United States Department of Labor
Employees' Compensation Appeals Board

G.C., Appellant	)	
and	)	**Docket No. 13-1493**
	)	**Issued: September 18, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Malden, MA, Employer	)	

Appearances:
Daniel B. Shapiro, Esq., for the appellant
Paul J. Klingenberg, Esq., for the Director

Oral Argument September 3, 2014

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 11, 2013 appellant, through her attorney, timely appealed the December 14, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP) regarding entitlement to a schedule award. 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.[2]

ISSUE

The issue is whether appellant has greater than 31 percent impairment of the left lower extremity.

[1] 5 U.S.C. §§ 8101-8193 (2006).

[2] The record on appeal contains evidence received after OWCP issued its December 14, 2012 decision. The Board is precluded from considering evidence that was not in the case record at the time OWCP rendered its final decision. 20 C.F.R. § 501.2(c)(1) (2012).

FACTUAL HISTORY

Appellant, a 67-year-old clerk, sustained a work-related injury on August 26, 1999 when a flat tub fell off a truck and hit her left leg. She twisted her knee in the process. OWCP accepted the claim for left knee sprain. Appellant previously injured the same knee at work in November 1994 and June 1995. The June 1995 injury (xxxxxx434) required arthroscopic surgery to repair a torn left medial meniscus.[3] Appellant also has an accepted claim for a December 2, 2004 right knee injury (xxxxxx846).[4]

Under the current claim (xxxxxx485), OWCP approved a June 29, 2006 arthroscopic procedure and a May 5, 2008 left total knee arthroplasty (TKA).[5] Appellant also underwent a May 17, 2010 right TKA, which OWCP authorized under claim number xxxxxx846. Her August 1999 and December 2004 lower extremity claims have been combined, with claim number xxxxxx846 designated as the master file.

On April 18, 2011 appellant filed a claim for a schedule award (Form CA-7) with respect to her August 26, 1999 left knee injury.

In an April 11, 2011 report, Dr. Byron V. Hartunian, a Board-certified orthopedic surgeon, found a combined 55 percent left lower extremity (LLE) impairment.[6] He applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (2008). Dr. Hartunian calculated 28 percent impairment for Class 3 hip arthritis under Table 16-4, Hip Regional Grid (LEI), A.M.A., *Guides* 514 (6th ed. 2008). Additionally, he calculated 37 percent LLE impairment based on the result of appellant's May 5, 2008 left total knee replacement. Dr. Hartunian found Class 3 impairment (fair result) under Table 16-3, Knee Regional Grid (LEI), A.M.A., *Guides* 511 (6th ed. 2008).[7] The left hip and knee impairments combined represented 55 percent LLE impairment. Dr. Hartunian advised that appellant reached maximum medical improvement (MMI) in November 2008; some six months after her left total knee replacement.

---

[3] On November 1, 2000 OWCP granted a schedule award for 20 percent LLE impairment under claim number xxxxxx434.

[4] OWCP accepted the claim for right medial meniscus tear and aggravation of right knee osteoarthritis.

[5] Appellant had follow-up surgery on May 16, 2008 to remove a deep hematoma from her left knee.

[6] Dr. Hartunian examined appellant on March 18, 2011.

[7] The default rating (grade C) was 37 percent. Dr. Hartunian excluded all grade modifiers, and thus, did not calculate a net adjustment. Grade modifiers for Physical Examination (GMPE) and Clinical Studies (GMCS) were excluded because Dr. Hartunian relied on these two factors in determining and/or confirming the appropriate diagnostic class (CDX). Under Table 16-6, Functional History Adjustment -- Lower Extremities, A.M.A., *Guides* 515 (6th ed. 2008), Dr. Hartunian assigned a grade modifier for Functional History (GMFH) of zero for gait derangement (none). Appellant also completed an AAOS (American Academy/Association of Orthopedic Surgeons) lower limb questionnaire during Dr. Hartunian's March 18, 2011 examination. *See* Section 16.9, Appendix 16-A: Lower Limb Questionnaire, A.M.A., *Guides* 555 (6th ed. 2008). Based on her AAOS response, Dr. Hartunian assigned a grade modifier of two representing a moderate deficit. In light of the disparity between the AAOS questionnaire two and gait derangement zero, Dr. Hartunian excluded functional history as unreliable.

In a May 5, 2011 report, the district medical adviser (DMA), Dr. Christopher R. Brigham, concurred with the 28 percent LLE rating for left hip arthritis, but questioned whether this condition was related to appellant's accepted left knee condition.[8] With respect to appellant's total knee arthroplasty, the DMA agreed with the Class 3 (fair result) designation under Table 16-3, Knee Regional Grid (LEI), A.M.A., *Guides* 511 (6th ed. 2008). However, he disagreed with Dr. Hartunian regarding the appropriate adjustment for functional history.[9] Whereas Dr. Brigham found a grade modifier of zero for functional history based on examination findings of no altered gait, Dr. Hartunian determined that appellant's functional history was unreliable and, therefore, should be excluded from the grading process.[10] Dr. Brigham's inclusion of functional history resulted in a net adjustment of -3, which corresponded to 31 percent impairment (grade A), rather than the default rating of 37 percent (grade C) as determined by Dr. Hartunian.[11] The DMA also noted that OWCP previously granted a schedule awarded for 20 percent LLE impairment, which should be subtracted for the current 31 percent LLE (knee) rating.

OWCP declared a conflict in medical opinion between appellant's physician, Dr. Hartunian, and Dr. Brigham. The referee physician was instructed to address the extent of appellant's left lower extremity impairment and whether her left hip condition was work related.

In a report dated November 11, 2011, Dr. John S. Ritter, a Board-certified orthopedic surgeon and impartial medical examiner (IME), found 31 percent LLE impairment under Table 16-3, Knee Regional Grid (LEI), A.M.A., *Guides* 511 (6th ed. 2008). The rating was based on a diagnosis of total knee replacement with a fair result (class 3, grade A).[12] Additionally, the IME found appellant reached MMI one year after her May 2008 left total knee replacement.

On February 29, 2012 another DMA, Dr. David I. Krohn, reviewed the record and noted his concurrence with the IME's November 11, 2011 findings.[13]

[8] Dr. Brigham is Board-certified in occupational medicine.

[9] Dr. Brigham and Dr. Hartunian agreed there should be no assignment of grade modifiers for physical examination and clinical studies.

[10] *See* Table 16-6, Functional History Adjustment -- Lower Extremities, A.M.A., *Guides* 515 (6th ed. 2008).

[11] Net Adjustment (-3) = (GMFH 0 - CDX 3) + (N/A GMPE - CDX) + (N/A GMCS - CDX). *See* Section 16.3d, A.M.A, *Guides* 521-22 (6th ed. 2008).

[12] Dr. Ritter found a functional history of zero based on examination findings of no altered gait. He did not include physical examination and clinical studies. Accordingly, Dr. Ritter calculated a net adjustment based on functional history alone. *See supra* note 11. Dr. Ritter also found that appellant's left hip condition was neither caused nor aggravated by the August 26, 1999 accepted trauma. Thus, he did not include arthritis-based hip impairment in his lower extremity rating.

[13] Dr. Krohn is a Board-certified orthopedic surgeon.

On May 16, 2012 OWCP granted a schedule award for an additional 11 percent impairment of the LLE, for a total LLE impairment of 31 percent.[14] The award covered a period of 31.68 weeks from May 16 through December 23, 2009.

By decision dated December 14, 2012, the Branch of Hearings and Review affirmed OWCP's May 16, 2012 schedule award.

LEGAL PRECEDENT

Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[15] FECA, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[16] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2008).[17]

If there is disagreement between the physician making the examination for OWCP and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[18] For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[19] Where OWCP has referred the employee to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[20]

ANALYSIS

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

OWCP properly found a conflict in medical opinion regarding the extent of appellant's left lower extremity impairment. One area of disagreement was Dr. Hartunian's inclusion of

[14] OWCP reduced this latest schedule award by the 20 percent LLE award appellant received on November 1, 2000 (xxxxxx434).

[15] For a total loss of use of a leg, an employee shall receive 288 weeks' compensation. 5 U.S.C. § 8107(c)(2).

[16] 20 C.F.R. § 10.404.

[17] *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 & Permanent Disability Claims*, Chapter 2.808.6a (February 2013).

[18] 5 U.S.C. § 8123(a); *see* 20 C.F.R. § 10.321; *Shirley L. Steib*, 46 ECAB 309, 317 (1994). The DMA, acting on behalf of OWCP, may create a conflict in medical opinion. 20 C.F.R. § 10.321(b).

[19] *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

[20] *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

impairment due to left hip arthritis. Dr. Brigham, the DMA at the time, questioned whether appellant's left hip condition was causally related to her August 26, 1999 left knee injury. The other area of disagreement was the significance accorded the March 18, 2011 AAOS lower limb questionnaire. Dr. Hartunian assigned a grade modifier of two based on appellant's AAOS results. He also assigned a grade modifier of zero based on gait analysis. Because of the disparity between gait derangement (zero) and the AAOS lower limb questionnaire (two), Dr. Hartunian determined that the grade modifier functional history was unreliable and should be excluded from consideration. Thus, there was no net adjustment. In contrast, Dr. Brigham did not believe the AAOS subjective assessment should nullify the gait derangement finding. Therefore, he assigned a grade modifier functional history of zero based on examination findings of no altered gait, which resulted in a -3 net adjustment.

Dr. Ritter, the IME, found that appellant's left hip arthritis was unrelated to her August 26, 1999 traumatic injury. With respect to appellant's right knee condition, Dr. Ritter found 31 percent LLE impairment. He too found a grade modifier functional history of zero based on examination findings of no altered gait, with a corresponding negative net adjustment from grade C (37 percent) to grade A (31 percent), but he appears not to have administered a new AAOS lower limb questionnaire when he examined appellant in November 2011 examination. Furthermore, Dr. Ritter's report makes no mention of appellant's March 18, 2011 AAOS questionnaire.

The A.M.A., *Guides* indicate that "[t]he evaluating physician ***may*** use outcome instruments and inventories," such as the AAOS lower limb questionnaire, as part of the process of evaluating functional symptoms.[21] The A.M.A., *Guides* further provide that, if there are multiple components to a grade modifier, the evaluator should choose the most ***objective*** grade modifier with the ***highest*** value, associated with the diagnosis being rated.[22] If a grade modifier is found to be unreliable or inconsistent, it should be disregarded and eliminated from the calculation.[23]

An IME's report must actually fulfill the purpose for which it was intended; it must resolve the conflict in medical opinion.[24] OWCP should ensure that the IME's report is comprehensive, clear and definite and that it is based on current information and supported by substantial medical reasoning, as well as a review of the case file.[25] If the referee specialist submits an opinion which is equivocal, lacks rationale, or fails to address the specified medical issues or conflict, OWCP is obliged to seek clarification from the IME.[26]

---

[21] Section 16.3a, A.M.A., *Guides* 516 (6th ed. 2008) (emphasis added); *see* Section 16.9, Appendix 16-A: Lower Limb Questionnaire, A.M.A., *Guides* 555 (6th ed. 2008).

[22] *See* Section 16.3d, A.M.A., *Guides* 521 (6th ed. 2008) (emphasis added).

[23] *Id.*

[24] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing & Evaluating Medical Evidence*, Chapter 2.810.11d(2) (September 2010).

[25] *Id.*

[26] *Id.* at Chapter 2.810.11e.

As noted, Dr. Ritter did not comment on the March 18, 2011 AAOS lower limb questionnaire results nor did he administer a new AAOS questionnaire as part of his November 2011 examination. Although inclusion of AAOS lower limb questionnaire results is not mandatory under the A.M.A., *Guides*, given this particular functional history component was part of the identified conflict, it is reasonable that Dr. Ritter obtain an updated lower limb questionnaire as part of his evaluation process.[27] Accordingly, the Board finds the case is not in posture for decision. OWCP's December 14, 2012 decision shall be set aside, and the case remanded for further development. If Dr. Ritter is either unwilling or unable to reexamine appellant and provide the necessary clarification regarding functional history, then OWCP should refer appellant to another IME.[28] After OWCP has developed the case record consistent with the Board's directive, a *de novo* decision shall be issued.

CONCLUSION

The case is not in posture for decision.

[27] Appellant's counsel would have the Board recalculate the latest schedule award based on a grade modifier functional history of two, but that is a medical determination best left to a qualified physician. Moreover, the March 18, 2011 AAOS lower limb questionnaire is somewhat dated.

[28] *See supra* note 26.

ORDER

IT IS HEREBY ORDERED THAT the December 14, 2012 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: September 18, 2014
Washington, DC

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

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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