United States Department of Labor
Employees' Compensation Appeals Board

K.A., Appellant	)	
and	)	**Docket No. 20-1463**
	)	**Issued: March 16, 2021**
U.S. POSTAL SERVICE, POST OFFICE, Centralia, IL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 31, 2020 appellant filed a timely appeal from a February 7, 2020 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 to consider the merits of this case.

ISSUE

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

FACTUAL HISTORY

On December 24, 2017 appellant, then a 53-year-old carrier technician, filed a traumatic injury claim (Form CA-1) alleging that on December 23, 2017 he sustained a left lower arm injury

[1] 5 U.S.C. § 8101 *et seq.*

when he was bitten on the arm by a dog while delivering mail in the performance of duty. He stopped work on the date of injury. On January 24, 2018 OWCP accepted appellant's claim for open bite of the left forearm, initial encounter.

On January 10, 2018 appellant underwent debridement of the skin, subcutaneous tissue, and muscle of the left forearm. He underwent split-thickness skin grafting of the left forearm open wound with donor skin harvest from the left thigh surgery on January 26, 2018. On February 18, 2018 appellant was released to return to work with no restrictions.

On April 3, 2019 appellant filed a claim for a schedule award (Form CA-7).

OWCP, in a development letter dated July 9, 2019, requested that appellant submit a report from his attending physician, which addressed whether he had reached maximum medical improvement (MMI) and, if so, to evaluate permanent impairment in accordance with the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] It afforded him 30 days to submit the requested information.

In response to OWCP's July 9, 2019 development letter, appellant submitted a July 16, 2019 medical report from Dr. John W. Ellis, a Board-certified family practitioner. Dr. Ellis noted appellant's December 23, 2017 employment injury and that he had reviewed appellant's medical records. He utilized the diagnosis-based impairment (DBI) methodology set forth in Table 15-4 on page 399 of the sixth edition of the A.M.A., *Guides* to calculate six percent permanent impairment of the left upper extremity for the diagnosis of traumatic amputation of extensive tissue in the left arm and extensor tendons (similar to epicondylitis surgery and the extensor tendons). Alternatively, Dr. Ellis determined that appellant had eight percent permanent impairment of the left upper extremity using the range of motion methodology (ROM) set forth in the A.M.A., *Guides*. Using Table 15-33, page 474, he found six percent permanent impairment for decreased ROM of the left elbow and three percent permanent impairment for decreased ROM of the right elbow. Using Table 15-32, page 473, Dr. Ellis found eight percent permanent impairment for decreased ROM of the left wrist and three percent permanent impairment for decreased ROM of the right wrist. He subtracted the impairment ratings for decreased ROM of the left and right elbows, resulting in three percent permanent impairment. Dr. Ellis also subtracted the impairment ratings for decreased ROM of the left and right wrists, resulting in five percent permanent impairment. He then combined the three percent bilateral elbow impairment rating with the five percent wrist impairment rating to calculate eight percent permanent impairment of the left upper extremity. Dr. Ellis further advised that appellant was entitled to a $1,000.00 schedule award for severe disfigurement to the left arm. Lastly, he advised that appellant reached MMI on the date of his impairment evaluation.

On November 27, 2019 Dr. Morley Slutsky, a Board-certified occupational medicine physician, serving as a district medical adviser (DMA), reviewed a statement of accepted facts (SOAF) and the medical record, including Dr. Ellis' July 16, 2019 findings. He determined that appellant had 13 percent permanent impairment of the left upper extremity under the sixth edition of the A.M.A., *Guides*. Utilizing the DBI method, the DMA determined that the most impairing

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

diagnosis for appellant's left elbow was epicondylitis status post surgery, which was a class of diagnosis (CDX) of 1 with a default of C or five percent permanent impairment. He assigned a grade modifier for functional history (GMFH) of 1 under Table 15-7 on page 406, a grade modifier for physical examination (GMPE) of 1 under Table 15-8 on page 408, and a grade modifier for clinical studies (GMCS) of 1 under Table 15-9 on page 410. Using the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), the DMA calculated that appellant had a net adjustment of (1-1) + (1-1) + (1-1) = 0, equaling a grade C, five percent permanent impairment of the left elbow. He further determined that the most impairing diagnosis for the left wrist was soft tissue injury, which was a CDX of 1 with a default of C or one percent permanent impairment. The DMA indicated that a GMFH was not applicable as appellant was still symptomatic. He assigned a GMPE of 1 under Table 15-8 on page 408 and a GMCS of 1 under Table 15-9 on page 410. Using the net adjustment formula (GMPE-CDX) + (GMCS-CDX), the DMA calculated that appellant had a net adjustment of (1-1) + (1-1) = 0, equaling a grade C, one percent permanent impairment of the left wrist. Alternatively, he used the ROM methodology rate permanent impairment of appellant's left upper extremity. Regarding impairment to the left wrist, the DMA referred to Table 15-32 on page 473 and found three percent impairment for 71 degrees of flexion, three percent impairment 60 degrees of extension, zero percent impairment for 100 degrees of radial deviation, and two percent impairment for 67 degrees of ulnar deviation. He combined these impairments to equal eight percent permanent impairment of the left wrist. The DMA assigned a grade modifier 1 for ROM under Table 15-35, page 477. Under Table 15-7, page 406, he found a GMFH of 1 due to appellant's *Quick*DASH score of 34. The DMA applied the formula (GMFH = 1) - (grade modifier for ROM = 1), which yielded a modifier adjustment of 0. He determined that the final impairment rating remained the same, eight percent permanent impairment of the left wrist. Regarding impairment to the left elbow, the DMA referred to Table 15-33, page 474 and found zero percent impairment 92 degrees of flexion, zero percent impairment for 100 degrees of wrist extension, one percent impairment for 75 degrees of pronation, and two percent impairment for 57 degrees of supination. He combined these impairments to equal three percent permanent impairment of the left elbow. The DMA assigned a grade modifier 1 for ROM under Table 15-35, page 477. Under Table 15-7, page 406, he found a GMFH of 1 due appellant's *Quick*DASH score of 34. He applied the formula (GMFH = 1) - (grade modifier for ROM =1), which yielded a modifier adjustment of 0. The DMA determined that final the impairment rating remained the same, three percent permanent impairment of the left elbow. Using the Combined Values Chart on page 604, he combined the eight percent ROM impairment rating for the wrist and the five percent DBI impairment for the elbow to calculate 13 percent permanent impairment of the left upper extremity. The DMA explained that the eight percent ROM impairment rating of the left wrist was more advantageous to appellant than the one percent DBI rating. He further explained that the five percent DBI impairment of the left elbow was also more advantageous to appellant than the three percent ROM rating. The DMA advised that appellant reached MMI on July 16, 2019, the date of Dr. Ellis' impairment evaluation.

The DMA noted that Dr. Ellis improperly applied the A.M.A., *Guides* as he erroneously subtracted the impairment of the affected wrist from the impairment of the unaffected wrist. He noted Table, 15-32 on page 473 does not allow such a calculation method. The DMA noted that the percentage of loss of ROM of the joint relative to the unaffected joint must be determined and this would determine the amount of the impairment for the affected motion.

By decision dated February 7, 2020, OWCP granted appellant a schedule award for 13 percent permanent impairment of the left upper extremity. The award ran for 40.56 weeks from July 16, 2019 through April 24, 2020 and was based on the November 27, 2019 impairment rating of the DMA.

LEGAL PRECEDENT

It is the claimant's burden of proof to establish permanent impairment of a scheduled member or function of the body as a result of an employment injury.[3]

The schedule award provisions of FECA[4] and its implementing regulations[5] 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 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 standard for evaluating schedule losses.[6] 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., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[8]

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).[9] Under the sixth edition, the evaluator identifies the CDX, which is then adjusted by grade modifiers of GMFH, GMPE, and GMCS.[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

[3] *See T.H.*, Docket No. 19-1066 (issued January 29, 2020); *D.F.*, Docket No. 18-1337 (issued February 11, 2019); *Tammy L. Meehan*, 53 ECAB 229 (2001).

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id. 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); Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

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

[9] *Supra* note 2 at page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

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

[11] *Id*. at 411.

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).
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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.,] *Guide*s 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.)
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> "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 [claims examiner] CE.
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> "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 DMA method, if possible, given the available evidence."[12]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[13]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than 13 percent permanent impairment of the left upper extremity, for which he previously received a schedule award.

In support of his schedule award claim, appellant submitted a July 16, 2019 report from Dr. Ellis who found six percent permanent impairment of the left upper extremity under the DBI methodology set forth in the sixth edition of the A.M.A., *Guides*. He also used the ROM

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

[13] *See supra* note 7 at Chapter 2.808.6(f) (March 2017); *see D.J.*, Docket No. 19-0352 (issued July 24, 2020).

methodology and found that appellant had eight percent permanent impairment of the left upper extremity.

OWCP properly routed Dr. Ellis' report to its DMA, Dr. Slutsky.[14] In November 27, 2019 report, the DMA opined that appellant had 13 percent permanent impairment of the left upper extremity. He utilized the DBI rating method and found that the most impairing diagnosis for appellant's left elbow was epicondylitis status post surgery, which was a CDX of 1 with a default value of five percent permanent impairment. The DMA assigned grade modifiers and applied the net adjustment formula and found a net adjustment of 1 for a permanent impairment rating of five percent for the left elbow. He further determined that the most impairing diagnosis for the left wrist was soft tissue injury, which was a CDX of 1 with a default of one percent permanent impairment. The DMA assigned grade modifiers and again applied the net adjustment formula and found a net adjustment of zero, equaling a one percent permanent impairment of the left wrist. He also used the ROM methodology to rate appellant's left upper extremity permanent impairment. In calculating impairment for the left wrist, the DMA determined that appellant had eight percent ROM permanent impairment. He found a net adjustment of 0, which resulted in eight percent permanent impairment of the left wrist. In calculating impairment for the left elbow, the DMA determined that appellant had three percent ROM permanent impairment. He found a net adjustment of 0, which resulted in three percent permanent impairment of the left elbow. The DMA determined that the final impairment rating remained the same, three percent permanent impairment of the left elbow. Utilizing the Combined Values Chart on page 604, he combined the eight percent left wrist impairment rating and the five percent left elbow impairment to calculate 13 percent permanent impairment of the left upper extremity. The DMA applied the higher impairment rating of eight percent left lower extremity permanent impairment. He explained that Dr. Ellis' calculation of permanent impairment was improper because Table 15-32 on page 473 of the A.M.A., *Guides* does not permit his subtraction of the impairment of the affected wrist from the impairment of the unaffected wrist.

The Board finds that the DMA's opinion constitutes the weight of the medical evidence with respect to the permanent impairment of appellant's left upper extremity because he properly applied the appropriate standards of the A.M.A., *Guides*.[15] Thus, appellant has not met his burden of proof.

Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

[14] *Id*.

[15] *See O.F.*, Docket No. 19-0986 (issued February 12, 2020); *M.C.*, Docket No. 15-1757 (issued March 17, 2016) (the only medical evidence that demonstrated a proper application of the A.M.A., *Guides* was the report of the DMA).

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish more than 13 percent permanent impairment of the left upper extremity, for which he previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the February 7, 2020 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 16, 2021
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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