United States Department of Labor
Employees' Compensation Appeals Board

K.B., Appellant	)	
	)	**Docket No. 19-0431**
and	)	**Issued: July 1, 2019**
	)	
DEPARTMENT OF AGRICULTURE, FOOD SAFETY INSPECTION SERVICE, Minneapolis, MN, 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
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On December 18, 2018 appellant filed a timely appeal from a July 5, 2018 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 met her burden of proof to establish greater than two percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On February 29, 2016 appellant, then a 42-year-old consumer safety inspector, filed a traumatic injury claim (Form CA-1) alleging that on that date she experienced pain and swelling in her right wrist, a knot in her arm, and shooting pain in her right small finger while in the performance of duty. OWCP accepted the claim for a right wrist sprain. It subsequently expanded acceptance of the claim to include a lesion of the ulnar nerve in the right upper limb and articular cartilage disorders of the right wrist.

On June 30, 2016 Dr. Jason P. Rehm, a Board-certified surgeon, performed a right Darrach procedure with extensor carpi ulnaris stabilization. On February 1, 2017 he performed a right cubital tunnel release.

An electromyogram (EMG) and nerve conduction velocity (NCV) study obtained on December 5, 2016 revealed mild right ulnar nerve compression at the elbow.

On May 15, 2017 appellant filed a claim for a schedule award (Form CA-7).

In a development letter dated May 23, 2017, OWCP requested that Dr. Rehm evaluate the extent of any permanent impairment in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] It advised him that, if the A.M.A., *Guides* provided that both the diagnosis-based impairment (DBI) and range of motion (ROM) methods could be used to calculate the extent of impairment, he should calculate the impairment using both methods.

On June 13, 2017 an occupational therapist evaluated appellant's impairment at the request of Dr. Rehm. She found normal sensation of the right hand and loss of ROM only in the index finger. The occupational therapist further found reduced strength and a *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand) score of 65.91.

On July 4, 2017 Dr. Rehm advised that appellant had one percent permanent impairment of the whole person.

In a report dated July 29, 2017, Dr. Herbert White, Jr., a Board-certified occupational medicine specialist and internist serving as a district medical adviser (DMA), related that the evidence was currently insufficient to rate the extent of impairment using either the DBI or ROM methods. He recommended that OWCP obtain additional information from Dr. Rehm, including three ROM measurements for the affected extremities in accordance with the A.M.A., *Guides*.

On August 2, 2017 OWCP requested that Dr. Rehm provide an impairment evaluation of the right upper extremity in accordance with the A.M.A., *Guides*. It afforded him 30 days to submit the required information. Dr. Rehm, however, failed to respond within the time allotted.

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

On September 21, 2017 OWCP referred appellant to Dr. James Peter Little, a Board-certified physiatrist, for a second opinion examination.

In a report dated October 9, 2017, Dr. Little found a negative Tinel's sign at the wrist and medial elbow areas bilaterally with no edema or atrophy. He advised that appellant's ROM of the right wrist was good except for mildly reduced flexion. Dr. Little measured symmetrical sensation of the extremities and 4+/5 grip strength of the right hand. He diagnosed right ulnar impingement and distal radioulnar joint arthritis treated with surgery causing a mild limitation in ROM and intermittent pain. Dr. Little further diagnosed right cubital tunnel syndrome after a release with dysesthesias of the distal forearm and medial hand and mild weakness but no sensory deficit. Using the DBI method, he identified the class of diagnosis (CDX) as a class 1 wrist sprain using Table 15-2 on page 395, the wrist regional grid, which yielded a default impairment of one percent. Dr. Little applied a grade modifier for functional history (GMFH) of two, a grade modifier for physical examination (GMPE) of one, and a grade modifier for clinical studies (GMCS) of one, to find a net adjustment of one and two percent right upper extremity impairment. He further diagnosed mild ulnar nerve entrapment based on test findings. Dr. Little found no impairment based on ROM.

On November 20, 2017 Dr. Morley Slutsky, Board-certified in occupational medicine and a DMA, found that appellant had one percent permanent impairment of the right wrist. He indicated that Dr. Little's ROM measurements were not in accordance with the provisions of the A.M.A., *Guides* and thus invalid. Dr. Slutsky identified the diagnosis as a class 1 right wrist sprain, and found no adjustment from the default impairment rating of one percent after applying grade modifiers. He noted that the record failed to contain the results of electrodiagnostic testing of the upper extremities. Dr. Slutsky found one percent permanent impairment of the right elbow based on the diagnosis of nonspecific right wrist pain, for a combined right upper extremity (right wrist sprain combined with right elbow) permanent impairment of two percent.

By decision dated December 11, 2017, OWCP granted appellant a schedule award for two percent permanent impairment of the right upper extremity. The award ran for 6.24 weeks for the period October 9 to November 21, 2017.

On January 10, 2018 appellant requested a review of the written record before an OWCP hearing representative.

By decision dated May 3, 2018, OWCP's hearing representative set aside the December 11, 2017 decision. She noted that appellant's impairment could alternatively be assessed using the ROM method. The hearing representative remanded the case for OWCP to obtain additional evidence pursuant to FECA Bulletin No. 17-06 (May 8, 2017).

On May 28, 2018 Dr. Slutsky advised that Dr. Little had provided only one ROM measurement per joint, and thus his measurements did not support an impairment rating based on ROM. He again found two percent permanent impairment of the right upper extremity using the DBI method.

By decision dated July 5, 2018, OWCP found that appellant had no more than the previously awarded two percent permanent impairment of the right upper extremity.

LEGAL PRECEDENT

The schedule award provision of FECA,[3] and its implementing federal regulation,[4] 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. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such a determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 2009.[5] 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.[6]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning Disability and Health (ICF).[7] Under the sixth edition, the evaluator identifies the impairment class of diagnosis (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE) and clinical studies (GMCS).[8] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[9] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[10]

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.[11] 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.[12] Adjustments for functional history may be made if the evaluator

[3] *Supra* note 1 at 8107.

[4] 20 C.F.R. § 10.404.

[5] For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides*, (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[6] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[7] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3, International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[8] *Id*. at 494-531.

[9] *Id*. 411.

[10] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[11] A.M.A., *Guides* 461.

[12] *Id*. at 473.

determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[13]

Regarding the application of ROM or DBI 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).
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> "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 impairment rating for the diagnosis in question, the method producing the higher rating should be used.*"[14] (Emphasis in the original.)
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> The Bulletin further advises:
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> "If the original impairment rating found by the DMA to be insufficient was provided from a second opinion or referee physician (*versus* the claimant's physician), the CE should request a supplemental/clarification report from the second opinion or referee physician to address the medical evidence necessary to complete the impairment assessment. Medical evidence received in response to this request should then be routed back to the DMA for a final determination.
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> "The CE should not render a decision on the schedule award impairment rating until the necessary medical evidence has been obtained."[15]

ANALYSIS

The Board finds that the case is not in posture for decision as OWCP has not properly developed the issue of the extent of appellant's permanent impairment of the right upper extremity.

Dr. Rehm, appellant's attending physician, advised that appellant had one percent permanent impairment of the whole person. A schedule award, however, is not payable for whole person impairment.[16] OWCP requested additional information from Dr. Rehm; however, he did

[13] *Id*. at 474.

[14] FECA Bulletin No. 17-06 (issued May 8, 2018); *V.L.*, Docket No. 18-0760 (issued November 13, 2018).

[15] *See* FECA Bulletin No. 17-06, *id.*

[16] *See E.F.*, Docket No. 18-1723 (issued May 1, 2019).

not respond to its request. Consequently, it referred appellant to Dr. Little for a second opinion examination.

On October 9, 2017 Dr. Little found two percent permanent impairment of the right upper extremity using the DBI impairment method. He found no impairment due to loss of ROM, noting that appellant had mildly reduced flexion of the right wrist.

Dr. Slutsky, the DMA, reviewed Dr. Little's report on November 20, 2017 and found one percent permanent of the right wrist and one percent permanent impairment of the right elbow using the DBI method. He noted that the record contained no reports of electrodiagnostic testing. Dr. Slutsky further found that Dr. Little had failed to provide valid ROM measurements in accordance with the A.M.A., *Guides.* Based on Dr. Slutsky's report, OWCP granted appellant a schedule award for two percent right upper extremity impairment.

An OWCP hearing representative remanded the case for OWCP to obtain any additional evidence necessary to assess the extent of appellant's impairment using the ROM method. On May 28, 2018 Dr. Slutsky opined that Dr. Little had provided only one ROM measurement, and thus concluded that his opinion was insufficient to support an impairment rating using the ROM method, which required three independent ROM measurements. However, as he found that the medical evidence of record was insufficient to render a rating based on ROM, he should have advised OWCP of the medical evidence necessary to complete the rating.[17] Instead, Dr. Slutsky reaffirmed his original permanent impairment rating of two percent for the right upper extremity.

As three independent ROM measurements are required, further development is warranted. The case will therefore be remanded for referral of appellant, along with the case record, to a new second opinion physician for an examination consistent with the procedures outlined in FECA Bulletin No. 17-06. Following this and any further development deemed necessary, OWCP shall issue a *de novo* decision on the extent of his right upper extremity permanent impairment.[18]

CONCLUSION

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

[17] *F.B.*, Docket No. 18-0903 (issued December 7, 2018); *D.K.*, Docket No. 18-0135 (issued August 20, 2018).

[18] *Id*.

ORDER

IT IS HEREBY ORDERED THAT the July 5, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: July 1, 2019
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board