United States Department of Labor
Employees' Compensation Appeals Board

W.B., Appellant	)	
and	)	**Docket No. 14-1982**
	)	**Issued: August 26, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Hartford, CT, Employer	)	

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

Oral Argument July 23, 2015

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 15, 2014 appellant, though counsel, filed a timely appeal from an August 22, 2014 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 a 31 percent impairment of his left lower extremity and a 31 percent impairment of his right lower extremity, for which he received schedule awards.

FACTUAL HISTORY

On May 3, 2012 appellant, then a 60-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that he developed right and left knee permanent acceleration of osteoarthritis as a result of his federal employment duties. On February 28, 2011 he underwent

[1] 5 U.S.C. § 8101 *et seq.*

bilateral knee replacement. By decision dated November 1, 2012, OWCP accepted the claim for bilateral knee permanent aggravation of osteoarthritis.

On November 9, 2012 appellant filed a claim for a schedule award (Form CA-7).

In support of his schedule award claim, appellant submitted an April 26, 2012 medical report from Dr. Byron V. Hartunian, a Board-certified orthopedic surgeon. In his report, Dr. Hartunian noted that he evaluated appellant on April 6, 2012 and reviewed prior medical reports pertaining to his bilateral knee condition. He provided a history of appellant's employment activities and findings on physical examination. Dr. Hartunian noted that right knee flexion range of motion (ROM) was 94 degrees, left knee flexion ROM was 98 degrees, and extension was 0 degrees for both knees. He diagnosed status post right and left knee replacement for end-stage degenerative arthritis. Using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[2] Dr. Hartunian opined that appellant had a total 37 percent impairment of the right lower extremity and 37 percent impairment of the left lower extremity. According to Table 16-3 Knee Regional Grid, section for total knee replacement, Dr. Hartunian identified the diagnosis as a class 3 severe problem, which yielded a default value of 37 percent.[3]

Dr. Hartunian explained that class placement for lower extremity arthroplasty required, in part, an analysis of hardware positioning through the use of postarthroplasty clinical studies. He noted that appellant's postarthroplasty clinical studies showed good hardware positioning. Class placement for lower extremity arthroplasty also required an analysis of range of motion. Dr. Hartunian explained that appellant's postarthroplasty physical examination indicated a mild motion deficit. He noted that, because clinical studies and physical examination were used to determine the class, they were not used as modifiers. Dr. Hartunian further explained that the A.M.A., *Guides* provide that "imaging studies" (as opposed to "clinical" studies) were used to grade arthritis. However, in a postarthroplasty situation, the arthritic cartilage surfaces have been replaced by prostheses and there is no longer any arthritis to grade. Dr. Hartunian stated that, for this additional reason, the clinical studies grade modifier was inapplicable as appellant's relevant clinical studies were imaging studies and x-rays used to confirm the diagnosis. He stated that the functional history adjustment as determined by gait derangement was a grade modifier 0 as there was no antalgic limp. When determining the grade modifier based on the AAOS Lower Limb Questionnaire completed by appellant, he assigned a grade modifier 2 for moderate problem.[4] Dr. Hartunian noted that, because the difference between these two methods of determination is 2, the functional history adjustment was considered unreliable and excluded from the grading process. Thus, the net adjustment formula did not apply in this situation, resulting in a default class 3, grade C impairment of 37 percent for the right lower extremity and 37 percent for the left lower extremity. Dr. Hartunian concluded that appellant reached maximum medical improvement (MMI) one year after his knee surgery in February 2012.

[2] A.M.A., *Guides* (2009).

[3] *Id.* at 511, Table 16-3.

[4] *Id.* at 516.

OWCP properly routed Dr. Hartunian's report and the case file to Dr. Morley Slutsky, an OWCP district medical adviser (DMA), for review and a determination on whether appellant sustained a permanent impairment of the lower extremities and the date of MMI.

In a November 27, 2012 report, Dr. Slutsky reported that appellant reached MMI on April 26, 2012, the date of Dr. Hartunian's examination. He calculated 31 percent impairment of the right lower extremity and 31 percent impairment of the left lower extremity. Dr. Slutsky reported that he agreed with Dr. Hartunian's diagnosis for bilateral knee arthroplasty and also placed appellant in class 3 for bilateral total knee arthroplasty with good alignment and stability and mild motion loss. Applying appellant's range of motion examination findings to Table 15-23, Dr. Slutsky noted that he had 10 percent knee motion impairment for the right and 10 percent impairment for the left.[5] Dr. Slutsky agreed with Dr. Hartunian that the clinical studies grade modifier was not applicable because diagnostic testing was used to place appellant's knee into the correct diagnostic class, and could not be used to assign a grade modifier.[6] He further agreed that the functional history was also not applicable in the grading process. Dr. Slutsky explained that appellant's AAOS score equaled a grade modifier 2 while the functional history adjustment as determined by gait derangement equaled a grade modifier 0 for no antalgic limp.[7] As there was a difference of two grade modifiers between these functional history measures, the functional history was unreliable and would not be used in the rating calculation. With respect to physical examination, Dr. Slutsky disagreed with Dr. Hartunian's assessment to exclude it from the net adjustment formula. Dr. Slutsky assigned a grade modifier 0, stating that appellant's ROM and stability testing were used to place the knees into the correct diagnostic class and no other objective deficits were documented.[8] Using the net adjustment formula, Dr. Slutsky found that the difference of 0 physical examination grade modifier from 3 for the class of diagnosis equaled a net adjustment of -3. As the lowest rating in the class -2, the final grade A resulting in a 31 percent impairment of the left lower extremity and 31 percent impairment of the right lower extremity.[9]

By letter dated January 10, 2014, OWCP informed appellant that Dr. Slutsky, the DMA, provided a 31 percent impairment rating for each lower extremity as opposed to the earlier 37 percent impairment rating provided by Dr. Hartunian. It provided appellant with a copy of Dr. Slutsky's report and advised him to obtain a supplemental report from his treating physician which would support further consideration of the additional six percent impairment difference for each lower extremity.

In a December 31, 2012 supplemental report, Dr. Hartunian reviewed Dr. Slutsky's report and disagreed with his final 31 percent impairment rating. He noted that, after further review of the A.M.A., *Guides*, he was amending his previous opinion regarding the applicability of the grade modifier for functional history, namely, that it should be excluded because the AAOS

[5] *Id.* at 549.

[6] *Id.* at 519, Table 16-8.

[7] *Id.* at 516, Table 16-6.

[8] *Id.* at 517, Table 16-7.

[9] *Supra* note 3.

finding was disparate by two or more from the gait derangement finding 0. Rather, Dr. Hartunian stated that appellant's functional history should be assigned a grade modifier 2 as the A.M.A., *Guides* stipulate that the highest class modifier should be used as the value for that adjustment in the net adjustment calculation.[10]

Dr. Hartunian also noted that Dr. Slutsky erroneously assigned a grade modifier 0 for physical examination when no grade modifier should be assigned as it was used to define the class. He referenced the section of the A.M.A., *Guides* which stated, "If a grade modifier, or nonkey factor, was used for primary placement in the regional grid, it may not be used again in the impairment calculations. For example, if a diagnostic class was determined using range of motion as a factor, then range of motion is not considered again when determining the physical examination adjustment factor."[11] Dr. Hartunian further disagreed with the date of MMI assigned by Dr. Slutsky, stating that MMI was reached in February 2012, one year after undergoing right and left knee total knee replacement. He stated that it was well accepted that the MMI for joint replacement was generally about one year following joint replacement surgery, noting that MMI applied to the function of a joint and focused on functional impairment.

Dr. Hartunian stated that all of his conclusions from his prior report remained the same: placing appellant in class 3 and no grade modifiers assigned for physical examination or clinical studies because they were used to confirm the diagnosis. Using the net adjustment formula, he took the difference of 2 for the functional history grade modifier from 3 for the class diagnosis resulting in a -1 adjustment. This resulted in a grade B impairment rating of 34 percent permanent impairment of the right lower extremity and 34 percent impairment of the left lower extremity.

OWCP provided Dr. Slutsky with Dr. Hartunian's January 4, 2013 supplemental report and requested an addendum report addressing the opposing opinions.

In a June 25, 2013 report, Dr. Slutsky reported that the findings made in his prior November 27, 2012 report remained unchanged. He disagreed with Dr. Hartunian's assignment of grade modifier 2 for functional history and maintained that the functional history could not be used in the net adjustment formula because it was unreliable. Dr. Slutsky noted that, while the AAOS score equaled a grade modifier 2, the primary determinate for functional history grade modifiers were objective factors found in Table 16-6.[12] He stated that appellant did not have a gait issue and there was no documentation of a positive Trendelenburg which resulted in a grade modifier 0. The DMA referenced section 16.3a of the A.M.A., *Guides* and stated that because there was a significant discrepancy of two grade modifiers between the observed functional status and that of appellant's history, the functional history was unreliable.[13]

Dr. Slutsky further maintained that physical examination should be assigned a grade modifier 0. He stated that appellant's knee ROM and stability testing were used to place

[10] *Supra* note 7.

[11] A.M.A., *Guides* 515-16.

[12] *Supra* note 7.

[13] A.M.A., *Guides* 516.

appellant into the correct diagnostic class and no other objective deficits were documented. Based upon this, appellant's physical examination grade modifier was 0. Dr. Slutsky noted that this was consistent with an example provided in the A.M.A., *Guides* for a total knee replacement rating.[14] Thus, he argued that Dr. Hartunian's assertion that the physical examination grade modifier should be excluded from the net adjustment calculation was incorrect. Dr. Slutsky concluded that MMI was April 26, 2012, the date of the rating examination performed by Dr. Hartunian.

By decision dated January 31, 2014, OWCP granted appellant a schedule award claim for 31 percent permanent impairment of the right lower extremity and 31 percent impairment of the left lower extremity. It found that the weight of the medical evidence rested with Dr. Slutsky serving as the DMA. The date of MMI was noted as April 6, 2012, the date of Dr. Hartunian's examination. The award covered a period of 178.56 weeks from April 6, 2012 to September 2, 2015.

On February 12, 2014 appellant, through counsel, requested an oral hearing before the Branch of Hearings and Review.

At the June 17, 2014 hearing, counsel argued that the weight of the medical evidence rested with Dr. Hartunian as Dr. Slutsky improperly utilized the A.M.A., *Guides*.

By letter dated July 16, 2014, counsel argued that OWCP deemed the medical evidence to be sufficiently complete to warrant a decision and as such, no further medical development was necessary. He argued that Dr. Slutsky's reports were not probative or of equal weight to the reports of Dr. Hartunian, and also argued that no conflict was created and no referee physician was warranted. Rather, the weight of the medical evidence rested with Dr. Hartunian and OWCP should utilize his report in determining appellant's schedule award.

By decision dated August 22, 2014, the Branch of Hearings and Review affirmed OWCP's January 31, 2014 schedule award. It noted that the weight of the medical opinion rested with Dr. Slutsky serving as the DMA.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations 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.[15] 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 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.[16]

[14] *Id.* at 527.

[15] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[16] *K.H.*, Docket No. 09-341 (issued December 30, 2011). For decisions issued after May 1, 2009, the sixth edition will be applied. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

The A.M.A., *Guides* provide a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability, and Health (ICF). For lower extremity impairments, the evaluator identifies the impairment class for the diagnosed condition Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[17] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[18] Evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[19]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP 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.[20]

ANALYSIS

OWCP accepted appellant's claim for right and left knee permanent aggravation of osteoarthritis. On February 28, 2011 appellant underwent bilateral knee replacement. The issue is whether he has more than a 31 percent permanent impairment of the right lower extremity and 31 percent permanent impairment of the left lower extremity, for which he received schedule awards. The Board finds that appellant is entitled to an additional six percent impairment for the right lower extremity and six percent impairment for the left lower extremity.[21]

Diagnosis-based impairment is the primary method for evaluating impairment to the lower limb. Impairment is determined first by identifying the relevant diagnosis, then by selecting the class of the impairment: no objective problem, mild problem, moderate problem, severe problem, very severe problem approaching total function loss. This provides a default impairment rating, which can be adjusted slightly up or down using grade modifiers or nonkey factors, such as functional history, physical examination, and clinical studies.[22]

The impairment values for a total knee replacement are found in Table 16-3, page 511 of the A.M.A., *Guides* or the Knee Regional Grid. A good result -- good position, stable, functional -- has a default impairment value of 25 percent. A fair result -- fair position, mild instability and/or mild motion deficit -- has a default impairment value of 37 percent. A poor result has a default impairment value of 67 percent. A poor result with chronic infection has a default impairment value of 75 percent.

[17] *Supra* note 2 at 493-531.

[18] A.M.A., *Guides* 521.

[19] *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[20] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (February 2013).

[21] *See A.G.*, Docket No. 14-1143 (issued December 10, 2014).

[22] *Supra* note 2 at 497.

In his November 27, 2012 and June 25, 2013 reports, Dr. Slutsky, serving as the DMA, reported that appellant was entitled to 31 percent impairment of the right lower extremity and 31 percent impairment of the left lower extremity. Dr. Hartunian's April 26, 2012 report found that appellant had 37 percent impairment for each lower extremity, which he later amended to 34 percent impairment in his subsequent January 14, 2013 report.

The Board notes that the medical evidence and findings pertaining to appellant's bilateral knee arthroplasty were sufficient such that a conflict in medical evidence was not created.[23] Dr. Slutsky and Dr. Hartunian agreed that appellant should be placed in class 3 for bilateral total knee arthroplasty based on his clinical studies and physical examination findings. Both physicians used appellant's physical examination findings for knee range of motion and stability testing to place him in the correct diagnostic class, with a class 3 grade C default impairment value of 37 percent.

With respect to assigning values for grade modifiers, both Dr. Slutsky and Dr. Hartunian agreed that no assignment value should be provided for clinical studies as diagnostic testing was used to place appellant into the correct diagnostic class.[24]

Dr. Slutsky further agreed with Dr. Hartunian's initial April 26, 2012 assessment that functional history could not be assigned a grade modifier and was not applicable in the grading process. Both physicians agreed that appellant's AAOS score equaled a grade modifier 2 while the functional history adjustment as determined by gait derangement equaled a grade modifier 0 for no antalgic limp.[25] As there was a difference of two grade modifiers between these functional history measures, Dr. Slutsky found that the functional history was unreliable and would not be used in the rating calculation. In his supplemental January 14, 2013 report, Dr. Hartunian amended his prior functional history assessment and argued that appellant should be assigned a grade modifier 2 because the A.M.A., *Guides* stipulate that the highest class modifier should be used as the value for that adjustment.

The Board notes that Dr. Slutsky properly determined that functional history could not be assigned a grade modifier as it was not applicable in the grading process. The A.M.A., *Guides* indicate that the evaluating physician may use outcome instruments and inventories, such as the AAOS lower limb questionnaire, as part of the process of evaluating functional symptoms.[26] The A.M.A., *Guides* further provide that, if there are multiple components to a grade modifier, the evaluator should choose the most objective grade modifier with the highest value, associated with the diagnosis being rated.[27] If a grade modifier is found to be unreliable or inconsistent, it should be disregarded and eliminated from the calculation.[28] In this instance, both physicians

[23] *See J.J.*, Docket No. 14-1143 (issued December 10, 2014); *Mary L. Henninger*, 52 ECAB 408 (2001).

[24] *Supra* note 6.

[25] *Supra* note 7.

[26] *Supra* note 4, section 16.3a (emphasis added); *see* section 16.9, Appendix 16-A: Lower Limb Questionnaire, A.M.A., *Guides* 555. *See also G.C.*, Docket No. 13-1493 (issued September 18, 2014).

[27] A.M.A., *Guides* 521, section 16.3d (emphasis added).

[28] *Id.*

agreed with the grade modifiers assigned based on appellant's AAOS score and gait derangement. As the functional history differed by two or more grades from that defined by physical examination or clinical studies, Dr. Slutsky properly determined that functional history was unreliable and should be excluded from the grading process.[29] Assigning the grade modifier with the highest value would not be appropriate in this case.

With respect to physical examination, Dr. Slutsky and Dr. Hartunian disagree regarding whether a grade modifier should be assigned. Dr. Slutsky stated that appellant's knee ROM and stability testing were used to place the knees into the correct diagnostic class and no other objective deficits were documented. Based upon this, he assigned a grade modifier 0 for physical examination. Dr. Hartunian disagreed with Dr. Slutsky stating that physical examination had to be excluded from the grading process because it was used to place appellant in the correct class.

The Board notes that Dr. Slutsky incorrectly assigned a grade modifier for physical examination, which must be excluded from the net adjustment calculation. Both physicians agree that range of motion and stability testing were used to place appellant in the correct diagnostic class. The A.M.A., *Guides* provide that if a grade modifier or nonkey factor, is used for primary placement in the regional grid, it may not be used again in the impairment calculations. For example, if a diagnostic class was determined using range of motion as a factor, then range of motion is not considered again when determining the physical examination adjustment factor.[30] As Dr. Slutsky stated that, range of motion and stability testing were used to place the knees into the correct diagnostic class, he improperly assigned a grade modifier 0 for physical examination as he previously explained that no other objective deficits were documented.[31] Thus, physical examination cannot be used in calculating the net adjustment formula.[32]

As the medical evidence establishes that functional history, clinical studies, and physical examination should be disregarded and eliminated from the net adjustment calculation, the default value of C for class 3 total knee replacement results in 37 percent impairment as the final

[29] If the functional history is determined to be unreliable or inconsistent with other documentation, it is excluded from the grading process. *Supra* note 26.

[30] *Id.* at 515-16.

[31] The A.M.A., *Guides* provide that a physical examination grade modifier assignment of 0 pertains to those patients who have had findings in the past but are now healthy (with no expectation that they will have recurrent findings). *Id.* at 15.

[32] The Board notes that the example Dr. Slutsky cites on page 527 of the A.M.A., *Guides* for total knee replacement does not establish that a grade modifier should be assigned for physical examination. In the example, the left knee was assigned class 2 while the right knee was assigned class 3. Physical examination was not used to assign the class for the left knee so physical examination was assigned a grade modifier 0 for the net adjustment calculation. With respect to the right knee, the example noted that range of motion was used to assign the class and thus could not be considered for grade assignment. The example provided a grade modifier 1 for physical examination, however, based on atrophy or weakness, which was not used in assigning the class. It noted that range of motion would be a grade modifier 2, but had to be excluded. Dr. Slutsky's reports explained that range of motion and stability testing were used to place the knees into the correct diagnostic class and no other objective deficits were documented. He incorrectly relied on this example as support for assigning a physical examination grade modifier 0.

rating value. In this case, appellant was previously awarded 31 percent impairment of the right lower extremity and 31 percent of the left lower extremity. The Board finds that he is entitled to an additional six percent impairment of the right lower extremity and six percent impairment of the left lower extremity.[33] The Board further finds that OWCP properly determined that the date of MMI was April 6, 2012, the date of Dr. Hartunian's examination.[34]

CONCLUSION

The Board finds that appellant has established entitlement to 37 percent impairment for the right lower extremity and 37 percent impairment for the left lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the August 22, 2014 decision of the Office of Workers' Compensation Programs is affirmed, as modified.

Issued: August 26, 2015
Washington, DC

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

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

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

[33] *Supra* note 21.

[34] In assessing eligibility for a schedule award, the medical evidence must show that the impairment has reached a permanent and fixed state, which is generally referred to as MMI. *See supra* note 20 at Chapter 2.808.5b(1) (February 2013). Assuming MMI has been attained, the date of MMI is usually considered to be the date of the evaluation by the attending physician that is accepted as definitive by OWCP. Schedule awards begin on the date of MMI, unless circumstances show that a later date should be used. A retroactive determination of the date of MMI is not per se erroneous. When the medical evidence establishes that the employee did in fact reach maximum improvement by such date, the determination is proper. *Supra* note 20 at Chapter 2.808.7b.