United States Department of Labor
Employees' Compensation Appeals Board

A.G., Appellant	)	
and	)	**Docket No. 18-0329**
	)	**Issued: July 26, 2018**
DEPARTMENT OF DEFENSE, DEFENSE LOGISTICS AGENCY, Tracy, CA, Employer	)	

Appearances:
Appellant, pro se
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 4, 2017 appellant filed a timely appeal from a July 24, 2017 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.[2]

ISSUE

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

[1] 5 U.S.C. § 8101 *et seq.*

[2] Together with his appeal request, appellant submitted a timely request for oral argument pursuant to 20 C.F.R. § 501.5(b). After exercising its discretion, by order dated May 17, 2018, the Board denied the request as appellant's arguments on appeal could be adequately addressed in a decision based on a review of the case as submitted on the record. *Order Denying Request for Oral Argument*, Docket No. 18-0329 (issued May 17, 2018).

FACTUAL HISTORY

On January 28, 2015 appellant, then a 46-year-old industrial equipment mechanic, filed a traumatic injury claim (Form CA-1) alleging that on January 27, 2015 he sustained injury at work when his right finger got caught between the drive chain and drive sprocket of a conveyor drive motor he was servicing. He stopped work on January 27, 2015.

On January 28, 2015 appellant underwent right index finger/hand surgery, including open debridement to the bone level and open reduction with Kirschner wire fixation of proximal phalanx fracture.[3] On February 12, 2015 OWCP accepted appellant's claim for right index finger crush injury with open fracture.[4]

On September 15, 2015 appellant underwent OWCP-approved right index finger/hand surgery, including extensor tenolysis and proximal interphalangeal joint capsulotomy.[5] On December 15, 2015 he underwent OWCP-approved right index finger/hand/wrist surgery including flexor tenolysis of the superficialis tendon from index finger to wrist and the profundus tendon from index finger to wrist.

On February 29, 2016 appellant filed a claim for compensation (Form CA-7) seeking a schedule award due to his accepted January 27, 2015 employment injury.

Due to the absence of a permanent impairment rating from an attending physician, OWCP referred appellant for a second opinion evaluation to Dr. Aubrey A. Swartz, a Board-certified orthopedic surgeon. It requested that Dr. Swartz provide an opinion regarding appellant's permanent impairment under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[6]

In a May 6, 2016 report, Dr. Swartz discussed appellant's factual and medical history regarding his accepted January 27, 2015 employment injury and reported the findings of the physical examination he conducted on May 6, 2016. He noted that appellant exhibited tenderness over the proximal and middle phalanges of the right index finger. Range of motion (ROM) testing of the right index finger revealed 0 to 80 degrees of motion at the metacarpophalangeal (MCP) joint, 0 to 40 degrees of motion at the proximal interphalangeal (PIP) joint, and -45 to 50 degrees of motion at the distal interphalangeal (DIP) joint. Dr. Swartz indicated that he could not apply the diagnosis-based impairment (DBI) rating method found at Table 15-2 on page 391 of the sixth edition of the A.M.A., *Guides* because "it is based upon a normal [ROM] of the involved finger." He determined that, under Table 15-31 on page 470 of the sixth edition, appellant had 6 percent

[3] On February 10, 2015 appellant returned to modified work for the employing establishment without wage loss.

[4] Prior to formally accepting appellant's claim on February 12, 2015, OWCP had administratively accepted appellant's claim for payment of limited medical expenses. It retroactively approved the January 28, 2016 surgery after formally accepting appellant's claim.

[5] Appellant stopped work from mid-September 2015 to early-January 2016 and received disability compensation on the daily rolls from September 15 to December 31, 2015. On February 11, 2016 he returned to modified work for the employing establishment without wage loss.

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

permanent impairment due to ROM findings for the MCP joint of the right index finger, 42 percent permanent impairment due to ROM findings for the PIP joint, and 10 percent permanent impairment due to ROM findings for the DIP joint. He combined these values, under the Combined Values Chart on page 604, to equal 58 percent permanent impairment of the right index finger. Dr. Swartz indicated that, under Table 15-12 on page 422, this rating converted to 12 percent permanent impairment of the right hand and 10 percent permanent impairment of the right upper extremity.

OWCP referred appellant's case to Dr. Herbert White, Jr., a Board-certified occupational medicine physician serving as its district medical adviser (DMA). It requested that Dr. White review the medical evidence of record, including Dr. Swartz' May 6, 2016 report, and provide an opinion regarding appellant's permanent impairment under the standards of the sixth edition of the A.M.A., *Guides*.

In a September 14, 2016 report, Dr. White indicated that he was unable to rate appellant's permanent impairment because Dr. Swartz did not obtain three measurements for each joint tested and did not otherwise obtain his ROM findings in accordance with the instructions found on page 464 of the sixth edition of the A.M.A., *Guides*.[7] He recommended that Dr. Swartz be asked to provide ROM findings obtained in accordance with the relevant instructions.

OWCP requested that Dr. Swartz provide a supplemental report containing ROM findings for appellant's right index finger that were obtained in accordance with the instructions found in the sixth edition of the A.M.A., *Guides*.

In an October 27, 2016 report, Dr. Swartz noted that he had obtained three ROM measurements for each joint of appellant's right index finger. Appellant had ROM findings of 50, 45, and 80 degrees for the MCP joint, 40, 45, and 50 degrees for the PIP joint, and 50, 75, and 75 degrees for the DIP joint. Dr. Swartz determined that, under Table 15-31 on page 470 of the sixth edition, appellant had 22 percent permanent impairment due to ROM findings for the MCP joint of the right index finger and 36 percent permanent impairment due to ROM findings for the PIP joint. He indicated that the 22 percent rating converted to 4 percent permanent impairment of the right hand and 4 percent permanent impairment of the right upper extremity. The 36 percent rating converted to 7 percent permanent impairment of the right hand and 6 percent permanent impairment of the right upper extremity. Dr. Swartz used the Combined Values Chart to combine the 4 percent and 7 percent rating values to determine that appellant had 10 percent permanent impairment of his right upper extremity.

OWCP again referred the case to Dr. White as the DMA. It requested that Dr. White review Dr. Swartz' October 27, 2016 report, and provide an opinion regarding appellant's permanent impairment under the standards of the sixth edition of the A.M.A., *Guides*.

In a December 5, 2016 report, Dr. White advised that he had reviewed Dr. Swartz' October 27, 2016 supplemental report. He indicated that the sixth edition the A.M.A., *Guides* (per the text on page 464) required that the three measurements for a given joint must fall within 10

[7] The A.M.A., *Guides* provides that ROM should be measured after a "warm up" in which the individual moves the joint through its maximum ROM at least three times. A.M.A., *Guides* 464.

percent of the mean value of the three measurements.[8] Dr. White found that Dr. Swartz' permanent impairment ratings based on the ROM method were not valid because the findings for MCP and DIP joint motion did not meet this requirement. Dr. White then applied the DBI rating method noting that, under Table 15-2 on page 393, appellant's right proximal phalanx fracture fell under class 1 with a default value of six percent. He calculated grade modifiers, applied the net adjustment formula, and noted that movement two spaces to the right of the default value on Table 15-2 was required. Therefore, appellant had eight percent permanent impairment of his right index finger due to the right proximal phalanx fracture. Dr. White noted that, under Table 15-2 on page 392, appellant's extensor tendon laceration fell under class 1 with a default value of six percent. He calculated grade modifiers, applied the net adjustment formula, and noted that movement one space to the right of the default value on Table 15-2 was required. Therefore, appellant had seven percent permanent impairment of his right index finger due to the right extensor tendon laceration. Dr. White used the Combined Values Chart to combine the 8 percent and the 7 percent rating values and concluded that appellant had 14 percent permanent impairment of his right index finger under the standards of the sixth edition of the A.M.A., *Guides*. He further indicated that 14 percent permanent impairment of the right index finger equaled 3 percent permanent impairment of the right upper extremity.

By decision dated January 5, 2017, OWCP granted appellant a schedule award for 14 percent permanent impairment of his right index finger. The award ran for 6.44 weeks from October 27 to December 11, 2016 and was based on the opinion of Dr. White.

On February 2, 2017 appellant requested a hearing with a representative of OWCP's Branch of Hearings and Review. During the hearing held on May 24, 2017, he discussed his right-hand problems, including his inability to make a fist due to his right index finger not being able to close.

By decision dated July 13, 2017, OWCP's hearing representative set aside OWCP's January 5, 2017 decision and remanded the case for further development. She found that, because appellant's permanent impairment extended from his right finger/hand into his right upper extremity, a permanent impairment calculation also should be made for his right upper extremity. The hearing representative indicated that, if the calculation for right upper extremity permanent impairment provided a greater amount of schedule award compensation, appellant should be awarded the greater amount. She determined that the calculation for right upper extremity permanent impairment would, in fact, provide a greater amount of schedule award compensation. The hearing representative directed that, upon remand, OWCP should issue a *de novo* schedule award decision finding that appellant has three percent permanent impairment of his right upper extremity and paying appropriate additional schedule award compensation.

[8] *Id.*

By decision dated July 24, 2017, OWCP granted appellant a schedule award for three percent permanent impairment of his right upper extremity (right arm). The total award ran for 9.36 weeks from October 27 to December 31, 2016.[9]

LEGAL PRECEDENT

The schedule award provision of FECA,[10] and its implementing federal regulation,[11] 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. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[12] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[13]

The sixth edition requires identifying the impairment class for the Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[14] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[15]

Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

> "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 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*

[9] OWCP indicated that appellant had already been paid $5,168.70 in schedule award compensation and noted that the present schedule award entitled him to an additional $2,343.54 in schedule award compensation.

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

[12] *Id.* at § 10.404(a).

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[14] A.M.A., *Guides* 494-531.

[15] *Id.* at 521.

impairment rating for the diagnosis in question, the method producing the higher rating should be used."[16] (Emphasis in the original.)

The Bulletin further advises:

"If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.

"If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* do not allow for the use of ROM for the diagnosis in question, the DMA should independently calculate impairment using the DBI method and clearly explain in the report, citing applicable tables in Chapter 15 of the [A.M.A.,] *Guides*, that ROM is not permitted as an alternative rating method for the diagnosis in question.

"If the rating physician provided an assessment using the DBI method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.

"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."[17]

ANALYSIS

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

The Board has previously found that OWCP had 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 had been followed regarding the proper use of the DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.[18] The purpose of 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 were at odds over the proper methodology for rating upper extremity impairment, having observed attending physicians, evaluating physicians, second opinion physicians, impartial medical

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

[17] *Id*.

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

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

examiners, and DMAs use both DBI and ROM methodologies interchangeably without any consistent basis. Furthermore, the Board observed that physicians interchangeably cited to language in the first printing or the second printing when justifying use of either ROM or DBI methodology. The Board therefore found that OWCP should develop a consistent method for calculating permanent impairment for upper extremities, which could be applied uniformly.

As noted above, FECA Bulletin No. 17-06 provides that, if the rating physician provided an assessment using the ROM method and the A.M.A., *Guides* allows for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.[20]

The Board therefore finds that this case requires further development of the medical evidence. Since Dr. Swartz provided a rating based upon appellant's loss of ROM of the right index finger, which is allowed (by asterisk) pursuant to Table 15-2 of the A.M.A., *Guides*, Dr. White should have independently calculated appellant's impairment using both the ROM and DBI methods under the relevant standards of the sixth edition of the A.M.A., *Guides*, and identified the higher rating for the claims examiner. Although Dr. White attempted to apply both the ROM and DBI rating methods, he did not do so in an appropriate manner. He indicated that the sixth edition of the A.M.A., *Guides* (per the text on page 464) required that the three measurements for a given joint must fall within 10 percent of the mean value of the three measurements and he entirely discounted Dr. Swartz' permanent impairment ratings based on the ROM method because the findings for MCP and DIP joint motion did not meet this requirement. However, Dr. Swartz failed to note that the three measurements for PIP joint motion did meet the above-noted requirement and that, under Table 15-31 on page 470, these measurements would warrant a permanent impairment rating.[21] If the medical evidence of record is insufficient for Dr. White to render a rating using the ROM or DBI method, he should advise as to the medical evidence necessary to complete the rating.[22]

This case will therefore be remanded for application of the new OWCP procedures found in FECA Bulletin No. 17-06. After such further development of the medical evidence as necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[20] *See supra* note 17.

[21] *See* A.M.A., *Guides* 470, Table 15-31.

[22] *See supra* note 17.

ORDER

IT IS HEREBY ORDERED THAT the July 24, 2017 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: July 26, 2018
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