. 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.

⁴ 5 U.S.C. § 8107.

permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.⁵

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.⁶ The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.⁷ 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.⁸ 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.⁹ The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.¹⁰ 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.¹¹ If more than one method can be used, the method that provides the higher impairment rating should be adopted.¹²

Section 8123(a) of the Act provides that “if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary [of Labor] shall appoint a third physician who shall make an examination.”¹³ Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.

ANALYSIS

In a January 17, 2008 report, Dr. McFarland reviewed the medical history and provided findings on physical examination. He stated that appellant moved about during the examination

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 A.M.A., *Guides* 525.

⁷ *Id.*

⁸ *Id.*

⁹ *Id.* at 525, Table 17-1.

¹⁰ *Id.* at 548, 555.

¹¹ *Id.* at 526.

¹² *Id.* at 527, 555.

¹³ 5 U.S.C. § 8123(a); *see also* *Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

without difficulty or complaint. Appellant ambulated at a normal speed without using an assistive device but with slight limp on the left side. She was unable to stand on her left lower extremity without using her hand for support and was somewhat unsteady when attempting heel-to-toe gait. There was full and equal motion of both hip joints but some pulling sensation on the left hip at 90 degrees flexion which was the maximum flexion for both hips. Appellant experienced some mild left lateral thigh cramping on adduction. She noted pain on the greater trochanter of the left hip with resisted abduction and to a lesser extent with resisted extension. Appellant exhibited normal and symmetrical strength of all motion of her hips except for 5 to 4+5 weakness associated with discomfort on abduction of the left hip. She had normal strength and unrestricted motion of the remainder of both lower extremities. Measured circumference of both lower extremities at 10 centimeters above the patella revealed mild atrophy of the left thigh which measured 68 centimeters at the thigh and 47 centimeters at the calf. The right lower extremity measured 69 and 47 centimeters, respectively, at the thigh and calf. Appellant could perform a moderate squat.

Dr. McFarland stated that appellant had residual pain from her left hip sprain and enthesopathy. Continued pain at that site, exacerbated by use, could significantly contribute to continued weakness and overall impairment of the hip. Dr. McFarland noted that appellant had residual weakness from the left hip sprain and enthesopathy. The persistent muscle atrophy of the left hip abductor muscles as shown on the October 24, 2007 MRI scan correlated with her continued fatigue with extended use of the left hip. Dr. McFarland calculated three to eight percent impairment of the left lower extremity for muscle atrophy measured at one centimeter difference from the right lower extremity, based on Table 17-6 at page 530 of the A.M.A., *Guides*. He noted that the cross-usage chart at page 526, Table 17-2, precludes the combination of impairment rating due to atrophy with impairment due to loss of muscle strength. Dr. McFarland chose the atrophy rating method for appellant's muscle weakness because section 17.2e, Manual Muscle Testing, states that individuals whose performance is inhibited by pain or the fear of pain are not good candidates for manual muscle testing.¹⁴

Dr. Eubanks reviewed Dr. McFarland's report and agreed that appellant had three percent impairment of the left lower extremity for one centimeter of left thigh atrophy based on Table 17-6 at page 530 of the A.M.A., *Guides*, fifth edition and the findings in Dr. McFarland's report. The Board finds that the report of Dr. McFarland is sufficiently well rationalized and based on a proper factual and medical background. Therefore his report is entitled to special weight and establishes that appellant has no more than three percent impairment of the left lower extremity for which she received a schedule award.

On appeal appellant inquired as to why the July 25, 2008 schedule award covered the period January 31 to March 31, 2008. She noted that she had no interruptions of pay during that period. The purpose of a schedule award is to compensate an employee for the loss, or loss of use of a member or function of the body.¹⁵ A schedule award is payable in addition to

¹⁴ Dr. McFarland stated that the section on muscle strength could not be applied in appellant's case because her strength impairment involved the causation of pain.

¹⁵ See 5 U.S.C. § 8107(a).

compensation for lost wages for periods of disability.¹⁶ The period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the accepted employment injury.¹⁷ This determination is factual in nature and depends primarily on the medical evidence.¹⁸ In this case, the appropriate date of maximum medical improvement for the July 25, 2008 schedule award was January 17, 2008, the date of the most recent medical report addressing appellant's left upper extremity impairment. However, appellant received compensation for lost wages through January 30, 2008. Therefore, the Office properly determined that the schedule award would begin on January 31, 2008 when compensation for lost wages ceased. Thus, appellant's schedule award began on January 31, 2008 and ended March 31, 2008, which equaled 8.64 weeks of compensation for appellant's three percent left lower extremity impairment.

CONCLUSION

The Board finds that appellant has no more than three percent impairment of the left lower extremity for which she received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 25, 2008 is affirmed.

Issued: July 8, 2009
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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

¹⁶ *Id.* at § 8107(a)(3).

¹⁷ *See Mark A. Holloway*, 55 ECAB 321 (2004).

¹⁸ *Peter C. Belkind*, 56 ECAB 580 (2005).