

On April 17, 2005 Dr. Marc E. Umlas, an attending Board-certified orthopedic surgeon, stated that appellant was able to return to work without restrictions on May 1, 2005. On May 23, 2006 he noted that appellant had undergone a left hip replacement. Dr. Umlas opined that appellant had 15 percent impairment of the whole person based on Table 17-33 at page 546 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (the A.M.A., *Guides*). On June 23, 2005 he stated that appellant was experiencing pain in his groin and left thigh. X-rays demonstrated thinning of the joint space, showing possible secondary osteoarthritis.

In letters dated August 29 and September 22, 2006 and February 9, 2007, the Office advised Dr. Umlas that the Federal Employees' Compensation Act¹ does not provide for whole person impairment. It asked him to provide an impairment evaluation of appellant's left lower extremity based on the A.M.A., *Guides*, explaining how he calculated the impairment by referring to the applicable tables and figures. There was no response from Dr. Umlas.

On April 26, 2007 James W. Dyer, a Board-certified orthopedic surgeon and an Office medical adviser, stated that appellant had 37 percent impairment of the left lower extremity for hip replacement with good results based on Dr. Umlas' reports and Tables 17-33 at page 546 and Table 17-34 at page 548 of the A.M.A., *Guides*, with a hip score of 85 to 100 points for good results following a hip replacement.² He noted that appellant returned to full duty without restrictions on May 1, 2005.³

By decision dated May 4, 2007, the Office granted appellant a schedule award based on 37 percent impairment of the left lower extremity for 106.56 weeks⁴ from May 23, 2006 to June 6, 2008.

In a September 20, 2006 report received by the Office on March 5, 2008, Dr. Umlas stated that appellant continued to have pain in his left hip and groin which was consistent with left hip traumatic osteoarthritis. Appellant described his pain as an 8 or 9 out of 10. Dr. Umlas indicated that appellant could walk a distance of two blocks and could climb stairs slowly, pausing to rest when necessary. Appellant had good range of motion of the left hip without significant pain.

¹ 5 U.S.C. §§ 8108-8193.

² Tables 17-33 and 17-34 are part of section 17.2j, Diagnosis-Based Estimates, beginning at page 545 of the A.M.A., *Guides*.

³ See Federal (FECA) Procedural Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002) (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).

⁴ The Act provides for 288 weeks of compensation for 100 percent loss or loss of use of a lower extremity. 5 U.S.C. § 8107(c)(2). Multiplying 288 weeks by 37 percent equals 106.56 weeks of compensation.

By decision dated March 14, 2008, the Office denied appellant's claim for an additional schedule award.⁵

LEGAL PRECEDENT

Section 8107 of the Act⁶ 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 permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.⁷

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.⁸ The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.⁹ 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.¹⁰ 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.¹¹ The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.¹² 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.¹³ If more than one method can be used, the method that provides the higher impairment rating should be adopted.¹⁴

⁵ Subsequent to the March 14, 2008 Office decision, additional evidence was associated with the file. 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.

⁶ 5 U.S.C. § 8107.

⁷ 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

⁸ A.M.A., *Guides*, 525.

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.* at 525, Table 17-1.

¹² *Id.* at 548, 555.

¹³ *Id.* at 526.

¹⁴ *Id.* at 527, 555.

ANALYSIS

In reports dated April 17 and June 23, 2005 and September 20, 2006, Dr. Umlas noted that appellant had undergone a left hip replacement. X-rays demonstrated a thinning of the joint space indicating possible secondary osteoarthritis. Dr. Umlas stated that appellant had left hip and groin pain which was consistent with traumatic osteoarthritis. Appellant described his pain as an 8 or 9 out of 10. Dr. Umlas stated that appellant had good range of motion of the left hip without significant pain. However, he did not provide any range of motion measurements. Dr. Umlas opined that appellant had 15 percent impairment of the whole person based on Table 17-33 at page 546 of the A.M.A., *Guides*. There are several deficiencies in Dr. Umlas' impairment rating of appellant's left lower extremity. Whole person impairment is not permitted under the Act.¹⁵ Additionally, although Dr. Umlas found that appellant had significant pain, rated 8 or 9 out of 10, he did not explain whether he had impairment for pain or sensory deficit due to peripheral nerve injury.¹⁶ Although he stated that appellant had good hip range of motion, he failed to provide measurements for hip flexion and extension, internal and external rotation and abduction and adduction.¹⁷ Dr. Umlas stated that x-rays demonstrated thinning of the hip joint space indicating possible secondary osteoarthritis. He also noted that appellant's left hip and groin pain was consistent with traumatic osteoarthritis. However, Dr. Umlas did not provide the joint cartilage interval measurements from appellant's hip x-rays and did not explain whether he had impairment due to arthritis.¹⁸ The Board notes that the cross-usage chart, Table 17-2 at page 526 of the A.M.A., *Guides* permits the combination of lower extremity impairment due to diagnosis-based estimates with range of motion impairment and peripheral nerve injury impairment. It also permits the combination of impairment due to diagnosis-based estimates with peripheral nerve injury impairment and impairment due to arthritis. Because Dr. Umlas did not provide the complete information required by the A.M.A., *Guides* for determining lower extremity impairment, his report is not sufficient to establish an appropriate schedule award for appellant's left lower extremity.

Dr. Dyer stated that appellant had 37 percent impairment of the left lower extremity for hip replacement with good results based on Dr. Umlas' report and Tables 17-33 at page 546 and Table 17-34 at page 548 of the A.M.A., *Guides*. However, as noted, Dr. Umlas' report is incomplete. Therefore, Dr. Dyer's calculation of appellant's left lower extremity impairment is not sufficient to establish an appropriate schedule award.

The Board finds that this case must be remanded to the Office for further development of the medical evidence on the issue of appellant's left lower extremity impairment.

¹⁵ See *Guiseppe Aversa*, 55 ECAB 164, 167 (2003).

¹⁶ See A.M.A., *Guides* 550-553, 17.2l, Peripheral Nerve Injuries.

¹⁷ See *id.* at 533-538, 17.2f, *Range of Motion*, including Table 17-9 at page 537 for hip range of motion.

¹⁸ See A.M.A., *Guides* 544-545, 17.2h, *Arthritis*, including Table 17-31 for impairment due to reduced joint cartilage levels.

CONCLUSION

The Board finds that this case is not in posture for a decision. On remand the Office should further develop the medical evidence on the issue of appellant's work-related left lower extremity impairment. It should obtain a medical report containing complete findings on physical examination and a rationalized opinion regarding appellant's left lower extremity impairment with reference to the applicable sections of the A.M.A., *Guides*. After such further development as it deems necessary, the Office should issue an appropriate decision regarding appellant's claim for a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 14, 2008 is set aside and the case is remanded for further action consistent with this decision.

Issued: April 2, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board