United States Department of Labor
Employees' Compensation Appeals Board

P.M., Appellant	)	
and	)	**Docket No. 16-0367**
	)	**Issued: March 27, 2017**
DEPARTMENT OF COMMERCE, U.S. CENSUS BUREAU, Toledo, OH, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On December 22, 2015 appellant, through counsel, filed a timely appeal from a July 28, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[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] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has more than 10 percent left lower extremity permanent impairment and more than 8 percent left upper extremity permanent impairment, for which she previously received schedule awards.

FACTUAL HISTORY

On April 9, 2010 appellant, then a 62-year-old enumerator, filed a traumatic injury claim (Form CA-1) alleging that she sustained injuries in a motor vehicle accident on April 6, 2010 while in the performance of duty. OWCP has accepted the claim for left ankle fracture and left arm distal radius fracture (Colles fracture). Appellant received wage-loss compensation through May 31, 2010, returned to work part time, and her employment was terminated as of July 31, 2010.

Appellant filed a claim for a schedule award (Form CA-7) on December 29, 2010. OWCP sent the treating physician, Dr. Robert Kalb, an orthopedic surgeon, a December 29, 2011 letter requesting information regarding whether appellant had permanent impairment of either the left upper or lower extremity. In a January 4, 2011 report, Dr. Kalb provided a history and results on examination. He completed a permanent impairment worksheet for the lower extremity and indicated that appellant had sustained no permanent impairment. As to the upper extremity, Dr. Kalb responded to the December 29, 2011 and indicated that she had left wrist pain, but no permanent impairment as there was full range of motion (ROM).

By report dated February 10, 2011, an OWCP medical adviser opined that appellant had no left leg or arm permanent impairment.

By decision dated February 14, 2011, OWCP denied the claim for a schedule award. It found that the medical evidence of record failed to establish an employment-related permanent impairment.

Appellant, through counsel, requested a hearing before an OWCP hearing representative on March 2, 2011. She submitted a report dated March 18, 2011 from Dr. William Grant, a Board-certified internist, who opined that she had 19 percent left arm permanent impairment based on the condition of entrapment neuropathy. Dr. Grant also opined that appellant had 21 percent left leg permanent impairment.

By decision dated August 18, 2011, the hearing representative remanded the case for further development. She found that the medical evidence from Dr. Grant was sufficient to require further development.

OWCP referred appellant to Dr. Richard Deerhake, a Board-certified orthopedic surgeon, for a second opinion examination. In a report dated January 10, 2012, Dr. Deerhake provided a history and results on examination. He opined that appellant had eight percent left upper extremity permanent impairment based on loss of ROM in the left wrist. For the left lower extremity, Dr. Deerhake found that she had 10 percent permanent impairment using the diagnosis-based impairment (DBI) method.

An OWCP medical adviser reviewed Dr. Deerhake's report and, in a March 5, 2012 report, indicated that he concurred there was 10 percent left lower extremity permanent impairment. He opined that he disagreed with Dr. Deerhake regarding the impairment assigned to the left upper extremity. The medical adviser opined that the permanent impairment based on loss of wrist ROM was four percent. A second medical adviser reviewed Dr. Deerhake's January 10, 2012 report and, in a May 3, 2012 report, opined that the left upper extremity impairment was eight percent. However, he indicated that Dr. Deerhake had used 50 degrees of extension and flexion, with 10 degrees adduction. According to the medical adviser, this would result in an eight percent left upper extremity permanent impairment.

By decision dated May 7, 2012, OWCP issued a schedule award for 10 percent left lower extremity permanent impairment and 8 percent left upper extremity permanent impairment. The period of the award was 28.80 weeks for the left leg and 24.96 weeks for the left arm, commencing November 10, 2011.

On May 30, 2012 appellant, through counsel, again requested a hearing before an OWCP hearing representative. A hearing was held on September 11, 2012. By decision dated November 21, 2012, the hearing representative affirmed the May 7, 2012 decision. She found that the medical evidence of record did not establish more than 10 percent left lower extremity permanent impairment or 8 percent left upper extremity permanent impairment.

On June 19, 2013 appellant submitted a February 7, 2013 report from Dr. John Dunne, an osteopath. Dr. Dunne provided a history and results on examination, including ROM test results for the left wrist and ankle. For the left ankle and foot, he reported 10 degrees dorsiflexion, 20 degrees plantar flexion, 5 degrees eversion, and 15 degrees inversion. Dr. Dunne opined that there was no applicable diagnosis under the wrist regional grid of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). He opined that, for loss of wrist ROM, appellant had 10 percent left arm permanent impairment. For the left lower extremity, Dr. Dunne found that she had 18 percent permanent impairment based on loss of ROM.

An OWCP medical adviser reviewed Dr. Dunne's report and submitted a November 29, 2013 report. He opined that appellant's left upper extremity permanent impairment was four percent. The medical adviser reported that the DBI method was "the preferred method" of evaluation. He also indicated that he felt the ROM results were "unreliable" for wrist flexion and extension. According to the medical adviser, applying the wrist regional grid resulted in four percent left upper extremity permanent impairment. As to lower extremity impairment, he again indicated that the DBI method was preferred, and that the ROM results were unreliable. The medical adviser opined that appellant had eight percent left lower extremity permanent impairment based on the diagnosis of left ankle fracture with mild motion loss.

On June 30, 2014 appellant submitted a May 16, 2014 report from Dr. Dunne. In this report, Dr. Dunne wrote that he disagreed with OWCP's medical adviser's November 29, 2013 report. He asserted that all ROM test results were determined in accord with the A.M.A., *Guides*, including taking the average of three or more ROM assessments. Dr. Dunne also indicated that he disagreed with the medical adviser as to the use of the DBI method taking preference over the ROM method as to the wrist. He noted that for upper extremities the DBI

grids refer to the ROM method. Dr. Dunne opined that this should apply to the lower extremities as well.

OWCP's medical adviser submitted a July 30, 2014 report. He again indicated that appellant had four percent left upper extremity permanent impairment and eight percent left lower extremity permanent impairment.

By decision dated November 6, 2014, OWCP found that appellant was not entitled to an additional schedule award. It found that the medical evidence did not establish an additional upper or lower extremity permanent impairment.

Appellant, through counsel, requested a hearing before an OWCP hearing representative on November 14, 2014. A hearing was held on June 1, 2015.

By decision dated July 28, 2015, the hearing representative affirmed the November 6, 2014 OWCP decision. He held that the probative medical evidence did not establish more than 10 percent left lower extremity permanent impairment or 8 percent left upper extremity permanent impairment.

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 implement FECA program with the Director of OWCP.[3] 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.[4] 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.[5]

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A. issued a 52-page document entitled "Clarifications and Corrections, Sixth Edition, *Guides to the Evaluation of Permanent Impairment.*" 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.

[3] *See* 20 C.F.R. §§ 1.1-1.4.

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

[5] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[6] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[7]

In determining impairment for 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 ankle, the relevant portion of the leg (foot) for the present case, reference is made to Table 16-2 (Foot and Ankle Regional Grid) beginning on page 501.[8] After the Class of Diagnosis (CDX) is determined from the Foot and Ankle Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the grade modifier for Functional History (GMFH), grade modifier for Physical Examination (GMPE), and grade modifier for Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[9] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[10]

Chapter 16 of the sixth edition of the A.M.A., *Guides*, pertaining to the lower extremities, provides that DBI 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 the grade modifiers for functional history, physical examination, and clinical studies.[11] Chapter 16 further provides: "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 and is only used to determine actual impairment values when it is not possible to otherwise define impairment."[12]

ANALYSIS

With respect to the left lower extremity, appellant received a schedule award on May 7, 2012 for 10 percent permanent impairment. She submitted a report dated February 7, 2013 from Dr. Dunne, who opined that she had 18 percent permanent impairment to the left lower extremity. Dr. Dunne used a ROM method and reported that he was applying Tables 16-20

[6] *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 (February 2013).

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

[8] *See* A.M.A., *Guides* 501-07 (6th ed. 2009).

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

[10] *Id.* at 23-28.

[11] *Id.* at 497.

[12] *Id.*

through 16-22, and Table 16-25. The first question presented is whether a ROM method is appropriate in this case.

As noted above, the DBI method is the primary method of lower extremity permanent impairment evaluation. The ROM method is used to determine actual impairment values of the lower extremities only when it is not possible to otherwise define impairment.[13] Dr. Dunne fails to explain why the percentage of impairment could not be defined under Table 16-2. He refers to the lack of an applicable rating for the wrist in his February 7, 2013 report, but does not discuss the ankle. In his May 16, 2014 report, Dr. Dunne again discusses the upper extremity with respect to ROM. OWCP's medical adviser identified the diagnosis of ankle fracture under Table 16-2, which is an accepted condition. The Board finds that the medical adviser properly determined the left lower extremity impairment should be evaluated using the DBI method.

OWCP's medical adviser identifies class 1 (mild problem) for an ankle fracture with mild motion deficits and/or mild malalignments.[14] This is consistent with the findings of Dr. Dunne. The medical adviser reported 10 degrees dorsiflexion and 20 degrees plantar flexion for the left ankle. Under Table 16-22, this is a mild impairment.[15] Dr. Dunne also reported 5 degrees eversion and 15 degrees of inversion, which are mild impairments under Table 16-20.[16]

The grade C (default) impairment is 10 percent under Table 16-2. The medical adviser applied the net adjustment formula noted above, and found an adjustment of -1 to a grade B impairment of eight percent. The net adjustment was based on grade modifiers for functional history of 1 (mild problem) and physical examination of 0 (stable, no consistent findings).[17]

The Board finds that the opinion of OWCP's medical adviser represents the weight of the evidence with respect to left lower extremity permanent impairment. OWCP's medical adviser properly applied the A.M.A., *Guides* using the DBI method, finding that the left lower extremity permanent impairment was eight percent. The probative evidence does not establish more than 10 percent left lower extremity permanent impairment for which appellant previously received a schedule award.

With respect to the upper extremity, the Board finds that the case is not in posture for decision. Dr. Dunne used the ROM method with respect to the upper extremity, opining that the DBI method was not appropriate in this case. 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. No consistent interpretation has been followed

[13] *E.M.*, Docket No. 14-0311 (issued July 8, 2014).

[14] A.M.A., *Guides* 503, Table 16-2.

[15] *Id*. at 549 Table 16-22. While OWCP's medical adviser referred to the ROM results as unreliable, Dr. Dunne indicated in his May 16, 2014 report that he followed A.M.A., *Guides* requirements for ROM.

[16] *Id.* at Table 16-20.

[17] *See id.* at 516-17, Table 16-6 and Table 16-7. The medical adviser did not use a grade modifier for clinical studies. When clinical studies are used to establish the diagnosis class, it is not used as a grade modifier. A.M.A., *Guides* 500.

regarding the proper use of the DBI or the ROM methodologies when assessing the extent of permanent impairment for schedule award purposes.[18] The purpose for the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[19] 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 methodologies. 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.[20]

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 July 28, 2015 decision with respect to the upper extremity. 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 additional upper extremity schedule award.

CONCLUSION

The Board finds that appellant has failed to establish more than 10 percent left lower extremity permanent impairment, for which she previously received a schedule award. The Board further finds that the case is not in posture with respect to left upper extremity permanent impairment, and the case is therefore remanded for further development consistent with this decision.

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

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

[20] *Supra* note 18.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 28, 2015 is affirmed with respect to left lower extremity permanent impairment, and set aside and remanded for further action consistent with this decision with respect to left upper extremity permanent impairment.

Issued: March 27, 2017
Washington, DC

Christopher J. Godfrey, 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