United States Department of Labor
Employees' Compensation Appeals Board

T.J., Appellant	)	
	)	**Docket No. 17-0736**
and	)	**Issued: July 10, 2017**
U.S. POSTAL SERVICE, STOCKYARDS, Chicago, IL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On February 14, 2017 appellant filed a timely appeal from a November 3, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has met her burden of proof to establish more than 31 percent permanent impairment of the right lower extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On April 26, 2013 appellant, then a 46-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on April 6, 2013 she experienced pain in her right leg when she

[1] 5 U.S.C. § 8101 *et seq.*

twisted it around in reaction to a dog's bark while delivering mail at work. OWCP assigned the claim File No. xxxxxx587.

On July 17, 2013 OWCP accepted the claim for sprain, other specified sites of the right hip and thigh. It authorized right total hip arthroplasty performed on September 23, 2014 by Dr. Scott Sporer, a Board-certified orthopedic surgeon.

On November 26, 2013 appellant filed occupational disease claims (Form CA-2) alleging that she developed right osteoarthritis with internal derangement following her right leg sprain. OWCP assigned the claims File No. xxxxxx720. It accepted the claims for aggravation of right hip osteoarthritis, spondylolisthesis at L4-5 level, degenerative lumbar disc disease, and lumbar radiculopathy. OWCP combined File No. xxxxxx720 and File No. xxxxxx587.

On April 7, 2015 appellant filed a claim for a schedule award (Form CA-7) (File No. xxxxxx587). She submitted a March 13, 2015 duty status report (Form CA-17) with an illegible signature. The report provided a diagnosis of right hip osteoarthritis due to appellant's accepted April 6, 2013 employment injury. It indicated that she was released to return to full-duty work with no restrictions. In addition, the report noted that appellant had reached maximum medical improvement (MMI).

By letter dated April 9, 2015, OWCP advised appellant that the evidence submitted was insufficient to establish her claim. It requested that she provide a medical report from her physician assessing her permanent impairment based on the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). Appellant was afforded 30 days to submit the requested evidence. She did not respond.

In a June 6, 2016 decision, OWCP denied appellant's claim for a schedule award, finding that she had not submitted the medical evidence necessary to establish permanent impairment of a scheduled member.

On July 19, 2016 appellant requested reconsideration. She submitted a June 22, 2016 report from Dr. Neil Allen, a Board-certified internist and neurologist. Dr. Allen noted a history of the April 6, 2013 injury and the September 23, 2014 right hip surgery. Appellant had complaints of intermittent right hip and thigh pain with right hip pain that ranged from 2 to 4 on a scale of 10 with reduced mobility and stiffness. She reported exacerbating factors that included standing more than 20 minutes, walking more than 15 minutes, walking her large dogs, kneeling while gardening, and working on cars. Relieving factors included rest, placing a pillow between the knees for sleeping, and medications. Appellant avoided riding her motorcycle. Dr. Allen advised that she had reached MMI.

Regarding appellant's functional history, Dr. Allen utilized Table 1-2, page 4 of the sixth edition of the A.M.A., *Guides* which listed activities of daily living (ADLs). He reported that she had no interference with self-care, personal hygiene, communication, sensory function, and nonspecialized hand activities. Appellant had moderate interference with physical activity, travel, and sleep. She experienced severe interference with sexual activity. Dr. Allen reported that appellant's American Academy of Orthopedic Surgery (AAOS) Lower Limb Questionnaire score was 75. On examination of the right hip, he observed left-sided hip sway. The thigh measured at 35 centimeters (cm) bilaterally and 10 cm proximal to the superior pole of the patella. Appellant had a 10 cm well-healed surgical scar in the region of the greater trochanter of

the femur. She also had a 4 cm well-healed surgical scar just posterior to the 10 cm scar. On palpation, global tenderness was mild. There was a mild increased tone through the gluteal musculature.

On neurovascular examination, popliteal pulses were intact bilaterally. Sharp/dull and soft touch discrimination were intact in all regions bilaterally. Muscle strength was 5/5 for the hamstrings, quadriceps, abductors, adductions, hip flexor, internal rotators, and external rotators bilaterally.

Dr. Allen reported right hip range of motion as "l00 degrees (90 degrees, 100 degrees) flexion, -13 degrees (-10 degrees, -10 degrees) extension, 50 degrees (40 degrees, 45 degrees) external rotation, 25 degrees (20 degrees, 25 degrees) internal rotation, 50 degrees (50 degrees, 50 degrees) abduction, 35 degrees (25 degrees, 30 degrees) abduction, 25 degrees (20 degrees, 25 degrees) adduction on the right, 120 degrees flexion, -10 degrees extension, 50 degrees external rotation, 40 degrees internal rotation, 25 degrees abduction, and 40 degrees adduction on the left." Clinical studies included a September 6, 2013 magnetic resonance imaging (MRI) scan of the pelvis and right hip which revealed severe asymmetric right hip osteoarthritis with femoral head and acetabular remodeling and small joint effusion. There was also relatively extensive bone marrow edema like signal involving the proximal right femur. A September 6, 2013 right hip x-ray showed asymmetric severe right hip arthropathy that was better seen by the MRI scan.

Dr. Allen utilized the diagnosis-based impairment rating method of the sixth edition of the A.M.A., *Guides* to calculate appellant's right hip impairment. He found that, under Table 16-4,[2] page 515, Hip Regional Grid, the medical records and physical examination findings of a mild motion deficit in flexion represented a class three impairment with a default value of 37 percent leg impairment. Dr. Allen adjusted this impairment rating based on functional history and physical examination findings. He assigned a grade modifier 3 for Functional History (GMFH) under Table 16-6, page 516 based on appellant's AAOS Lower Limb Questionnaire score of 75. Dr. Allen assigned a grade modifier 1 for Physical Examination (GMPE) under Table 16-7, page 517 based on consistently documented mild palpatory findings without observed abnormalities, stability, no alteration in alignment/deformity compared to unaffected side, and no muscle atrophy. He assigned a grade modifier 4 for Clinical Studies (GMCS) under Table 16-8, page 519 based on the MRI scan and x-ray results. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), Dr. Allen found that (3-3) + (1-3) + (4-3) resulted in a net grade modifier of -1, equaling 37 percent permanent impairment, grade C, which he reduced to grade B or 34 percent permanent impairment of the right lower extremity.

On October 23, 2016 Dr. Eric M. Orenstein, an OWCP district medical adviser (DMA) and Board-certified orthopedic surgeon, reviewed the medical record, including Dr. Allen's June 22, 2016 findings. He agreed with the methodology used by Dr. Allen to calculate his impairment rating, but disagreed with his assessment of the functional history and clinical studies adjustments. Dr. Orenstein used Table 16-4, Hip Regional Grid, page 515, with a key factor of total hip replacement. He determined that appellant had class 3 impairment with a default grade C or 37 percent permanent impairment. Dr. Orenstein noted Dr. Allen's finding that appellant

[2] It appears to the Board that Dr. Allen inadvertently indicated that he utilized Table 16-3 on page 515 rather than Table 16-4 on page 515 as his findings correspond to the values listed in Table 16-4 on page 515 for a partial or total hip replacement.

had an AAOS Lower Limb Inventory Score of 75. According to the American Board of Independent Medical Examiners (ABIME) training he received on using the sixth edition of the A.M.A., *Guides* to determine an impairment rating, an AAOS Lower Limb questionnaire score of 75 equated to a grade 1 modifier for GMFH. Dr. Orenstein assigned a grade 1 modifier for GMPE based on minimal palpatory findings without observed abnormalities. He related that a grade modifier for GMCS was not warranted as there were no current x-rays of appellant's right total hip replacement. Dr. Orenstein calculated a net adjustment of two positions to the left resulting in a final 31 percent permanent impairment rating for the right leg. He found that appellant had reached MMI on June 22, 2016, the date of Dr. Allen's evaluation.

In a November 2, 2016 decision, OWCP vacated the June 6, 2016 decision. It found that the medical evidence of record was sufficient to establish that appellant sustained a permanent impairment to a scheduled member due to her accepted April 6, 2013 work injuries.

By decision dated November 3, 2016, OWCP granted appellant a schedule award for 31 percent permanent impairment of the right lower extremity.

LEGAL PRECEDENT

The schedule award provision of FECA[3] and its implementing federal regulations[4] 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, FECA 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[5] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to rate permanent impairment.[6]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method for evaluating permanent impairment.[7] For lower extremity impairments, the evaluator identifies the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on functional history, physical examination, and clinical studies.[8] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[9] Under Chapter 2.3 of the A.M.A.,

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Id.* at § 10.404(a).

[6] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

[7] A.M.A., *Guides* 493-531.

[8] *Id.*

[9] *Id.* at 521.

Guides, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[10]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed through an OWCP medical adviser for an opinion concerning the nature and extent of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.[11]

ANALYSIS

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

OWCP accepted appellant's claim for right hip and thigh sprain, aggravation of right hip osteoarthritis, spondylolisthesis at L4-5 level, degenerative lumbar disc disease, and lumbar radiculopathy. It authorized right total hip arthroplasty performed on September 23, 2014.

OWCP granted appellant a schedule award for 31 percent permanent impairment of her right leg. In his June 22, 2016 report, Dr. Allen, appellant's treating physician, opined that appellant had 34 percent permanent impairment of the right lower extremity. In his October 23, 2016 report, Dr. Orenstein, serving as OWCP's DMA, found that appellant had 31 percent permanent impairment of the right lower extremity for a total hip replacement.

With respect to assigning values for grade modifiers, both Dr. Allen and Dr. Orenstein agreed that appellant had a grade modifier 1 for GMPE based on minimal or mild palpatory findings without observed abnormalities. However, the physicians disagreed on the value of the grade modifier for GMFH. Dr. Allen found that under Table 16-6, page 516, a grade modifier for GMFH of 3 for the right leg was justified by appellant's AAOS Lower Limb Questionnaire score of 75 (Appendix 16A of the sixth edition of the A.M.A., *Guides*). Dr. Orenstein disagreed with Dr. Allen's assessment and determined that based on his ABIME training regarding the use of the sixth edition of the A.M.A., *Guides* to rate impairment, appellant's AAOS score of 75 represented a grade modifier 1 for GMFH. The Board notes, however, that reference to Table 16-6 and accompanying text regarding calculation of the grade modifier for functional history reveals that the Lower Limb Questionnaire is only meant to serve as an optional supplemental source for deriving the grade modifier for functional history and not as a sole source.[12] Both Dr. Allen and Dr. Orenstein failed to apply the primary source of Table 16-6 for evaluating the grade modifier for functional history, *i.e.*, the gait derangement portion of Table 16-6 which places individuals in various grades based on whether gait derangement exists and, if so, the level of such derangement.[13]

[10] *Id.* at 23-28.

[11] *See supra* note 6 at Chapter 2.808.6(f) (February 2013).

[12] Section 16.3a of the sixth edition provides, "The evaluating physician may use outcome instruments and inventories as part of the process of evaluating functional symptoms." "The [AAOS] Lower Limb Instrument is 1 inventory that may be used." "An inventory is used only to assist the examiner in defining the grade for functional history and does not serve as a basis for defining further impairment nor does the score reflect an impairment percentage." *See supra* note 7 at 516.

[13] *P.R.*, Docket No. 15-1782 (issued August 12, 2016).

Drs. Allen and Orenstein also disagreed regarding the grade modifier value for clinical studies. Dr. Allen assigned a grade modifier 4 for clinical studies under Table 16-8, page 519 based on the September 6, 2013 right hip MRI scan and x-ray results. However, he did not sufficiently explain how he calculated his assessment as Table 16-8 does not provide any criteria for a grade 4 modifier with regard to the hip. Dr. Orenstein disagreed with Dr. Allen's assessment and noted that a clinical studies grade modifier was not applicable as there were no current x-rays of appellant's right total hip replacement.

The Board finds that neither Dr. Allen nor Dr. Orenstein sufficiently explained how the impairment was determined under the criteria of the sixth edition of the A.M.A., *Guides*. Accordingly, the Board will set aside OWCP's February 14, 2017 decision and will remand the case to OWCP for such further medical development as it deems necessary and the issuance of a *de novo* decision on the extent of appellant's right lower extremity impairment.

On appeal appellant contends that she is entitled to a greater schedule award. As set forth above, the case will be remanded to OWCP for additional medical development on the extent of appellant's right lower extremity impairment.

CONCLUSION

The Board finds that the case is not posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the November 3, 2016 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: July 10, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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