United States Department of Labor
Employees' Compensation Appeals Board

J.R., Appellant	)	
and	)	**Docket No. 16-1460**
	)	**Issued: December 14, 2016**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Stockton, CA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 1, 2016 appellant filed a timely appeal from a February 2, 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 more than 12 percent permanent impairment of the right upper extremity and 24 percent permanent impairment of the right lower extremity, for which he received schedule awards.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On July 12, 2014 appellant, then a 53-year-old revenue officer, filed a traumatic injury claim (Form CA-1) alleging that on June 23, 2014 he shattered his right femur and right elbow joint when he fell down stairs.[2] He stopped work on June 23, 2014.

OWCP accepted the claim for a closed peritrochanteric fracture of the neck of the femur, intertrochanteric section, an open fracture of the lower end of the humerus, a closed fracture of the upper end of the humerus, and a right elbow contusion. On June 23, 2014 appellant underwent a "drainage and splinting of the open, right distal humerus fracture and intramedullary fixation of the right proximal femur fractures." He received hospital treatment in July 2014 due to his surgery for right hip wound cellulitis.

In a report dated October 15, 2015, Dr. Helen Mindy Weinrit, a Board-certified anesthesiologist, opined that appellant had reached maximum medical improvement. She advised that she was not providing an impairment evaluation as she had no training in the application of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). Dr. Weinrit diagnosed an intertrochanteric fracture of the right femur and an open, comminuted fracture of the right distal humerus with intra-articular extension. She related that appellant could not fully extend his right arm and experienced upper right arm pain that was mild but increased with exercise. Appellant further complained of mild-to-moderate right hip pain and "numbness of the posterior right elbow, right buttock, and right groin." Dr. Weinrit described appellant's difficulties performing activities of daily living. On examination, she found mild tenderness of the upper right arm with full strength and no swelling or atrophy. Dr. Weinrit provided range of motion measurements obtained by a physical therapist for the elbows, forearms, and right hip. She found full strength with no swelling, atrophy, or tenderness of the right hip area but "decreased sensation to pinprick that correlates with an L2-3 nerve distribution, of the right proximal groin and anterolateral hip." Dr. Weinrit measured appellant's leg length as 40.25 on the right and 41.75 on the left.

OWCP, on November 12, 2015, referred appellant to Dr. Aubrey A. Swartz, a Board-certified orthopedic surgeon, for a second opinion examination to determine the extent of any employment-related permanent impairment.

In an impairment evaluation dated December 2, 2015, Dr. Swartz discussed appellant's symptoms of pain rated 5/10 in his right hip and elbow. He measured range of motion for both elbows. For the right elbow, Dr. Swartz measured -35 degrees extension, 75 degrees flexion, 90 degrees pronation, and 45 degrees supination. He found 4/5 strength of the right arm. On right hip examination, Dr. Swartz found a 2.7 inch shortening of the right leg and thigh circumference of 67 centimeters on the right and 71 centimeters on the left. He diagnosed status post fracture of the right distal humerus extending into the elbow joint treated with an open reduction and internal fixation with plate and screw instrumentation and status post open reduction and internal fixation of the right hip with an intramedullary nail and compression screw in the femoral head

[2] Appellant fell down stairs at his residence while on flexi place and packing for "approved work[-]related travel." The employing establishment confirmed that he "was engaged in official duties at his residence" when the injury occurred.

and neck. Referencing the elbow regional grid set forth at Table 15-4 on page 399, Dr. Swartz identified the diagnosis as a right distal humerus fracture. He determined, however, that he could not use the elbow regional grid to rate the diagnosed condition as it required "normal range of motion of the elbow to proceed with an impairment rating." Dr. Swartz used the range of motion measurements he obtained and determined that, under Table 15-33 on page 474, -35 degrees extension yielded 2 percent impairment, 75 degrees extension yielded 8 percent impairment, 90 degrees pronation yielded no impairment, and 45 degrees supination yielded 2 percent impairment, for a total right upper extremity impairment of 12 percent. He applied grade modifiers of two for functional history of pain and loss of use, which he found did not exceed the range of motion grade modifier of two, for a total right upper extremity impairment of 12 percent. For the right hip, Dr. Swartz identified the diagnosis as a class 2 fractured right hip and femur using Table 16-4, the hip regional grid, set forth on page 514 of the A.M.A., *Guides*. He applied a grade modifier of 2 for functional history due to appellant's use of a cane and severe limp, and a grade modifier of 4 due to the shortening of his right leg to the default value of 20 percent. Applying the net adjustment formula, Dr. Swartz found a grade modifier of 2, or 24 percent right leg impairment.

On January 6, 2016 an OWCP medical adviser reviewed Dr. Swartz' report and concurred with his impairment rating for the right upper and lower extremities.

By decision dated February 2, 2016, OWCP granted appellant a schedule award for 12 percent permanent impairment of the right upper extremity and 24 percent permanent impairment of the right lower extremity. The period of the award ran for 106.56 weeks from December 2, 2015 to December 16, 2017.

On appeal appellant contends that he has a class 3 hip fracture with a default value of 30 percent rather than a class 2 hip fracture with a default value of 24 percent under Table 16-4 on page 514. He asserts that he has a discrepancy in leg length of seven centimeters, uses a cane or crutch for walking, and has an unstable gait. Appellant also notes that he had cellulitis of his wound, which yields a class 4 impairment. He cites an example provided on page 529 of the A.M.A., *Guides* for a hip fracture and maintains that he has at least 30 percent lower extremity impairment, which should be increased to 50 percent right lower extremity impairment based on his wound infection.

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

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

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 calculate schedule awards.[6]

The sixth edition requires identifying the impairment Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[7] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

ANALYSIS

OWCP accepted that appellant sustained a closed peritrochanteric fracture of the femur, an open fracture of the lower end of the humerus, a closed fracture of the upper end of the humerus, and a right elbow contusion as a result of a June 23, 2014 employment injury. Appellant underwent surgery on June 23, 2014 to repair the fractures.

Dr. Weinrit, an attending physician, advised in an October 15, 2015 report that appellant had reached maximum medical improvement. She diagnosed a right femur fracture and an open fracture of the right distal humerus with intra-articular extension. Dr. Weinrit related that appellant was unable to fully extend his arm. Appellant further experienced mild right arm pain that increased with exercise and mild-to-moderate pain in the right hip with numbness into the right buttock and groin. Dr. Weinrit provided examination findings of upper right arm tenderness without a loss of strength, swelling, or atrophy. She further found no right hip atrophy, swelling, or loss of strength but decreased sensation in the L2-3 nerve distribution. Dr. Weinrit did not rate appellant's impairment as she indicated that she was unfamiliar with the sixth edition of the A.M.A., *Guides*.

OWCP referred appellant to Dr. Swartz for an impairment evaluation. On December 2, 2015 Dr. Swartz diagnosed status post fracture of the right distal humerus extending into the elbow joint treated with an open reduction and internal fixation and status post internal fixation of the right hip. He noted that the diagnosed condition of a right distal humerus fracture could not be rated using the elbow regional grid as appellant's range of motion was abnormal.[8] Dr. Swartz thus rated the elbow impairment using range of motion. He found that, according to Table 15-33 on page 474, a loss of 35 degrees extension equaled 2 percent impairment, 75 degrees flexion equaled 8 percent impairment, 90 degrees pronation equaled no impairment, and 45 degrees supination yielded 2 percent impairment, for a total right arm permanent impairment

[5] *Id.* at § 10.404(a).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[7] A.M.A., *Guides* 494-531.

[8] The A.M.A., *Guides* 399, Table 15-4, the elbow regional grid, provides that the diagnosed condition of an elbow fractures is used to rate an impairment that causes residuals symptoms with "consistent objective findings and/or functional loss, with normal motion."

due to loss of motion of 12 percent. Dr. Swartz applied a grade modifier to the loss of range of motion of two for functional history, which did not alter the 12 percent impairment rating.

Dr. Swartz identified the right hip diagnosis as a class 2 fracture. Utilizing the hip regional grid set forth in Table 16-4 on page 514, he found a default impairment of 20 percent. Dr. Swartz applied a grade modifier of two for functional history due to appellant's limp and use of a cane and a grade modifier of four for clinical studies findings of shortening of the right leg. Applying the net adjustment formula moved the impairment rating two places to the right, for 24 percent right lower extremity permanent impairment.[9]

An OWCP medical adviser reviewed the evidence on January 6, 2016 and agreed with Dr. Swartz's findings. The Board finds that there is no medical evidence of record showing that appellant has more than 12 percent impairment of the right upper extremity and 24 percent permanent impairment of the right lower extremity.

On appeal appellant contends that his diagnosed condition should be a class 3 hip fracture, for a default value of 30 percent under Table 16-4. He notes that he has leg length discrepancy and experienced cellulitis following surgery. Appellant asserts that due to his cellulitis he has a class 4 hip fracture under Table 16-4, for 50 percent impairment. He has the burden, however, to submit probative medical evidence showing more than 24 percent right lower extremity impairment.[10] Appellant's lay opinion on the extent of his impairment is insufficient to discharge his burden of proof as the Board has held that lay individuals are not competent to render a medical opinion.[11]

Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has no more than 12 percent permanent impairment of the right upper extremity and 24 percent permanent impairment of the right lower extremity, for which he received schedule awards.

[9] Utilizing the net adjustment formula discussed above, (GMFH-CDX) + (GMPE-CDX) or (2-2) + (4-2) =2, yielded an adjustment of two. Clinical studies were used to identify the diagnosis and thus are not applicable in the impairment calculation. A.M.A., *Guides* 515-16.

[10] *See K.S.*, Docket No. 15-0741 (issued August 10, 2015); *D.H.*, 58 ECAB 358 (2007).

[11] *See L.W.*, Docket No. 14-0503 (issued June 20, 2014); *Gloria J. McPherson*, 51 ECAB 441 (2000).

ORDER

IT IS HEREBY ORDERED THAT the February 2, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 14, 2016
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board