United States Department of Labor
Employees' Compensation Appeals Board

R.H., Appellant	)	
and	)	**Docket No. 19-1503**
	)	**Issued: February 2, 2022**
U.S. POSTAL SERVICE, BELMONT POST OFFICE, Belmont, MA, Employer	)	

Appearances:
Daniel B. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 3, 2019 appellant, through counsel, filed a timely appeal from a May 15, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP).[2] Pursuant to the

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] Appellant, through counsel, submitted a timely request for oral argument before the Board. 20 C.F.R. § 501.5(b). Pursuant to the Board's *Rules of Procedure*, oral argument may be held in the discretion of the Board. 20 C.F.R. § 501.5(a). In support of his oral argument request, counsel asserted that oral argument should be granted as: there were errors in the percentage of impairment; OWCP's Branch of Hearings and Review improperly denied the issuance of subpoenas to the doctors who determined the impairment rating; and a district medical adviser is not competent to create a conflict in medical opinion evidence as he did not examine appellant. The Board, in exercising its discretion, denies appellant's request for oral argument because this matter requires an evaluation of the medical evidence required. As such, the arguments on appeal can be adequately addressed in a decision based on a review of the case record. Oral argument in this appeal would not serve a useful purpose. As such, the oral argument request is denied and this decision is based on the case record as submitted to the Board.

Federal Employees' Compensation Act[3] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish greater than 23 percent permanent impairment of the right lower extremity and 18 percent impairment of the left lower extremity for which he previously received schedule award compensation; and (2) whether OWCP's hearing representative properly denied appellant's request for the issuance of subpoenas.

FACTUAL HISTORY

On April 4, 2016 appellant, then a 53-year-old letter carrier, filed a claim for an occupational disease (Form CA-2) alleging that he developed osteoarthritis of both hips causally related to factors of his federal employment. He noted that he first became aware of his injury and its relationship to factors of his federal employment on December 1, 2015. In an accompanying March 1, 2015 statement, appellant claimed that he sustained bilateral hip arthritis due to repetitive work duties he had performed since he was hired by the employing establishment on August 21, 2014, including lifting and carrying tubs of mail, loading and unloading mail and parcels from the truck, driving the truck, and walking to deliver mail in various types of weather. He noted that he underwent right total hip arthroplasty on May 14, 2014. On December 9, 2016 OWCP accepted appellant's claim for permanent aggravation of underlying degenerative joint disease of the right and left hips based upon the opinion of second opinion physician, Dr. Christopher B. Geary, a sports medicine specialist.

On March 21, 2017 appellant filed a claim for compensation (Form CA-7) for a schedule award due to his accepted employment injuries. In support of his claim, he submitted a March 17, 2017 letter by Dr. Byron V. Hartunian, an attending orthopedic surgeon. Dr. Hartunian noted that he evaluated appellant on December 1, 2015. He diagnosed status post right total hip replacement for end-stage degenerative arthritis and left hip arthritis with two-millimeter (mm) cartilage interval at the femoral-acetabular joint. Dr. Hartunian referred to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[4] and determined that appellant had 37 percent permanent impairment of the right lower extremity and 18 percent permanent impairment of the left lower extremity.

On April 6, 2017 OWCP routed Dr. Hartunian's report, a statement of accepted facts (SOAF), and the case file to Dr. Arnold T. Berman, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), for review and a determination of permanent impairment of the lower extremities under the sixth edition of the A.M.A., *Guides* and the date of maximum medical improvement (MMI).

In an April 21, 2017 report, Dr. Berman disagreed with Dr. Hartunian's impairment ratings and opined that appellant had 23 percent permanent impairment of the right lower extremity and

[3] 5 U.S.C. § 8101 *et seq.*

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

18 percent permanent impairment of the left lower extremity under the sixth edition of the A.M.A., *Guides*.

By letter dated May 4, 2017, OWCP requested that Dr. Hartunian review Dr. Berman's report and provide an addendum report within 30 days.

In a May 12, 2017 letter, Dr. Hartunian noted the deficiencies in Dr. Berman's report. He explained the basis for his impairment ratings based on the A.M.A., *Guides*. Additionally, Dr. Hartunian advised that appellant reached MMI on December 1, 2015, the date of his impairment evaluation.

On June 9, 2017 Dr. Berman reviewed Dr. Hartunian's May 12, 2017 letter and reiterated his finding that appellant had 23 percent permanent impairment of the right lower extremity and 18 percent permanent impairment of the left lower extremity. He determined that he reached MMI on March 17, 2017, the date of Dr. Hartunian's letter.

On August 30, 2017 OWCP determined that a conflict existed between Dr. Hartunian and Dr. Berman regarding the extent of appellant's bilateral hip permanent impairment and date of MMI. On September 7, 2017 it referred appellant, together with a SOAF and the medical record, to Dr. Murray J. Goodman, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the conflict of medical opinion evidence.

In an October 30, 2017 report, Dr. Goodman noted his review of the SOAF and medical records, including the reports of Dr. Hartunian and Dr. Berman. On physical examination he reported that appellant had a tandem heel-toe gait with no antalgic component. Appellant could walk on his toes and heels; however, there may be a slight dorsiflexion weakness on heel walking on the right compared to the left. He could squat fully and arise from a squat. Appellant forward flexed 80 degrees at the lumbar spine bringing his fingertips to his ankles and reversing his lumbar lordosis. He extended 20 degrees, lateral bent 30 degrees, and twisted 60 degrees. Straight leg raising on the right was positive at 70 degrees for shin and calf pain and on the left was 70 degrees. Calf circumference was 14-1/4 inches bilaterally and thigh circumference was 17 inches bilaterally. There was a healed six-inch incision posterolaterally about the right hip that was somewhat widened and thinned and the proximal extent was covered by a blood sugar monitoring unit. There was no erythema, warmth, or tenderness locally. Range of motion (ROM) about the right hip was 110 degrees of flexion, 20 degrees of extension, 40 degrees of abduction, 20 degrees of adduction, 70 degrees of external rotation, and 15 degrees of internal rotation. ROM about the left hip was 110 degrees of flexion, 15 degrees of extension, 80 degrees of external rotation, and 10 degrees of internal rotation. Sensory examination was intact to pinprick in both lower extremities. Motor examination was normal for quadriceps, tibialis anterior, extensor hallucis longus, and gastrocnemius. Deep tendon reflexes were 2+ at the knees and 1+ at the ankles with reinforcement. Dr. Goodman noted that there were no actual imaging studies available for review, however he reviewed reports of imaging studies of record. He diagnosed osteoarthritis of both hips and status post right total hip arthroplasty. Dr. Goodman advised that appellant reached MMI on May 14, 2015, one year following his right hip surgery, when he returned to his regular job and there was no need for further medical treatment. Using Table 16-4, page 515, regarding a class of diagnosis (CDX) for partial or total hip replacement, he noted it fell under class 2 (moderate problem) with a default value of 25 percent. According to Table 16-6, page 516, Dr. Goodman assigned a grade modifier for functional history (GMFH) of 0 and noted that according to the American Association of Orthopedic Surgeons (AAOS) Lower Limb Questionnaire cited by

Dr. Hartunian this was classified as a moderate deficit and therefore it was considered unreliable and excluded. He then found that according to Table 16-24, page 549, appellant's hip motion impairment was classified as mild based on 15 degrees of internal rotation. Utilizing Table 16-7, page 517, Dr. Goodman assigned a grade modifier for physical examination (GMPE) of 1 as appellant had minimal palpatory findings on examination. He assigned a grade modifier for clinical studies (GMCS) of 2 according to Table 16-8, page 519, which confirmed the diagnosis and showed moderate pathology. Dr. Goodman applied the net adjustment formula on page 521, (GMPE-CDX) (1-2) + (GMCS-CDX) (2-2) to find a net adjustment of -1 or a class C, 23 percent permanent impairment of the right hip.

Regarding left hip impairment, Dr. Goodman utilized Table 16-4, page 514 and determined that a CDX of hip arthrosis was a class 2 diagnosis with a default value of 20 percent based on a 2 mm cartilage interval as demonstrated by x-ray. He excluded a GMFH for the same reason as noted above for the right hip. Dr. Goodman assigned a GMPE of 1 based on mild loss of ROM. He noted that a GMCS was not applicable as it was used to establish the class 2 diagnosis. Dr. Goodman applied the net adjustment formula (GMPE-CDX) (1-2) to find a net adjustment of -1 or a class C, 18 percent permanent impairment of the left hip.

On May 25, 2018 OWCP routed the medical record, including Dr. Goodman's October 30, 2017 report, a SOAF, and a set of questions, to Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a DMA.

In a May 29, 2018 report, Dr. Katz agreed with Dr. Goodman's impairment ratings of 23 percent permanent impairment of the right lower extremity and 18 percent permanent impairment of the left lower extremity using the sixth edition of the A.M.A., *Guides*. He noted that the date of MMI was October 30 2017, the date of Dr. Goodman's impairment evaluation.

By decision dated September 13, 2018, OWCP granted appellant a schedule award for 23 percent permanent impairment of the right lower extremity and 18 percent permanent impairment of the left lower extremity. The period of the award ran for 118.08 weeks, from October 30, 2017 to February 3, 2020, and was based on the opinions of Dr. Goodman and Dr. Katz.

On September 20, 2018 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. In a November 19, 2018 letter, counsel requested that OWCP's Branch of Hearings and Review issue subpoenas for Dr. Goodman and Dr. Katz to attend the hearing for questioning because their opinions were improperly accorded the weight of the medical evidence.

By decision dated February 19, 2019, the hearing representative denied appellant's request for the issuance of subpoenas under 20 C.F.R. § 10.619, finding that the testimony of Dr. Goodman and Dr. Katz could be obtained through written reports, affidavits, or statements.

In a February 28, 2019 letter, counsel clarified that appellant did not contest OWCP's schedule award for 18 percent permanent impairment of the left lower extremity. He contended, however, that Dr. Goodman's analysis regarding appellant's left lower extremity permanent impairment did not comply with the A.M.A., *Guides*. Counsel submitted a February 21, 2019 letter from Dr. Hartunian and contended that the physician addressed the deficiencies in Dr. Goodman's impairment analysis and provided his own impairment analysis in accordance with Board precedent, which indicated that a difference of opinion between physicians on how to

properly apply the A.M.A., *Guides* to uncontested medical findings was not a conflict in the medical evidence warranting referral to a referee physician. He, thus, asserted that it was necessary for subpoenas to be issued to OWCP's physicians. Counsel further asserted that Dr. Goodman's opinion should be excluded as it was obtained as a result of a conflict between DMA, Dr. Katz, a nonexamining physician, and Dr. Hartunian, an examining physician, and not by two examining physicians under 5 U.S.C. § 8123(a).

In his February 21, 2019 letter, Dr. Hartunian cited Board precedent and maintained that Dr. Goodman improperly applied the A.M.A., *Guides*. He noted that the A.M.A., *Guides* required that class selection be based upon diagnosis and physical examination criteria. Dr. Hartunian contended that Dr. Goodman incorrectly selected the CDX for total hip replacement under Table 16-4, page 515 of the A.M.A., *Guides*, based upon his subjective opinion that appellant had a good result from his hip arthroplasty as his hip was in good position, stable, and functional, which represented a class 2 moderate problem according to the A.M.A., *Guides*. He related that the proper methodology of class selection required an analysis of physical examination criteria. Dr. Hartunian acknowledged that Dr. Goodman correctly determined that appellant's hip motion impairment was classified as mild based on 15 degrees of internal rotation, which represented a class 3, mild motion deficit, according to Table 16-4. He noted Dr. Goodman's finding that grade modifiers for GMPE and GMCS were not applicable as they were used to select the class diagnosis. Dr. Hartunian agreed with Dr. Goodman's opinion that a grade modifier for GMFH was not applicable, but for different reasons, which resulted in a class 3 impairment with a default value of C or 37 percent permanent impairment of the right lower extremity.

By decision dated May 15, 2019, a second OWCP hearing representative affirmed the September 13, 2018 schedule award decision. She also denied appellant's request for the issuance of subpoenas.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA,[5] and its implementing federal regulation,[6] 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 the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based impairment (DBI) method of evaluation utilizing the World Health Organization's *International Classification of*

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id*. at § 10.404(a).

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

Functioning, Disability and Health (ICF): *A Contemporary Model of Disablement*.[9] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by the GMFH, GMPE, and GMCS.[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

Section 8123(a) of FECA provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[12] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.[13] Where a case is referred to an impartial medical examiner (IME) for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[14]

The Board has long held that an OWCP DMA may create a conflict in medical opinion with an examining physician.[15] OWCP's procedures provide that cases returned from an IME should not routinely be sent to an OWCP DMA for review unless a schedule award is at issue.[16]

Where a referee examination was arranged to resolve a conflict created by a DMA with respect to a schedule award issue, the same DMA should not review the IME's report.[17] Instead, another DMA or OWCP medical consultant should review the file.[18]

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met his burden of proof to establish greater than 23 percent permanent impairment of the right lower extremity for which he previously received a schedule award.

OWCP properly determined that there was a conflict in the medical opinion evidence between Dr. Hartunian, an attending physician, and Dr. Berman, OWCP's DMA, regarding the extent of appellant's permanent impairment due to his accepted right hip injury and surgery, and

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[9] A.M.A., *Guides* (6th ed., 2009), page 3, section 1.3(a).

[10] *Id.* at 494-531.

[11] *Id.* at 411.

[12] 5 U.S.C. § 8123(a); *see R.C.,* Docket No. 18-0463 (issued February7, 2020).

[13] *See M.R.*, Docket No. 19-0526 (issued July 24, 2019); *C.R.*, Docket No. 18-1285 (issued February 12, 2019).

[14] *Id.*

[15] *See G.W.,* Docket No. 16-0525 (issued August 2, 2017); *Harold Travis*, 30 ECAB 1071 (1979); *see* 20 C.F.R. § 10.321(b).

[16] *Supra* note 8 at Chapter 2.810.11f (September 2010).

[17] *Id.*

[18] *Id.*

referred appellant to Dr. Goodman for an impartial medical examination and opinion on permanent impairment, pursuant to 5 U.S.C. § 8123(a). As noted above, a DMA may create a conflict in medical opinion with an examining physician.[19]

In an October 30, 2017 report, Dr. Goodman opined that appellant had 23 percent permanent impairment of his right lower extremity under the sixth edition of the A.M.A., *Guides*. He indicated that, under Table 16-4, page 515, appellant had a class 2 impairment as a result of a right partial or total hip replacement with a good result, which represented 25 percent permanent impairment of his right lower extremity. Utilizing Table 16-6, page 516, Dr. Goodman assigned a grade modifier 0 for GMFH secondary to appellant's AAOS score was unreliable and would be excluded for impairment calculations because it represented a moderate deficit. He then found that appellant had a class 1 impairment for 15 degrees of internal rotation of the hip under Table 16-24, page 549. Dr. Goodman assigned a grade modifier 1 for GMPE due to appellant's minimal palpatory findings on examination under Table 16-6, page 516. Utilizing Table 16-8, page 519, he found a grade modifier 2 for GMCS, which confirmed the diagnosis and showed moderate pathology. Dr. Goodman applied the net adjustment formula on page 521, (GMPE-CDX) (1-2) + (GMCS-CDX) (2-2) to find a net adjustment of -1 or a class C, 23 percent permanent impairment of the right hip.

Regarding left hip impairment Dr. Goodman utilized Table 16-4, page 514 and determined that a diagnosis CDX of hip arthrosis was a class 2 diagnosis with a default value of 20 percent based on a 2 mm cartilage interval as demonstrated by x-ray. He excluded a grade modifier for GMFH for the same reason as noted above for the right hip. Dr. Goodman assigned a grade modifier 1 for GMPE of 1 based on mild loss of ROM. He noted that a grade modifier for GMCS was not applicable as it was used to establish the class 2 diagnosis. Dr. Goodman applied the net adjustment formula (GMPE-CDX) (1-2) to find a net adjustment of -1 or a class C, 18 percent permanent impairment of the left hip.

The Board finds that Dr. Goodman's October 30, 2017 report is entitled to the special weight of the medical evidence, establishing that appellant had no more than 23 percent permanent impairment of the right lower extremity and 18 percent impairment of the left lower extremity.[20] His opinion was based on a proper factual and medical history, and on the proper tables and procedures in the A.M.A., *Guides*. Dr. Goodman provided medical rationale for his impairment rating.

Dr. Hartunian, in a February 21, 2019 letter, cited Board precedent and maintained that Dr. Goodman improperly applied the A.M.A., *Guides*. He, however, was on one side of the conflict resolved by Dr. Goodman. The Board has held that reports from a physician who was on one side of a medical conflict are generally insufficient to overcome the special weight accorded to the IME, or to create a new conflict.[21] Dr. Hartunian's report is, therefore, insufficient to

[19] *Supra* note 15.

[20] *B.M.*, Docket No. 19-1069 (issued November 21, 2019); *D.S.*, Docket No. 18-0336 (issued May 29, 2019); *T.C.*, Docket No. 17-1741 (issued October 9, 2018).

[21] *See M.R.*, Docket No. 19-0526 (issued July 24, 2019); *S.S.*, Docket No. 17-1361 (issued January 8, 2018); *Jaja K. Asaramo*, 55 ECAB 200 (2004); *Michael Hughes*, 52 ECAB 387 (2001).

overcome the special weight accorded to Dr. Goodman's opinion or to create a new conflict in medical opinion.[22]

The Board, thus, finds that appellant has not met his burden of proof to establish more than 23 percent permanent impairment of the right lower extremity and 18 percent permanent impairment of the left lower extremity for which he previously received schedule award compensation.

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 permanent impairment.

LEGAL PRECEDENT -- ISSUE 2

In requesting a subpoena, a claimant must explain why the testimony is relevant to the issues in the case and why a subpoena is the best method or opportunity to obtain such evidence because there is no other means by which the testimony could have been obtained.[23] The hearing representative of OWCP's Branch of Hearings and Review has discretion to approve or deny a subpoena request.[24] Abuse of discretion is generally shown through proof of manifest error, a clearly unreasonable exercise of judgment, or actions taken which are clearly contrary to logic and probable deductions from established facts.[25]

ANALYSIS -- ISSUE 2

The Board finds that OWCP's hearing representative properly denied appellant's request for the issuance of subpoenas.

Appellant requested that OWCP's hearing representative issue subpoenas to Dr. Goodman and Dr. Katz, OWCP's DMA, to obtain testimony regarding their determination of the extent of his permanent impairment. The hearing representative denied his request, noting that the testimony of these physicians could be obtained through written reports, affidavits, or statements. Appellant has insufficiently explained why a subpoena was the best method to obtain this evidence or shown that there was no other method to obtain the information. The Board finds that OWCP's hearing representative's denial of appellant's request for subpoenas was reasonable and did not constitute an abuse of discretion.[26]

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[22] *See S.S.*, *id.*; *K.R.,* Docket No. 16-0542 (issued December 21, 2016).

[23] *See* 20 C.F.R. § 10.619; *P.F.,* Docket No. 19-0547 (issued December 20, 2019); *E.C.,* Docket No. 18-1808 (issued May 16, 2019).

[24] *See id.*

[25] *B.M.,* Docket No. 17-1157 (issued May 22, 2018); *Gerald A. Carr,* 55 ECAB 225 (2004).

[26] *See P.F., supra* note 24; *E.C., supra* note 24; *L.M.,* Docket No. 17-0159 (issued September 27, 2017).

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish more than 23 percent permanent impairment of the right lower extremity and 18 percent permanent impairment of the left lower extremity, for which he previously received schedule award compensation. The Board further finds that OWCP properly denied appellant's request for subpoenas.

ORDER

IT IS HEREBY ORDERED THAT the May 15, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 2, 2022
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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