U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of LIONEL LEWIS and U.S. POSTAL SERVICE,
POST OFFICE, Atlanta, GA

Docket No. 03-1518; Submitted on the Record;
Issued November 19, 2003

DECISION and ORDER

Before ALEC J. KOROMILAS, DAVID S. GERSON,
A. PETER KANJORSKI

The issue is whether appellant has more than a 20 percent impairment of the left lower extremity, for which he received a schedule award.

On April 13, 2001 appellant, then a 64-year-old maintenance support clerk sustained a left hip fracture when he was hit by a forklift. The Office of Workers' Compensation Programs accepted the claim for a left hip fracture and authorized surgery to repair the injury. Appellant stopped work on April 17, 2001 and returned to a limited-duty position on August 14, 2001.

An operative report dated May 9, 2001 noted that appellant underwent a pinning of the left femoral neck fracture and was diagnosed with a subcapital fracture of the left femoral neck. The work capacity evaluation dated October 8, 2001 noted that appellant could return to work regular duties, eight hours per day. Dr. Roberson's reports note that appellant was status post left hip fracture with early changes of degenerative arthritis. He returned appellant to limited duty on August 13, 2001. In a report dated June 19, 2002, Dr. Clifford W. Roberson, a Board-certified neurologist, noted that appellant was not having any pain in the left hip and would be discharged from his treatment. Examination findings included weakness in hip flexion of 4/5, 90 degrees flexion, 0 degrees internal rotation, 15 degrees external rotation and a 1 centimeter length discrepancy.

Dr. Roberson submitted an impairment evaluation dated August 28, 2002 in accordance with the fifth edition of American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (hereinafter A.M.A., *Guides*).[1] He diagnosed appellant with a hip fracture and advised that he had discharged appellant from his care on June 19, 2002. Dr. Roberson advised that appellant had a 55 percent permanent impairment of the left lower extremity.

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[1] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.,* 53 ECAB __ (Docket No. 01-1361, issued February 4, 2002).

Dr. Roberson's report and the case record were referred to the Office's medical adviser who determined in accordance with the A.M.A., *Guides* that appellant sustained a 25 percent impairment of the left lower extremity. The Office medical adviser noted that the range of motion figures on Dr. Roberson's report dated June 19, 2002 were as follows: forward flexion of 90 degrees,[2] internal rotation of 0 degrees,[3] external rotation of 15 degrees[4] and loss of limb length of 1 centimeter[5] for a total impairment of 25 percent permanent impairment of the left lower extremity.

The Office determined that a conflict of opinion existed between appellant's treating physician, Dr. Roberson, who noted that appellant sustained a 55 percent permanent impairment of the left lower extremity and the Office medical adviser who determined that appellant sustained a 25 percent permanent impairment of the left lower extremity.

To resolve the conflict appellant was referred to an impartial physician, Dr. John G. Keating, a Board-certified orthopedist. The Office provided Dr. Keating with appellant's medical records, a statement of accepted facts as well as a detailed description of appellant's employment duties. In a medical report dated February 14, 2003, Dr. Keating indicated that he reviewed the records provided to him and performed a physical examination of appellant. Hip range of motion was reported as forward flexion was 90 degrees;[6] internal rotation 10 degrees;[7] external rotation 20 degrees;[8] abduction 20 degrees;[9] adduction 20 degrees;[10] and loss of limb length 2.5 centimeters.[11] He then provided analysis under the A.M.A., *Guides* and determined the whole body impairment rating was 37 percent.

In a letter dated March 6, 2003, the Office requested that Dr. Keating provide a permanent impairment rating with respect to the hip, not a whole body rating as set forth in his report of February 14, 2003. Dr. Keating submitted an Office form report dated March 17, 2003 and reported retained forward flexion of 90 degrees for a lower extremity impairment rating of 5 percent;[12] retained internal rotation of 10 degrees for an impairment rating of 2 percent;[13]

[2] *See* A.M.A., *Guides*, *supra* note 1 at page 537, Table 17-9 (5th ed. 2001).

[3] *Id.*

[4] *Id.*

[5] *See id.* at page 528, Table 17-4.

[6] *Id.* at 537.

[7] *Id.*

[8] *Id.*

[9] *Id.*

[10] *Id.*

[11] *Id.* at 528.

[12] *Id.* at 537.

[13] *Id.*

retained external rotation of 20 degrees for an impairment rating of 2 percent;[14] retained abduction of 20 degrees for an impairment rating of 2 percent;[15] retained adduction of 20 degrees for an impairment rating of 4 percent;[16] and loss of limb length of 2.5 centimeters for an impairment rating of 3 percent[17] for a total of 17 percent permanent impairment of the hip. He advised that the date of maximum medical improvement was June 19, 2002. In a letter dated March 20, 2003, Dr. Keating advised that he had utilized the fifth edition of the A.M.A., *Guides* in his analysis.

Dr. Keating's reports and the case record were referred to the Office's medical adviser who determined that, in accordance with the A.M.A., *Guides*, appellant sustained a 20 percent permanent impairment of the left lower extremity. He referred to example 17-21 on page 556 of the A.M.A., *Guides* and advised that range of motion should not be combined with either arthritis or atrophy and recommended using the range of motion parameters because they were more specific and best characterized the impairment. Dr. Keating noted that the example did not add all the motion impairments but, indicated that the impairment was severe and gave the maximum rating of 20 percent. The district medical adviser agreed that maximum medical improvement had been reached on June 19, 2002 and concluded that appellant sustained a 20 percent permanent impairment.

In a decision dated May 8, 2003, the Office granted appellant a schedule award for a 20 percent permanent impairment of the left lower extremity for a total of 57.6 weeks, to run from June 19, 2002 to July 27, 2003.

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

The schedule award provisions of the Federal Employees' Compensation Act[18] and its implementing regulation[19] 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, the Act 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 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. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.

The Board has carefully reviewed Dr. Keating's reports dated February 14 and March 17, 2003 and notes that, while he found a 17 percent permanent impairment of the left lower extremity it is not clear how he came to this conclusion. He noted that forward flexion was 90

[14] *Id.*

[15] *Id.*

[16] *Id.*

[17] *Id.* at 528.

[18] 5 U.S.C. § 8107.

[19] 20 C.F.R. § 10.404 (1999).

degrees for an impairment rating of 5 percent of the lower extremity which corresponds to his figures for internal rotation.[20] However, Dr. Keating notes internal rotation of 10 degrees for an impairment rating of 2 percent which does not correspond to Table 17-9 which provides that range of 10 to 20 of internal rotation would equal an impairment rating of 5 percent.[21] He noted external rotation of 20 degrees for an impairment rating of 2 percent. Table 17-9 provides that range of 20 to 30 degrees of external rotation equals an impairment rating of 5 percent.[22] Dr. Keating noted abduction of 20 degrees for an impairment rating of 2 percent.[23] Again, Table 17-9 provides that a range of 15 to 25 degrees of abduction equals an impairment of 5 percent. He noted adduction of 20 degrees for an impairment rating of 4 percent.[24] However, under Table 17-9 of the A.M.A., *Guides*, appellant would not be entitled to an impairment rating for this finding.[25] Dr. Keating also provided a loss of limb length of 2.5 centimeters for an impairment rating of 3 percent.[26] Table 17-4 of the A.M.A., *Guides* provides that a discrepancy of 2-2.9 cm. would equal an impairment of 5 to 9 percent.[27] While Dr. Keating advised that he utilized the fifth edition of the A.M.A., *Guides*, he did not provide an explanation or make reference to particular tables as to how he determined the above impairment ratings in calculating appellant's lower extremity impairment. Therefore, the Board cannot determine whether Dr. Keating's figures for left lower extremity impairment were in conformance with the fifth edition of the A.M.A., *Guides*.

Moreover, the Board finds that the Office medical adviser report of April 3, 2003 is similarly deficient as it is unclear from his report how he determined that the left lower extremity impairment was 20 percent. He referred to example 17-21 on page 556 of the A.M.A., *Guides* and properly advised that range of motion should not be combined with either arthritis or atrophy and recommended using the range of motion parameters because they were more specific and best characterize the impairment. The Office medical adviser noted that the example did not add all the motion impairments but, indicated that the impairment was severe with flexion of 50 degrees therefore, appellant in this hypothetical was entitled to a maximum rating of 20 percent. Under Table 17-9 of the A.M.A., *Guides*, appellant would be entitled to a 20 percent impairment for his range of motion deficits, *i.e.*, 5 percent each for forward flexion, internal rotation, external rotation, and abduction impairments.[28] However, based on Dr. Keating's finding of a 2.5 cm loss of limb length, under Table 17-4 appellant would be entitled to an additional 5 to 9 percent impairment. The Board finds that the Office medical adviser provided an incomplete

[20] A.M.A., *Guides*, *supra* note 1 at 537.

[21] *Id.*

[22] *Id.*

[23] *Id.*

[24] *Id.*

[25] *Id.*

[26] *Id.* at 528.

[27] *Id.*

[28] *Id.* at 537.

explanation regarding his impairment finding. Thus, the reports of the impartial medical examiner and the Office medical adviser's reports do not appear to be in conformance to the fifth edition of the A.M.A., *Guides.*

Proceedings under the Act are not adversary in nature nor is the Office a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[29] Accordingly, once the Office undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.

In view of the disparity in the evaluations of the impartial medical examiner and the failure of the Office medical adviser to fully explain his calculations using the medical evidence of record, the Office should refer the matter back to the impartial medical examiner to fully explain his calculations in accordance with the A.M.A., *Guides*.[30]

Following this, and any other further development as deemed necessary, the Office shall issue an appropriate merit decision on appellant's schedule award claim.

The decision of the Office of Workers' Compensation Programs dated May 8, 2003 is hereby set aside and the case is remanded for further development in accordance with this decision of the Board.

Dated, Washington, DC
November 19, 2003

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

A. Peter Kanjorski
Alternate Member

[29] *John W. Butler*, 39 ECAB 852 (1988).

[30] See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (March 1995) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).