United States Department of Labor
Employees' Compensation Appeals Board

D.S., Appellant	)	
and	)	**Docket No. 17-0419**
	)	**Issued: August 8, 2018**
DEPARTMENT OF THE NAVY, PUGET SOUND NAVAL SHIPYARD, Bremerton, WA, 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 December 16, 2016 appellant filed a timely appeal from a November 18, 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 the claim.[2]

ISSUE

The issue is whether appellant has established more than 24 percent permanent impairment of his right lower extremity, for which he previously received schedule awards.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The record provided to the Board includes evidence received after OWCP issued its November 18, 2016 decision. The Board's jurisdiction is limited to the evidence that was before OWCP at the time of its final decision. Therefore, the Board is precluded from considering this additional evidence for the first time on appeal. 20 C.F.R. § 501.2(c)(1).

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts of the case as presented in the prior Board decision are incorporated herein by reference. The relevant facts are as follows.

On February 4, 2009 appellant, then a 54-year-old engineering equipment operator, filed a traumatic injury claim (Form CA-1) alleging that on January 13, 2009 his right foot slipped while he was exiting his truck and experienced right leg and hip pain. He stopped work on February 4, 2009.[4] OWCP accepted the claim for right groin strain, right hip strain, and right leg/knee sprain and paid compensation benefits. Appellant underwent right total hip replacement surgery on May 18, 2009. His postoperative diagnosis was avascular necrosis and right hip osteoarthritis. Appellant returned to work on July 1, 2009.

By decision dated November 10, 2009, OWCP issued appellant a schedule award for 11 percent permanent impairment of his right lower extremity for a total of 21 percent.[5] This award was based upon the October 13, 2009 report from appellant's treating physician, Dr. Michael S. McManus, Board-certified in occupational medicine, who explained that appellant's total right hip replacement with good outcome equaled 21 percent permanent impairment of the right leg. OWCP's district medical adviser concurred with Dr. McManus that appellant had 21 percent permanent impairment of the right lower extremity due to this right hip condition.

On December 31, 2009 appellant appealed to the Board. By decision dated December 22, 2010, the Board set aside the November 10, 2009 schedule award decision and remanded the case for further development. The Board noted that appellant previously received a schedule award for 10 percent permanent impairment of his right lower extremity under OWCP File No. xxxxx616 due to an accepted back condition, but OWCP did not consider whether appellant's permanent impairment due to his right hip total replacement duplicated the compensation previously paid for impairment due to his back under File No. xxxxxx667 or whether it should be combined with the prior award under File No. xxxxx616.[6]

By decision dated March 7, 2011, OWCP issued appellant a schedule award for an additional 3 percent right lower extremity permanent impairment, for a total permanent impairment of 24 percent.

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[3] Docket No. 10-0620 (issued December 22, 2010).

[4] OWCP assigned File No. xxxxxx603. Appellant has two relevant previous claims. Under OWCP File No. xxxxxxx616, date of injury September 30, 2002, OWCP accepted lumbar conditions and authorized the 2005 surgery involving a pedicle screw fixation at L3-4 and bilateral L4-5, L5-S1 redo foraminotomies. Under OWCP File No. xxxxxx667, date of injury August 15, 2003, OWCP accepted lumbosacral strain and subluxation lumbar with no time loss. These cases have been administratively combined, with File No. xxxxxx603 serving as the master file.

[5] OWCP previously granted on March 30, 2007, a schedule award for 10 percent permanent impairment of his right lower extremity under OWCP File No. xxxxxx616 due to impairment for motor and sensory deficit that affected his right leg.

[6] *Supra* note 3.

Appellant retired as of September 3, 2013. On October 21, 2013 he underwent an authorized total revision of the right hip.

On March 12, 2015 appellant filed a Form CA-7 claim for an increased schedule award. In a March 5, 2015 report, Dr. McManus opined that appellant had a total combined right lower extremity permanent impairment rating of 61 percent. He noted clinical findings and referenced appropriate tables within the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[7] Dr. McManus concluded that there was 59 percent impairment of the right lower extremity based on a "poor" result from his total hip replacement. He combined the 59 percent with 6 percent for right L5 radiculopathy to find a total combined 61 percent permanent impairment of the right lower extremity.

Dr. Kenneth D. Sawyer, a Board-certified internist serving as an OWCP district medical adviser (DMA), reviewed Dr. McManus' report on April 13, 2015 and disagreed with the impairment rating as appellant did not have a "poor" result from the total hip replacement.[8] He recommended that appellant undergo a new impairment examination of the right hip and right lower extremity neurologic function by a different examiner.

In a July 2, 2015 report, Dr. Guy H. Earle, a Board-certified family practitioner and OWCP second opinion physician, opined that appellant had 59 percent right lower extremity permanent impairment due to his hip condition. He did not address any neurologic deficit in the right lower extremity unrelated to this claim, other than noting that it needed to be combined with the impairment due to the hip condition.

On July 22, 2015 Dr. Sawyer noted that Dr. Earle did not separate the cause of appellant's limitations between those caused by his lumbar spine conditions and his right hip. He noted that Dr. Earle also did not address any neurologic deficit in the right lower extremity unrelated to this claim, which had been requested. The medical adviser indicated that Dr. Earle was of the opinion that the increased rating was partly because the right lower extremity was underrated in 2009 and that range of hip motion was the "key factor" in determining the functional class when rating total hip replacement. The medical adviser disagreed and indicated that range of motion was not the "key factor," rather function was key. He again recommended that appellant be referred to another medical specialist to consider both the impairment from the right total hip replacement and any lower extremity neurologic impairment related to the prior claim.

OWCP referred appellant, along with an updated statement of accepted facts (SOAF), the case record, and a list of questions, to Dr. Steven P. Nadler, a Board-certified orthopedic surgeon, for a second opinion examination. In a December 16, 2015 report, Dr. Nadler reviewed the medical record along with the SOAF and provided examination findings. He found that appellant had 1.5 centimeters of leg length discrepancy and that range of motion of the hip was "painful, and [that] it was difficult … to determine if the range of motion [wa]s real or not, as it [wa]s based on

[7] A.M.A., *Guides* (6th ed. 2009).

[8] Dr. Sawyer disagreed that appellant had a poor result from his total hip replacement and that an impairment increase for the right hip was justified based on a change in right hip motion of 10 degrees or less, which appellant could not perceive. He also found that appellant's March 5, 2015 right hip motion measurements were overall better than those previously reported.

claimant's complaints of pain." Dr. Nadler found flexion of 80 degrees, extension of 0 degrees, internal rotation of 0 degrees, external rotation of 60 degrees, abduction of 60 degrees, and adduction of 20 degrees without instability of the hip. He noted that there was a question of whether appellant's symptoms were reliable as he appeared angry during the examination and was upset with the impairment rating process regarding his right hip. Dr. Nadler indicated that the examination showed some improvement in range of motion since the July 2, 2015 examination. He also indicated his agreement with Dr. Sawyer that the repair was a good result as appellant's pain was not constant, he did not use assistive devices, his strength was good, and he had no instability. Dr. Nadler opined that appellant had 21 percent right lower extremity impairment based on a good result for the hip replacement. Under Table 16-24, page 549, he found 5 percent impairment for 80 degrees flexion and 10 percent impairment for 0 degrees internal rotation, for a 15 percent total loss of range of motion. Under Table 16-25, page 550, this would be classified as class 2. Under Table 16-4, page 515, a class 2 partial or total hip replacement with good result had default rating of 25 percent. Under Table 16-5, page 515, Dr. Nadler found grade modifiers of 1 for functional history, 0 for physical examination, and 0 for clinical studies. Applying the net adjustment formula, Dr. Nadler found -5 net adjustment which moved the class 2 impairment to the left and resulted in a final right lower extremity rating of 21 percent.

On January 13, 2016 Dr. James W. Butler, a Board-certified family practitioner serving as an OWCP district medical adviser (DMA), reviewed the medical evidence, including Dr. Nadler's December 16, 2015 report, and opined that appellant had a right lower extremity rating of 23 percent for the right hip replacement. He indicated that appellant was rated for total hip replacement under Table 16-4, page 515. Dr. Butler noted that both Dr. Earle and Dr. Nadler found that appellant did not use any assistive device. He also noted that Dr. Earle indicated that appellant had pain in both legs, but noted that appellant had back surgery and multiple other back problems. Dr. Butler noted that there was a difference in hip range of motion measurements between Dr. Nadler, Dr. McManus, and Dr. Earle and that the previous medical adviser had indicated that range of motion could be a factor, but function was more important, as the intent of the A.M.A., *Guides* clearly outlined in Chapter 1. He rated appellant class 2, with a default rating of 25 percent lower extremity, for a good result as all doctors noted that the hip replacement was in good position, it was stable and it was functional. Under Table 16-6, page 516, Dr. Butler found functional history modifier 1. Under Table 16-7, page 517, he found physical examination modifier 2. Dr. Butler indicated that there were 0 or no clinical modifiers. Applying the net adjustment formula, he found a net adjustment of -1, which resulted in a grade B final lower extremity impairment of 23 percent. In an amended report of January 26, 2016, the DMA opined that appellant reached maximum medical improvement (MMI) on March 3, 2015.

By decision dated March 3, 2016, OWCP denied appellant's claim for an additional schedule award for the left lower extremity. It found that appellant had not established entitlement over the 24 percent total right lower extremity impairment previously awarded as Dr. Nadler had concluded that appellant's hip impairment to the right lower extremity was 21 percent, while the DMA adjusted the impairment rating to 23 percent.

On March 21, 2016 appellant requested a review of the written record before an OWCP hearing representative. In a March 9, 2016 letter, Dr. McManus disagreed with the impairment rating of 23 percent based on Dr. Nadler's examination and the DMA's review. He argued that the moderate limitation in appellant's right hip active range of motion placed him in a poor

functional category or class 4 rating based on a poor result. Therefore, Dr. McManus opined the lowest rating after application of the modifiers would be 59 percent lower extremity impairment.

By decision dated July 7, 2016, an OWCP hearing representative conducted a preliminary review and set aside OWCP's March 3, 2016 decision for further medical development. He found that the DMA needed to address Dr. McManus' argument regarding impairment classification. Any impairment secondary to the motor or sensory deficits due to the spine injury under File No. xxxxxx616 also needed to be addressed.

OWCP prepared an updated statement of accepted facts (SOAF) dated July 18, 2016. This SOAF noted that appellant had received a schedule award for 10 percent permanent impairment of the right lower extremity for his accepted lumbar claim in OWCP File No. xxxxxx616.

OWCP referred the case record to its DMA with a list of questions. On July 24, 2016 Dr. Butler reviewed the case record, including his previous report of January 13, 2016 at which time he had assigned an impairment rating of 23 percent right lower extremity. He indicated that there was no data to assign ratings of the right lower extremity emanating from the spine. Based on Dr. Nadler's December 16, 2015 examination, Dr. Butler opined that appellant had zero percent permanent impairment from the spine. He noted that there was no statement in appellant's records which indicated that appellant had radicular findings on examination. Dr. Butler noted that Dr. Nadler, in his December 16, 2015 examination, found that appellant's sensory function was intact throughout the lower extremities. Appellant's reflexes were decreased, but symmetrical. Manual muscle testing was 5/5. Dr. Nadler did not address radicular signs and symptoms for the right lower extremity. Thus, Dr. Butler concluded that appellant had no evidence of any radicular signs or symptoms that would be ratable for the spine; therefore, no additional impairment had been incurred. With regard to the right hip arthroplasty, he noted that Dr. Nadler assigned a 21 percent impairment rating. Dr. Butler indicated that in his January 25, 2016 report he opined that appellant had 23 percent right lower extremity impairment with a date of MMI of March 5, 2015. He additionally stated that, when range of motion was used a part of the diagnosis-based impairment, it becomes a functional modifier, which in this case was a moderate functional modifier grade 2. Dr. Butler indicated that Dr. McManus misread the intent of the A.M.A., *Guides* and that the moderate functional modifier grade 2 was included in the rating. He indicated that Dr. McManus noted that appellant did not use assistive devices, he had good positioning of the artificial hip, it was stable, and he was functional. Therefore, based on that information, appellant would continue to be placed in the diagnosis-based impairment rating at class 2 with good results (good position, stable functional). Dr. Butler noted that to be placed in class 4, the hip replacement would have to have "poor position, moderate-to-severe instability, and/or moderate-to-severe motion deficit." He indicated therefore motion deficit became a functional modifier.

In a September 27, 2016 report, Dr. Butler noted that appellant had previously received schedule awards for the right lower extremity totaling 24 percent. These schedule awards were paid for his lumbar radiculopathy injury, as well for his subsequent right hip injury. Dr. Butler stated that he had been asked to review Dr. Nadler's December 16, 2015 impairment rating and the date he was assigning as MMI. He was also asked to re-review his impairment rating of 23 percent compared to the letter from Dr. McManus of March 9, 2016. Dr. Butler indicated that he found 21 percent right lower extremity impairment, but because of appellant's previously assigned rating of 24 percent, there was no further impairment from this injury. He indicated that appellant's

range of motion that was given had multiple varying measurements by different examiners. Under Chapter 16, page 544, 16.7b, Dr. Butler advised the range of motion method could not be used because "if multiple evaluations exist and there is inconsistency of a rating class between the findings of two observers or in the findings of separate occasions by the same observers, results are considered invalid." He noted that Dr. Nadler found appellant had good position, a stable arthroplasty and that he used no assistive devices. Under Table 16-4, page 515, Dr. Butler placed appellant in class 2, moderate problem, with default rating of 25 percent for total hip replacement. Under Table 16-6, page 516, a grade modifier 1 for functional history was provided as Dr. Nadler found minimally antalgic gait and no use of assistive devices. Dr. Butler stated range of motion could not be used in the physical examination modifier because of invalid range of motion reports, but since Dr. Nadler found the hip was stable, under Table 16-7, page 517, the physical examination modifier was 0. As clinical studies placed appellant into the class, a clinical study modifier could not be used. Utilizing the net adjustment formula, a net adjustment of -3 was found, which placed appellant into class 2, grade A or 21 percent right lower extremity impairment.[9] Dr. Butler concurred with the 21 percent right lower extremity rating from Dr. Nadler. He indicated that appellant attained MMI on March 31, 2015 as no further treatment was available at that time. Dr. Butler noted that, while Dr. Nadler's noted range of motion numbers resulted in 15 percent lower extremity impairment, he was not sure they were reliable and therefore he did not use them. He disagreed with Dr. McManus that Dr. Nadler's range of motion measurements placed him in a moderate category. Dr. Butler stated that, while Dr. Nadler's range of motion totaled 15 percent, the rating cannot be used as there was inconsistency between evaluators. He indicated that his revised rating of 21 percent right lower extremity impairment was the most appropriate. Dr. Butler further noted that Dr. Nadler's examination showed no sensory loss, normal reflexes, and no muscle strength loss for any secondary impairment due to the spinal injury.

On October 27, 2015 OWCP requested that Dr. Butler issue an addendum to his September 27, 2016 report to include new impairment calculations that included both the hip and any secondary impairment due to the spinal injury under this claim. It noted that appellant had previously been awarded compensation for 4 percent impairment as residuals of the lumbar injury (File No. xxxxxx616) and 21 percent impairment due to the hip injury (File No. xxxxxx603) for a total permanent impairment of 24 percent to the right lower extremity.

In a November 1, 2016 report, Dr. Butler reviewed Dr. McManus' December 1, 2009 report in which 21 percent rating for the hip and 4 percent impairment for L5 spinal nerve deficit was assigned with a MMI date of September 9, 2009. He indicated that Dr. McManus had used the A.M.A., *Guides* as well as an electromyogram (EMG) report for the L5 radiculopathy, but had stated there was no abnormality on EMG. Dr. Butler also reported Dr. McManus' examination findings at that time. Dr. Butler indicated that he has previously assigned 21 percent right lower extremity impairment rating for the right hip based on the previous evaluations and records he reviewed. He noted that for the reported lumbar radiculopathy under File No. xxxxxx616, he was to use *The Guides Newsletter* July-August 2009. Dr. Butler noted that for the reported lumbar radiculopathy under File No. xxxxxx616, Dr. McManus stated that appellant had decreased light touch at the right L5 dermatome, and right large toe extension strength 4/5 as well as right ankle extension and eversion of 4/5. Dr. McManus also noted that "clinical studies grade modifier 0

[9] In his impairment chart, Dr. Butler miscalculated the final right lower extremity impairment as 23 percent.

(electrodiagnostic studies right lower extremity negative)." Dr. Butler stated that Dr. McManus had rated appellant on subjective testing that was nonverifiable and inconsistent with Dr. Nadler's examination. Therefore, based on that information, he assigned no impairment based on the negative EMG as opposed to subjective evaluations. Dr. Butler concluded that his total rating for the right lower extremity was 21 percent. Thus, there was no additional impairment rating from what appellant previously received.

By decision dated November 18, 2016, OWCP denied appellant's claim for an increased schedule award. It noted that the final rating of 21 percent right lower extremity permanent impairment due to appellant's right hip injury was properly determined by its OWCP medical adviser. OWCP also indicated that the medical adviser found that no additional impairment was provided for appellant' lumbar injury under File No. xxxxxx616. It concluded that as appellant had received a total of 14 percent permanent impairment of his right lower extremity for his right hip condition, and 10 percent of his right lower extremity for his lumbar injury, appellant's current 21 percent permanent impairment rating did not warrant an additional award.

LEGAL PRECEDENT

The schedule award provisions of FECA[10] and its implementing regulations[11] 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. FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.[12] 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 regulations as the appropriate standard for evaluating schedule losses.[13] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[14]

The sixth edition requires identifying the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

[12] *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

[13] *Ronald R. Kraynak*, 53 ECAB 130 (2001).

[14] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.5a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

Examination (GMPE), and Clinical Studies (GMCS).[15] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[16]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the 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.[17]

ANALYSIS

The Board finds that appellant has established entitlement to a schedule award for 21 percent permanent impairment of his right hip and a combined permanent impairment of his right lower extremity of 25 percent.

By decision dated March 7, 2011, appellant received a total combined right lower extremity impairment of 24 percent.

On March 12, 2015 appellant filed a Form CA-7 for an increased schedule award. Following development, by decision dated November 18, 2016, OWCP denied appellant's claim for an increased schedule award beyond the 24 percent previously received for right lower extremity impairment based on the opinion of its DMA, Dr. Butler. It concluded that Dr. Butler properly found that appellant had 21 percent permanent impairment of his right lower extremity due to his right hip condition; however, since appellant had already received a schedule award for 24 percent permanent impairment of the right lower extremity he was not entitled to an additional schedule award.

In his March 5, 2015 report, Dr. McManus opined that appellant had 59 percent impairment based on "poor" result from the total hip replacement and 6 percent impairment based a mild right L5 sensory deficit and mild right L5 motor deficit, for a total combined 61 percent right lower extremity impairment. Class and impairment status post revision right total hip arthroplasty were determined using range of motion method. In a December 16, 2015 report, Dr. Nadler, the second opinion physician, opined that appellant had 21 percent right lower extremity impairment based on a "good" result for the hip replacement.

The DMA, Dr. Butler, reviewed the medical reports from Dr. McManus and second opinion physician Dr. Nadler and presented his analysis in reports dated July 24, September 27, and November 16, 2016. He explained the range of motion measurements to determine lower extremity impairment could not be used in this case as there were multiple inconsistent measurements by different examiners. Properly citing to Chapter 16, page 544, 16.7b, Dr. Butler noted that if multiple evaluations exist and there was inconsistency of a rating class between the findings of two observers, results are considered invalid. As Dr. McManus's impairment rating

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

[16] *Id*. at 521.

[17] *See supra* note 12 at Chapter 2.808.6(f) (February 2013).

for total right hip arthroplasty was determined under the range of motion method, it was of little probative value.

Dr. Butler reviewed Dr. Nadler's December 16, 2015 impairment rating and found that the total right lower extremity impairment rating was 21 percent. He indicated that Dr. Nadler found appellant had good position, a stable arthroplasty and that he used no assistive devices. Under Table 16-4, page 515, appellant had class 2, moderate problem, with default rating of 25 percent for total hip replacement. Under Table 16-6, page 516, a grade modifier 1 for functional history was provided as Dr. Nadler found minimally antalgic gait and no use of assistive devices. Dr. Butler stated range of motion could not be used in the physical examination modifier because of invalid range of motion reports, but since Dr. Nadler found the hip was stable, under Table 16-7, page 517, the physical examination modifier was 0. As clinical studies placed appellant into the class, a clinical study modifier could not be used. Applying the net adjustment formula, (GMFH-CDX)(1-2) + (GMPE-CDX)(0-1) + (GMCS-CDX)(n/a), a net adjustment of -2 placed appellant into class 2, grade A or 21 percent right lower extremity impairment.

Dr. Butler also reviewed the medical documents based on the lumbar injury under File No. xxxxxx616. He noted that Dr. McManus had rated right L5 sensory deficit and right L5 motor deficit based on subjective testing that was nonverifiable and inconsistent with Dr. Nadler's examination. Dr. Butler instead rated appellant based on the negative EMG report of the right lower extremity. Thus, he opined that there was no secondary impairment due to the lumbar injury.

The Board finds that the medical evidence establishes that appellant has 21 percent permanent impairment of his right hip. The Board further finds, however, that appellant has only received a schedule award for 14 percent permanent impairment of the right hip, as noted in the Board's December 22, 2010 decision. OWCP denied payment for the full 21 percent impairment of the right hip because appellant had previously received an additional 10 percent schedule award for permanent impairment of right lower extremity due to his lumbar injury.

OWCP regulations provide that benefits payable under section 8107(c) shall be reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) OWCP finds that the later impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[18]

The Board finds that the DMA properly explained in his November 1, 2016 report that Dr. McManus had found no L5 radiculopathy based upon EMG examination. Pursuant to *The Guides Newsletter*, appellant therefore did not have a ratable permanent impairment of the right lower extremity due to his lumbar injury.[19] Since appellant no longer had an impairment of his

[18] 20 C.F.R. § 10.404(d); *see also A.T.*, Docket No. 17-1806 (issued January 12, 2018).

[19] *See J.S.*, Docket No. 17-0541 (issued October 17, 2017). The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP's procedures indicate that *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009) is to be applied. *See G.N.*, Docket No. 10-0850 (issued November 12, 2010); *see also supra* note 12 at Chapter 3.700, Exhibit 1, note 5 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

right lower extremity resulting from his lumbar injury, his right hip permanent impairment was not duplicative of the previously determined impairment.

Appellant however remains entitled to the 10 percent schedule award he received for his lumbar injury, as this prior schedule award was rated under the fifth edition of the A.M.A., *Guides*, rather than the sixth edition.[20] The Board has previously explained OWCP's procedures make clear that a subsequent calculation under the sixth edition of the A.M.A., *Guides* sometimes, as in this case, results in a percentage of impairment that is lower than the original award. When this occurs, OWCP should find that the evidence does not establish an increased impairment and that the claimant has no more than the percentage of impairment originally awarded.[21] Appellant therefore has no more than 10 percent permanent impairment of the right lower extremity due to his September 30, 2002 lumbar injury. He remains entitled to a schedule award which combines this 10 percent permanent impairment finding with his 21 percent permanent impairment of the right hip as these awards are not duplicative. Utilizing the Combined Values Chart of the A.M.A., *Guides*, appellant is entitled to a total schedule award for 25 percent permanent impairment of his right lower extremity.[22] Upon return of the case record, OWCP shall grant appellant an additional one percent schedule award for permanent impairment of his right lower extremity.

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 established a combined 25 percent right lower extremity permanent impairment.

[20] OWCP's procedures make clear that a subsequent calculation under the sixth edition of the A.M.A., *Guides* sometimes, as in this case, results in a percentage of impairment that is lower than the original award. When this occurs, OWCP should find, as it did here, that the evidence does not establish an increased impairment and that the claimant has no more than the percentage of impairment originally awarded should not be reconsidered merely on the basis that the A.M.A., *Guides* have changed. (All permanent impairment calculations made on or after May 1, 2009 must be based on the sixth edition.)

[21] *See R.S.*, Docket No. 12-1030 (issued December 19, 2012).

[22] A.M.A., *Guides* 604.

ORDER

IT IS HEREBY ORDERED THAT the November 18, 2016 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision.

Issued: August 8, 2018
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