United States Department of Labor
Employees' Compensation Appeals Board

F.V., Appellant	)	
and	)	**Docket No. 14-0986**
	)	**Issued: January 27, 2017**
PEACE CORPS VOLUNTEER SERVICES, La Paz, Honduras, 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
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 18, 2014 appellant filed a timely appeal from a February 6, 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 the decision.

ISSUE

The issue is whether appellant has met his burden of proof to establish more than 13 percent permanent impairment of the right upper extremity for which he previously received a schedule award.

On appeal, appellant asserts that he has established greater permanent impairment, that the date of maximum medical improvement is incorrect, that OWCP refused to reimburse him for a medical report, and that he continues to be permanently disabled.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On February 9, 2011 appellant, then a 68-year-old Peace Corps volunteer, injured his right arm when he fell down steps. The claim was accepted for fracture of the right radius head, closed fracture of the olecranon process of the right ulna, contracture of elbow joint, and pain in joint, arm, and hand of the right upper extremity. Appellant had emergency surgery in Honduras, was evacuated to Panama for further surgery, and was then transferred to Seattle, Washington, where on June 1, 2011 he underwent submuscular ulnar nerve transposition with resection of heterotopic ossification and release of posterior and anterior capsulotomy and manipulation of elbow. The pre- and postoperative diagnoses were capsular contracture and heterotopic ossification of the right elbow and ulnar nerve neuropathy.

On March 21, 2012 OWCP terminated appellant's wage-loss compensation as he had no further disability due to his work injury. In a merit decision dated July 6, 2012, it denied modification of the prior decision.

Appellant filed a schedule award claim (Form CA-7) on July 27, 2012. Shortly, thereafter he moved from Washington State back to Honduras. In a July 24, 2012 report, Dr. Honorio Claros Fortin, an orthopedic surgeon, noted right elbow active flexion of 50 degrees, extension to 165 degrees, right wrist dorsiflexion of 55 degrees, left wrist dorsiflexion of 75 degrees, right volar flexion of 55 degrees, and left volar flexion of 80 degrees. There was no pronation or supination, and the fingers of the right and left hand had complete mobility and normal strength.

By letter dated August 21, 2012, OWCP asked appellant to provide an impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).[2] Appellant was afforded 30 days to submit the requested information. He submitted no additional medical reports, and on September 26, 2012 OWCP denied his claim for a schedule award.

On October 10, 2012 appellant requested reconsideration, asserting that he should have been sent for a second-opinion evaluation. In a merit decision dated November 1, 2012, OWCP denied modification of the prior decision. It noted that it was unable to arrange second-opinion evaluations overseas.

In a November 1, 2012 letter, OWCP provided a copy of the medical evidence to Dr. Douglas P. Hanel, a treating Board-certified orthopedic surgeon, and requested an impairment evaluation, in accordance with the sixth edition of the A.M.A., *Guides*. On November 19, 2012 appellant informed OWCP that he would be stateside from January 9 to February 9, 2013.

In a treatment note dated January 14, 2013, Dr. Hanel indicated that appellant had been examined 15 months status post right elbow resection of heterotopic ossification with contracture release on October 12, 2011. He provided physical examination findings and advised that right shoulder range of motion was full, flexion-extension of the right elbow was 25 to 130 degrees,

[2] A.M.A., *Guides* (6th ed. 2008).

and appellant could pronate to 30 degrees and supinate to neutral. Sensation was normal. Dr. Hanel indicated that arthritis of the ulnohumeral joint was continuing to worsen and that appellant was at maximum medical improvement. He indicated that appellant would require a total elbow arthroplasty or arthrodesis in the future.

OWCP attempted to schedule a second-opinion evaluation while appellant was stateside, but was unsuccessful. Appellant scheduled his own appointment with Dr. Brian D. Cameron, a Board-certified orthopedic surgeon, and OWCP authorized the visit. In his February 3, 2013 report, Dr. Cameron described the employment injury and subsequent medical treatment and appellant's complaint of persistent right elbow pain and a sense of weakness. He indicated that appellant continued to use his arm and had noticed a significant benefit from the contracture release and the surgeries that had been performed by Dr. Hanel. Dr. Cameron advised that physical examination demonstrated 30 degrees of flexion contracture to approximately 110 degrees with profound weakness in both pronation and supination due to ankylosis. Sensation was intact distally. Dr. Cameron diagnosed severe post-traumatic arthritis of the right elbow with associated ankylosis in supination, status post radial head prosthetic arthroplasty. He indicated that appellant had reached maximum medical improvement and advised that at some point he would require a total elbow replacement.

In accordance with the fifth edition of the A.M.A., *Guides*,[3] Dr. Cameron found 8 percent right upper extremity permanent impairment due to radial head replacement, 3 percent permanent impairment due to a 30 degree flexion contracture, 4 percent permanent impairment due to 110 degrees of flexion, 8 percent impairment due to profound supination weakness, 8 percent permanent impairment rating due to profound pronation weakness, 22 percent permanent impairment due to ankylosis of 20 degrees, for a total of 53 percent right upper extremity permanent impairment.

On March 13, 2013 OWCP asked Dr. Cameron to provide an impairment rating in accordance with the sixth edition of the A.M.A., *Guides*. On June 10, 2013 Dr. Cameron advised that, in accordance with Table 15-33, Elbow/Forearm Range of Motion (ROM), appellant had a class 1 limitation of flexion to approximately 110 degrees, for 3 percent permanent impairment, 30 degrees lack of full extension for 2 percent permanent impairment, and 20 degrees of supination for 15 percent upper extremity impairment rating, for a total right upper extremity impairment of 20 percent.

On June 20, 2013 Dr. Morley Slutsky, an OWCP medical adviser Board-certified in occupational medicine, reviewed the medical record, including Dr. Cameron's report. He indicated that Dr. Cameron's range of motion measurements were not in accordance with the procedures proscribed by section 15.7 of the A.M.A., *Guides*, which require three measurements per joint motion and the use of a goniometer. The medical adviser noted that diagnosis-based impairment (DBI) was the preferred rating method under the A.M.A., *Guides*, and that appellant's most impairing diagnosis was radial head arthroplasty, complicated. He indicated that, under Table 15-4, Elbow Regional Grid, for this diagnosis, appellant had a class 1 impairment with a default value of 11 percent. The medical adviser found a modifier of 2 for

[3] *Id*. at (5th ed. 2000).

functional history and 3 each for physical examination and clinical studies. After applying the net adjustment formula, Dr. Slutsky concluded that appellant had 13 percent right upper extremity permanent impairment, the maximum allowed for this diagnosis.

On July 18, 2013 OWCP forwarded Dr. Slutsky's evaluation to Dr. Cameron for review. On July 24, 2013 it advised appellant that it would not authorize another physician visit for an impairment evaluation.

Appellant submitted an August 13, 2013 report, in which Dr. Charles N. Brooks, a Board-certified orthopedic surgeon, noted appellant's complaint of pain and stiffness in the right elbow, and that he had limitations in using his right arm in activities of daily living. Dr. Brooks indicated that motions on left and right elbows respectively were extension 0/10 degrees and flexion 140/110 degrees. There was readily apparent (both palpable and audible) crepitus in lateral right elbow upon motions of the joint. Forearm pronation was 90/10 degrees and supination 0/90 degrees. Grip and pinch, were weaker on right. Sensory testing revealed hypesthesia throughout most of right forearm and also involving ulnar aspect of right hand, ring, and little fingers. Dr. Brooks diagnosed open fracture dislocation right elbow, including comminuted fractures of radial head and neck, fractures of olecranon and coronoid process, and tears of both medial and lateral collateral ligaments, due to the February 9, 2011 injury. He further diagnosed post-traumatic arthritis right elbow, complicating the elbow fracture-dislocation, and right ulnar neuropathy, also complicating the elbow fracture-dislocation, status post submuscular ulnar nerve transposition.

Dr. Brooks indicated that, in accordance with Table 15-4 of the sixth edition of the A.M.A., *Guides*, the radial head arthroplasty diagnosis, complicated by heterotopic ossification and ankylosis, was the highest causally-related impairment rating, and had an impairment range of 9 to 13 percent. Dr. Brooks found a grade modifier of 2 for functional history and 3 for physical examination. He found no modifier for clinical studies. He applied the net adjustment formula and concluded that appellant had a 13 percent right upper extremity permanent impairment based on the radial head arthroplasty diagnosis.

Dr. Brooks further found that the A.M.A., *Guides* indicated that a peripheral nerve impairment could be combined with a DBI of the upper extremity level as long as the DBI did not encompass the nerve impairment. He advised that appellant's ulnar neuropathy was a separate and distinct diagnosis, which caused an increased impairment. Dr. Brooks utilized Table 15-23, Entrapment/Compression Neuropathy Impairment, and indicated that appellant had no modifier for test findings because there was no electrodiagnostic study, and he had a grade modifier of 3 for history due to constant hypesthesia in ulnar distribution. He further indicated that appellant had a modifier of 2 for physical examination due to decreased sensation. Dr. Brooks averaged the grade modifiers, concluding that appellant had grade modifier of 2, which under Table 15-23 yielded an impairment of 7 to 9 percent. He concluded that, based on appellant's *Quick*DASH score of 45, he had an 8 percent right upper extremity impairment due to peripheral nerve impairment. Dr. Brooks combined the 13 percent permanent impairment due to radial head arthroplasty with the 8 percent permanent impairment due to peripheral nerve impairment and concluded that appellant had 20 percent right upper extremity permanent impairment.

On January 14, 2014 Dr. Slutsky again reviewed the medical record, including Dr. Brooks' report. He advised that the date of maximum medical improvement was August 13, 2013, the date of appellant's impairment evaluation by Dr. Brooks. The medical adviser agreed with Dr. Brooks' conclusion that appellant had 13 percent permanent impairment under Table 15-4. However, Dr. Slutsky found that he was not entitled to an additional impairment rating for right ulnar nerve peripheral neuropathy. He concluded that the condition was first diagnosed on June 1, 2011 during surgery and had not been accepted as caused by the employment injury. Dr. Slutsky concluded that appellant's final right upper extremity permanent impairment rating was 13 percent, based on the complicated right radial head arthroplasty.

By decision dated February 6, 2014, appellant was granted a schedule award for 13 percent permanent impairment of the right upper extremity, for a total of 283.92 days, to run from August 13, 2013 to May 23, 2014.

LEGAL PRECEDENT

Section 8149 of FECA delegates to the Secretary of Labor the authority to prescribe rules and regulations for the administration and enforcement of FECA. The Secretary of Labor has vested the authority to FECA's program with the Director of OWCP.[4] Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.[5] FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[6]

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A., *Guides* issued a 52-page document entitled, "Clarifications and Corrections, [s]ixth [e]dition, [A.M.A.,] *Guides*." The document included various changes to the original text, intended to serve as an erratum/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[7] The Board has approved the use by OWCP of the A.M.A.,

[4] *See* 20 C.F.R. §§ 1.1-1.4.

[5] For a complete loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

[6] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[7] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id* at Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a (February 2013).

Guides for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[8]

ANALYSIS

The issue on appeal is whether appellant has met his burden of proof to establish more than 13 percent permanent impairment of the right upper extremity for which he previously received a schedule award.

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

After significant observation of upper extremity schedule award appeals the Board has found that OWCP has inconsistently applied Chapter 15 of the sixth edition of the A.M.A., *Guides* when granting schedule awards for upper extremity claims. This is because of an inconsistent application of the proper use of the DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.[9] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[10] In *T.H.*, the Board concluded that OWCP physicians are at odds over the proper methodology for rating upper extremity impairment, having observed attending physicians, evaluating physicians, second opinion physicians, impartial medical examiners, and district medical advisers use both DBI and ROM methodologies interchangeably without any consistent basis. Furthermore, the Board has observed that physicians interchangeably cite to language in the first printing or the second printing when justifying use of either ROM or DBI methodology. Because OWCP's own physicians are inconsistent in the application of the A.M.A., *Guides*, the Board finds that OWCP can no longer ensure consistent results and equal justice under the law for all claimants.[11]

In light of the conflicting interpretation by OWCP of the sixth edition with respect to upper extremity impairment ratings, it is incumbent upon OWCP, through its implementing regulations and/or internal procedures, to establish a consistent method for rating upper extremity impairment. In order to ensure consistent results and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the February 6, 2014 decision. Following OWCP's development of a consistent method for calculating permanent impairment for upper extremities to be applied uniformly, and such other development as may be deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for an upper extremity schedule award.

CONCLUSION

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

[8] *Isidoro Rivera*, 12 ECAB 348 (1961).

[9] *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

[10] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[11] *Supra* note 9.

ORDER

IT IS HEREBY ORDERED THAT the February 6, 2014 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.[12]

Issued: January 27, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

[12] James A. Haynes, Alternate Judge, participated in the original decision but was no longer a member of the Board effective November 16, 2015.