United States Department of Labor
Employees' Compensation Appeals Board

P.J., Appellant	)	
and	)	**Docket No. 26-0332**
	)	**Issued: June 9, 2026**
DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF PRISONS, FEDERAL CORRECTIONAL INSTITUTION McKEAN, Lewis Run, PA, Employer	)	

Appearances:
John L. DeGeneres, Jr., Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On February 25, 2026 appellant, through counsel, filed a timely appeal from a February 18, 2026 merit decision of the Office of Workers' Compensation Programs (OWCP).[2]

[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 the oral argument request, counsel requested that oral argument be granted so that he could further explain his contentions concerning the evaluation of the medical evidence. The Board, in exercising its discretion, denies appellant's request for oral argument because this matter requires an evaluation of the evidence of record. As such, the issues on appeal can be adequately addressed in a decision based on a review of the case record. Oral argument in this appeal would further delay issuance of a Board decision and 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.

Pursuant to the 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.[4]

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 34 percent permanent impairment of the left lower extremity for which he previously received a schedule award.

FACTUAL HISTORY

On June 23, 2022 appellant, then a 54-year-old materials handler, filed an occupational disease claim (Form CA-2) alleging that he developed permanent osteoarthritis of the hips and right knee due to factors of his federal employment. He noted that he first became aware of his claimed conditions on April 16, 2021, and realized their relation to his federal employment on March 11, 2022. Appellant did not stop work. OWCP accepted the claim for permanent aggravation of unilateral primary osteoarthritis right knee and permanent aggravation of bilateral primary osteoarthritis of the hips.

On August 19, 2022 appellant filed a claim for compensation (Form CA-7) for a schedule award.

By decision dated February 22, 2023, OWCP granted appellant a schedule award for 59 percent permanent impairment of the right lower extremity. The period of the award ran for 169.92 weeks of compensation during the period March 11, 2022 through June 12, 2025.

On January 24, 2024 appellant, through counsel, requested reconsideration. In an impairment rating report dated January 12, 2024, Dr. Kevin Scott, a physician specializing in family medicine, applied American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[5] to his left hip examination findings. On physical examination he found that appellant walked with a limp and provided three range of motion (ROM) measurements of the left hip including 90 degrees of flexion, internal and external rotation of 35 degrees, 15 degrees of extension, abduction of 25 degrees and adduction of 15 degrees. Dr. Scott found tenderness over the anterior and lateral portion of the left hip. He related appellant's medical history of right hip replacement on April 16, 2021 and left hip replacement on February 9, 2022 and found that appellant had reached MMI of the left hip on January 12, 2024. Using the diagnosis-based impairment (DBI) rating methodology, he utilized Table 16-4 (Hip Regional Grid), page 515. For the class of diagnosis (CDX) for left total hip replacement, he found a Class 4 impairment due to moderate motion deficit with a default rating of 67 percent permanent impairment of the left lower extremity. Dr. Scott applied Table 16-24 page 549 to the ROM figures to find that flexion, abduction, adduction, and extension were all mild motion

[3] 5 U.S.C. § 8101 *et seq*.

[4] The Board notes that, following the February 18, 2026 decision, appellant submitted additional evidence to the Board. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

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

deficits and assigned five percent lower extremity impairment. He added these impairments to reach 20 percent lower extremity impairment a moderate severity level in accordance with Table 16-25, page 550. Dr. Scott applied the net adjustment formula and determined that a grade modifier clinical studies (GMCS) and was inapplicable as x-rays were used to establish the diagnosis and for class placement. He further found that a grade modifier for physical examination (GMPE) was inapplicable as range of motion was used to determine the class. Dr. Scott related a grade modifier for functional history (GMFH) of 1, based on Table 16-6 due to gait derangement, but that when determined by the American Academy of Orthopedic Surgeons (AAOS) lower limb questionnaire it was 3, moderate deficit. He opined that the A.M.A., *Guides*, page 515 required the use of the highest class modifier as the value for that adjustment in the net adjustment calculation. Dr. Scott concluded that as appellant's DBI was a Class 4 condition, one unit was added to the GMFH, resulting in a GMFH of 4, which equaled 67 percent permanent impairment of the left lower extremity.

OWCP referred Dr. Scott's January 12, 2024 report and SOAF to Dr. Eric M. Orenstein, a Board-certified orthopedic surgeon, serving as a district medical adviser (DMA), for a review and an opinion regarding appellant's permanent impairment. In his May 18, 2024 report, the DMA applied the A.M.A., *Guides* to Dr. Scott's January 12, 2024 findings and agreed with the DBI Class 4 diagnosis. However, he determined that the GMFH was 1, "both by the fact that the claimant as a limb and by the AAOS lower limb score of 70…." The DMA related that by convention the GMFH would be increased to grade 2 as appellant's diagnosis was Class 4, that the GMPE and GMCS were discounted, and that the net adjustment would be two to the left with a final 59 percent permanent impairment rating for the left lower extremity.

By decision dated May 20, 2024, OWCP vacated the February 22, 2023 decision, finding that there was a conflict in the medical opinion evidence between Dr. Scott, appellant's treating physician, and Dr. Orenstein, OWCP's DMA, regarding the permanent impairment of appellant's left lower extremity.

On September 17, 2024, in order to resolve the conflict, OWCP referred appellant, pursuant to section 8123(a) of FECA (5 U.S.C. § 8123(a)), to Dr. Ralph T. Salvagno, a Board-certified orthopedic surgeon, for an impartial medical examination and an evaluation of the permanent impairment of appellant's left lower extremity in accordance with the standards of the sixth edition of the A.M.A., *Guides*. OWCP provided Dr. Salvagno with a copy of the medical record, an undated SOAF, and a series of questions.

In a November 1, 2024 report, Dr. Salvagno, serving as the impartial medical examiner (IME), discussed appellant's factual and medical history, noting that he currently complained of mild anterior groin pain following his bilateral total hip arthroplasties. He reported that the findings of his physical examination including ROM results from the average of three goniometric measurements. In the right hip, Dr. Salvagno found 100 degrees of flexion, 20 degrees of extension, 30 degrees of abduction, 20 degrees of adduction, 30 degrees of internal rotation, and 40 degrees of external rotation. In the left hip, he reported 100 degrees of flexion, 30 degrees of extension, 35 degrees of abduction, 20 degrees of adduction, 40 degrees of internal rotation, and 35 degrees of external rotation. Dr. Salvagno diagnosed bilateral hip osteoarthritis status post total hip arthroplasty. He disagreed with the prior impairment ratings finding that appellant had a good outcome following his hip replacements and had returned to all functional activities, which would place him in Class 2 with a grade C impairment of 25 percent in accordance with Table 16-4, page 515. Dr. Salvagno opined that ROM deficits of less than 5 degrees in all planes could not even be considered as a mild motion deficit following total hip

arthroplasty. He determined that appellant's right hip GMFH of 0, GMPE of 0, and GMCS was excluded and in the left hip, he found GMFH 2, and GMPE 1. For the right hip, Dr. Salvagno found a good result of 21 percent permanent impairment, and for the left hip, 23 percent permanent impairment. He posited that if mild loss of mobility would increase the Class of diagnosis to 3, then appellant had 31 percent permanent impairment of the right hip and 34 percent permanent impairment of the left hip. Dr. Salvagno found that appellant had reached MMI as of the date of his evaluation.

On December 20, 2024 and February 26, 2025, OWCP requested a supplemental report from Dr. Salvagno addressing the permanent impairment of the lower extremities.

In a March 20, 2025 report, Dr. Salvagno related that his impairment rating differed from the previous bilateral hip impairment ratings as his ROM measurements ranged less than given degrees from normal in all planes and in his opinion could not even be considered as a mild motion deficit following total hip arthroplasties. He further noted that appellant had no permanent impairment of his right knee. Dr. Salvagno opined that appellant had 31 percent permanent impairment of the right lower extremity and 34 percent permanent impairment of the left lower extremity.

By decision dated April 24, 2025, OWCP vacated the May 20, 2024 decision.

By decision dated July 11, 2025, OWCP granted appellant a schedule award for 34 percent permanent impairment of the left lower extremity. The period of the award ran for 97.92 weeks of compensation during the period June 13, 2025 through April 29, 2027.

On July 22, 2025 appellant, through counsel requested a review of the written record by a representative of OWCP's Branch of Hearings and Review.

By decision dated February 18, 2026, OWCP's hearing representative affirmed the July 11, 2025 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing federal regulations[7] 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. Through its implementing regulations, OWCP has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9] The Board has approved the use by OWCP of the A.M.A.,

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id. See also C.B.*, Docket No. 24-0757 (issued August 30, 2024); *V.J.*, Docket No. 1789 (issued April 8, 2020); *Jacqueline S. Harris*, 54 ECAB 139 (2002); *Ronald R. Kraynak*, 53 ECAB 130 (2001).

[9] *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 and Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

Guides for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[10]

Chapter 16 of the sixth edition of the A.M.A., *Guides*, pertaining to the lower extremities, provides that the DBI methodology is the primary method of calculation for the lower limb and that most impairments are based on the DBI where impairment class is determined by the diagnosis and specific criteria as adjusted by a GMFH, a GMPE, and/or a GMCS. It further provides that alternative approaches are also provided for calculating impairment for peripheral nerve deficits, complex regional pain syndrome, amputation, and ROM. ROM is primarily used as a physical examination adjustment factor.[11] The A.M.A., *Guides*, however, also explain that some of the diagnosis-based grids refer to the ROM section when that is the most appropriate mechanism for grading the impairment. This section is to be used as a stand-alone rating when other grids refer to this section or no other diagnosis-based sections of the chapter are applicable for impairment rating of a condition.[12]

In determining permanent impairment of the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the hips, reference is made to Table 16-4 (Hip Regional Grid).[13] Under that table, after the diagnosis and the CDX is determined, a default grade value is identified, the net adjustment formula is then applied. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed through an OWCP medical adviser for an opinion concerning the nature and extent of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.[15]

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.[16] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case. In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an IME for the purpose

[10] *C.B.*, *supra* note 8; *M.D.*, Docket No. 20-0007 (issued May 13, 2020); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[11] A.M.A., *Guides* 497, section 16.2.

[12] *Id*. at 543; *see also C.B.*, *supra* note 8; *M.D.*, Docket No. 16-0207 (issued June 3, 2016); *D.F.*, Docket No. 15-0664 (issued January 8, 2016).

[13] A.M.A., *Guides* 515.

[14] *Id*. at 515-22.

[15] *See supra* note 9 at Chapter 2.808.6f (March 2017).

[16] 5 U.S.C. § 8123(a). *See M.B.,* Docket No. 25-0749 (issued September 10, 2025); *R.C.,* Docket No. 18-0463 (issued February 7, 2020); *see also G.B.*, Docket No. 16-0996 (issued September 14, 2016).

of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[17]

When OWCP obtains an opinion from an IME for the purpose of resolving a conflict in medical opinion evidence and the specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to correct the defect in the original report.[18] However, when the IME is unable to clarify or elaborate on the original report or if a supplemental report is also vague, speculative or lacking in rationale, OWCP must submit the case record and a detailed SOAF to a second IME for the purpose of obtaining a rationalized medical opinion on the issue.[19]

ANALYSIS

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

OWCP properly declared a conflict in medical opinion between Dr. Scott, appellant's treating physician, and Dr. Orenstein, the DMA, regarding appellant's left lower extremity permanent impairment rating. Dr. Scott found 67 percent permanent impairment for left hip arthroplasty, utilizing the DBI methodology, while Dr. Orenstein rated appellant's left lower extremity permanent impairment as 59 percent permanent impairment based on appellant's left hip arthroplasty. This conflict required referral to an IME pursuant to 5 U.S.C. § 8123(a).[20]

OWCP selected Dr. Salvagno as an IME to resolve the conflict in the medical opinion evidence. In a November 1, 2024 report, Dr. Salvagno diagnosed bilateral hip osteoarthritis status post total hip arthroplasty. He opined that appellant had 31 percent permanent impairment of the right hip, 34 percent permanent impairment of the left hip, and found that appellant had reached MMI as of the date of his evaluation. In a March 20, 2025 supplemental report, Dr. Salvagno opined that appellant had 31 percent permanent impairment of the right lower extremity and 34 percent permanent impairment of the left lower extremity. However, he did not sufficiently explain his application of the A.M.A., *Guides.*

As Dr. Salvagno's opinion is insufficiently rationalized, the Board finds that it cannot constitute the special weight of the medical evidence.[21]

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[17] 20 C.F.R. § 10.321. *See also J.H.*, Docket No. 22-0981 (issued October 30, 2023); *N.D.*, Docket No. 21-1134 (issued July 13, 2022); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001); *James P. Roberts*, 31 ECAB 1010 (1980).

[18] *A.W.*, Docket No. 25-0542 (issued June 24, 2025); *G.C.*, Docket No. 24-0718 (issued September 19, 2024); *Raymond A. Fondots*, 53 ECAB 637, 641 (2002); *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232 (1988); *Ramon K. Ferrin, Jr.*, 39 ECAB 736 (1988); *Harold Travis*, 30 ECAB 1071, 1078 (1979).

[19] *A.W., id.*; *Nancy Keenan*, 56 ECAB 687 (2005); *Roger W. Griffith*, 51 ECAB 491 (2000); *Talmadge Miller*, 47 ECAB 673 (1996); *Harold Travis, id*.

[20] *J.W.,* Docket No. 25-0803 (issued December 8, 2025); *J.M.,* Docket No. 25-0212 (issued May 1, 2025); *M.O.,* Docket No. 24-0087 (issued September 6, 2024); *A.T.,* Docket No. 23-0309 (issued August 13, 2024). *Supra* notes 15 and 16.

[21] *See J.W., id.*; *D.S.,* Docket No. 25-0131 (issued July 25, 2025); *A.W., supra* note 18; *R.C.*, Docket No. 25-0414 (issued May 30, 2025); *R.W.,* Docket No. 24-0746 (issued September 30, 2024).

As there remains an unresolved conflict in medical evidence, the case must be remanded. On remand, OWCP shall refer appellant, along with the medical record and a SOAF to a new physician in the appropriate field of medicine to resolve the existing conflict as to the extent of any additional permanent impairment of the left lower extremity. After this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the February 18, 2026 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: June 9, 2026
Washington, DC

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

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

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