United States Department of Labor
Employees' Compensation Appeals Board

T.M., Appellant	)	
and	)	**Docket No. 18-0182**
	)	**Issued: July 26, 2018**
DEPARTMENT OF THE NAVY, ASSISTANT FOR ADMINISTRATION, Washington, DC, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On November 1, 2017 appellant filed for review from an August 22, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] 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.

ISSUE

The issue is whether appellant has established more than 32 percent permanent impairment of her left upper extremity, for which she previously received schedule awards

[1] Appellant timely requested oral argument in this case. By order dated April 5, 2018, the Board exercised its discretion and denied her request as oral argument would further delay issuance of a Board decision and not serve a useful purpose. *Order Denying Request for Oral Argument*, Docket No. 18-0182 (issued April 5, 2018).

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On November 1, 2011 appellant, then a 50-year-old administrative support technician, filed a traumatic injury claim (Form CA-1) alleging that on September 26, 2011 she fractured her left wrist when she was trying to put a box in the backseat of her car while in the performance of her federal duties. She explained that the box caught on the seat and started to fall. As appellant grabbed the box, her left wrist struck the car door. By decision dated December 7, 2011, OWCP accepted the claim for left closed fracture of lower end of radius with ulna. On January 6, 2015 it expanded acceptance of the claim to include left nonunion fracture.

Following her injury, appellant sought treatment with Dr. Marc Suffis, Board-certified in emergency medicine, for her left wrist fracture. On February 16 and September 13, 2012 she underwent OWCP-approved left wrist surgery.

On May 7, 2015 appellant filed a claim for a schedule award (Form CA-7).

By decision dated June 12, 2015, OWCP denied appellant's claim for a schedule award as the evidence of record was insufficient to establish permanent impairment of a scheduled member or function of the body.

On July 21, 2015 appellant filed a subsequent claim for a schedule award.

In support of her claim appellant submitted a September 9, 2015 impairment evaluation from Dr. Suffis. Dr. Suffis diagnosed left wrist navicular fracture with resultant nonunion, avascular necrosis, and carpal collapse. He further diagnosed left wrist triangular fibrocartilage complex ligamental disruption and determined that appellant had reached maximum medical improvement (MMI). Utilizing the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] Dr. Suffis reported that her diagnosis-based impairment (DBI) was best characterized by Table 15-3, Wrist Regional Grid, wrist sprain history of dislocation including severe carpal instability, which would place her in class 2 with a default grade C value of 24 percent.[4] He reported that, following assignment of grade modifiers, application of the net adjustment formula resulted in no net change, amounting to 24 percent permanent impairment of the left upper extremity.

In an October 8, 2015 medical report, Dr. L. Jean Weaver, serving as an OWCP district medical adviser (DMA), reviewed the case file and Dr. Suffis' September 9, 2015 report, finding that appellant had reached MMI on the date of his examination. He agreed with Dr. Suffis' impairment rating, noting that the injury was best identified as a left wrist injury/sprain with severe instability since her arthrodesis had not resulted in a successful fusion and she had carpal instability with pain on minimal everyday activity.[5] Dr. Weaver reported that this resulted in class 2 with a default grade C impairment rating of 24 percent. Application of the net adjustment formula

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

[4] *Id.* at 396, Table 15-3.

[5] *Id.*

resulted in zero, warranting no movement from the default grade C value, resulting in 24 percent permanent impairment of the left upper extremity.

By decision dated October 20, 2015, OWCP granted appellant a schedule award for 24 percent permanent impairment of her left upper extremity. The date of MMI was reported as September 9, 2015 and the award covered a period of 74.88 weeks from September 10 through October 17, 2015.[6]

On May 19, 2016 appellant underwent an OWCP-approved surgery for excision of left scaphoid bone surgery.

On February 17, 2017 appellant again filed a claim for a schedule award.

By letter dated April 4, 2017, OWCP requested that appellant submit an impairment evaluation from her attending physician in accordance with the sixth edition of the A.M.A., *Guides*.

In support of her claim, appellant submitted an April 26, 2017 impairment evaluation from Dr. Suffis. Dr. Suffis discussed her medical history, examination findings, and diagnostic reports. He reported that on September 9, 2015 he performed a rating examination finding 24 percent permanent impairment of her left upper extremity as a result of carpal instability. Dr. Suffis noted that on May 19, 2016 appellant underwent excision of the left scaphoid bone and was released to full duty on June 17, 2016. He diagnosed left fracture of navicular with secondary avascular necrosis and carpal instability with resultant scaphoidectomy and left wrist fusion, development of post-traumatic osteoarthritis in the scaphotrapeziod-trapezial joint, and post-traumatic carpal tunnel syndrome. Dr. Suffis determined that appellant had reached MMI. Utilizing Table 15-3 of the A.M.A., *Guides*, he provided a diagnosis of wrist arthrodesis, class 3 with a grade C default rating of 30 percent with functional position.[7] Dr. Suffis assigned a grade modifier of 3 for functional history,[8] a grade modifier of 4 for physical examination due to severe decrease from normal range of motion (ROM) as a result of her fusion,[9] and a grade modifier of 3 for clinical studies for the arthritis showing joint space narrowing.[10] Applying the net adjustment formula, Dr. Suffis subtracted 3, the numerical value of the class, from the numerical value of the grade modifier for each applicable component (functional history, physical examination, and clinical studies) and then added those values, resulting in a net adjustment of 1 ((3-3) + (4-3) + (3-3)).[11] Application of the net adjustment formula meant that movement was warranted one place to the

[6] OWCP reported that, as appellant received wage-loss compensation through September 9, 2015, the schedule award was adjusted to September 10, 2015. It noted that a schedule award was not payable concurrently with an award for wage loss of the same injury.

[7] *Supra* note 4 at 397.

[8] *Id.* at 406, Table 15-7.

[9] *Id.* at 408, Table 15-8.

[10] *Id.* at 410, Table 15-9.

[11] *Id.* at 411.

right of class 3 default value grade C to grade D based on Table 15-3.[12] Therefore, the DBI for appellant's left wrist arthrodesis amounted to 32 percent permanent impairment of the left upper extremity.[13] Dr. Suffis noted that, as appellant had previously received an award for 24 percent left upper extremity permanent impairment, this would result in an increase of 8 percent permanent impairment of the left upper extremity.

On July 14, 2017 OWCP routed Dr. Suffis' report, a statement of accepted facts, and the case file to Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as an OWCP DMA, for review and determination regarding whether appellant sustained a permanent impairment and date of MMI in accordance with the sixth edition of the A.M.A., *Guides.*

In a July 15, 2017 report, Dr. Katz reviewed the case file and Dr. Suffis' July 14, 2017 report and found that appellant had reached MMI. He agreed with Dr. Suffis' impairment rating and findings, determining that she sustained 32 percent permanent impairment of the left upper extremity for a class 3 left wrist arthrodesis.[14] Dr. Katz explained that as appellant had previously received an award for 24 percent permanent impairment of the left upper extremity, the net additional award now due would be determined by subtracting the prior overlapping 24 percent from the present impairment of 32 percent, resulting in a net additional award of 8 percent permanent impairment of the left upper extremity. He also noted that Table 15-5 permitted an alternative ROM calculation for her diagnostic factor of wrist fusion; however, this information was not provided by Dr. Suffis, nor could it be obtained through review of the record therefore only a DBI rating was provided.

By decision dated August 22, 2017, OWCP granted appellant a schedule award for an additional 8 percent permanent impairment of the left upper extremity based on a total 32 percent permanent impairment rating, less the previously paid 24 percent awarded. It noted the date of MMI as May 25, 2017 and the award covered a period of 174.72 days from May 25 through August 19, 2017.

LEGAL PRECEDENT

The schedule award provisions 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. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate

[12] *Supra* note 7.

[13] *Id.*

[14] *Id*.

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

standard for evaluating schedule losses.[16] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[17] 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.[18]

The sixth edition requires identifying the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[19] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).

The A.M.A., *Guides* also provide that the ROM impairment method is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[20] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[21] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[22]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology basis for rating of upper extremity impairments.[23] Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
>
> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, DBI

[16] *Id.* at § 10.404. *See also, Ronald R. Kraynak*, 53 ECAB 130 (2001).

[17] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a (March 2017).

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

[19] A.M.A., *Guides* 401-19.

[20] *Id.* at 461.

[21] *Id*. at 473.

[22] *Id.* at 474.

[23] FECA Bulletin No. 17-06 (issued May 8, 2017).

or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. If the [A.M.A.,] *Guides* allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used." (Emphasis in the original).[24]

The Bulletin further advises:

"If the medical evidence of record is not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence.

"Upon receipt of such a report, and if the impairment evaluation was provided from the claimant's physician, the CE should write to the claimant advising of the medical evidence necessary to complete the impairment assessment and provide 30 days for submission. Any evidence received in response should then be routed back to the DMA for a final determination. Should no evidence be received within 30 days of the date of the CE's letter, the CE should proceed with a referral for a second opinion medical evaluation to obtain the medical evidence necessary to complete the rating. After receipt of the second opinion physician's evaluation, the CE should route that report to the DMA for a final determination."[25]

ANALYSIS

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

OWCP accepted appellant's claim for left closed fracture of lower end of radius with ulna and left nonunion fracture, and approved the requisite left wrist surgeries. The Board notes that on October 20, 2015, she was previously awarded 24 percent permanent impairment of the left upper extremity for her accepted left wrist condition based on Dr. Suffis' September 9, 2015 medical report and the October 8, 2015 DMA report.

Appellant thereafter underwent a surgical procedure on May 19, 2016 for excision of the left scaphoid bone. Dr. Suffis prepared a new permanent impairment evaluation report on April 16, 2017. Dr. Katz, serving as OWCP DMA, reviewed Dr. Suffis' findings from his April 26, 2017 report and agreed with his impairment rating based upon DBI. He noted that, since ROM findings were not of record, it was not possible to evaluate appellant's permanent impairment utilizing the ROM methodology. Pursuant to Bulletin 17-06, Dr. Katz proceeded to evaluate appellant's impairment using the DBI methodology. Both Dr. Suffis and Dr. Katz properly utilized the sixth edition of the A.M.A., *Guides* in determining that appellant had 32 percent permanent impairment of the left upper extremity based upon the diagnosis of her left wrist arthrodesis. Both physicians referred to Table 15-3 and explained the basis for a class 3 assignment

[24] *Id.*

[25] *Id.*

of wrist arthrodesis, as well as findings supporting assignment of the grade modifiers for functional history, physical examination, and clinical studies. Utilizing the net adjustment formula resulted in a net adjustment of 1 ((3-3) + (4-3) + (3-3)),[26] meaning that movement was warranted one place to the right of class 3 default value grade C to grade D, yielding a 32 percent permanent impairment of the left upper extremity.[27]

However, as noted by Dr. Katz, while Table 15-5 of the A.M.A., *Guides* allowed an alternative ROM calculation for appellant's diagnosis, ROM findings were not of record. Pursuant to FECA Bulletin 17-06, if ROM rating is allowed, after review of the DBI rating, the DMA should advise as to the medical evidence necessary to complete the ROM rating if the medical evidence of record is insufficient to rate appellant's impairment using ROM. If the claimant's treating physician has provided an impairment rating, the claims examiner should then write to the treating physician advising of the medical evidence necessary to complete the rating. If the necessary evidence is not received within 30 days, OWCP is to refer appellant for a second opinion evaluation. In the present case, it did not follow the procedures outlined in Bulletin 17-06 after Dr. Katz advised that the necessary evidence was not of record to rate appellant's permanent impairment utilizing the ROM methodology. For this reason, this case must be remanded for OWCP to complete the proper procedures outlined in FECA Bulletin 17-06 to rate appellant's upper extremity permanent impairment. After such further development as necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[26] *Supra* note 11.

[27] *Supra* note 7.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated August 22, 2017 is set aside and this case is remanded for further proceedings consistent with this opinion.

Issued: July 26, 2018
Washington, DC

Patricia H. Fitzgerald, Deputy 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