United States Department of Labor
Employees' Compensation Appeals Board

J.D., Appellant	)	
and	)	**Docket No. 09-2007**
	)	**Issued: May 21, 2010**
U.S. POSTAL SERVICE, ROSELAND POST OFFICE, Chicago, IL, 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 July 28, 2009 appellant filed a timely appeal from a February 3, 2009 decision of the Office of Workers' Compensation Programs regarding a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.[1]

ISSUE

The issue is whether appellant sustained more than a 20 percent impairment of the lower extremities, for which she received a schedule award.

On appeal, appellant contends that the Office did not include all her lower extremity impairments in determining the February 3, 2009 schedule award. She asserts that bilateral hip

[1] The record contains a January 22, 2009 decision denying a schedule award for the upper extremities and a May 13, 2009 decision of the Office's Branch of Hearings and Review vacating the January 22, 2009 decision. The Office found the issue not in posture for a decision due to a conflict of medical opinion. Appellant did not appeal from the January 22 and May 13, 2009 decisions. As the upper extremity schedule award issue in an interlocutory position, the Board duly has jurisdiction of the lower extremity schedule award.

weakness, lumbar radiculitis, possible deep venous thrombosis in the right leg and several accepted injuries caused additional impairments.[2]

FACTUAL HISTORY

The Office accepted that on or before March 28, 2005 appellant, then a 48-year-old schemed distribution mail processing clerk, sustained a herniated C5-6 disc, lumbar strain and right rotator cuff tear due to repetitive lifting and bending while handling mail. It also accepted a bilateral hip strain/sprain and an aggravation of osteoarthritis of both hips. Appellant stopped work in May 2005 and did not return.

Appellant submitted medical reports dated April 14, 2005 through July 14, 2008 from Dr. Samuel J. Chmell, an attending Board-certified orthopedic surgeon,[3] who diagnosed lumbar disc derangement and lumbar degenerative disc disease. On May 30, 2006 Dr. Chmell diagnosed a bilateral traumatic hip strain. He diagnosed right-sided lumbar sciatica and right-sided radiculopathy on June 27, 2006. In an October 24, 2006 report, Dr. Chmell noted lumbar and bilateral hip weakness and diagnosed a herniated lumbar disc and bilateral hip sprain/strain.

On June 20, 2008 appellant claimed a schedule award. The Office requested that Dr. Chmell submit an impairment rating utilizing the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*).

On November 19, 2008 Dr. Chmell diagnosed bilateral hip strains and aggravation of osteoarthritis of both hips. According to Tables 17-8[4] and 17-9[5] of the A.M.A., *Guides*, appellant had 57 percent impairment to each leg due to restricted motion and weakness. In attached worksheets, Dr. Chmell noted the following measurements for the right and left hips, respectively: 75 and 65 degrees forward flexion; 20 and 25 degrees extension; 10 and 10 degrees abduction; 0 and 0 degrees adduction; 5 and 0 degrees internal rotation; 15 and 10 degrees external rotation. He opined that, according to Table 17-9, these limitations equaled 10 percent impairment for moderate restriction of bilateral hip motion. Referring to Table 17-8, Dr. Chmell also assessed 47 percent impairment to each hip due to weakness, as follows: 5 percent for diminished flexion; 17 percent for diminished extension; and 25 percent for diminished

[2] Appellant has several prior accepted claims: File No. xxxxxx273 for September 8, 1978 face, scalp, neck and right shoulder contusions; File No. xxxxxx089 and xxxxxx159 for December 20, 2001 lower extremity injuries; File No. xxxxxx608 for a December 8, 2004 umbilical hernia; File No. xxxxxx055 for bilateral carpal tunnel syndrome and right radial styloid tenosynovitis; File No. xxxxxx827 for a chronic respiratory condition. On December 15, 2006 the Board issued a decision under Docket No. 06-1980 regarding the respiratory condition and on April 7, 2009 issued an Order Remanding Case under Docket No. 08-962 to double two hernia claims. These claims are not before the Board on the present appeal.

[3] Appellant also submitted imaging results. October 18, 2001 x-rays showed minimal osteophytes of both hips likely related to childbirth trauma. December 16, 2003 bilateral hip x-rays showed no arthritis. A May 4, 2005 lumbar magnetic resonance imaging (MRI) scan was normal.

[4] Table 17-8, page 532 of the fifth edition of the A.M.A., *Guides* is entitled "Impairment Due to Lower Extremity Muscle Weakness."

[5] Table 17-9, page 537 of the fifth edition of the A.M.A., *Guides* is entitled "Hip Motion Impairment."

abduction. He found that appellant had reached maximum medical improvement as of August 28, 2008.

On November 26, 2008 the Office referred Dr. Chmell's opinion to an Office medical adviser for calculation of the percentage of permanent impairment. On December 8, 2008 an Office medical adviser concurred that appellant had a 10 percent impairment of each lower extremity due to restricted hip motion according to Table 17-9. He explained, however, that according to paragraph 1, page 508 of the A.M.A., *Guides*,[6] decreased motion and weakness cannot be rated conjunctively in the same region. Therefore, Dr. Chmell erred by rating impairments both for restricted motion and loss of strength. The Office medical adviser discounted the 47 percent impairment of each lower extremity due to hip weakness. He concluded that appellant had a 10 percent impairment of each leg due to limited hip motion.

In a February 3, 2009 decision, the Office granted appellant schedule awards for 10 percent impairment of the left and right leg.[7]

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[8] provides for compensation to employees sustaining impairment from loss or loss of use of specified members 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 mater 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 as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[9]

FECA Bulletin No. 01-5 provides that, in making an impairment rating for the lower extremities, different evaluation methods cannot be used in combination. For example, arthritis impairments obtained from Table 17-31 cannot be combined with impairment determinations based on gait derangement (Table 17-5), muscle atrophy (Table 17-6), muscle strength (Tables 17-7 and 17-8) range of motion loss (section 17.2f). Before finalizing any physical impairment calculation, the Office medical adviser is to verify the appropriateness of the combination of evaluation methods with that listed in Table 17-2, the cross-usage chart.[10]

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[6] The first paragraph on page 508 of the A.M.A. *Guides*, section 16.8a) provides in pertinent part: "Decreased strength *cannot* be rated in the presence of decreased motion…." (Emphasis in the original.)

[7] Following the February 3, 2009 decision, appellant submitted additional medical reports regarding her lower extremities. However, the Office has not yet issued a decision on this evidence. The Board may not consider evidence for the first time on appeal that was not before the Office at the time it issued the final decision in the case. *See* 20 C.F.R. § 501.2(c).

[8] 5 U.S.C. §§ 8101-8193.

[9] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[10] *See* FECA Bulletin No. 01-5 (issued January 29, 2001); *see also* A.M.A., *Guides* 526, Table 17-2 (5th ed. 2001).

ANALYSIS

The Office accepted that appellant sustained bilateral hip strain/sprains, an aggravation of osteoarthritis of both hips and a lumbar strain, in addition to a herniated C5-6 disc and a right rotator cuff tear. It granted schedule awards for 10 percent impairment to each lower extremity. On appeal, appellant asserts that she has a 57 percent impairment of each lower extremity as rated by Dr. Chmell, an attending Board-certified orthopedic surgeon.

Dr. Chmell found a 57 percent impairment of each lower extremity, 10 percent due to restricted hip motion under Table 17-9 of the A.M.A., *Guides* and 47 percent due to weakness according to Table 17-8. An Office medical adviser concurred with Dr. Chmell's assessment of a 10 percent impairment of each leg due to restricted motion. However, he explained that, under paragraph 16.8a, page 508 of the A.M.A., *Guides*, decreased strength cannot be rated in the presence of decreased motion.[11] The A.M.A., *Guides* provide that loss of strength can berated separately only in rare cases, if the examiner believed that weakness represents an impairment factor not considered adequately by other methods in the A.M.A., *Guides*.[12] Dr. Chmell did not explain why strength impairment should be rated separately from the range of motion impairment. Therefore, he improperly assessed strength impairment under Table 17-8 in conjunction with restricted motion under Table 17-9.

The Board finds that the Office medical adviser used the appropriate portions of the A.M.A., *Guides* to calculate the percentage of impairment awarded. The Office medical adviser accurately applied the rating criteria to Dr. Chmell's findings. He explained that Dr. Chmell improperly assessed impairments for weakness in conjunction with restricted motion. Thus, the Board finds that the Office medical adviser's opinion is sufficient to represent the weight of the medical evidence in this case.[13]

Appellant also contends that the Office failed to consider her bilateral knee injuries, lumbar radiculitis and a possible deep venous thrombosis in the right leg in determining the percentage of permanent impairment. Dr. Chmell diagnosed right-sided lumbar sciatica and radiculopathy on June 27, 2006; but he did not address whether these conditions caused any impairment of the lower extremities. Also, there is no medical evidence before the Board on appeal regarding knee injuries or a deep venous thrombosis. Appellant has not established any additional lower extremity impairments due to these factors.

CONCLUSION

The Board finds that appellant has not established that she sustained more than a 20 percent impairment of the lower extremities, for which she received a schedule award.

[11] A.M.A., *Guides* 508, section 16.8a. *See also J.G.*, 61 ECAB ___ (Docket No. 09-1128, issued December 7, 2009).

[12] *Id*.

[13] *See Bobby L. Jackson*, 40 ECAB 593, 601 (1989).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 3, 2009 is affirmed.

Issued: May 21, 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